NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body will take place on Tuesday 12th December 2017 commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

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		22	Any Other Business		
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			Date and time of next meeting ~ Date Not Specified ~ Wolverhampton Clinical Commissioning Group Governing Body		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 14 November 2017
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~

Dr S Reehana	Chair

Clinical ~

Dr M Asghar	Board Member
Dr D Bush	Board Member
Dr R Gulati	Board Member
Dr M Kainth	Board Member
Dr J Parkes	Board Member
Dr R Rajcholan	Board Member

Management ~

Mr T Gallagher	Chief Finance Officer – Walsall/Wolverhampton
Dr H Hibbs	Chief Officer

Lay Members/Consultant

Mr A Chandock	Consultant
Ms S McKie	Lay Member
Mr J Oatridge	Deputy Chair
Mr P Price	Lay Member
Ms H Ryan	Lay Member
Mr L Trigg	Lay Member

In Attendance

Ms R Bajar	Observer – Price Waterhouse Cooper
Ms H Cook	Engagement, Communications and Marketing Manager (part)
Ms T Cresswell	Health Watch representative
Mr S Forsyth	Head of Quality and Safety
Ms K Garbutt	Administrative Officer
Mr M Hartland	Chief Finance Officer – Dudley CCG (Strategic Financial Adviser)
Mr P McKenzie	Corporate Operations Manager
Mr V Middlemiss	Head of Contracts and Procurement (part)
Ms S Southall	Head of Primary Care (part)

Apologies for absence

Apologies were received from Mr M Hastings, Mr D Watts, Mr S Marshall and Mr J Denley.

Declarations of Interest

WCCG.1965 Dr J Parkes declared he is an employee of The Royal Wolverhampton Trust (RWT). Ms S McKie declared she is currently an employee of the Wolverhampton Local Authority

RESOLVED: That the above is noted.

Minutes

WCCG.1966 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 10 October 2017 be approved as a correct record.

Matters arising from the Minutes

WCCG.1967 There were no matters arising.

RESOLVED: That the above is noted

Committee Action Points

WCCG.1968 **Minutes WCCG.1946 Communication and Engagement**

Dr H Hibbs confirmed leaflets relating to the Minor Eye Conditions Service have been ordered and will be distributed to GP practices. This action can now be closed.

Ms T Cresswell stated that a discussion has taken place regarding the service and this action can now be closed.

RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Chief Officer Report

WCCG.1969 Dr Hibbs presented the report. She highlighted section 2.2.3 Longitudinal Patient Record. The Graphnet Care Portal has been successfully installed. This is a major step towards a shared care record between

primary, secondary, social care and mental health in line with the Clinical Commissioning Groups (CCGs) IT Strategy.

With regard to the work on joint commissioning across the Black Country She added that at the current time each area is developing its placed based arrangements alongside work to commission some services on a Black Country footprint. Given the importance of local public accountability and partnerships with our local authorities, the Committee can see no basis for bringing together the four CCGs into a single CCG arrangement for the foreseeable future.

Ms Cresswell referred to work around sharing care records and how this will be communicated with patients once finalised. Dr Hibbs stated that this is about patient care and for patient records to be shared between clinicians to improve care pathways. She confirmed that they will work with Health Watch. Mr P Price asked what the controls are regarding data protection. Dr Hibbs confirmed a lot of work has been carried out around data sharing agreements and it was agreed for this to be raised at the next Audit and Governance Committee.

RESOLVED: That Mr Price will raise data sharing relating to care records being shared at the next Audit and Governance Committee.

Board Assurance Framework

WCCG.1970 Mr P McKenzie presented the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register for the Governing Body's consideration. In future the framework will be considered by the Audit and Governance Committee and it will then be presented to the Governing Body.

The report includes the latest updated version of the GBAF and Strategic level risks. Updates impacting on the risk profile for each objective in the GBAF are included that have led to the development of the overall scoring. Further detail on the development of overall risk management arrangements will be reported in the Private Governing Body meeting.

Mr Mckenzie referred to the framework adding good progress has taken place. He suggested having a summary report regularly in order to monitor the risks. Dr S Reehana agreed this would be helpful adding that risk management is a corporate responsibility for all of us.

RESOLVED: That a summary report is provided regularly to the Governing Body.

Committee Appointments

WCCG.1971 Mr McKenzie presented the report to ask the Governing Body to agree to the appointment of Clinical Members of the Governing Body Committees. He pointed out that following discussions with the Governing Body Members, the following members are to be appointed as follows ~

Commissioning	Dr Kainth (Lead), Dr Gulati (Deputy)
Finance and Performance	Dr Bush (Lead), Dr Asghar (Deputy)
Quality and Safety	Dr Rajcholan (Lead), Dr Parkes (Deputy)

In addition to these committees, there are roles on the Remuneration Committee and non-voting positions on the Primary Care Commissioning Committee which are allocated on a rotational basis. It is suggested that these roles be filled as required on delegated authority by the Chair.

RESOLVED: That the Governing Body agreed to the appointment of Clinical Committee Members as outlined in the report.

Lay Member for Patient and Public Involvement

WCCG.1972 Mr McKenzie stated that following a recruitment process, Sue McKie has been appointed as the Lay Member for Patient and Public Involvement. He added that she will also formally act as Deputy Chair of the Governing Body.

RESOLVED: That the above is noted.

Modern Slavery Statement

WCCG.1973 Mr S Forsyth gave a brief overview of the report. The Modern Slavery Act 2015 requires a slavery and human trafficking statement to be approved by Quality and Safety Committee and signed at Governing Body level. This ensures senior level accountability, leadership and responsibility for modern slavery and gives it the serious attention it deserves.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.1974 Dr R Rajcholan presented the report. She gave an overview of the key areas of concern pointing out maternity. The number of women booking to give birth at the Royal Wolverhampton Trust has increased significantly month by month in the last 12 months. Ms McKie asked for clarity regarding the capped maternity activity the provider has put in place. Mr

Forsyth confirmed this only applies to patients booking from areas outside Wolverhampton. Dr Reehana requested that this is reviewed regularly.

Dr Hibbs gave clarity regarding patients attending the Urgent Care Centre. Patients. All walk in patients including adults and children, are triaged within 15 minutes of attending. Patients who have booked appointments through 111 have had an initial telephone triage so are not routinely triaged again. It has been agreed that children under one will however be triaged again as they can become unwell very quickly She confirmed that the service is being closely monitored to ensure this runs effectively.

Ms S Southall arrived

Dr D Bush referred the Never Events on page 12 of the report. Dr Rajcholan pointed out the recent Never Event which occurred which related to a child who had the wrong tooth extracted. A number of exercises have taken place at the Trust together with unannounced visits from the Quality Team. This has been discussed at great length at the Quality and Safety Committee. Mr Forsyth added RWT have taken immediate action and the CCG are continuing to do everything they can to ensure Never Events do not occur. Mr Price referred to RWT safeguarding level 3 training. There has been significant improvement for compliance with level 3 training children and adults but the provider has continuously failed to achieve the 95% compliance. Mr Forsyth confirmed the mandatory compliance rate is lower than 95% and that RWT are continuing to achieve against their safeguarding targets.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.1975 Mr T Gallagher presented the report. He stated that the financial position has been scrutinised in month 6 and following a review of assumptions the recurrent overspend has decreased to an estimated £900k forecast outturn which is currently offset by non-recurrent underspends and the use of reserves. Sepsis is carrying a higher tariff in this year and as this is an in year costing and coding change CCGs will be submitting a joint letter which will be challenging the in year changes

Dr Asghar arrived

Mr Gallagher reported that additional Quality, Innovation, Productivity and Prevention (QIPP) has been identified over and above month 5 and the CCG is reporting achieving the QIPP target. He highlighted the table on page 22 of the report which details the current risk assessment for the CCG a risk of £2m with mitigations of £2m. There has been a reduction of

£200k in overall risk following a re-assessment of the Better Care Fund (BCF) overspend risk. He gave assurance that we are looking at best practice and liaising with other CCGs to ensure we have a QIPP programme that covers all areas.

Mr Middlemiss arrived

With regards to performance the number of Clostridium Difficile (C.Diff) has failed to achieve the in- month threshold of 3 with 4 cases report for August at the Trust. We need to ensure we meet the target. RWT have failed to achieve the 90% target in respect of the 62 day referral for cancer screening. Dr Hibbs reported that the CCG are working with RWT, regular telephone calls are taking place. Dr Reehana reinforced the importance that this is monitored closely.

Mr M Hartland pointed out that contracts for next year are required to be agreed within the next 6 weeks.

RESOLVED: That the above is noted

Commissioning Committee

WCCG.1976 Mr V Middlemiss presented the report on behalf of Mr Marshall. He highlighted the Urgent Care Centre. Totally Plc announced their intention to buy Vocare and the acquisition has now taken place. Dr J Parkes asked if this affects the CCG. The change of ownership is not expected to impact on the contractual and commissioning arrangements the CCG has in place.

Mr Middlemiss pointed out Probert Court Nursing Home. The suspension to the service has been lifted from 4 October 2017. This follows an intense period of scrutiny which has included weekly inspections and agreement that the provider Accord has demonstrated satisfactory improvement to warrant a return to normal operational service.

RESOLVED: That the above is noted.

Mr Middlemiss left

Remuneration Committee

WCCG.1977 Mr Price gave a brief overview of the report.

RESOLVED: That the above is noted.

Primary Care Programme Milestone Review

WCCG.1978 Ms Southall presented the report on behalf of Mr Marshall. She highlighted the keys points stated the Committee has reviewed the frequency of meetings with the intention of reducing to quarterly meetings from October 2017 onwards and propose a name change from Committee to Milestone Review Board.

Ms H Cook arrived

Ms Southall highlighted the Workforce Development. Together Everyone Achieves More in Wolverhampton (Team W) – protected learning time for GPs. A reduction in the number of attendees has been evident over recent months. Discussions have taken place with the Local Medical Committee and Group Leads. A series of changes have been made to the timing and format of future sessions, this will continue to be overseen at monthly Group Leads Meetings. She reported that the Sound Doctor is now fully implemented and is available to be utilised by practices. The utilisation of this will be tracked on a month by month basis and this will be shown in future reports.

Dr M Asghar asked about the new home visiting pilot. Ms Southall reported there are a number of practices involved in the pilot in the first instance which is planned through expansion of the Rapid Response Team. There will be an evaluation at the end of the pilot. Dr M Kainth pointed out the importance of including all practices on board as this needs to reflect all of Wolverhampton. Dr Hibbs stated once the pilot has taken place the evaluation will be looked at.

Ms Southall left

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.1979 Ms Cook presented the report highlighting the key points. The Minor Eye Conditions Service (MECS) campaign has a web and social media presence following its launch in September. Work has begun with young people from across the city to develop a multi-media piece to complete the campaign.

The winter campaign has continued to focus on flu jabs. All public who are identified as being at an “at risk” group are invited to take up their flu jab at their GP surgery or with their local pharmacy. She pointed out that the Health Directory is now available on Wolverhampton Information

Network (WIN). The health directory is the latest addition which already has comprehensive sections offering information and advice and details of support available to adults, carers, families and children and young people with special educations needs and disabilities.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.1980 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.1981 RESOLVED: That the minutes are noted..

Minutes of the Primary Care Strategy Committee

WCCG.1982 RESOLVED: That the minutes are noted.

Minutes of the Commissioning Committee

WCCG.1983 RESOLVED: That the minutes are noted.

Minutes of the Health and Wellbeing Board

WCCG.1984 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.1985 RESOLVED: That the above is noted.

Members of the Public/Press to address any questions to the Governing Board

WCCG.1986 RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.1987 The Board noted that the next meeting was due to be held on **Tuesday 12 December 2017** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.25 pm

Chair……..

Date ……

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Wolverhampton Clinical Commissioning Group Governing Body

12 December 2017

Date of meeting	Minute Number	Action	By When	By Whom	Status
14.11.17	WCCG.1969	Chief Officer Report ~ data sharing relating to care records being shared to be raised at the next Audit and Governance Committee	February 2018	Peter Price	
14.11.17	WCCG.1970	Board Assurance Framework ~ a summary is provided in order to monitor risks on a regular basis		Peter McKenzie	

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
12 DECEMBER 2017

Agenda item 7

TITLE OF REPORT:	Chief Officer Report
AUTHOR(s) OF REPORT:	Dr Helen Hibbs – Chief Officer
MANAGEMENT LEAD:	Dr Helen Hibbs – Chief Officer
PURPOSE OF REPORT:	To update the Governing Body on matters relating to the overall running of Wolverhampton Clinical Commissioning Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Strategic work around accountable systems continues. • Primary Care groupings continue to develop. • Our Better Care Fund 2017 -2019 has been approved.
RECOMMENDATION:	That the Governing Body note the content of the report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties. By its nature, this briefing includes matters relating to all domains contained within the BAF.
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body Members on matters relating to all the overall running of Wolverhampton Clinical Commissioning Group (CCG).

2. CHIEF OFFICER REPORT

2.1 Accountable Care Systems (Helen)

2.1.1 Work continues in Wolverhampton to develop a local place based health and care system which will relate to the overarching system developing at STP level. NHS England policy is for accountable systems to be developed on a population basis of at least 500k population but with local place based solutions within that.

2.2 Emergency Planning, Resilience and Response (EPRR)

2.2.1 We have presented our annual assessment of EPRR to NHS England and we have been rated as Substantially Compliant by them. We continue to ensure we are prepared and have a training programme in place for all staff members. We are also pleased to confirm that Les Trigg has been named as the Lay Member of the Governing Body charged with ensuring that the Operations directorate is managing our EPRR readiness appropriately.

2.3 **Sustainability and Transformation Plan (STP) / Joint Commissioning** (Helen)

2.3.1 Work continues on the Black Country STP footprint with Wolverhampton taking a lead on mental health services which is a key area for delivery for the STP.

2.4 Primary Care

2.4.1 All member practices have aligned to a practice group, there are 5 groups each comprising of in the region of 55-60,000 patients. Practices are working towards the key principles of the Primary Care Home model whilst one of the groups of practices have aligned with the local trust having entered into a sub-contracting agreement.

2.4.2 Publicity is planned for the month of December to promote the availability of a range of general practice hubs who are providing appointments for patients on Saturday(s) and many will also be open over the Christmas and New Year period. Local advertising via newspapers in addition to a range of posters and associated information displayed in practices will promote availability of appointments. A range of projects continue to be rolled out across primary care, further detail can be found in the report of the Primary Care Milestone Review Board.

2.4.3 The CCG Members Meeting took place on 15 November 2017, in the region of 25 GPs attended and were involved in group discussions about the development of a local QOF (Quality and Outcomes Framework) Scheme (QOF+). Discussions focussed on long term conditions, particularly prevention, early identification and management of such illness(es).

Development work continues with GP engagement and the scheme will be implemented April 2018.

2.4.4 Discussions with GP representatives from each of our practice groups and Local Medical Committee commenced earlier in November. Meetings have been structured around 4 core areas, involvement and co-design with our member practice involvement is crucial to the success of the work we are undertaking. Over the coming weeks those discussions will be extended to include a range of stakeholders from across the City including the Royal Wolverhampton NHS Trust, Black Country Partnership NHS Foundation Trust (BCPFT), Healthwatch and Wolverhampton City Council. The aspiration is to have in place a local alliance agreement that will run in shadow form from April 2018

2.5 **Better Care Fund (BCF)**

2.5.1 The BCF plan for 2017-19 was completed and submitted in line with national deadlines. The plan has subsequently been fully approved. We are now working on the Section 75 and Risk Share Agreement which has to be agreed by 30 November 2017. Within the plan is a significantly challenging Delayed Transfer of Care target that as a health and social care economy we are working hard to achieve, supported by the implementation of the High Impact Change model for managing transfers of care. A number of actions are being taken such as the Local Authority commissioning of additional reablement and rapid assessment, housing colleagues working two days per week within the Integrated Discharge team and additional Healthcare Assistants being employed to support the Rapid Intervention Team in admission avoidance.

2.5.2 The Health Channel on the Wolverhampton Information Network (WIN) has now been developed and launched with communication materials being distributed to key stakeholders i.e. GP Practices, Social Prescribing team and A&E.

2.5.3 Wolverhampton Voluntary Sector Council have submitted a bid to the Department of Health for funding to enhance the existing Social Prescribing model. If successful it will see the addition of two further link workers and dedicated support from the Citizens Advice Bureau to the scheme.

2.5.4 Fibonacci is a system which allows professionals to view health and social care data for individuals. The system is used primarily within the community Multidisciplinary Team meetings and work is now underway with the company and BCPFT to enable mental health data to be included. Plans will then look at how the system can incorporate Primary care data and how it could be used in other settings such as A&E and the new Ambulatory/frailty hub at RWT.

2.6 **Winter Planning**

2.6.1 Urgent Care providers across the health economy have approved plans in place to address the increased pressure services face during the Winter period. These plans are targeted at alleviating the additional strain on services as a result of weather related slips/trips/falls, Norovirus, general increased demand and seasonal flu. Additional funding has been invested in key areas such as flu vaccination for both staff and patients in high risk groups and capacity has been increased across GP practices with additional appointments both in and out of hours. Increased public communications will take place through to Easter 2018,

focusing on the Stay Well Campaign. Services across the health economy are working together to maintain the flow of patients from ambulance conveyance through to waits in A&E and, where required, emergency admissions without excessive delays. There is increased focus on reducing delays where patients are discharged both to the patients' own place of residence and to temporary care in community services. Both commissioners and providers are closely monitoring of the whole system to ensure the increased seasonal pressure does not adversely impact on patient care.

3. CLINICAL View

3.1 Not applicable to this report.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable to this report.

5. KEY RISKS AND MITIGATIONS

5.1. Not applicable to this report.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Not applicable to this report.

Quality and Safety Implications

6.2. Not applicable to this report.

Equality Implications

6.3. Not applicable to this report.

Legal and Policy Implications

6.4. Not applicable to this report.

Other Implications

6.5. Not applicable to this report.

Name **Dr Helen Hibbs**
Job Title **Chief Officer**
Date: **29 November 2017**

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Dr Helen Hibbs**	**29/11/17**

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12th December 2017

Agenda item 8

TITLE OF REPORT:	**Commissioning Committee – Reporting Period November 2017**
AUTHOR(s) OF REPORT:	Dr Manjit Kainth
MANAGEMENT LEAD:	Mr Steven Marshall
PURPOSE OF REPORT:	To provide the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) with an update from the Commissioning Committee in November 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	This report is submitted to meet the Committee's constitutional requirement to provide a written summary of the matters considered at each meeting and to escalate any significant issues that need to be brought to the attention of the Governing Body.
RECOMMENDATION:	That the report is noted.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	[Outline how the report is relevant to the Strategic Aims and objectives in the Board Assurance Framework – See Notes for Further information]
1. Improving the quality and safety of the services we commission	
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

1.1. The purpose of the report is to provide an update from Commissioning Committee to the Governing Body of Wolverhampton Clinical Commissioning Group (CCG) for the period of November 2017.

2. MAIN BODY OF REPORT

2.1. Contracting Update

Royal Wolverhampton NHS Trust

Sepsis Counting and Coding Change - The Committee was advised last month that a national counting and coding change has been implemented regarding sepsis.

A lengthy discussion took place about this issue at the October CRM, during which different views were expressed about cost neutrality. The Trust's view is if they lose income then that is not cost neutral. The CCG view is that it should operate like any other counting and coding, whereby a shadow year applies and that any financial increase resulting from the change will need to be reimbursed.

An analysis of the impact has now been completed by the CSU and this will be shared with the Trust as part of a formal challenge.

Cancer Activity Transfer: The Trust has confirmed there is going to be a 70/30 split of the Oncology and Gynaecology Oncology work from City/ Sandwell Hospital. The City work (70%) will go to University Hospital of Birmingham (UHB) and Birmingham Women's Hospital (BWH) with the Sandwell work (30%) coming to the Royal Wolverhampton Hospital. The existing Service Level Agreement (SLA) will cease from 22nd October 2017.

The Trust is anticipating that this will adversely impact on the Cancer 62 day standard. However, the full impact on performance cannot be predicted at present as potential numbers to RWT from Sandwell, via patient choice, is currently not clear.

Overall there is a risk that constitutional standards could and will be affected by this additional activity and therefore it has been recorded as a risk at Trust Board by the CCG Director of Operations.

Black Country Partnership Foundation Trust (BCPFT)

Data Quality Improvement Plan (DQIP): The DQIP has been agreed and a contract variation sent to the Trust. Meetings are being held monthly to work through the actions jointly, with the ultimate aim of improving data quality.

A number of CAMHS indicators that are being monitored by NHSE are not on the monthly performance report or in the DQIP. Work needs to be done with commissioners and provider to agree these indicators and capture the data.
CAMHS (LAC) a report provided in November for 2017-18 suggested that LAC waiting times reached up to 80 weeks in October 2016 and the average waiting time was 41 weeks. However, Sarah Smith informed the Committee that waiting times have improved and this information is not accurate. Vic Middlemiss responded that the data inaccuracy is being addressed and clarity will be provided in the report submitted to the Committee in January 2018.

Learning Disability (LD) Psychiatrists – Letter of Concern: The CCG had raised an issue with the Trust back in July, expressing concern that community based psychiatrists were being used as receiving consultants for patients in Assessment and Treatment beds.

The CCG has since received confirmation that this practice has changed and that the LD consultants, whilst having some presence in the inpatient unit, are no longer being used as receiving consultants.

Nuffield

At the Contract Review Meeting in October, the CCG proposed re-basing the Nuffield plan so that it is set at a more realistic level for the rest of this year and next year. Following discussion it was agreed that the CCG will complete a proposal using months' 1-5 data.

Primary Care Contract Issues

MGS Practice: Contract Breach Notice – It was confirmed that the Practice remains closed.

Action – The Committee request that Governing Body note the above.

2.2 **Community Falls Service Specification**

The Committee was presented with the draft Community Falls Prevention Service Specification, based on a tiered model of care, with a focus on prevention, proactive multi-factorial assessment and case management.

The Committee approved the Service Specification and it was agreed that if the service is not re-developed by 1st April 2018, a re-procurement exercise would take place.

Action – The Committee request that Governing Body note the above.

2.3 **CAMHS Transformation Refresh 2017-2020**

The Committee approved the CAMHS Transformation Refresh 2017-2020.

Action – The Committee request that Governing Body note the above.

3. RECOMMENDATIONS

- Receive and discuss the report.
- Note the action being taken.

Name: **Dr Manjit Kainth**
Job Title: **Lead for Commissioning & Contracting**
Date: **28th November 2017**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
Tuesday 12th December 2017

Agenda item 9

TITLE OF REPORT:	**Executive Summary from the Quality and Safety Committee**
AUTHOR(s) OF REPORT:	Molly Henriques-Dillon Quality Nurse Team Leader
MANAGEMENT LEAD:	Steve Forsyth Deputy Director of Nursing
PURPOSE OF REPORT:	To share with the Governing Body a reflective report regarding the undertaking of the clinical quality monitoring framework .The report includes, performance against key clinical indicators (reported by exception).
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	Public.
RECOMMENDATION:	Provides assurance on quality and safety of care, and any exception reports that the Governing Body should be sighted on.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	Domains 1, 2, 3 and 4.

1. **Key areas of concern are highlighted for the Quality & Safety Committee below:**

	Level 2 RAPS breached escalation to executives and/or contracting/Risk Summit/NHSE escalation
	Level 2 RAPs in place
	Level 1 close monitoring
	Level 1 business as usual

Key issue	Comments	RAG	Page number in report
Urgent Care Provider	Vocare CQC Rating is INADEQUATE for the visit took place in March 2017 and a further CQC announced visit took place on 26th October 2017. NHSE Quality and Surveillance Group have agreed to stand down the NHSE Quality Surveillance Vocare meetings, with ongoing scrutiny/monitoring by NHSE taking place at the routine Quality Surveillance Group each month		21
Maternity Performance Issues	There were 2 SI's reported for the maternity services for Nov, 2017 and in total 8 SI's has been reported for maternity services since June 2017. The key performance indicators on maternity dashboard are a growing concern which is impacting on quality and safety. Escalated to NHSI, NHSE, LSE and Maternity STP. The provider has also capped the maternity activity for the trust from 13th November 2017.		*13*
Non-Emergency patient transport service issues	Mainly there are performance issues with this provider with a potential for its impact on quality issues. The provider has failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality report etc and the current performance has not been at the levels expected and has recently impacted adversely upon the quality element of the service.		*21-22*
Mortality	Raised SHMI/HSMR. Action plan in place, Trust has commissioned independent coding, diagnostic, palliative and case note reviews. Internal practices strengthened. Update from extraordinary MORAG meeting (Sep 2017)		15-16

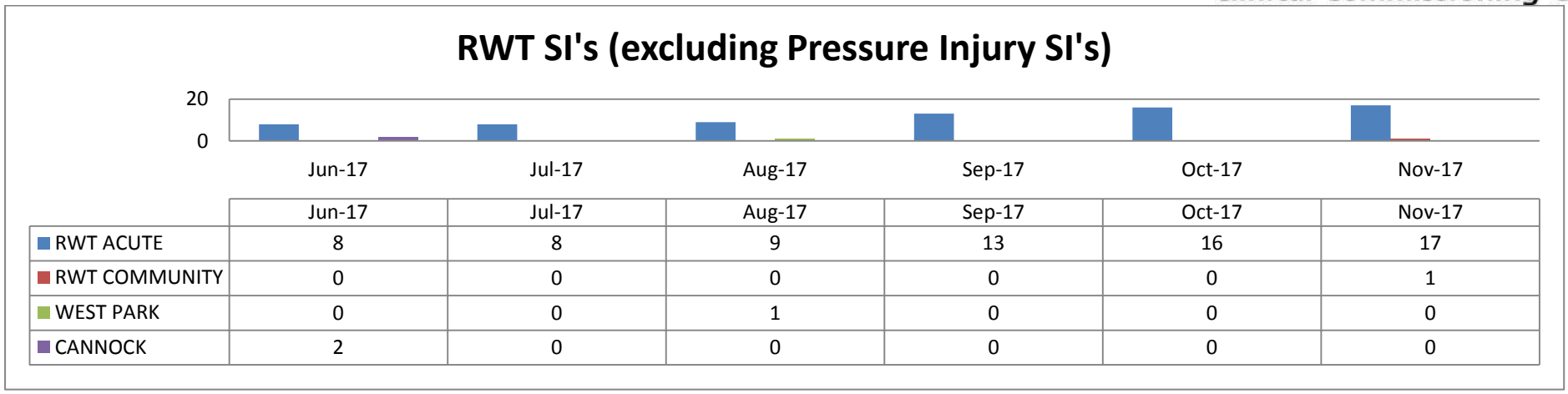
	• Early indication from reviews suggests coding for palliative care and people dying in hospital		
Increased number of NEs 16/17	16/17 total 5. 17/18 ytd total is 6.		13
Safety, experience and effectiveness	Continuous scrutiny on PIs, SIs, Falls, FFTs, Surveys, NICE, IPC etc. Improvements seen in avoidable pressure injuries, CDiff and falls. There is rise in the number of health care acquired infection and diagnostic delay incidents reported for Nov 2017.		12
Improving primary care services	Continuous monitoring of Infection Prevention ratings, Friends and Family Test, Quality Matters, Complaints, Serious Incidents , NICE, and Workforce.		QSC Agenda Item

ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

The Committee is asked to note the following:

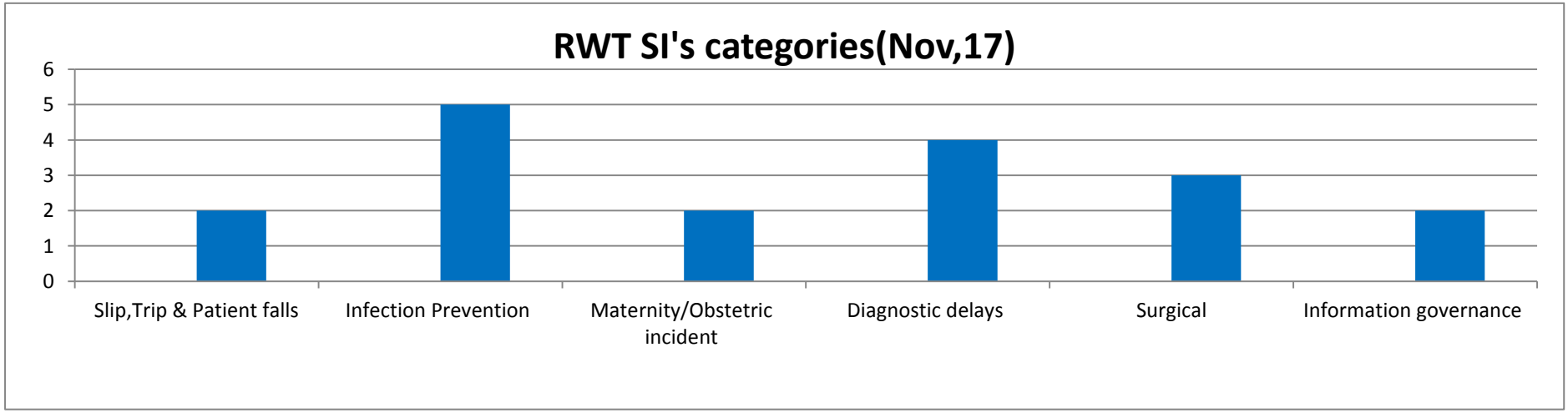
2a Serious Incidents (excluding pressure injury incidents)

Fig.1



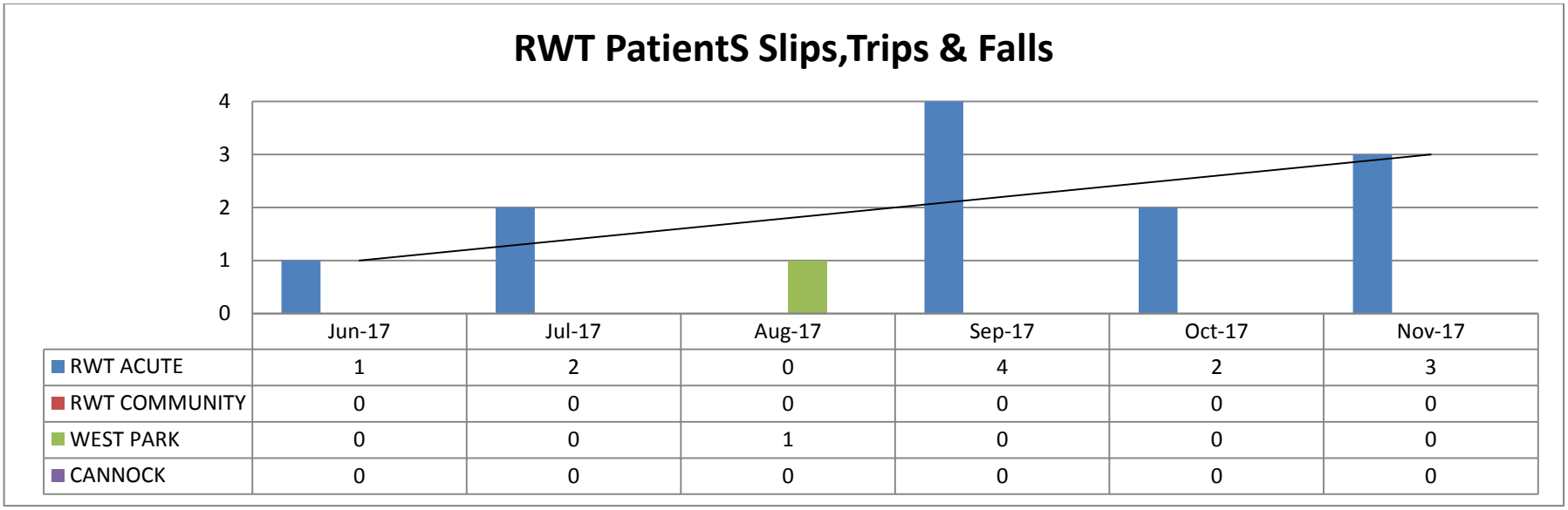
	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
RWT ACUTE	8	8	9	13	16	17
RWT COMMUNITY	0	0	0	0	0	1
WEST PARK	0	0	1	0	0	0
CANNOCK	2	0	0	0	0	0

Fig.2



Slip Trip and Patient Falls SI's (RWT)

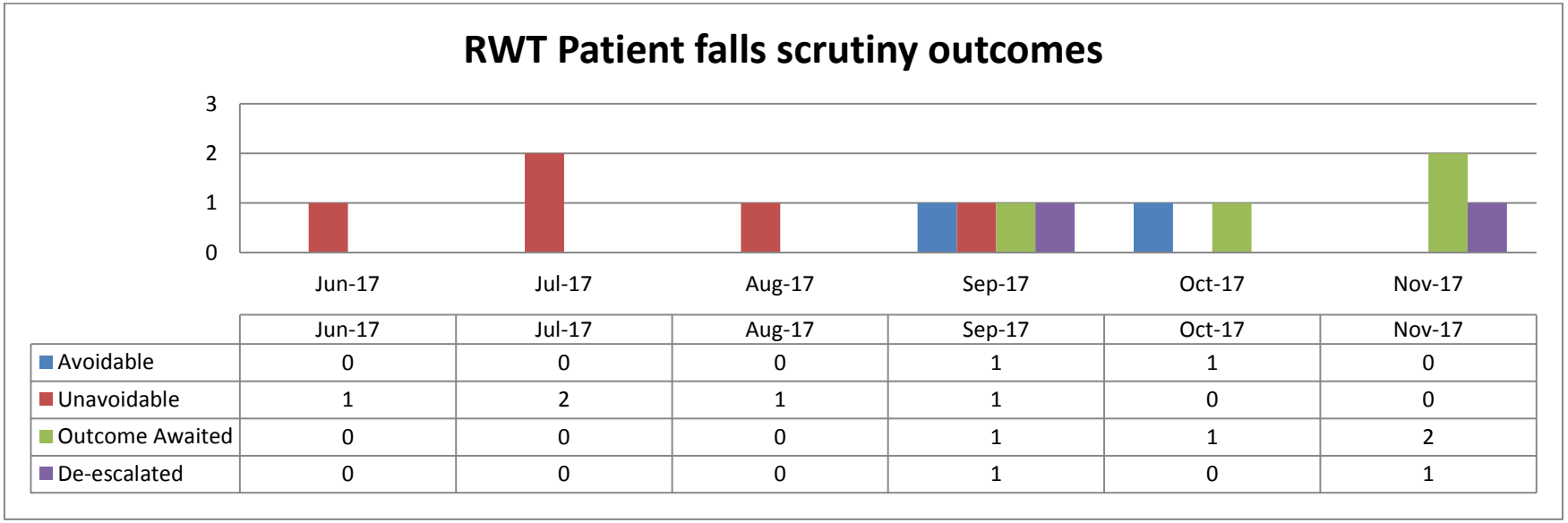
Fig.3



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
RWT ACUTE	1	2	0	4	2	3
RWT COMMUNITY	0	0	0	0	0	0
WEST PARK	0	0	1	0	0	0
CANNOCK	0	0	0	0	0	0

Although 3 falls SI's were reported, one was de-escalated post initial investigation identify that patient harm was not caused by fall but due to their underlying medical condition. All patient falls SI's are discussed at the provider weekly scrutiny meeting and this meeting is regularly attended by the WCCG quality and safety manager.

Fig.4



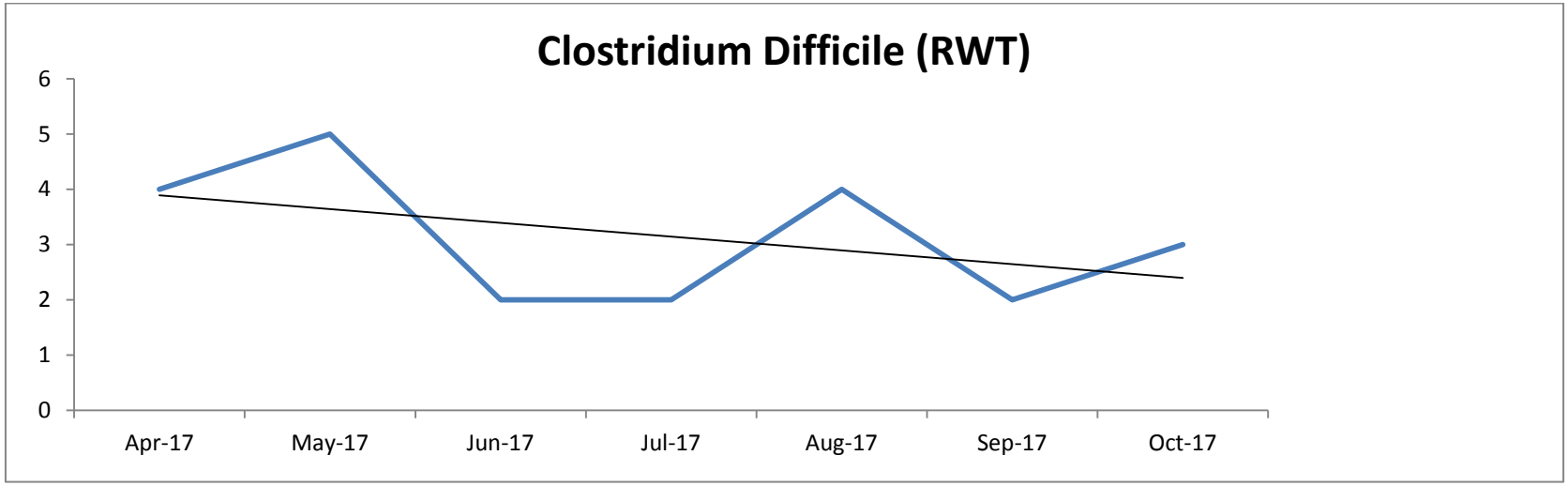
	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Avoidable	0	0	0	1	1	0
Unavoidable	1	2	1	1	0	0
Outcome Awaited	0	0	0	1	1	2
De-escalated	0	0	0	1	0	1

Fig.4 shows that there is a reduction in the number of avoidable patient falls for Q2.

Infection Prevention

Clostridium difficile

Fig.5



There were 3 CDiff cases reported for October 2017 which is an increase compared to 2 CDiff reported in Sep 17. The Provider is currently one case above their external target at the end of month 7.

Trust actions: Sustainability actions continue from last year. Antimicrobial prescribing audits are being completed in most areas.

CPE (Carbapenemase Producing Enterobacteriaceae)

Fig.6

Breakdown of CPE	Total
2012/2013	2
2013/2014	8
2014/2015	8
2015/2016	12
2016/2017	18
2017/2018 to date October	21

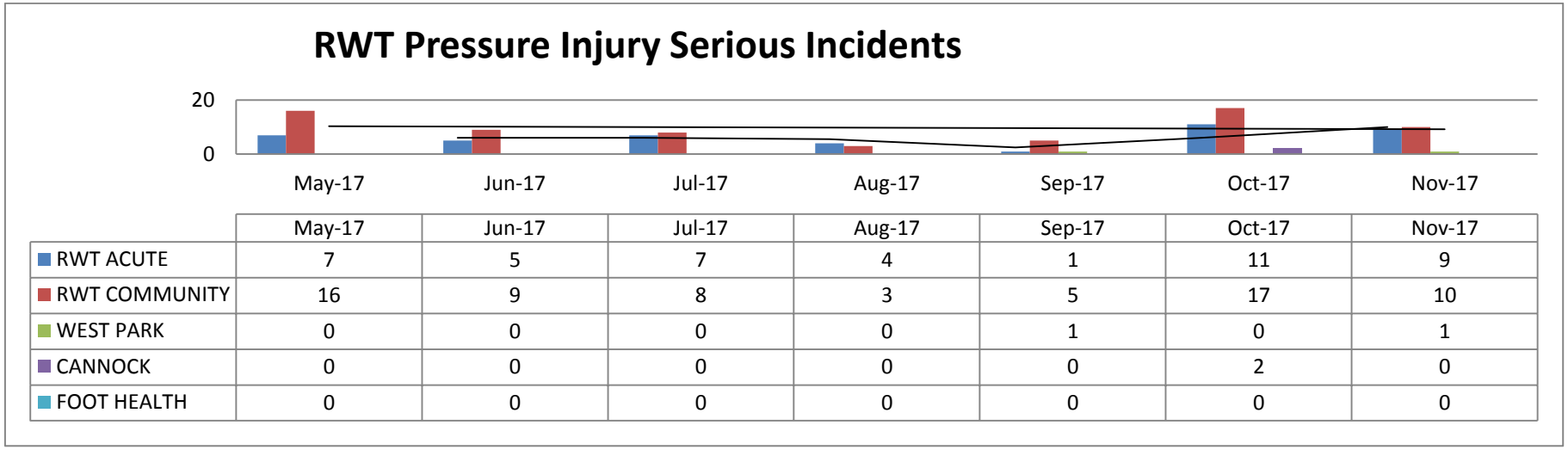
There were no new cases confirmed during October 2017.

Trust CPE plan:
Admission screening processes continue. The business case for the laboratory to cope with demand for sampling is in development. Focus on regional intra-hospital transfers as highest risk. CPE Virtual Strategy Group meeting took place in November to discuss recent incident and to re-evaluate the screening process and high risk patients. Further updates of this meeting will be provided at the next meeting.

MRSA bacteraemia

No new MRSA Bacteraemia cases since the one case reported in October 2017. RCA investigation underway.

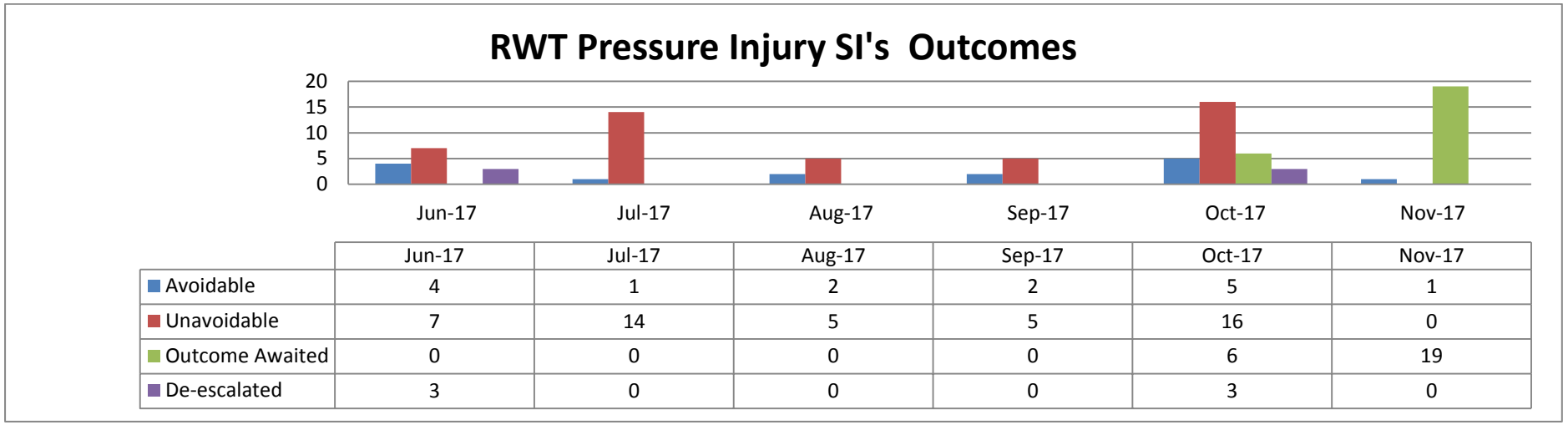
Fig.7



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
RWT ACUTE	7	5	7	4	1	11	9
RWT COMMUNITY	16	9	8	3	5	17	10
WEST PARK	0	0	0	0	1	0	1
CANNOCK	0	0	0	0	0	2	0
FOOT HEALTH	0	0	0	0	0	0	0

20 pressure injury incidents were reported for this reporting period which is a 33.3% reduction compared to 30 pressure injury for Oct 17. 2 of these pressure injury incidents has been reported at stage 4 PI's and 18 pressure injuries SI's reported for stage 3 PI's. The Q&S manager attends the weekly pressure injury scrutiny meetings to seek assurances of current pressure injury prevention and management practices and to seek assurance that all pressure injury SI's are investigated appropriately and the learning from SI's is shared within the wider team.

Fig.8



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Avoidable	4	1	2	2	5	1
Unavoidable	7	14	5	5	16	0
Outcome Awaited	0	0	0	0	6	19
De-escalated	3	0	0	0	3	0

There has been reduction in the number of avoidable pressure injury SI's at the trust but the increase prevalence of pressure injury SI's is still an issue and WCCG has liaised with TVN lead to seek assurance around this issue. The Trust is involved in the first phase of the NHS improvements pressure ulcer collaborative and an audit and quality improvement plan has been submitted. The Trust new accountability process, which includes stage 2 pressure injuries is in place with an escalation to the Chief Nurse, for services that have 2 or more avoidable incidents within a 3 month period or if there is a cause for concern.

RWT Never Events

Fig.9

Dec,16	**1**	Retained foreign object post-procedure
Mar,17	**1**	Wrong implant/prosthesis
Apr,17	**1**	Retained foreign object post-procedure
July,17	**1**	Wrong site surgery
Aug,17	**1**	Wrong site surgery
Oct,17	**1**	Retained foreign object post-procedure
Nov,17	**2**	Wrong site surgery

The Provider has reported two new never events and the total counts now stands at 6 ytd. The WCCG quality and safety lead has asked the Provider for a themed report into these never events to identify learning and to mitigate reoccurrence.

Maternity

a) The number of women booking to give birth at RWT has increased significantly month by month in the last 12 months. The forecast for 17/18 is 5300 births in total at RWT.
b) The midwife to birth ratio has slightly improved from 1:32 in September 2017 to 1.31 in October 2017
c) Midwifery sickness rate has also slightly improved from 5.1% in August 2017 to 5% October 2017
d) Midwifery vacancy rate significantly improved from 4.5% in August 0.7% October.

Mortality

RWTs most recent HSMR and SHMI data is indicating deterioration in their position and the Trust has commenced the following actions;

- External clinical review
- External review of some clinical pathways

- External coding review
- External data review
- Internal work on data variation, review of processes, improvement of documentation and coding – in various stages of completion

CQC has recently sent a mortality outlier alert for increase in standardised mortality rate for pneumonia at The Royal Wolverhampton NHS Trust and trust has responded to CQC as they believe that this outlier position is data driven and the changes are most notable from around the time they implemented a new admission model towards the end of quarter 3 of 2015-16. This is also supported by the fact that our crude mortality rates have remained the same over the last 3 years for all activity and have seen only very little variation for the ordinary admissions.

Items to Note from CQR Meeting – October 2017

Cancer Waiting Times/Cancer Target Compliance

	Target	Q2 2017/18				Q3 2017/18			
		Jul-17	Aug-17	Sep-17		Oct-17	Nov-17	Dec-17	Oct-17
2 Week Wait Cancer	93%	93.18%	93.71%	93.51%		94.79%			Excluding Tertiary Referrals
2WW Breast Symptomatic	93%	97.52%	94.21%	95.07%		97.47%			
31 Day to First Treatment	96%	98.19%	98.64%	97.26%		97.05%			
31 Day Sub Treatment - Anti Cancer Drug	98%	100.00%	100.00%	100.00%		100.00%			
31 Day Sub Treatment - Surgery	94%	95.00%	94.87%	90.91%		89.47%			
31 Day Sub Treatment - Radiotherapy	94%	99.09%	97.06%	98.92%		97.50%			
62 Day Wait for First Treatment	85%	77.71%	78.03%	72.26%		76.17%			76.85%
62 Day Wait - Screening	90%	87.50%	86.49%	84.62%		100.00%			100.00%
62 Day Wait - Consultant Upgrade (local target)	88%	91.57%	88.69%	90.81%		93.10%			94.20%

Site	Total Patients	Breaches	%
Breast	12	2	83.33%
Colorectal	11	6	45.45%
Gynaecology	13.5	1.5	88.89%
Haematology	6	2	66.67%
Head & Neck	6.5	1.5	76.92%
Lung	7.5	4	46.67%
Other	2	1	50.00%
Skin	24	2	91.67%
Upper GI	9.5	3.5	63.16%
Urology	25.5	4.5	82.35%
Total	**117.5**	**28**	**76.17%**

Comments:

31 Day Sub Surgery - 4 patient breaches in month - all capacity issues.

62 Day Traditional - 31 patient breaches in month - 6 x Tertiary referrals received between days 56 and 87 of the patients pathway (operating guidelines state referrals should be made within 42 days), 7 x Capacity Issues, 10 x Patient Initiated and 8 x Complex Pathways. Of the tertiary referrals received 0 (0%) were received before day 42 of the pathway, and 4 (67%) were received after day 62 of the patient pathway.

Patients over 104 days - There are currently 15 patients at 104+ days on the cancer waiting list (compared with 13 reported in September), all of these patients have had a harm review and no harm has been identified.

Total Time Spent in Emergency Department (4 hours)

		Q2 2017/18				Q3 2017/18		
	Target	Jul-17	Aug-17	Sep-17		Oct-17	Nov-17	Dec-17
New Cross	95%	90.57%	88.18%	86.44%		86.88%		
Walk in Centre		100.00%	100.00%	100.00%		100.00%		
Cannock MIU		100.00%	100.00%	100.00%		100.00%		
Vocare		95.94%	95.02%	96.22%		94.76%		
Combined		93.76%	92.09%	91.42%		91.55%		

Ambulance Handover

The fine for Ambulances during October was £10,200,00. This is based on 46 patients between 30-60 minutes @ £200 per patient and 1 patient >60 minutes @ £1,000 per patient. There were no patients who breached the 12 hour target during October 2017.

	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Number between 30-60 mins	0	33	69	54	27	48	70	46					
Number over 60 minutes	0	1	2	5	0	5	2	1					

Safeguarding Adult & Children Mandatory Training Compliance

Safeguarding Adult - Mandatory Training Compliance

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Level 3	80.0%	80.0%	86.7%	93.3%	93.3%	93.3%	92.9%		

Safeguarding Children - Mandatory Training Compliance

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Level 3	84.3%	87.3%	85.3%	87.7%	86.4%	83.9%	80.2%		

The provider is contractually compliant with achieving adult and children training compliance above 80%

3. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

The Committee is asked to note the following:

a) **Serious Incidents**

2 serious incidents were reported by Black Country Partnership Foundation Trust for November 2017 and both of these incidents were reported under the self-inflicted harm category. The Trust is undertaking full RCA into these incidents and the final RCA will be submitted to the WCCG in February, 2017.
An extra ordinary meeting was held between the provider and the WCCG SISG team to discuss serious incidents which remained open despite going through SISG panel meetings on several occasions. The joint meeting was well attended and well received by both provider and SISG panel and number of serious incidents were closed as agreed by the SISG panel.

b) Items to note from CQRM held in November 2017 (theme: Mental Health Services)

- The Divisional Report highlighted that there had been a reduction in the number of restraints (zero prone restraints), seclusions and medication errors..
- The Trust confirmed a reduction in self-harm incidents which correlates with the implementation of the new nursing observation policy.
- The Trust confirmed it was to review the number of younger adult falls due to an increase in the number of incidents reported. The Trust would attempt to identify any specific trends and report back to the CQRM to be held in February 2018.

4. PRIVATE SECTOR PROVIDERS

Vocare

There was no serious incident reported by Vocare for this reporting period. The CCG and Vocare have agreed a set of priority actions that must be delivered within the agreed timeframe. Progress has been made in this area although performance has not improved to the standards required as key

actions require a period of time to embed into daily practice and realise the benefits over the longer term. Governing body has agreed to extend the enhanced scrutiny until 1 February. Several performance issues are being addressed through Contract Performance Notices (CPN), and an Information Breach Notice.

A CQC visit took place in March 2017 which resulted in an 'Inadequate' rating. As a result, the CCG has increased scrutiny by introducing a Vocare Improvement Board in addition to the routine Contract/Quality Review meetings. A further CQC visit took place in Oct 2017 where the CQC, who have quoted "things are moving in the right direction". The Vocare Improvement Board will continue to meet until sufficient progress has been made. NHSE Quality and Surveillance Group have agreed to stand down the NHSE Quality Surveillance Vocare meetings, with ongoing scrutiny/monitoring by NHSE taking place at the routine Quality Surveillance Group each month.

NEPTS (Non-emergency Patient Transport Services)

An Information breach notice was served to the provider; which relates to four reported incidents that require further information and assurance of mitigating actions, including two potential Serious Incidents that are of significant concern to the commissioner. A SI fall with fracture incident has still not been reported on STEIS by the provider and this has been escalated to the WCCG chief officer and contracting team.

Probert Court

The Probert court suspension has been lifted now with the caveat that Accord need to manage admissions based on risk stratification: staffing and patient complexity. Probert has actively recruited to the vacant posts and currently there are only two outstanding vacancies for staff nurses to which they are planning to recruit. All actions from the Improvement board meeting has been achieved therefore the improvement board meeting group has been disbanded. WCCG will be closely monitoring the provider through monthly quality visits and monthly CQRM'S.

5. CHILDREN'S SAFEGUARDING

Threshold Guidance

- WSCB has approved a revised version of the 'Threshold Guidance'. This refreshes the document launched in 2014.
- The Threshold document is the responsibility of WSCB as outlined in statutory Guidance Working Together 2015.

- The revised document and electronic MARF will be available from 1.12.17 on the link below: www.wolverhamptonsafeguarding.org.uk

CP-IS (Child Protection- Information Sharing)

The CP-IS project is helping health and social care staff to share information securely to better protect society's most vulnerable children.

- A report is due for presentation at WSCB in December 2017 regarding the current progress.
- The first update meeting is scheduled for January 2018 with further meetings expected until full implementation of CP-IS in Wolverhampton.

LAC Update

RWT recruited a Paediatric Community Consultant who commenced in post on 30th Oct and will take on the Named Doctor for LAC role.

The RWT implementation plan around new commissioning for our LAC was due to commence in Sept with the advertisement of additional nursing and administration posts. However they are running 5 weeks behind and as a result the new post for Band 7 Named Nurse LAC went out to advert on the 31/10/17.

6. ADULT SAFEGUARDING

6.1 Care Homes

Pressure injury incidence is an ever improving picture with only 1 pressure injury during November compared to 2 in October 2017. The improvements can be attributed to the implementation of intensive improvement initiatives facilitated by the QNAT. There were 6 safeguarding referrals compared to 11 on the previous report. Care homes are working towards completion of improvement action plans. The team continue to have a positive impact on admission avoidance with no admissions related to UTI was reported during October demonstrating the improvements made with hydration.

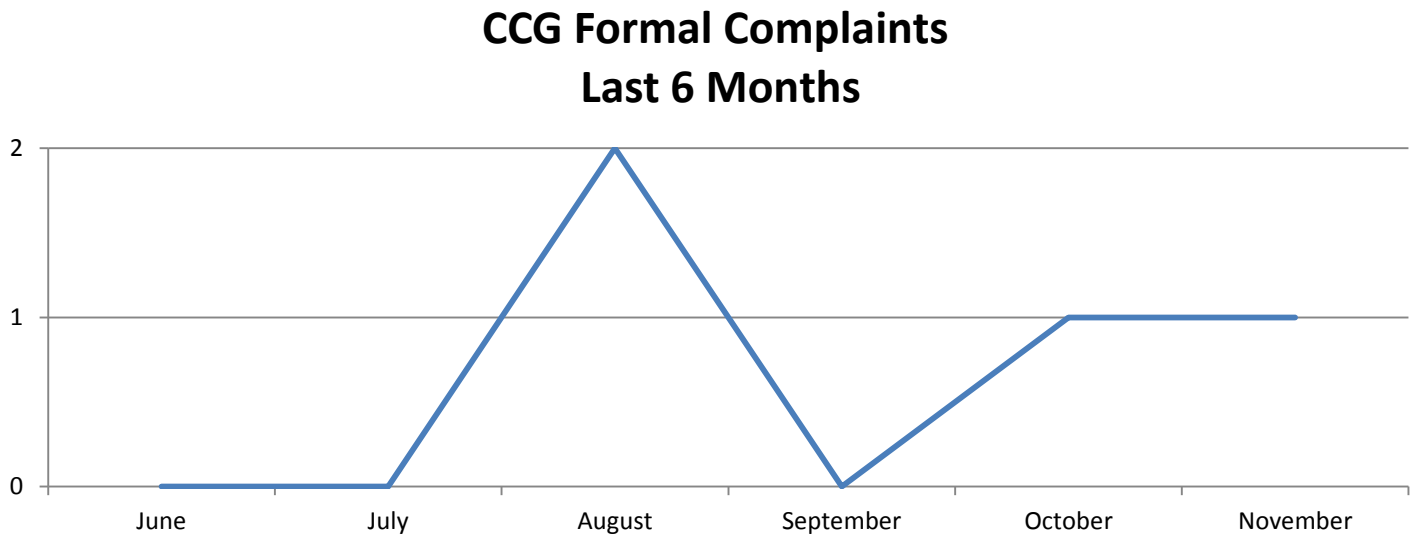
The SPACE programme continues to deliver quality improvement training, promoting falls training and the implementation of safety crosses and PDSA cycles with 18 homes continuing to be fully engaged. Care homes where recognised for their achievements in quality and safety improvements at an awards event during November 2017 receiving awards for most improved home, most innovative improvement and manager of the year.

6.2 Adult Safeguarding

- The new Wolverhampton Domestic Violence Forum Chair role has been appointed to.
- CWC have reported that there are currently only a Backlog of 12 DoLS referrals which is a significant improvement from this time last year

7. USER AND CARER EXPERIENCE

7.1 New formal complaints



There has been 1 new complaint registered by the CCG in November 2017, this is the only complaint that is currently ongoing and it is anticipated that the complaint will be fully resolved by January 2018. The CCG also closed 1 complaint in November 2017.

The CCG has also registered 3 concerns or complaints for other commissioned providers where the complainant has contacted the CCG in the first instance, in all 3 concerns or complaints, the complainant has been given the appropriate details of the provider for the provider to investigate in the first instance, or where consent was supplied, the CCG have forwarded the complaint / concern onto the provider responsible.

8. HEALTH AND SAFETY

Health and Safety discussions have taken place at the most recent JNCC regarding the best forum for Health and Safety. Quarter 2 Health and Safety Audit had been conducted and the Quarter 2 report was reported at the October Quality & Safety Committee.

STK will be assisting the CCG with the review of the Health and Safety Policy in line with Health and Safety action plan through Quarter 2.

The Committee is requested to:

- **Receive** and **note** the information provided in this report.
- **Discuss** any aspects of concern and **agree** on action to be taken.

Name: Molly Henriques-Dillon
Job Title: Quality Nurse Team Leader
Date: 4th December 2017

Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 10

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 28th November 2017**
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	• **Receive** and **note** the information provided in this report.
Public or Private:	This Report is intended for the public domain.
Relevance to CCG Priority:	The organisation has a number of finance and performance related statutory obligations including delivery of a robust financial position and adherence with NHS

Agenda Item 10

	Constitutional Standards.
Relevance to Board Assurance Framework (BAF):	
• **Domain 1:** A Well Led Organisation	The CCG must secure the range of skills and capabilities it requires to deliver all of its Commissioning functions, using support functions effectively, and getting the best value for money; and has effective systems in place to ensure compliance with its statutory functions. meet a number of constitutional, national and locally set performance targets.
• **Domain2:** Performance – delivery of commitments and improved outcomes	The CCG must meet a number of constitutional, national and locally set performance targets.
• **Domain 3:** Financial Management	The CCG aims to generate financial stability in its position, managing budgets and expenditure to commission high quality, value for money services. The CCG must produce a medium to long term plan that allows it to meet its objectives in the future.

1. FINANCE POSITION

The Committee was asked to note the following year to date position against key financial performance indicators;

Financial Targets Statutory Duties	Target	FOT	Variance o(u)	RAG
Expenditure not to exceed income	£9.130m surplus	£9.130m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£403.171m	£403.171m	Nil	G
Revenue Administration Resource not exceeded	£5.535m	£5.435m	(£0.10m)	G

Non Statuory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance £'000	301	276	(25)	G
Maximum closing cash balance %	1.25%	1.15%	-0.10%	G
BPPC NHS by No. Invoices (cum)	95%	100%	-5%	G
BPPC non NHS by No. Invoices (cum)	95%	97%	-2%	G
QIPP	£6.19m	£6.01m	£0.18m	A
Programme Cost £'000*	224,295	225,661	1,365	G
Reserves £'000*	1,246	0	(1,246)	G
Running Cost £'000*	3,228	3,128	(100)	G

- NHSE reporting requirements have changed and as such the CCG has undertaken a remapping of codes and services. This exercise has affected the groupings of services and therefore for this month it has been impossible to provide movements between months with the exception of Continuing Care, Prescribing, Delegated Primary Care and Running Costs. This part of the report will be reinstated in December.
- The net effect of the three identified lines (*) is a small overspend.
- The CCG's cash performance has improved in October with the RAG rating being reviewed to green.
- The CCG is anticipating meeting all its statutory duties in 2017/18 and in doing so has utilised all its reserves.
- Following a review of the financial position at M7 the level of risks has been adjusted to reflect those risks now incorporated into the FOT and the CCG is maintaining a nil net risk as mitigations match identified risks.
- Programme Costs are forecast to overspend which is partially compensated for by under-spends on Running Costs.
- The financial position has been scrutinised in M7 and following the adoption of a series of assumptions the recurrent overspend has decreased to an estimated £885k FOT which is currently offset by non-recurrent under-spends and the use of reserves. This has serious implications for 18/19 onwards most importantly the level of QIPP will have to increase.
- Royal Wolverhampton Trust (RWT) is giving concern as the M6 activity is indicating a potential forecast out turn (FOT) of c £2m. The CCG is seeing new HRGs codes being used as a result of the expansion of codes in 17/18 many of which carry a higher tariff e.g. Sepsis.
- Other Providers such as University Hospitals Birmingham (UHB) and Dudley Group are also over performing which appears to be linked to new HRGs and Specialist activity now in the CCG portfolio.
- Mental Health Complex cases are continuing to over perform. Assurances have been given by the MH Commissioner that spend will reduce and fall back in line with budget as cases are reviewed and costs reduced.
- Within Delegated Primary Care there is some flexibility to utilise in bringing forward plans and commit recurrent spend.
- Expenditure on GP prescribing has increased compared to month 6. This movement predominately relates to increased costs for NCSO drugs.

- CHC/FNC continues to report an overall forecast under-spend and this has reduced again in month 7 due to a reduction in the number of CHC patients.
- As reported in month 6, the inclusion of the “cap” arrangement for BCF has released £706k into the recurrent position.
- No additional QIPP has been identified in M7. The CCG is reporting achieving its QIPP target as shortfall is being covered by reserves and other under-spends. However, actual achievement of reduced activity levels associated with QIPP schemes are not materialising, (section 13) and are manifesting themselves in overspends, largely within the Acute portfolio.

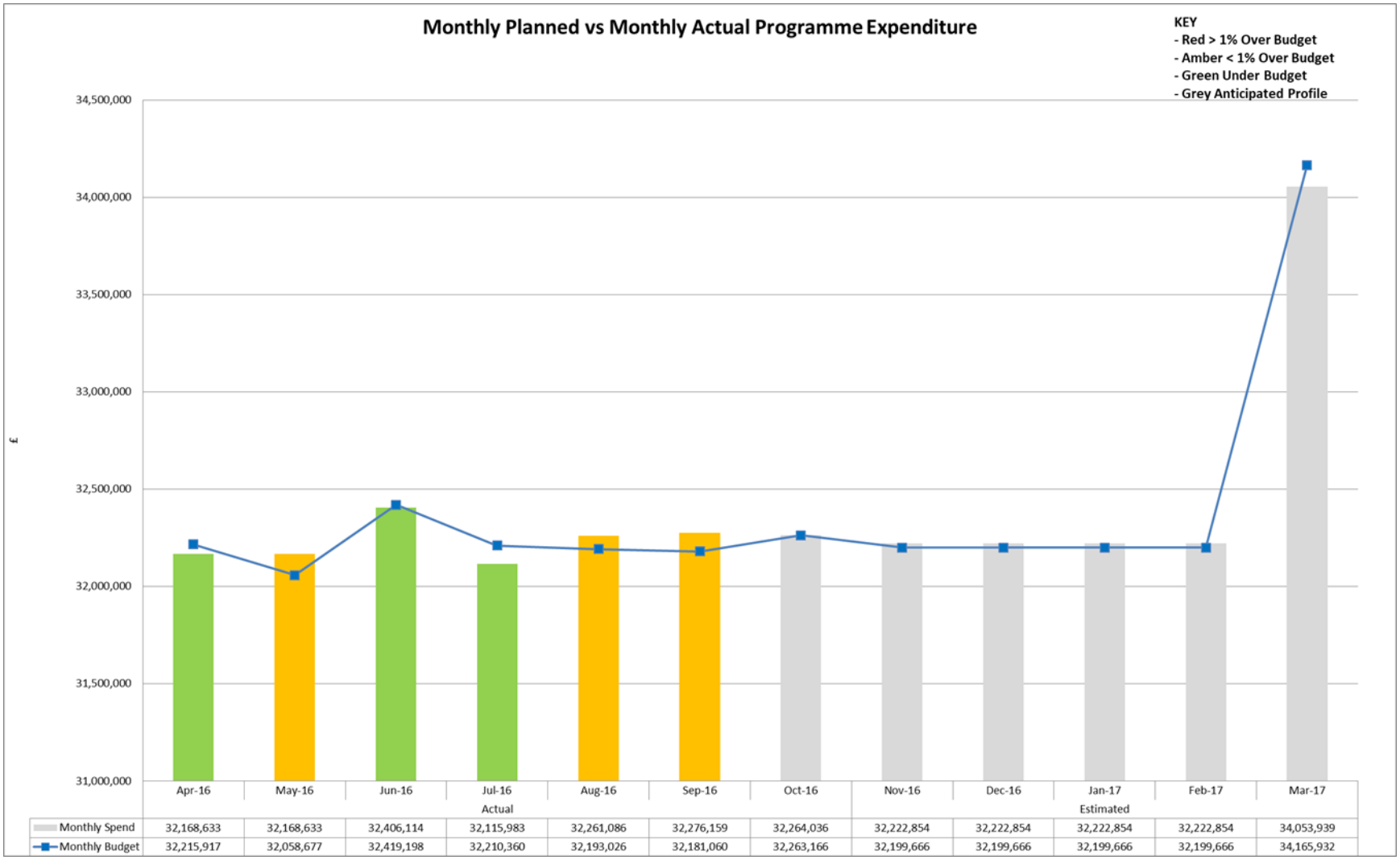
The table below highlights year to date performance as reported to and discussed by the Committee;

	Annual Budget £'000	YTD Performance M07						
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)
Acute Services	194,612	113,524	114,363	839	0.7%	196,248	1,636	0.8%
Mental Health Services	35,992	20,971	21,195	223	1.1%	36,169	177	0.5%
Community Services	48,547	28,265	27,765	(500)	(1.8%)	47,727	(821)	(1.7%)
Continuing Care	14,484	8,449	8,201	(248)	(2.9%)	14,097	(387)	(2.7%)
Primary Care Services	52,297	30,506	30,964	458	1.5%	53,109	812	1.6%
Delegated Primary Care	35,165	20,513	20,716	203	1.0%	34,665	(500)	(1.4%)
Other Programme	3,542	2,066	2,457	390	18.9%	4,514	971	27.4%
Total Programme	**384,640**	**224,295**	**225,661**	**1,365**	**0.6%**	**386,529**	**1,888**	**0.5%**
Running Costs	5,535	3,228	3,128	(100)	(3.1%)	5,435	(100)	(1.8%)
Reserves	3,866	1,246	0	(1,246)	(100.0%)	2,077	(1,788)	(46.3%)
Total Mandate	**394,041**	**228,770**	**228,789**	**19**	0.0%	**394,041**	**(0)**	**(0.0%)**
Target Surplus	9,130	5,326	0	(5,326)	(100.0%)	0	(9,130)	(100.0%)
Total	**403,171**	**234,096**	**228,789**	**(5,307)**	(2.3%)	**394,041**	**(9,130)**	(2.3%)

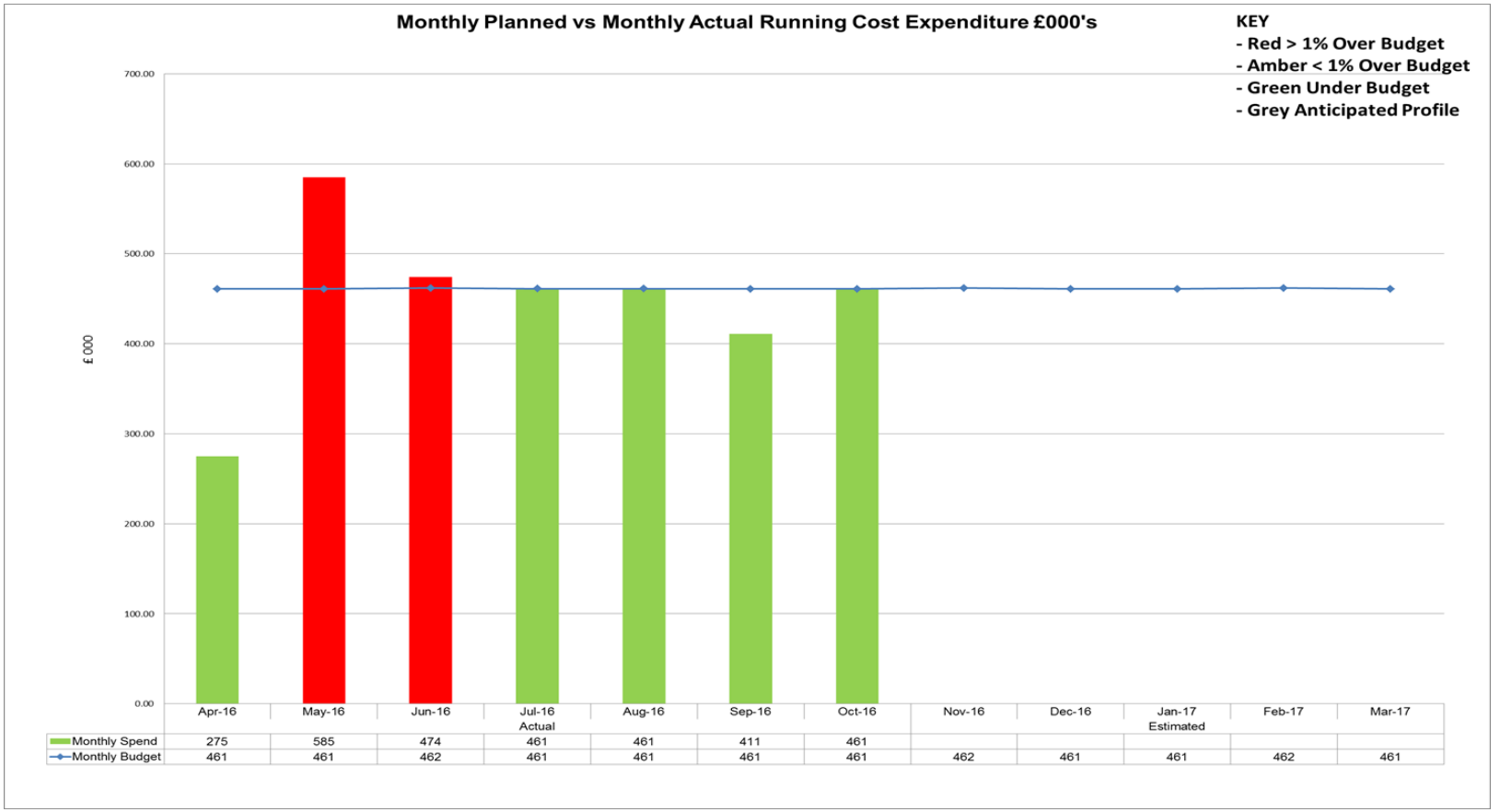
	Annual Budget £'000	Yr End Forecast £'000	Yr End Variance Total £'000 o(u)	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent	Yr End Variance %
Acute Services	194,612	196,248	1,636	1,869	(232)	0
Mental Health Services	35,992	36,169	177	(18)	195	0
Community Services	48,547	47,727	(821)	(641)	(180)	(0)
Continuing Care	14,484	14,097	(387)	(556)	170	(0)
Primary Care Services	52,297	53,109	812	372	439	0
Delegated Primary Care	35,165	34,665	(500)	0	(500)	(0)
Other Programme	3,542	4,514	971	6,369	(5,398)	0
Total Programme	**384,640**	**386,529**	**1,888**	**7,394**	**(5,506)**	**0**
Running Costs	5,535	5,435	(100)	0	(100)	(0)
Reserves	3,866	2,077	(1,788)	(1,788)	0	(0)
Total Mandate	**394,041**	**394,041**	**(0)**	**0**	**0**	**(0)**
Target Surplus	9,130	0	(9,130)	0	(9,130)	(1)
Total	**403,171**	**394,041**	**(9,130)**	**5,606**	**(14,736)**	**(0)**
Recurrent/Non Recurrent Adjustment				**(4,721)**	**4,721**	
Removal of Target Surplus					**9,130**	
Residual Position				**885**	**(885)**	

- Of the recurrent year end variance, £4.721m is a consequence of recurrent spend being offset by a non-recurrent allocation in relation to HRG4+ and IR (national coding and costing changes which impacted upon the 17/19 contract). The CCG will have a non-recurrent allocation again in 18/19 thereafter the sum should be incorporated into the new allocations published after the next CSR (Comprehensive spending review). This is reflected in the table above.
- The above table demonstrates that after adjusting for the required target and non-recurrent allocation, the CCG is overcommitted recurrently by £885k, which is offset by non-recurrent underspends.
- To achieve the target surplus the CCG has utilised all of the Contingency Reserve, £1.780m. For 18/19 the CCG will need to reinstate the Contingency and this will be a first call on growth monies.

	Annual Recurrent £'000	Annual Non Recurrent £'000	Total £'000	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent £'000	Total £'000
Contingency Reserve	1,788	0	1,788	(1,788)	0	(1,788)
Mandated 0.5% of 1%	1,729	0	1,729	0	0	0
Delegated Primary Care 1%	348	0	348	0	0	0
Total	**3,866**	**0**	**3,866**	**(1,788)**	**0**	**(1,788)**



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Monthly Spend	32,168,633	32,168,633	32,406,114	32,115,983	32,261,086	32,276,159	32,264,036	32,222,854	32,222,854	32,222,854	32,222,854	34,053,939
Monthly Budget	32,215,917	32,058,677	32,419,198	32,210,360	32,193,026	32,181,060	32,263,166	32,199,666	32,199,666	32,199,666	32,199,666	34,165,932



- Running costs historically have reported a stable position from M3 onwards and this is anticipated to continue through to year end. Traditionally the last 3 months of the financial year see a proportionally higher spend per month but overall a breakeven position is forecast at year end.

2. Delegated Primary Care

Delegated Primary Care allocations for 2017/18 as at M07 are £35.513m. The forecast outturn is £35.013m delivering an under-spend position.

- The table below shows the revised forecast for month 07:

	YTD budget £'000	YTD spend £'000	YTD Variance £'000 o/(u)	Annual Budget £'000	FOT £'000	Variance £'000 o/(u)	In Month Movement Trend	In Month Movement £'000 o/(u)	Previous Month FOT Variance £'000 o/(u)
General Practice GMS	12,251	12,281	29	21,002	21,002	0		0	0
General Practice PMS	1,055	1,049	(6)	1,809	1,809	0		0	0
Other List Based Services APMS incl	1,341	1,483	142	2,298	2,298	0		0	0
Premises	1,566	1,551	(14)	2,684	2,684	0		0	0
Premises Other	53	30	(23)	90	90	0		0	0
Enhanced services Delegated	493	486	(7)	845	845	0		0	0
QOF	2,113	2,094	(19)	3,622	3,622	0		0	0
Other GP Services	1,541	1,742	202	2,641	2,141	(500)		0	(500)
Delegated Contingency reserve	102	0	(102)	174	174	0		0	0
Delegated Primary Care 1% reserve	203	0	(203)	348	348	0		0	0
Total	**20,716**	**20,716**	**203**	**35,513**	**35,013**	**(500)**		**0**	**(500)**

The forecast outturn shows an under-spend of £500k against other GP services which relates to the release of an accural previously managed by NHSE. The benefit is non recurrent in nature. The 0.5% contingency will be commited in line with the 2017/18 planning metrics. The CCG has plans in place to utilise this resource.

In line with national guidance the 1% Non-Recurrent Transformation Fund can be utilised in year non-recurrently to help and support the delegated services. The CCG has plans in place to meet this metric.

3. QIPP

The key points to note are as follows:

- Following the finalisation of the year end figure the plan QIPP target of £10.62m increased to £11m. As a result, the level of non-contracted QIPP without plans increased to £1.519m as £616k has identified plans.

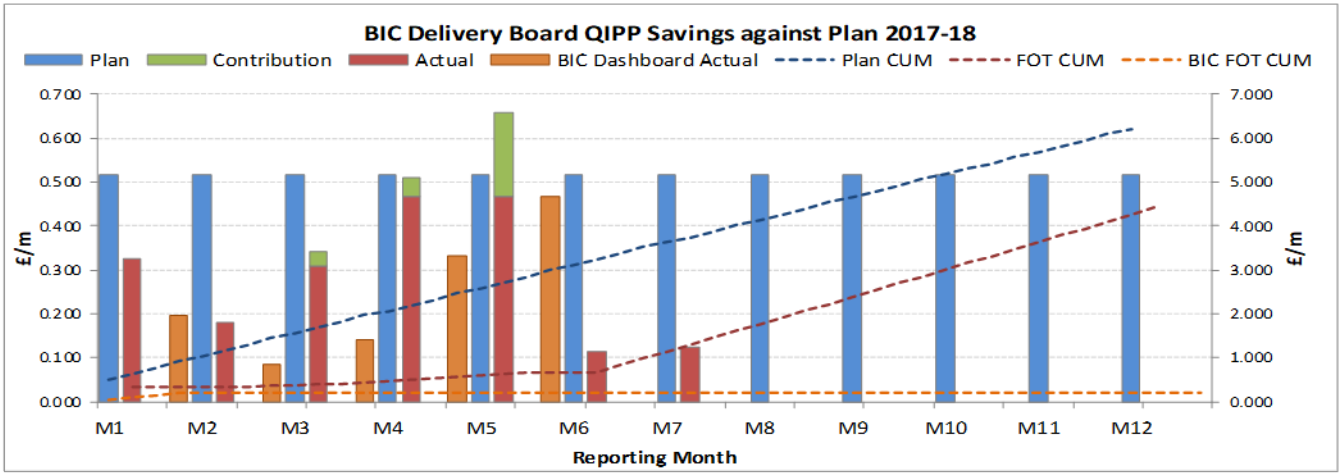
- No additional QIPP has been identified in M7.
- Any non-recurrent QIPP will potentially be carried forward into the 18/19 target although the CCG is covering undelivered QIPP in its recurrent reported position.
- Reporting to NHSE requires QIPP to be split between Transactional QIPP and Transformational QIPP. The table below details the split between categories:

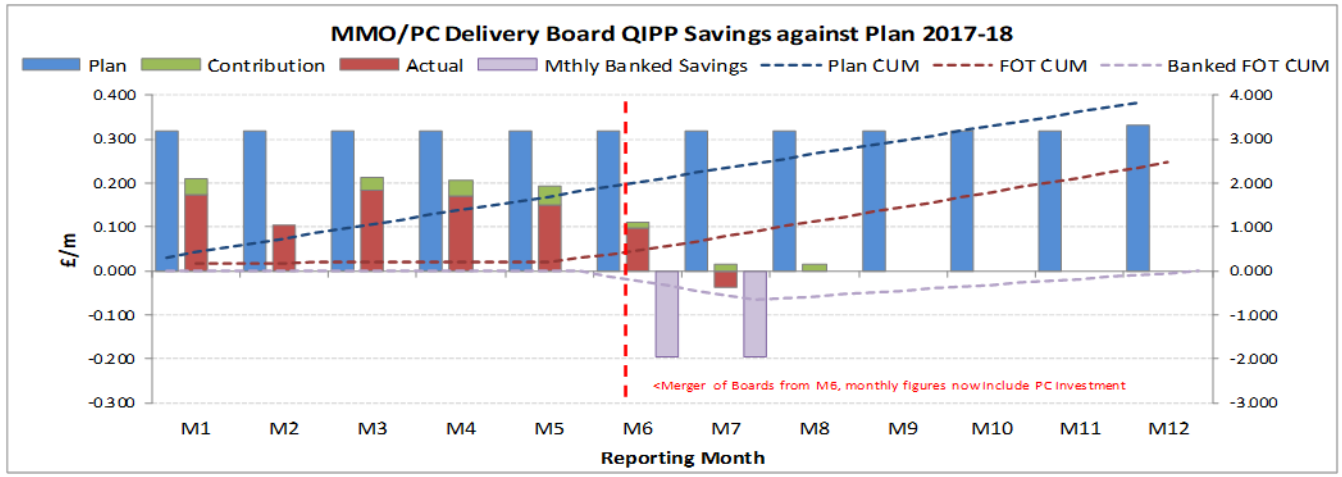
	YTD Plan £'m	YTD Actual £'m	YTD Var o(u) £m	An. Plan £'m	FOT £'m	Var o(u) £m
Transactional	2.36	2.36	-0.01	4.05	4.05	0.00
Transformational	3.82	3.58	-0.24	6.56	6.56	0.00
Unallocated		0.00	0.00	0.00	0.00	0.00
Total	**6.19**	**5.94**	**-0.25**	**10.61**	**10.61**	**0.00**

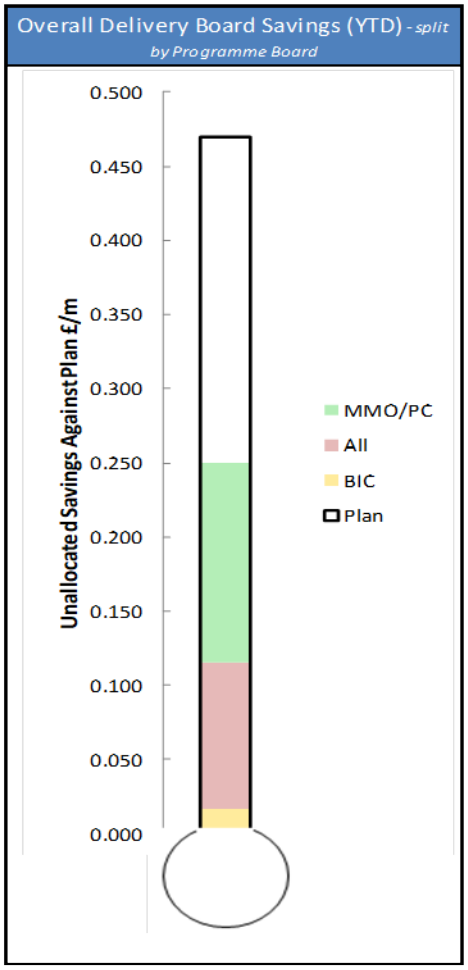
QIPP Programme Delivery Board

Mth 7 - Oct 17/18

Source : Annual Non ISFE Plan, Monthly Project Leads Updates and validated figures from Non ISFE Finance Return







4. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 31st October is shown below.

	31 October '17 £'000	30 September '17 £'000	Change In Month £'000
Non Current Assets			
Assets	0	0	0
Accumulated Depreciation	0	0	0
	0	0	
Current Assets			
Trade and Other Receivables	1,682	1,591	90
Cash and Cash Equivalents	276	687	-411
	1,958	2,279	
Total Assets	**1,958**	**2,279**	
Current Liabilities			
Trade and Other Payables	-29,893	-25,648	-4,245
	-29,893	-25,648	
Total Assets less Current Liabilities	**-27,935**	**-23,369**	
TOTAL ASSETS EMPLOYED	**-27,935**	**-23,369**	
Financed by:			
TAXPAYERS EQUITY			
General Fund	27,935	23,369	4,566
TOTAL	**27,935**	**23,369**	

Key points to note from the SoFP are:

- The CCG has hit its cash target this month achieving 1.15% against a target of no greater than 1.25%, (see 13.2 below);
- Performance continues to be high against the target of paying at least 95% of invoices within 30 days, (97% for non-NHS invoices and 100% for NHS invoices);
- The current position of trade payables and receivables is shown in the charts below:

5. PERFORMANCE

The following tables are a summary of the performance information presented to the Committee;

NHS
Wolverhampton
Clinical Commissioning Group

Executive Summary - Overview

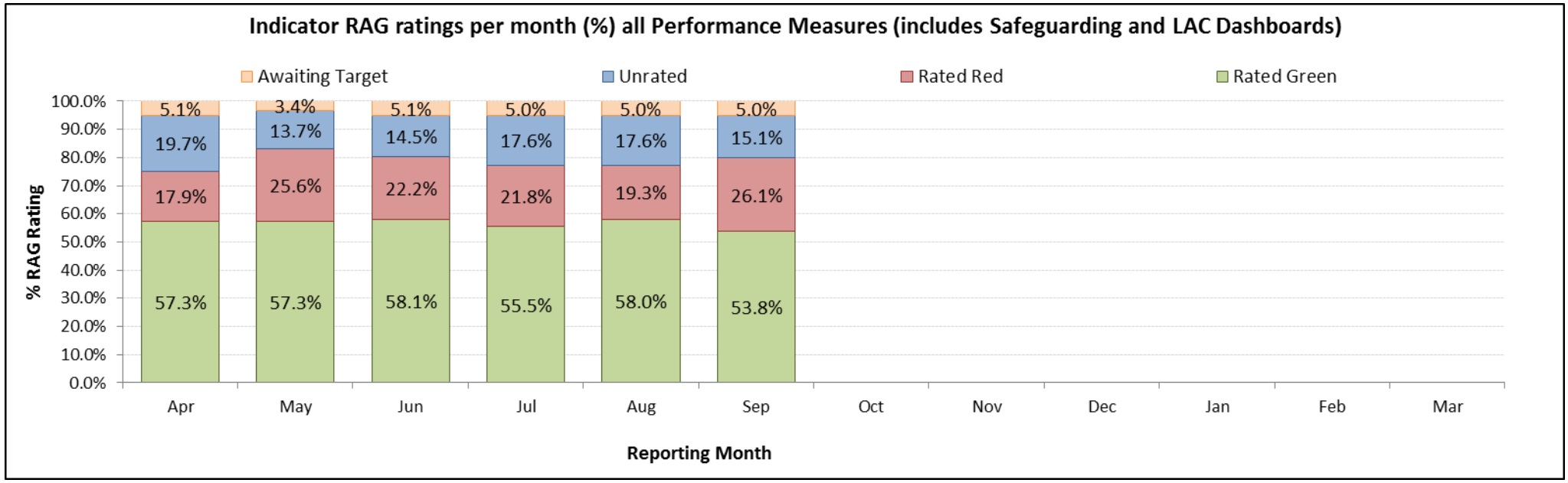
Sep-17

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	15	14	8	8	1	2	0	0	**24**
Outcomes Framework	7	6	7	9	12	11	0	0	**26**
Mental Health	24	23	4	9	8	4	0	0	**36**
Safeguarding - RWT	9	8	4	5	0	0	0	0	**13**
Looked After Children (LAC)	0	0	0	0	0	0	6	6	**6**
Safeguarding - BCP	14	13	0	0	0	1	0	0	**14**
Totals	**69**	**64**	**23**	**31**	**21**	**18**	**6**	**6**	**119**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC or n/a *
NHS Constitution	63%	58%	33%	33%	4%	8%	0%	0%
Outcomes Framework	27%	23%	27%	35%	46%	42%	0%	0%
Mental Health	67%	64%	11%	25%	22%	11%	0%	0%
Safeguarding - RWT	69%	62%	31%	38%	0%	0%	0%	0%
Looked After Children (LAC)	0%	0%	0%	0%	0%	0%	100%	100%
Safeguarding - BCP	100%	93%	0%	0%	0%	7%	0%	0%
Totals	**58%**	**54%**	**19%**	**26%**	**18%**	**15%**	**5%**	**5%**

* Note : Performance for Looked After Children (LAC) has been included on the Dashboard section of the report for information only as currently does not have targets or thresholds applied to the indicators.

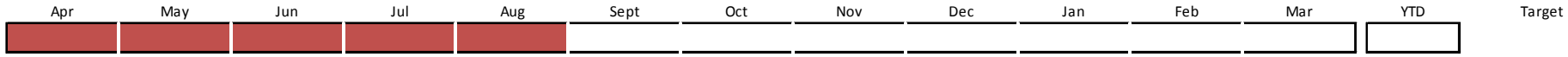
From August 2017 : additional of C.Diff and MRSA indicators for the Black Country Partnership Foundation Trust reporting, increases number to 119 overall indicators



Exception highlights were as follows;

Indicator Ref:	Title and Narrative	Direction of Travel / Yr End Target
	Royal Wolverhampton Hospital NHS Trust (RWT)	

Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral



RWT_EB3

The performance data for headline Referral To Treatment (RTT - 18wks) Incompletes was not reported on the September SQPR submission, however, has since been confirmed at the Royal Wolverhampton Trust Board (Integrated Quality and Performance Report) as 90.80%. When compared to the previous years performance, the validated National Unify2 figures show that there has been a decrease in referral numbers and compliance (Sept16 = 91.22%, 3,053 breaches out of 34,790, Sept17 = 90.80%, 3,082 breaches out of 33,501). The September performance remains below the 92% National standard and agreed 17/18 STF Trajectory for September of 92.10%. Failing specialties include : ENT (88.83%), General Surgery (87.72%), Ophthalmology (90.04%), Oral Surgery (78.18%), Plastic Surgery (87.61%), Trauma & Orthopaedics (86.47%) and Urology (81.24%). The Trust have confirmed that performance saw a deterioration during September due to a knock on effect of reduced activity during August which was a result of the holiday/bank holiday period with patients choosing to prolong their waits. There is continued work with Directorates to focus on reducing the backlog where possible. Monthly prediction reports are circulated to highlight priority patients with expected activity numbers for each month. Orthodontics continues to be monitored closely and remains as a weekly report (Activity versus Plan Report) presented at the Divisional Managers performance meeting.

Following the SLA termination for the provision of Paediatric Orthopaedics by Walsall Healthcare NHS Trust, RWT confirmed there are 146 new patients (and 113 follow up patients) - 53 of which are over 18 weeks which have been factored into the STF recovery trajectory. Complex patients will continue to be seen at the Birmingham Children's Hospital and Walsall sanction monies are being utilised to fund 14-15 additional clinics to assist backlog clearance. A data quality exercise has been undertaken to identify the exact numbers of patients who will be taken on. An On-line RTT training package is being developed for all administration staff (with the aim to make this a mandatory training course). Performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The Trust have also confirmed performance of patients reported waiting over 52 weeks has recovered and there have been 0 patients waiting more than 52 weeks since the end of May submission. The Commissioner Incomplete performance for September has been confirmed as 91.62% (below target) with Neurosurgery = 75.64%, Urology = 81.03%, General Surgery = 87.06%, T&O = 88.71%, ENT = 88.84%, Plastic Surgery = 89.01% and Ophthalmology = 89.24% as the failing specialties.

A RAP with a revised recovery trajectory, which supercedes the STF trajectory, has been submitted to NHSI with recovery at headline level expected by March 2018. Performance against the 18 week target is expected to achieve for October and November, however early indications are that the October performance has failed to achieve target but has seen improvement to 91.12%.

Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
92.52%	94.12%	93.44%	93.76%	92.09%	91.42%							92.89%	95.00%

The September performance has seen a decrease from the previous month to 91.42% and has failed to achieve the National target (Type I and All Types) of 95%. However, the in month performance has achieved the agreed 17/18 STF Trajectory for September of 91.0%. The performance can be split into the following : Emergency Department Type I (New Cross) - 86.44%, Walk-in centre Type 4 - 100%, Cannock Minor Injury Unit (MIU) Type 3 - 100% and Vocare Type 3 - 96.22%.

When comparing the Nationally validated number of attendances from the previous year, there has been a 1.8% increase (Sept16: 18,408- 93.86% compliance, Sept17: 18,740 - 91.42% compliance). The Trust have indicated that they are beginning to see Winter Pressures affecting the overall A&E performance. This aligned with the key issues affecting performance including: activity levels, locum staffing and batching of ambulances have led to a small decrease in performance in month.

As previously commented on, the access standard to meet the STF payment is solely now based on the A&E 4 Hour Wait Performance and subsequent actions. In Q2 2017/18, the Trust did achieve the Q2 STF payment for A&E performance. In Q3, Trusts have been advised by the National Director for Urgent Care, Pauline Philip, that to achieve the Q3 STF payment, they are required to achieve the higher of performance over 90% in Q3 or exceed reported performance in Q3 in 2016/17.

Overall performance is being reviewed and managed through the A&E Delivery Board and in particular there are Winter plans in place. The CCG are also planning to advertise in the local free press around additional access in Primary Care in an effort to reduce activity in A&E.

The Trust and CCG hold Urgent Care teleconferences (Exec to Exec) three times a week and the A&E Delivery Board meet monthly to review progress and manage performance.

We are currently not experiencing issues around bed capacity due to the low numbers of Emergency Admissions and Elective activity.

Early indications are that the October performance has seen a positive increase to 91.55% however remains RED.

RWT_EB5

Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
77.40%	77.30%	71.56%	77.09%	75.00%	72.96%							75.22%	85.00%

The performance for the 62 Day from GP Referral to 1st definitive treatment has failed to achieve both the 85% National target and the trajectory of 85.1% for September and has seen a decrease in performance to 72.96% in month. The Trust have since confirmed via the Integrated Quality and Performance Report that there were 26 patients that breached target during September (9 x tertiary referrals, 10 x capacity issues, 2 x patient initiated and 5 x complex pathways). Of the tertiary referrals, 1 referrals were received after day 62 of the patient pathway and had already breached standard. Analysis by Cancer site confirms the breaches are relating to : Head & Neck (0.5 breaches out of 2.5 - 80.00%), Colorectal (3.5 breaches out of 5.5 - 36.36%), Upper GI (1 out of 4 - 75.00%), Urology (8.5 breaches out of 21.5 - 60.47%) and Haematology (0.5 breaches out of 6 - 91.67%), Skin (2 out of 16.5 - 87.88%), Gynaecology (2.5 out of 5 - 50.00%), Breast (2 breaches out of 14 - 85.71%), Lung (1 breaches out of 4.5 - 77.78%. There were no Sarcoma 62 day wait patients. The Trust have in place a revised trajectory, giving the weekly expected backlog and expected performance from October 2017 through to March 2018 and a RAP is in place with actions to recover performance. Some of the actions detailed within the Trust Integrated Quality and Performance Report have highlighted include : On-going weekly Radiology Waiting List initiatives targeting cancer patients to reduce waits for reports, weekly escalation meetings with Divisional and Directorate Managers to review performance against standards with a view to identify process bottlenecks and expediting treatments where possible.

The Commissioner is reviewing the weekly extracts of the Cancer Patient Tracking List (PTL) for 62 Day Cancer Waits which focuses on the following 3 areas : Numbers of patients waiting with No Decision to Treat, numbers waiting with a Decision to Treat and the numbers who have received treatment within the last 7 days. Changes in numbers are analysed in 8 week blocks to enable the CCG to spot any changes and potential issues. There are ongoing discussions between Trusts across the STP around a shared breach policy for Tertiary Referrals, which should have a positive impact on performance. Further to this, the Accountable Officers have been invited to attend a monthly/6 weekly, Risk and Review Meeting, with other AO's from across the STP. This will provide an opportunity for AO's to discuss shared issues affecting performance across the STP area.

The 70/30 split of the Oncology work from City/Sandwell commenced from 23rd October and was planned as a phased approach by specialty, however has been fully transferred and this is estimated to show in a drop in performance from the transfer date. The City work (70%) has transferred to University Hospital of Birmingham (UHB) and Birmingham Womens Hospital (BWH) and the Sandwell work (30%) transferred to the Royal Wolverhampton Hospital. All existing patients and new Chemotherapy and Radiotherapy patients will be given the choice of Wolverhampton or UHB.

From the 1st December 2017, Gynaecology Oncology services will no longer be available from City/Sandwell and the Royal Wolverhampton Hospital, University Hospital of Birmingham (including Heart of Englands and Birmingham Womens) are expected to submit a joint bid to provide an estimated 50/50 split of the service. This is based on an estimate of 150 patients, however could be between 250 and 300 patients which could impact on the overall performance and wait times for patients.

It should be noted that the impact of the additional Oncology/Gynae Oncology activity has not been factored into the revised recovery trajectory. Also it is expected that the additional activity is likely to impact on RTT performance and potentially Diagnostics. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and August performance has been confirmed as 78.03% (21 patients breaching target out of 77) and therefore remains RED. Performance is discussed at the CQRM and CRM meetings with the Trust. Early indications are that the October performance has seen a positive increase in performance to 76.25% however remains below the STF recovery trajectory.

Zero tolerance RTT waits over 52 weeks for incomplete pathways

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
6	4	0	0	0	0							10	0

RWT_EBS4

This indicator has breached the Year End zero threshold for 52 week waiters due to the April and May breaches for Orthodontic patients. The M6 performance confirms that there were no patients waiting over 52 weeks during September, however the Year End threshold has already breached for 2017/18 due to the performance in April and May. RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. Early indications are that there are no further breaches during October.

Trolley waits in A&E not longer than 12 hours

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
0	0	0	0	0	0							0	0

RWT_EBS5

The performance for the number of Trolley waits in A&E (not longer than 12 hours) has achieved the zero threshold since June 2015, however has been included as part of the Horizon Scan Report as there was a potential breach under investigation for October. Following a review of the patient timeline, both the Commissioner and the Black Country Partnership Foundation Trust have agreed that this patient did not meet the Trolley Breach criteria. Early indications are that the Trust have reported no breaches for October and therefore remains GREEN.

Delayed Transfers - % occupied bed days - to exclude social care delays

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
1.75%	2.10%	1.12%	1.58%	1.81%	1.49%							1.64%	2.00%

The Delayed Transfers of Care (DToC) indicator is based on the proportion of delays by occupied bed days (excluding Social Care) and has achieved the 2.4% threshold in-month reporting 1.49% for September.

National DTOC submission data from the Unify2 collection system confirms that there were 1031 total delay days for September at the Royal Wolverhampton Trust (of which 516 x Wolverhampton, 365 x Staffordshire, 98 x Walsall, 36 x Dudley and 4 x Shropshire). As a Commissioner, September delays days totals were : 516 x Royal Wolverhampton NHS Trust, 30 x South Staffordshire and Shropshire Healthcare, 6 x Robert Jones and Agnes Hunt, 42 x Black Country Partnership, 61 x Dudley Group of Hospitals and 10 x Berkshire Healthcare.

Changes in the format of the numerator data received via the SQPR submission has been confirmed to match the revised methodology for the National monthly submissions and are based on the calculation of: Number of delay days divided by the number of days in the reporting month. Trust have confirmed that the denominator is based on a monthly average of the occupied bed days. Nationally reported performance percentages utilise the quarterly published occupied bed day figures (KH03 Unify2 submission) which are unavailable at time of the Trusts monthly submission. Following a request from the Midlands and East Regional Team, a DTOC a trajectory of NHS Delay numbers has been submitted to provide assurance that systems with agreed BCF trajectories will meet their November DTOC target (NHS delays only). The Wolverhampton submission confirms that the CCG are taking a whole system approach to reducing DTOC and upon review of the DTOC data, we are confident that the November target (6.4 delays days per day for November, with September currently 6.17) for NHS Health related delays will be achieved.

Activities currently underway that are expected to impact on achieving the trajectory are as follows:-

RWT_LQR3

- Continual roll out of new discharge to assess process (including a 'Trusted Assessment')
- Implementation of the High Impact Model for Managing Transfers of Care
- Commissioning of additional reablement, rapid response, step down and extra care provision.

The Trust have indicated the following delay reasons for September:

35.4% - Delay Awaiting Assessment (prev 29.3% - increase)
9.2% - Delay awaiting further NHS Care (prev 8.6% - increase)
29.2% - Delay awaiting domiciliary package (prev 23.3% - increase)
6.2% - Delay awaiting family choice (prev 11.2% - decrease)
5.4% - Delay awaiting equipment/adaptations (prev 7.8% - decrease)
0.0% - Delay awaiting public funding (prev 0.0% - no change)

Delayed Transfers of Care continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. A threshold of 3.5% by September 2017 (combined NHS and Social Care related delays) had been agreed between the Royal Wolverhampton Hospital and Local Authority (stretched from 4.9% to 3.5%) which has not been achieved (4.45% combined delays).

Early indications are that the October performance is 1.49% and remains below the 2.4% threshold (excluding Social Care).

E-Referral – ASI rates

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
34.66%	32.42%	30.57%	37.38%	32.54%	26.04%							32.27%	10.00%

RWT_LQR12

Performance for this indicator has achieved the 50% recovery trajectory threshold for September , achieving 26.04%. Analysis of the year on year performance shows that the Month 5 performance relates to a lower number of referrals (16/17 denominator = 4281, 17/18 denominator = 4094, a decrease of 187) and a performance below that of the same period in 2016/17 (18.06%). Reviewing the recovery trajectory shows that there is an expectation that performance will decline before it improves. The Trust have confirmed that Ophthalmology, Orthopaedics, Neurology and Dermatology are the most challenging areas for slot issue performance. A recovery trajectory has been developed as part of the Quarter 1 CCG CQUIN submission for the ASI indicator with achievement of 8% by March 2018 (4% by April 2018). The September performance has achieved the Month 6 recovery trajectory of 50% with early indications that the October performance is also ahead of trajectory at 28.71% (against a recovery trajectory of 45%). The Commissioner has queried the figures reported by the Trust via the Clinical Quality Review Meeting as they differ from the National validated reports eg September reported figures= 1177/4520 (26.04%), whereas the NHS Digital confirmed data = 1347/4520 (29.80%). The initial response has indicated that the difference in performance figures related to Dermatology activity and the CGG are awaiting confirmation from the Trust are to confirm if these figures are included. The National Appointment Slot Issue report for September17 allows us to benchmark performance :

Walsall Healthcare NHS Trust - 61.05 (1,251 issues out of 2,049 bookings)
Sandwell and West Birmingham - 67.46 (3,865 issues out of 5,729 bookings)
Dudley Group of Hospitals - 33.48 (1,730 issues out of 5,168 bookings)
Royal Wolverhampton - 28.71 (1,287 issues out of 4,482 bookings)
The National performance (Acute Trusts only) for September has been confirmed as 27.98, with the West Midlands (Acute Trusts only) currently performing at 20.42.

Note : The National Data is based on the E-Referral System data only, The Royal Wolverhampton Trust data does not include urgent referrals as these are received via email, it is not known if other providers figures include or exclude these referrals.

Black Country Partnership NHS Trust (BCP)

Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*

BCPFT_EBS3

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
97.06%	96.72%	94.51%	98.51%	97.22%	94.67%							96.45%	95.00%

The performance for this indicator failed to achieve the 95% target during September (94.67%), however, the YTD currently remains above target at 96.45%. The Wolverhampton breaches for September relates to 4 patients (out of 39) which calculates as 89.74% of the Wolverhampton patients were followed up within 7 days from psychiatric in-patient care. A Standard Operating Procedure (SOP) developed in September has been updated and implemented outlining roles and responsibilities for both Community and Ward staff in relation to completion of the 7 day follow up standard. Service Leads in planned and urgent care have been contacted to ensure that the SOP is followed and that all relevant patient data is completed on discharge. An audit has been scheduled to take place in January 2018 to ensure that templates and processes are completed and followed. The Trust have provided an exception report for the breaches which confirm the following reasons for breaching target :

1 x patients refusal to provide contact details

1 x patient of No Fixed Abode (NFA) offered appointment at Penn Hospital however DNA'd (Did Not Attend)

1 x patient DNA'd (Did Not Attend) appointment, further telephone and postal contact attempted.

1 x patient open to multiple teams at time of discharge with a delay in attempting contact leading to follow up outside of the 7 day standard.

Evidence of using HONOS: Proportion of patients with a HONOS score

BCPFT_LQGE09

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
96.07%	96.21%	96.40%	95.93%	97.03%	95.21%							96.14%	95.00%

The submitted data for this indicator is at a Provider level and includes both Wolverhampton and Sandwell figures. The Wolverhampton element has achieved the 95% target since April 2017, however has seen a decrease in compliance from 97.30% in August to 95.86% in September. The Sandwell element has also seen a decrease in performance and has failed to achieve target during September 2017 (94.66%). There was a 11.46% increase in the reported number of patients (provider total denominator) with the Wolverhampton denominator increasing by 3.89% (from 3,701 in August to 3,845 in September) and Sandwell by 18.65% (from 3,899 in August to 4,626 in September).

Delayed Transfers of Care to be maintained at a minimum level

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
5.12%	3.29%	3.16%	2.50%	2.25%	2.33%							3.11%	7.50%

BCPFT_LQGE11

The Delayed Transfers of care programme (DTOC) has seen a positive decrease since February 2017 with the overall Trust performance for September being confirmed as 2.33% against the 7.5% threshold. The Wolverhampton only performance has been confirmed as 4.54% (Sandwell = 1.42%) As delayed discharges remain a National issue, performance will monitored via the 2017/18 Local Quality Requirements contract and remain an agenda item on both the CCG's monthly performance call with NHS England (NHSE) and the Trusts CQRM meetings. From April 2017 there has been a change to the methodology used for the submission of the National DTOC returns. Data is no longer available for the number of patients delayed (on a monthly snapshot) and figures are based on the number of delayed days divided by the number of days in the month. The September National figures have been confirmed as follows for the Black Country Partnership (all commissioners) :

NHS delay days = 0 (0 month average - decrease from 0.45 in July)

Social Care delay days = 78 (2.52 bed day average - increase from 2.48 in July)

Both delay days = 31 (1.00 bed day average - no change from 1.00 in July)

Trust Total = 109 delay days (3.52 bed day average - overall decrease from 3.94 average in July)

Percentage of people who are moving to recovery of those who have completed treatment in the reporting period [Target - >50%, Sanction: GC9]

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
51.05%	55.06%	56.74%	64.46%	50.68%	58.52%							56.08%	50.00%

BCPFT_LQIA01

The IAPT Moving to Recovery performance has previously been reported as part of the IAPT Dashboards and has consistently achieved over the 50% target. The performance for 2017/18 has continued this trend with 58.52% of patients moving to recovery during September 2017. However, this indicator has been included as part of the Horizon Scanning Report as there has been a variance in the figures published by NHS England. The Black Country Partnership NHS Foundation Trust have performed a full data cleanse and established that several discharged patient system records had incorrectly been flagged for inclusion to the denominator for the National Data Set. The Trust continue to analyse system reports to ensure that all cases are deactivated correctly, however current efforts will not filter through and impact on the National data until the August report (publication due November) due to the rolling quarter calculations. The latest National data available is for July 2017 and is currently reporting at 55.68% and is GREEN for this first time this year. The Trust continue to work closely with the system provider and providing regular updates to the Commissioner, NHS Digital, the Trust Boards and CQRM.

6. Contract and Procurement Report

The Committee received the latest overview of contracts and procurement activities. There were no significant changes to the procurement plan to note.

7. Risk Report

The Committee received and considered an overview of the risk profile for the Committee including Corporate and Committee level risks.

8. RISK and MITIGATION

The CCG submitted an annual plan which presented a nil net risk. Following discussion within the CCG the risk profile has changed to reflect changes between plan submission (March 2017), and Month 7, and continues to report a nil net risk.

The table below details the current risk assessment for the CCG' a risk of £2.2m with mitigations of £2.2m.

CCG RISKS & MITIGATIONS	Forecast Net Expenditure				RISKS (enter negative values only)						MITIGATIONS (enter positive values only)									TOTAL NET (RISK) / MITIGATION	Of Which: RECURRENT
	Plan	Actual	Variance	Variance	Contract	QIPP	Performance Issues	Prescribing	Other	TOTAL RISKS	Contingency Held	Contract Reserves	Investments Uncommitted	Further QIPP Extensions	Non-Recurrent Measures	Delay / Reduce Investment Plans	Other Mitigations	Potential Funding	TOTAL MITIGATIONS		
	£m	£m	£m	%	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
REVENUE RESOURCE LIMIT (IN YEAR)	394.0																				
REVENUE RESOURCE LIMIT (CUMULATIVE)	403.2																				
Acute Services	193.7	195.4	(1.7)	(0.9%)	(1.4)	(0.3)				(1.7)				0.3					0.3	(1.4)	(1.4)
Mental Health Services	36.0	36.1	(0.1)	(0.3%)		0.0				0.0				0.0					0.0	0.0	
Community Health Services	48.5	47.7	0.8	1.7%		0.0				0.0				0.0					0.0	0.0	
Continuing Care Services	14.5	14.1	0.4	2.7%		0.0				0.0				0.0					0.0	0.0	
Primary Care Services	52.3	53.1	(0.8)	(1.6%)		0.0		(0.5)		(0.5)				0.0	0.5				0.5	0.0	
Primary Care Co-Commissioning	35.5	35.0	0.5	1.4%		0.0				0.0				0.0	0.4				0.4	0.4	
Other Programme Services	7.9	7.1	0.8	10.3%		0.0				0.0				0.0		0.9	0.1		1.0	1.0	
Commissioning Services Total	388.5	388.6	(0.1)	(0.0%)	(1.4)	(0.3)	0.0	(0.5)	0.0	(2.2)	0.0	0.0	0.0	0.3	0.9	0.9	0.1	0.0	2.2	0.0	(1.4)
Running Costs	5.5	5.4	0.1	1.8%		0.0				0.0				0.0					0.0	0.0	
Unidentified QIPP										0.0									0.0	0.0	
TOTAL CCG NET EXPENDITURE	394.0	394.0	0.0	0.0%	(1.4)	(0.3)	0.0	(0.5)	0.0	(2.2)	0.0	0.0	0.0	0.3	0.9	0.9	0.1	0.0	2.2	0.0	(1.4)
IN YEAR UNDERSPEND / (DEFICIT)	0.0	0.0	0.0	0.0%																	
CUMULATIVE UNDERSPEND / (DEFICIT)	9.1	9.1	0.0	0.0%																	

There has been a change in reporting requirements to NHSE as the above table now reflects risk and mitigations by service line as well as by recurrent /non recurrent. It is clear that the CCG is carrying a recurrent risk, particularly in the Acute portfolio which is being offset by non-recurrent solutions.

A further potential risk not included in the financial position or the risk schedule relates to the outstanding issue with RWT £4.8m for lost income relating to Non Elective admissions. This issue has been escalated to NHSE at Regional level and the CCG is awaiting an update.

In summary the CCG is reporting the following:

	£m Surplus(deficit)	
Most Likely	£9.130	No risks or mitigations, **achieves** control total
Best Case	£11.330	Control total and mitigations achieved, risks do not materialise **achieves** control total
Risk adjusted case	£9.130	Adjusted risks and mitigations occur. CCG **achieves** control total
Worst Case	£6.930	Adjusted risks and no mitigations occur. CCG **misses** revised control total

9. Other Risk

Breaches in performance and increases in activity will result in an increase in costs to the CCG. Performance must be monitored and managed effectively to ensure providers are meeting the local and national agreed targets and are being managed to operate within the CCG's financial constraints. Activity and Finance performance is discussed monthly through the Finance and Performance Committee Meetings to provide members with updates and assurance of delivery against plans.

A decline in performance can directly affect patient care across the local healthcare economy. It is therefore imperative to ensure that quality of care is maintained and risks mitigated to ensure patient care is not impacted. Performance is monitored monthly through the Finance and Performance Committee and through the following committees; including Clinical Quality Review Meetings, Contract Review Meetings and Quality and Safety Committee.

There are potentially two additional risks not factored into the financial position or Risk schedule as follows:

- Any contribution to the currently disputed £4.8m invoice received from RWT in respect of lost income as Emergency activity continues to reduce (a national directive)
- Any potential financial consequences resulting from issues arising with services provided at the Urgent Care Centre (Vocare Ltd).

10. RECOMMENDATIONS

- **Receive** and **note** the information provided in this report.

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **27th November 2017**

NHS
Wolverhampton
Clinical Commissioning Group

Performance Indicators 17/18

Current Month: Sep

Key:

(based on if indicator required to be either Higher or Lower than target/threshold)

- Improved Performance from previous month
- Decline in Performance from previous month
- Performance has remained the same

17/18 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month A M J J A S O N D J F M Yr End
RWT_EB5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	RWT	95%	91.42%	R	92.89%	R	↓	
RWT_EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	RWT	93%	93.44%	G	93.12%	G	↓	
RWT_EB7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	RWT	93%	95.10%	G	95.26%	G	↑	
RWT_EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	RWT	96%	97.16%	G	96.82%	G	↓	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	RWT	94%	84.85%	R	89.62%	R	↓	
RWT_EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	RWT	98%	100.00%	G	100.00%	G	→	
RWT_EB11	Percentage of service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	RWT	94%	98.72%	G	98.96%	G	↑	
RWT_EB12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.	RWT	85%	72.96%	R	75.22%	R	↓	
RWT_EB13	Percentage of Service Users waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	RWT	90%	83.78%	R	85.12%	R	↓	
RWT_EBS1	Mixed sex accommodation breach	RWT	0	0.00	G	0.00	G	→	
RWT_EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	RWT	0	0.00	G	0.00	G	→	
RWT_EAS4	Zero tolerance Methicillin-Resistant Staphylococcus Aureus	RWT	0	0.00	G	0.00	G	→	
RWT_EAS5	Minimise rates of Clostridium Difficile	RWT	Mths 1-11 = 3 Mth 12 = 2	2.00	G	19.00	R	↑	
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	RWT	0	0	G	10	R	→	
RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	RWT	0	70	R	301	R	↓	
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	RWT	0	2	R	15	R	↑	
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	RWT	0	0	G	0	G	→	
RWT_EBS6	No urgent operation should be cancelled for a second time	RWT	0	0	G	0	G	→	
RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	95.00%	G	95.46%	G	↓	
RWTCB_S10B	Duty of candour (Note : Yes = Compliance, No = Breach)	RWT	Yes	Yes	G	-	-		
RWTCB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	99.00%	99.88%	G	99.86%	G	↑	
RWTCB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	95.00%	99.20%	G	99.01%	G	↑	
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	RWT	95.00%	95.91%	G	95.00%	R	↑	
RWT_LQR2	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all assessment units [e.g. PAU, SAU, AMU, AAA, GAU etc.]	RWT	Q1 - 85% Q2 - 90% Q3 - 90% Q4 - 92.5%	85.49%	R	87.10%	R	↓	
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	RWT	Q1 - 2.5% Q2 - 2.4% Q3 - 2.2% Q4 - 2.0%	1.49%	G	1.64%	G	↑	
RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the date of incident occurrence (as per SI Framework) Exceptions will be considered with Chief Nurse discussions. Note: Date of occurrence is equal to the date, the incident was discovered	RWT	0	3.00	R	4.00	R	↓	

17/18 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month
RWT_LQR5	Serious incident (SI) reporting – 72 hour review to be undertaken and uploaded onto the STEIS system by the provider (offline submission may be required where online submission is not possible). To be completed within 3 working days of the incident occurrence date. Note: Date of occurrence is equal to the date, the incident was discovered	RWT	0	0.00	G	2.00	R	↑	
RWT_LQR6	Serious incident reporting - Share investigation report and action plan, all grades within timescales set out in NHS Serious Incident Framework. 60 working days of the incident being identified unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced.	RWT	0	0.00	G	11.00	R	↑	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.62%	G	0.34%	G	↓	
RWT_LQR11	% Completion of electronic CHC Checklist	RWT	Q1 - 86% Q2 - 90% Q3 - 94% Q4 - 98%	96.61%	G	95.12%	G	↓	
RWT_LQR12	E-Referral – ASI rates	RWT	10.00%	26.04%	R	32.27%	R	↑	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	80.00%	G	85.95%	G	↓	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	72.92%	G	75.45%	G	↑	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	92.50%	100.00%	G	99.59%	G	↑	
RWT_LQR21	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Combined Safeguarding Dashboard. (Submit : Yes if all Dashboard is compliant, No if breaches)	RWT	Yes	No	R	-	-		
RWT_LQR28	All Staff Hand Hygiene Compliance	RWT	95.00%	92.88%	R	92.28%	R	↑	
RWT_LQR29	Infection Prevention Training Level 2	RWT	95.00%	94.45%	R	94.61%	R	↓	
BCPFT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	BCP	92.00%	96.45%	G	97.28%	G	↓	
BCPFT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	BCP	0.00	0.00	G	0.00	G	→	
BCPFT_DC1	Duty of Candour	BCP	YES	Yes	G	-	-		
BCPFT_IAPT1	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	BCP	90.00%	100.00%	G	100.00%	G	→	
BCPFT_EH4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	BCP	50.00%	100.00%	G	87.92%	G	↑	
BCPFT_EH1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral	BCP	75.00%	97.08%	G	93.96%	G	↑	
BCPFT_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	BCP	95.00%	99.64%	G	99.79%	G	↓	
BCPFT_EBS1	Mixed sex accommodation breach	BCP	0	0	G	0	G	→	
BCPFT_EBS3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	94.67%	R	96.45%	G	↓	
BCPFT_LQGE01a	Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	BCP	90.00%	84.21%	R	90.59%	G		
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge from secondary care. (NB: exclusions apply to patients who discharge themsleves against clinical advice or who are AWOL)	BCP	100.00%	92.59%	R	97.41%	R	↓	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	90.22%	G	91.66%	G		
BCPFT_LQGE06	IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	BCP	85.00%	0.85	G	0.86	G		
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	95.21%	G	96.14%	G	↓	
BCPFT_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	BCP	95.00%	100.00%	G	99.63%	G	↑	
BCPFT_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	BCP	7.50%	2.33%	G	3.11%	G	↓	
BCPFT_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	BCP	95.00%	96.64%	G	95.93%	G	↓	
BCPFT_LQGE12b	% of Crisis assessments carried out within 4 hours (Sandwell Psychiatric Liaison Service Emergency)	BCP	95.00%	97.22%	G	97.62%	G	↓	

17/18 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month
BCPFT_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	BCP	85.00%	84.44%	R	90.95%	G	↓	
BCPFT_LQGE13b	% of Urgent assessments carried out within 48 hours (Sandwell Psychiatric Liaison Service)	BCP	85.00%	89.66%	G	90.62%	G	↓	
BCPFT_LQGE14a	% of Routine assessments carried out within 8 weeks (Sandwell SQPR)	BCP	85.00%	98.28%	G	88.71%	G	↑	
BCPFT_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	BCP	85.00%	100.00%	G	98.05%	G	↑	
BCPFT_LQGE15	Percentage of SUIs that are reported onto STEIS within 2 working days of notification of the incident	BCP	100.00%	100.00%	G	96.67%	R	→	
BCPFT_LQGE16	Update of STEIS at 3 working days of the report. The provider will keep the CCG informed by updating STEIS following completion of 48 hour report (within 72 hours of reporting incident on STEIS. Day one commences as of reporting date). CCG will do monthly data checks to ensure sufficient information has been shared via STEIS and report back to CQRM.	BCP	100.00%	100.00%	G	96.67%	R	↑	
BCPFT_LQGE17	Provide commissioners with Level 1 (concise) and Level 2 (comprehensive) RCA reports within 60 working days and Level 3 (independent investigation) 6 months from the date the investigation is commissioned as per Serious Incident Framework 2015 page 41. All internal investigations should be supported by a clear investigation management plan.	BCP	100.00%	50.00%	R	76.67%	R	↓	
BCPFT_LQIA01	Percentage of people who are moving to recovery of those who have completed treatment in the reporting period [Target - >50%, Sanction: GC9]	BCP	50.00%	58.52%	G	56.08%	G	↑	
BCPFT_LQIA02	75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral [Target - >75% Sanction: GC9]	BCP	75.00%	97.08%	G	96.12%	G	↑	
BCPFT_LQIA03	95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral [Target - >95%, Sanction: GC9]	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_LQIA04	Percentage achievement in data validity across all IAPT submissions on final data validity report [Target - >80%, Sanction: GC9]	BCP	80.00%	92.15%	R	91.17%	G	↑	
BCPFT_LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,880 = 15% of prevalence.	BCP	1.25%	1.28%	R	1.44%	G	↓	
BCPFT_LQIA05CUM	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,880 = 15% of prevalence. CUMULATIVE	BCP	1.25% per mth 15% by YrEnd	8.64%	G	8.64%	G	↑	
BCPFT_LQCA01	Percentage of children referred who have had initial assessment and treatment appointments within 18 weeks. This indicator will follow the rules applied in the 'Improving access to child and adolescent mental health services' reducing waiting times policy and practice guide (including guidance on the 18 weeks referral to treatment standard)' in 'Documents Relied Upon'	BCP	90.00%	100.00%	G	98.59%	G	→	
BCPFT_LQCA03	Percentage of all referrals from paediatric ward/s for self-harm assessed within 12 working hours of referral	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_LQCA04	Every person presenting at A&E with crisis seen within 4 hours. The clock starts when A&E make the referral to crisis.	BCP	100.00%	100.00%	G	100.00%	G	→	
BCPFT_EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	BCP	0	0	G	0	G	→	
BCPFT_EAS5	Minimise rates of Clostridium Difficile	BCP	0	0	G	0	G	→	

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
GOVERNING BODY
12 December 2017

Agenda item 11

TITLE OF REPORT:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 14 November 2017**
AUTHOR(s) OF REPORT:	Peter Price – Interim Chair, Audit and Governance Committee
MANAGEMENT LEAD:	Tony Gallagher – Chief Finance Officer
PURPOSE OF REPORT:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
RECOMMENDATION:	• **Receive** this report and **note** the actions taken by the Audit and Governance Committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	n/a
2. Reducing Health Inequalities in Wolverhampton	n/a
3. System effectiveness delivered within our financial envelope	n/a

1. BACKGROUND AND CURRENT SITUATION

1.1 Internal Auditor Progress Report
The Senior Internal Audit Manager reported on progress on risk had been made since the last Audit and Governance Committee meeting.

1.2 Risk Register Reporting/Board Assurance Framework
The Corporate Operations Manager updated on the move of Risk from Quality and into the Operations Team. He outlined the new processes that were to be put in place and that updates would be given at the next meeting by himself and from observations by the Head of Internal Audit.

1.3 Annual Governance Statement
The Corporate Operations Manager gave an update and reminder of the content of the annual governance statement.

1.4 Update from the Black Country Joint Commissioning Governance Forum
The Corporate Operations Manager presented a paper and terms of reference to the committee regarding the establishment of the Black Country and Joint Commissioning Governance Forum.

1.5 Losses and Compensation Payments – Quarter 2 2017/18
There was 1 loss and no special payments were reported in quarter 2 2017/18

1.6 Suspensions, Waiver and Breaches of SO/PFPS
There were no suspensions of SO/PFPS in quarter 2 of 2017/18

1.7 Receivable/Payable Greater than £10,000 and over 6 months old
The Committee noted that as at 30 June 2017, there were 0 receivables and 13 payables over £10,000 and greater than 6 months old.

CLINICAL VIEW

1.1. N/A

2. PATIENT AND PUBLIC VIEW

2.1. N/A

3. KEY RISKS AND MITIGATIONS

3.1. The Audit and Governance Committee will regularly scrutinise the risk register and Board Assurance Framework of the CCG to gain assurance that processes for the recording and management of risk are robust. If risk is not scrutinised at all levels of the organisation, particularly at Governing Body level, the CCG could suffer a loss of control with potentially significant results.

4. IMPACT ASSESSMENT

Financial and Resource Implications

4.1. N/A

Quality and Safety Implications

4.2. N/A

Equality Implications

4.3. N/A

Legal and Policy Implications

4.4. N/A

Other Implications

4.5. N/A

Name: Tony Gallagher
Job Title: Chief Finance Officer
Date: 15 November 2017

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)		

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY MEETING
12 DECEMBER 2017

Agenda item 12

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 7 November 2017
AUTHOR(s) OF REPORT:	Sue McKie, Primary Care Commissioning Committee Chair
MANAGEMENT LEAD:	Mike Hastings, Associate Director of Operations
PURPOSE OF REPORT:	To provide the Governing Body with an update from the meeting of the Primary Care Commissioning Committee on 7 November 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• The practices with no submission for Friends and Family Test has reduced for the month of August (7% compared to 11% in July 2017). • The delegated primary care allocations for 2017/2018 as at month 6 are £35,513m. The forecast outturn is £35,013m delivering a underspend position. The forecast outturn indicates an underspend of £500k against other GP services which relates to pre delegated i.e. 2016/17.
RECOMMENDATION:	The Governing Body is asked to note the progress made by the Primary Care Joint Commissioning Committee.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Commissioning Committee monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Commissioning Committee works with clinical groups within Primary Care to transform delivery.

3. System effectiveness delivered within our financial envelope	Primary Care issues are managed to enable Primary Care Strategy delivery.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Primary Care Commissioning Committee met on 7 November 2017. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

Primary Care Commissioning Committee – 7 November 2017

2.1 Primary Care Quality Report

2.1.1 The Committee received an overview of primary care and it was noted that there are no major concerns around infection prevention. Of the three reports received from the provider, The Royal Wolverhampton NHS Trust, in the last month two have scored bronze and one has scored silver.

2.1.2 Overall, the practices with no submission for Friends and Family Test has reduced for the month of August (7% compared to 11% in July 2017). The supressed data has remained the same for the month at four practices and the total number of practices with no data available was eight. The number of responses which were rated at positive was 82% (3464).

2.2 WCCG Quarterly Finance Report

2.2.1 The CCG Quarterly finance report was presented to the Committee, which outlined the financial position at month 6.

2.2.2 The delegated primary care allocations for 2017/2018 as at month 6 are £35,513m. The forecast outturn is £35,013m delivering a underspend position. The forecast outturn indicates an underspend of £500k against other GP services which relates to pre delegated i.e. 2016/17. The CCG has been given the income to offset the expenditure and consequently the CCG is reporting a non-recurrent benefit of £500k.

2.2.3 In relation to primary care reserves, the forecast outturn includes a 1% Non-Recurrent Transformation Fund and a 0.5% contingency in line with the 2017/18 planning metrics. In line with national guidance the 1% non-recurrent transformation fund can be utilised in year non-recurrently to help support the delegated services.

2.2.4 It was highlighted that the £500k underspend could only be used on non-recurrent projects and be committed before March 2018.

The Committee received the following update reports:-

2.3 **Governing Body Report / Primary Care Strategy Committee Update**

2.3.1 The Committee were informed of the work progressed against the Primary Care Strategy and each Task and Finish Group and noted that the Governing Body agreed the status of the programme of work to the name change from a Committee to a Programme Board, which would now report on a quarterly basis.

2.4 **Primary Care Operational Management Group Meeting**

2.4.1 The Committee were updated around the discussions which took place at the Primary Care Operational Management Group on 24 October 2017. It was noted that the IT migration plan remains on track and currently there are only four practices left to migrate over to EMIS. The Collaborative Contract Review Visit Programme continues to be rolled out across Wolverhampton and it was noted that no significant issues have been raised.

2.5 **Other Issues Considered**

2.5.1 The Committee met in private to receive an update on the sub-contracting Assurance Framework and the serving of a contract breach notice to a Wolverhampton practice.

3. CLINICAL VIEW

3.1. Not applicable.

4. PATIENT AND PUBLIC VIEW

4.1. Patient and public views are sought as required.

5. KEY RISKS AND MITIGATIONS

5.1. Project risks are reviewed by the Primary Care Operational Management Group.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. Any Financial implications have been considered and addressed at the appropriate forum.

Quality and Safety Implications

6.2. A quality representative is a member of the Committee.

Equality Implications

6.3. Equality and inclusion views are sought as required.

Legal and Policy Implications

6.4. Governance views are sought as required.

Other Implications

6.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Sue McKie
Job Title: Lay Member for Public and Patient Involvement, Committee Chair
Date: 29 November 2017

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Sue McKie**	**29/11/17**

WOLVERHAMPTON CCG
Governing Body
12th December 2017
Agenda item 13

TITLE OF REPORT:	Report of the Primary Care Programme Milestone Review
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To update the governing body on continued progress that has been demonstrated to the Primary Care Strategy Committee following the last update presented on 14th November 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Update on task and finish group workbooks • Update on progress towards Care Navigation implementation • Update on progress towards development of Document Management and Online Consultation • Update on the refreshed Workforce Strategy
RECOMMENDATION:	The recommendations made to governing body regarding the content of this report are as follows:- • Receive and discuss this report • Note the assurance provided by the Director of Strategy & Transformation • Consider and approve the Workforce strategy
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of the services we commission : Ensure on-going safety and performance in the system 2 Reducing Health Inequalities in Wolverhampton: Improve and develop primary care in Wolverhampton; Deliver new models of care that support care closer to home and improve management of Long Term Conditions. 3 System effectiveness delivered within our financial envelope : Deliver improvements in the infrastructure for health and care across Wolverhampton

1 BACKGROUND AND CURRENT SITUATION

1.1. The CCGs Primary Care Strategy Implementation commenced in the summer of 2016. The corresponding programme of work is closely monitored by the Primary Care Team via regular reports to the Primary Care Strategy Committee confirming progress and the effectiveness of action taken during the reporting period. This report confirms the findings from those discussions & the controls in place to safeguard delivery of the programme of work for the Primary Care Strategy and also the General Practice Forward View.

1.2. The CCGs vision is to achieve universally accessible high quality out of hospital services that promote the health and wellbeing of our local community, ensuring that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and also reduce health inequalities. Our vision is that this will be achieved continued development of services available in the community and in general practice.

2. Task and Finish Group Workbooks

2.1 Workbooks are submitted on a monthly basis by programme leads, and monitored through a quarterly Milestone Review Board. A steering group meets in the intervening period to ensure no risks or slippage arise & if so they are duly escalated.

2.2 The programme was running in accordance with anticipated timescales hence there was no slippage on any part of the programme. Workbooks were reviewed for all task and finish groups, with acknowledgement from the responsible Director on current progress and next steps. The highlights are captured within the table below:-

Task & Finish Group	Highlights
Practices as Providers	- Risk Stratification Specification has been agreed at CRG. Pilot is taking place in Church Street Surgery, with roll out to remaining practices anticipated once findings are shared with CRG in December with a view to roll out across other practices commencing in January 2018. - The Home Visiting service business case was agreed by PC/MMO Programme Board in October, and mobilisation is currently underway with an intended commencement of this service by the end of Janaury 2018.. - Recruitment of additional Clinical Pharmacists is currently underway and the allocation of Clinical Pharmacists to practice(s) associated with the successful NHSE bid is anticipated before Christmas.
Localities as Commissioners	- Peer Review findings are being tracked via the task and finish group & discussed at the Group Leads Meeting at regular intervals to review recommendations & emerging themes. - The group are regularly receiving group level data presented in a dashboard. This has highlighted some areas requiring further scrutiny at group level. - Updates on progress with service redesign projects are also presented at this forum to enable clinical ownership/engagement ie Home Visiting Pilot, Risk Stratification, Primary Care Counselling Service, Peer Review and Social Prescribing.

Workforce Development	- STP Workforce Strategy, including information about Wolverhampton, has been submitted and considered by NHSE. Feedback is anticipated early December to confirm whether the strategy has been fully assured. - Workforce analysis, recruitment at group level, development needs & workforce planning have all taken place and contributed to the refreshed Workforce Strategy. - The revised strategy has been considered & agreed at the workforce task and finish group and is attached for ratification by Governing Body. Following ratification the strategy will be implemented across primary care. - The CCG website has been developed as part of this work stream, additional content will be launched early December. - A LinkedIn page is being developed, and a greater emphasis will be placed on updating social media across all departments. - A specific page for PPG chairs to showcase their work is being added to the website. - Recruitment events that we can be involved in are being scoped and will be attended when held. - Apprenticeships are being scoped.
General Practice Contract Management	- Accountable Care Alliance (ACA) Group has been established with representatives from each practice grouping and LMC. Meetings will continue to take place through until the end of March in line with the timeline & priorities identified. - Contracting Model for Primary Care has been defined to ensure the most appropriate contract type(s) are being utilised now & in the future.
Estates Development	- North East BCF locality has a potential base at the Science Park. The option is to be discussed and finances to be taken to the next programme board. PCH are holding a workshop in October for and update on the service specification being developed and delivery of services in Wolverhampton. - Lease agreements issue is still on-going, however the CCG and practices have been notified that Internal Repair Leases will not be offered. Practices continue to worth with NHSPS to iron out service charge issues and meetings have been on-going with CCG support. PCC delegated authorisation to Mike Hastings for reallocation of ETTF funding which the Operations team are currently scoping and working with practices on.
IM&T	- Data Checking and finalisation of documentation for migration of Dr Wagstaff complete, a 3 practice merger is also due to conclude in December. - Patient Online Uptake: working with Group Managers to engage the practice groups to increase usage. Also met with NHS Digital Regional Lead to review progress and agree future steps. - Two way text messaging project has been costed & a trial due by the end of November with a view to full rollout before the end of the financial year to all other practices. - Initial discussions regarding online consultations have also commenced & a bid for funding will be submitted to NHS England early December.

2.2 General Practice Five Year Forward View Progress

Specific updates for consideration are in the following areas;

2.2.1 Care Navigation

The preparatory measures for the inception of care navigation are moving forward. The current focus is training of staff, and ensuring practices are ready to utilise care navigation once it is launched in January.

The five navigation points in phase one are:-

- Community Pharmacy
- Minor Eye Conditions
- One You/ Healthy Lifestyles Service
- Carer Support
- Community Dentist

The five identified navigation pathways are well engaged with the programme, and are scheduled to attend face to face training with practice staff in January, this will follow online training also due to be undertaken in December. The IT requirements are all in place, templates including referral criteria have been built into the EMIS system ready for staff to navigate patients when appropriate.

Practices are taking up the offer of an informal training session delivered by the Primary Care Development Manager during their staff meetings or training sessions. The aim of these sessions is to answer any questions the staff may have and alleviating any concerns there are about incorporating Care Navigation in their daily working practices. The sessions are being accessed by staff who have not attended any of the previous training sessions, and are creating a consistent Wolverhampton wide message.

A communications pack is being developed to support staff and patients with understanding the concept of care navigation, and the changes to the patient pathway as a result of this. Practice managers have been consulted on the content to ensure it is relevant to their needs, and it has also been discussed at the Practice Managers Forum & Lay Member for Patient & Public Engagement.

Clinicians attending the general practitioner educational event (Team W) in November will receive a presentation by the provider (West Wakefield) to provide an overview of the model & progress so far, their endorsement of the programme is an important aspect of successful implementation at practice level. There will also be information in the communications pack specifically aimed at the GP and clinical staff within the practice.

2.2.2 Document Management

Document Management is part of the next phase of programmes to be implemented to support the on-going development of non-clinical staff.

A procurement exercise will commence shortly in preparation of provision of training that will enable reception and admin staff to effectively deal with medical correspondence, freeing up GP time therefore creating capacity. Research shows that up to 80% of medical correspondence can be safely and effectively processed by an administrator, and saves 40 minutes a day per GP.

A specification is being developed and discussions being held with providers, with the proposed time for inception of this training and support being late February 2018.

This will also form part of a communications plan, to ensure that patients are involved in the introduction & any changes that may arise in the patient journey.

2.2.3 Online Consultation

At STP level, CCGs are formulating a bid for funding to enable roll out of online consultation across each CCG. The needs of the population are currently being scoped, and procurement will commence early in the new year. Evidence suggests that online consultations may have value for some patients, such as straightforward medical enquiries, but are not suitable to replace face-to-face consultations in situations which are more complex. Most patients said they valued the eConsult system and clinicians said it worked best for "simple and routine inquiries" they could respond to without the need for a face-to-face or telephone follow up.

The most common reason for an online consultation was for administrative reasons such as requesting "fit notes" or repeat prescriptions, followed by infections or back or knee pain issues.

We are also looking at potentially piloting this out to care homes, so that a home visit can be prevented by a skype type appointment taking place between a health professional that is in attendance, the patient, and a GP virtually.

2.2.4 Extended access/ winter opening

Plans for access over the winter period are now in place. Appointments will be available for patients to access every day except Christmas day and Sunday 31st December. This will be provided through their usual practices or via group hubs.

In addition, the CCG is funding a Winter Pressures Scheme to increase the number of appointments available to patients during the period December to March. Practices willing to participate in the scheme will provide additional appointments Monday to Friday in addition to existing arrangements already in place.

A communications plan is also in place, with promotion of the availability taking place through websites, newsletters and via text messages from the registered practice.

There will also be a series of advertisements in the local newspapers during the winter period promoting access to care featuring health messages and a breakdown of access routes over the bank holiday period. Group specific information leaflets are also being printed & will be available to patients.

2.2.5 Workforce Strategy

A range of personnel and stakeholders have been consulted as part of the refresh of the strategy. A final draft of the strategy is attached; this document has been finalised following endorsement by the Workforce Task and Finish Group. Our Vision is to develop and sustain a workforce built around the needs of our population, which has the skills, knowledge and values to transform at scale and delivery high quality care within Wolverhampton.

3 CLINICAL VIEW

3.1 There are a range of clinical and non-clinical professionals who are actively involved in discussions at the committee along with involvement at task and finish group level too. This assist in delivery of a clinically driven programme.

4 PATIENT AND PUBLIC VIEW

4.1 Whilst patients and the public were engaged in the development of the Primary Care Strategy and Patient Participation Group Chairs are involved in discussions associated with both programmes of work the Governing Body lay member is also appraised of ongoing developments & intentions through regular liaison & discussions.

4.2 An update on Primary Care was provided to the Patient Participation Group Chairs in November, and meetings at group level have been introduced on a quarterly basis to ensure patients and the public are invited to share their suggestions on areas for improvement and take part in discussions about changes affecting patients within their respective practice group. A meeting has been set up with representatives to discuss the implications the above programmes of work will have on patients and their journey. The communications plan will also be discussed.

5 RISKS AND IMPLICATIONS

Key Risks

5.1 The Primary Care Strategy Committee has in place a risk register that captures the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise with the Governing Body.

Financial and Resource Implications

5.2 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and task and finish group level will enable appropriate discussions to take place in a timely manner.

Quality and Safety Implications

5.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme has established is anticipated to be met with positive experiences of care. The quality team are actively engaged as service design / redesign takes place and evaluation of existing care delivery is undertaken.

Equality Implications

5.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

5.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

Legal and Policy Implications

5.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

Name Sarah Southall
Job Title Head of Primary Care
Date 30.11.17

Enclosure Primary Care Workforce Strategy

SLS/GBR-PCSC/Dec17

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**NA**	
Public/ Patient View	**NA**	
Finance Implications discussed with Finance Team	**NA**	
Quality Implications discussed with Quality and Risk Team	**NA**	
Equality Implications discussed with CSU Equality and Inclusion Service	**NA**	
Information Governance implications discussed with IG Support Officer	**NA**	
Legal/ Policy implications discussed with Corporate Operations Manager	**NA**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**NA**	
Any relevant data requirements discussed with CSU Business Intelligence	**NA**	
Signed off by Report Owner (Must be completed)	**Steven Marshall**	

Workforce and Development (October17)

What is current week? 77

Ref	Milestone Action	Owner	Week Start Date	Duration of Milestone	Milestone Action Completed - Not Started In Progress Completed Slippage
					July 2017: 03 July 2017 (66); 10 July 2017 (67); 17 July 2017 (68); 24 July 2017 (69); 31 July 2017 (70)
					Aug 2017: 07 August 2017 (71); 14 August 2017 (72); 21 August 2017 (73); 28 August 2017 (74)
					Sep 2017: 04 September 2017 (75); 11 September 2017 (76); 18 September 2017 (77); 25 September 2017 (78)
					Oct 2017: 02 October 2017 (79); 09 October 2017 (80); 16 October 2017 (81); 23 October 2017 (82); 30 October 2017 (83)
					Nov 2017: 06 November 2017 (84); 13 November 2017 (85); 20 November 2017 (86); 27 November 2017 (87)
					Dec 2017: 04 December 2017 (88); 11 December 2017 (89); 18 December 2017 (90); 25 December 2017 (91)
					Jan 2018: 01 January 2018 (92); 08 January 2018 (93); 15 January 2018 (94); 22 January 2018 (95); 29 January 2018 (96)
					Feb 2018: 05 February 2018 (97); 12 February 2018 (98); 19 February 2018 (99); 26 February 2018 (100)
					March 2018: 05 March 2018 (101); 12 March 2018 (102); 19 March 2018 (103); 26 March 2018 (104)
1	**Primary Care Workforce Strategy**	Director of Nursing	78	27	Not Started
1.1	Develop and finalise strategy covering all staff groups spanning both clinical and non-clinical roles within Primary Care	Marianne Thompson	78	8	Not Started
1.2	Implementation plan to be developed	Marianne Thompson	81	7	Not Started
1.3	Implementation plan and draft strategy to be submitted for ratification at the Primary Care Strategy Committee	Marianne Thompson	87	4	Not Started
1.4	Commence implementation and provide on going update to workforce task and finish group	Marianne Thompson	88	17	Not Started
1.5	Workbook to be updated on a regular basis (monthly) pertaining to the strategy at every stage.	ALL	79	26	Not Started
2	**Primary Care Strategy**	Sarah Southall	53	52	In Progress
2.1	Pro-actively undertake workforce analysis at regular intervals to inform the workforce plan achieving a multi professional workforce	Group Managers/ Marianne Thompson	84	21	Not Started
2.2	The plan should be owned at practice group/locality level and due consideration given to the recruitment, retention and development of personnel across all staff groups	Group Managers	79	26	Not Started
2.3	Regularly review training and development needs spanning all staff groups (linked to 4.2 and 4.7)	Marianne Thompson	78	14	Not Started
2.4	Evaluate training and development review spanning all staff groups (linked to above 2.3)	Marianne Thompson	92	5	Not Started
2.5	To ensure identified needs within each practice group and skill mix are reflected in workforce plan(s), overseen by the task and finish group (linked to 4.2 and 4.7)	Group Managers	81	7	Not Started
2.6	Develop a strong correlation between skill mix and health care need including MEC (Making Every Contact Count) (link to 4.2,4.6,4.7)	SS/LC	53	52	In Progress
2.7	prevention and innovative ways of delivering care to patients through multi-disciplinary team working with health and social care partners i.e. community teams, also including mental health therapists	Sarah Southall	66	22	In Progress
2.8	Develop a recruitment programme to attract and recruit personnel to work in Wolverhampton offering the necessary training and development to train them locally in the city (this also includes trainees and development of existing employees).	Sarah Southall/ Marianne Thompson	66	26	In Progress
2.8.1	Through work with practice groups/localities create a working environment that encourages trainees to remain in Wolverhampton	Marianne Thompson	79	26	Not Started
2.9	Encourage and support those living in the area with suitable qualifications to work in primary care, maximising their employment potential i.e. hours, working at scale and seven day working.	Marianne Thompson	88	17	Not Started
2.10	Occupational Health Service for GPs facing burnout	NHSE/Jo Reynolds	53	26	Completed
2.11	Establish and maintain strong links with stakeholder educational establishments with the following:	Marianne Thompson	78	14	Not Started
2.11.1	Wolverhampton University (bi monthly update via workbook)	Marianne Thompson	78	14	Not Started
2.11.2	CPEN (SLA)	Liz Corrigan	78	14	Not Started
2.11.3	Health Education West Midlands	Marianne Thompson/ Liz Corrigan	78	14	Not Started
2.11.4	Voluntary Training Scheme (link to 4.8)	Marianne Thompson	78	14	Not Started
2.11.5	Develop a portfolio of educational events and oversee delivery of educational events for both medical, nursing and non-clinical staff groups:	Marianne Thompson	62	43	In Progress
2.11.5.1	Clinical Education for nurses (10 point action plan)	Liz Corrigan	62	43	In Progress
2.11.5.2	Clinical Education for GPS (Team W/Trainees)	Jo Reynolds/ Dr Agarwal	62	43	In Progress
2.11.5.3	Education for non clinical staff	Marianne Thompson/ Jo Reynolds	62	43	In Progress

2.12	Review effectiveness of 2.9 (link to 3.4 Practice Nurse Ten Point Action Plan)	Marianne Thompson	92	9	Not Started
2.13	Primary Care workforce dashboard to be developed based on the principles of the Primary Care Workforce Strategy and General Practice Five Year Forward View (including National Study) (link to 4.4)	Marianne Thompson	88	17	Not Started
2.14	To seek approval of Primary Care workforce dashboard and the relevant Committee/Boards	Marianne Thompson	88	17	Not Started
2.15	To implement the Primary Care Workforce dashboard	Marianne Thompson	88	17	Not Started
2.16	To monitor the progress and identify early warnings where shortfalls/risks affecting the workforce can be identified and mitigated at the earliest opportunity.	Marianne Thompson	88	17	Not Started
2.17	To report upon findings of the Primary Care Workforce Dashboard to relevant Committees/Boards	Marianne Thompson	88	17	Not Started
2.18	Identifying and securing resources internal and external to WCCG to support the implementation of the strategy through strong partnership working	Marianne Thompson/ ALL	88	17	Not Started
2.19	sound information sharing among other task and finish group leads to aid effective implementation of the Workforce Strategy and strong allegiance with wider implementation of the Primary Care Strategy.	Marianne Thompson/ Chair	88	17	Not Started
2.20	Comm's and Engagement Sub Group (linked to 2.2,2.8,2.9,2.11, 3.0 and 4.0)	Sarah Southall	66	39	In Progress
3.0	**GPFV/STP Collaborative working**	Jo Reynolds			
3.1	Increase recruitment and retention of doctors within Primary Care	Jo Reynolds	To be confirmed		
3.1.1	West Midlands Training allocation	Jo Reynolds	To be confirmed		
3.1.2	Multi-disciplinary Primary Care Careers Marketing campaign (STP)/ Workforce coms and engagement sub group	Jo Reynolds	66	39	In Progress
3.1.3	International recruitment of qualified overseas doctors	Jo Reynolds	75	30	In Progress
3.1.4	Targeted Enhanced Recruitment Schemes (£20,000 bursaries in the areas that have found it hardest to recruit unto GP training	Jo Reynolds	To be confirmed		
3.1.5	Post CCT Fellowships	Jo Reynolds / Dr Agarwal	62	43	In Progress
3.2	Increase numbers of other staff working in primary care:	Jo Reynolds	To be confirmed		
3.2.1	Mental Health therapists	Jo Reynolds	79	26	Not Started
3.2.2	Clinical Pharmacists and existing community pharmacy working in general practice	Group Managers	66	39	In Progress
3.2.3	practice nursing workforce development plan and improve training capacity in general practice increasing in the number of pre-registration nurse and return to practice. (link to 4.2, 4.3,4.8)	Liz Corrigan/CPEN	53	52	In Progress
3.2.4	Physician Associates to support General Practice	Marianne Thompson/ Dr Agarwal	62	43	In Progress
3.2.5	Self referral to physiotherapists	Jo Reynolds	79	26	Not Started
3.5.6	medical assistant roles	Jo Reynolds	79	26	Not Started
3.2.7	Practice Manager development, alongside access for practice managers to the new national development programme	Jo Reynolds/ Group Managers	58	39	In Progress
3.2.8	£3.5 million investment in multi-disciplinary training hubs in every part of England to support the development of the wider workforce within general practice (link to 2.11.2))	Jo Reynolds	To be confirmed		
3.3	Practices need to create protected time and space to support effective team	Marianne Thompson	66	39	In Progress
3.3.1	Workforce Strategy implementation/monitoring within groups	Marianne Thompson/ Group Managers	92	13	Not Started
3.3.2	STP baseline assessment (workforce)	Sarah Southall	66	5	Completed
3.3.3	Develop STP workforce strategy	Sarah Southall	75	4	In Progress
3.3.4	STP workforce strategy monitoring (via STP GPFV working group quarterly update)	Sarah Southall	92	5	Not Started
3.3.5	STP workforce strategy monitoring (via STP GPFV working group quarterly update)	Sarah Southall	105	5	Not Started
3.3.6	STP workforce strategy monitoring (via STP GPFV working group quarterly update)	Sarah Southall	118	5	Not Started

3.3.7	STP workforce strategy monitoring (via STP GPFV working group quarterly update)	Sarah Southall	131	5	Not Started
3.3.8	Realisation from benefits from all training programmes	Jo Reynolds	88	13	Not Started
4.0	**Practice Nurse Ten Point Action Plan**	Liz Corrigan			
4.1	**Action 1 - Celebrate and raise the profile of general practice nursing and promote general practice as a first destination career**	Liz Corrigan	53	52	In Progress
4.1.1	Workforce promotional video to feature local GPNs and HCAs (including a Nursing Associate) focusing on promoting the profession from a local point of view also including information on development and employment opportunities.	Sarah Southall	66	18	In Progress
4.1.2	Refresh and upgrade of the Practice Nurse webpages to reflect, training opportunities, vacancies, guidance and celebration of good practice. To be based on other local and national information pages and signposting to other useful pages.	Liz Corrigan	71	39	In Progress
4.2.3	Work with Locality Managers and Project Manager, and the CEPN to consolidate workforce plans and provide intelligence on local nursing workforce needs, taking into account regional and national drivers and guidance.	Liz Corrigan	53	52	In Progress
4.2	**Action 2 - Extend Leadership and Educator roles**	Liz Corrigan	53	52	In Progress
4.2.1	Working with HEWM to promote access to on-line leadership programmes e.g. Edward Jenner and access to the Triumvirate Leadership Programme is underway (the application process for the Triumvirate Programmes managed by HEWM).	Liz Corrigan	53	78	In Progress
4.2.2	Encourage nurses to play an active role in identifying training and development opportunities via the GPN forum/Practice Makes Perfect	Liz Corrigan	92	31	Not Started
4.2.3	To identify local GPN educators within higher education	Liz Corrigan	71	8	Completed
4.2.4	Explore scope for employment of a Primary Care Nurse Facilitator as part of future workforce development plans.	Liz Corrigan	66	39	In Progress
4.3	**Action 3 - Increase the number of pre-registration placements in general practice**	Liz Corrigan	53	52	In Progress
4.3.1	promote mentor training and maintenance of placement sites in liaison with the CEPN and the University of Wolverhampton	Liz Corrigan/CPEN	53	52	In Progress
4.3.2	CCG to work in conjunction with the university to encourage all practices and groups to consider placements, and to encourage those with an existing mentor qualification to have an update as well as new mentors to undergo training.	Liz Corrigan/ University	53	52	In Progress
4.4	**Action 4 - Establish inductions and preceptorships**	Liz Corrigan	53	104	In Progress
4.4.1	Work with the GPN leads steering group and the CEPN to explore how we can pre-empt and look at embedding this via practice groups in advance via collaboration with the Project and Locality Managers.	Liz Corrigan	105	52	Not Started
4.4.2	Explore opportunities at present to link with RWT training and development team and other providers to provide a basket of recommended induction training that is suitable for RNs and HCAs.	Liz Corrigan	66	39	In Progress
4.4.3	Work with HEWM, CEPN and local universities to facilitate access to the Fundamentals of General Practice Nursing programmes and identify alternative funding streams e.g. Learning and Development Loans where required.	Liz Corrigan	53	26	Completed
4.5	**Action 5 - Improve access to 'return to practice' programmes**	Liz Corrigan	92	57	Not Started
4.5.1	The development of GPN specific Return to Nursing programmes by HEWM and local universities to be driven by the National Team then the CCG to ensure that candidates can access suitable mentorship.	Liz Corrigan (driven nationally)	92	57	Not Started
4.6	**Action 6 - Embed and deliver a radical upgrade in prevention**	Liz Corrigan	53	52	In Progress
4.6.1	Promote the MECC agenda within Primary Care and explore to identify what is already in place and what needs to be done.	Sarah Southall/ Liz Corrigan	53	52	In Progress
4.6.2	Work with Public Health to promote the prevention agenda within nurse and HCA training and raise awareness (quarter 1)	Liz Corrigan	71	4	In Progress
4.6.3	Work with Public Health to promote the prevention agenda within nurse and HCA training and raise awareness (quarter 2)	Liz Corrigan	91	4	Not Started
4.6.4	Work with Public Health to promote the prevention agenda within nurse and HCA training and raise awareness (quarter 3)	Liz Corrigan	101	4	Not Started

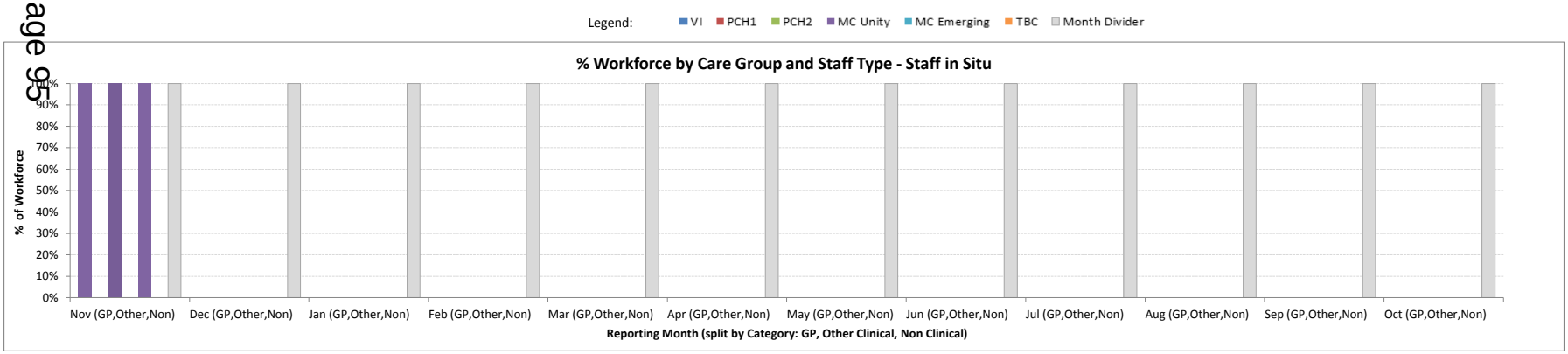
4.7	**Action 7 - Support access to educational programmes to deliver national priorities as set out in the Five Year Forward View**	Liz Corrigan	53	52	In Progress	
4.7.1	Work is ongoing with the CEPN and HEWM to ensure that funding opportunities are made available for Wolverhampton GPNs.	Liz Corrigan/ CPEN	53	26	Completed	
4.7.2	Provide information on local training and development opportunities for primary care via the practice nurse website.	Liz Corrigan	71	39	In Progress	
4.7.3	liaise with Locality Managers to work with practice groups and ensure that nurses and HCAs have the opportunity to access programmes via access to study leave.	Liz Corrigan/ Marianne Thompson	84	21	Not Started	
4.7.4	To provide ongoing information around alternative funding streams such as, advanced learner loans, training and development loans, student loans for part-time courses, post-graduate student loans and training bursaries from QNI and RCN.	Liz Corrigan	71	39	In Progress	
4.8	**Action 8 - Increase access to clinical academic careers and advanced clinical practice**	Liz Corrigan	53	52	In Progress	
4.8.1	Work with the CEPN and HEWM to ensure that funding opportunities are made available for Wolverhampton GPNs as well as for other professionals.	Sarah Southall/ Liz Corrigan	53	52	In Progress	
4.8.2	identify and promote alternative funding streams for ACP courses (see above)	Liz Corrigan	53	26	Completed	
4.9	**Action 9 - Develop healthcare support worker (HCSW), apprenticeship and nursing associate career pathways**	Liz Corrigan	53	52	In Progress	
4.9.1	Project Managers, Locality Managers and Practice Leads to identify practice needs regarding staff development (forms part of the GPN training agenda and the workforce development plans)	Liz Corrigan/ CPEN	84	21	Not Started	
4.9.2	Ensure that HCAs are included in the overall GPN training agenda including access to study leave	Liz Corrigan/ Group Managers	84	21	Not Started	
4.9.3	Work with CEPN, HEWM and local apprenticeship providers to identify what is available and provide information around the nursing/HCA agenda and local requirements relating to NMC guidance around placements and mentorship. Liaising with the Project Manager to provide intelligence for the overall agenda.	Liz Corrigan/CPEN	53	52	In Progress	
4.10	**Action 10 - Improve Retention**	Liz Corrigan	To be confirmed			
4.10.1	Review programmes in other areas as per GPFV and liaise with HEWM around plans relating to the action plan.	ALL (driven nationally)			Not Started	

Workforce Mapping Dashboard

Select Required Care Group from Drop Down >	CCG Headline if no selection made

Staff in Situ (WTE) - by Role Type

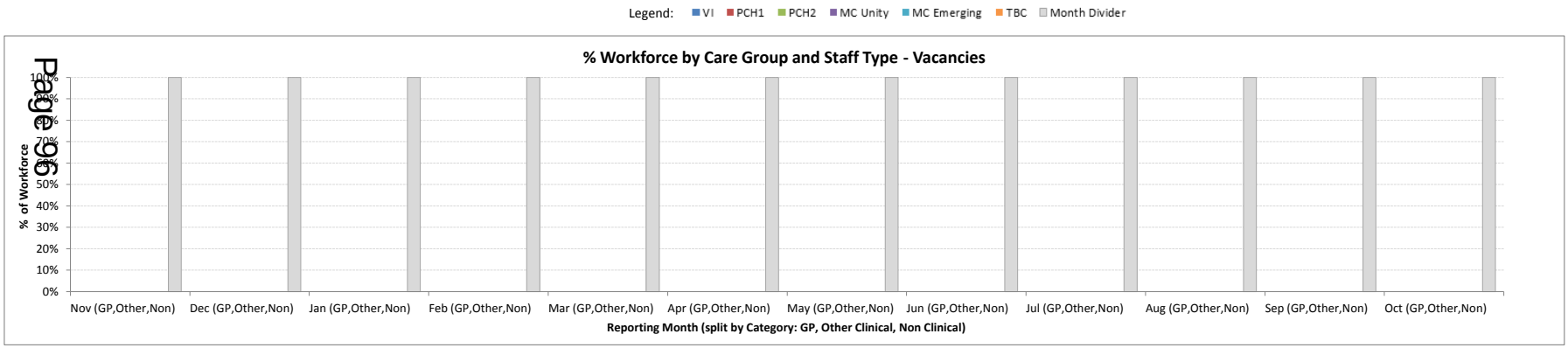
		2017/18											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Staff in Situ	Reception	12	0	0	0	0	0	0	0	0	0	0	0
	Admin	9	0	0	0	0	0	0	0	0	0	0	0
	Practice Manager	6	0	0	0	0	0	0	0	0	0	0	0
	Nurses	6	0	0	0	0	0	0	0	0	0	0	0
	GP	10	0	0	0	0	0	0	0	0	0	0	0
	Other - HCA	2	0	0	0	0	0	0	0	0	0	0	0
	Other - Social Worker	0	0	0	0	0	0	0	0	0	0	0	0
	Other - Care Navigator	0	0	0	0	0	0	0	0	0	0	0	0
	Other Physician Associate	0	0	0	0	0	0	0	0	0	0	0	0
	Social Prescribing	0	0	0	0	0	0	0	0	0	0	0	0
	Students (without supervision)	0	0	0	0	0	0	0	0	0	0	0	0
	Clinical Pharmacists	0	0	0	0	0	0	0	0	0	0	0	0
	Staff in Situ Total	45	0	0	0	0	0	0	0	0	0	0	0
	GP	10	0	0	0	0	0	0	0	0	0	0	0
	Other Clinical	8	0	0	0	0	0	0	0	0	0	0	0
	Non Clinical Staff	27	0	0	0	0	0	0	0	0	0	0	0
	Overall percentage of workforce	*100.00%*											



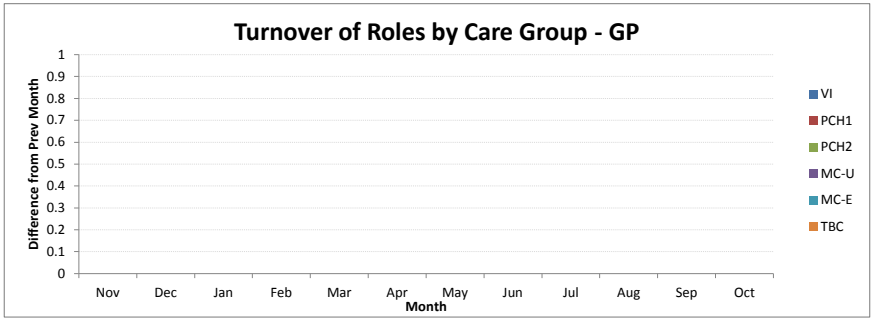
Vacancies (WTE) - by Role Type

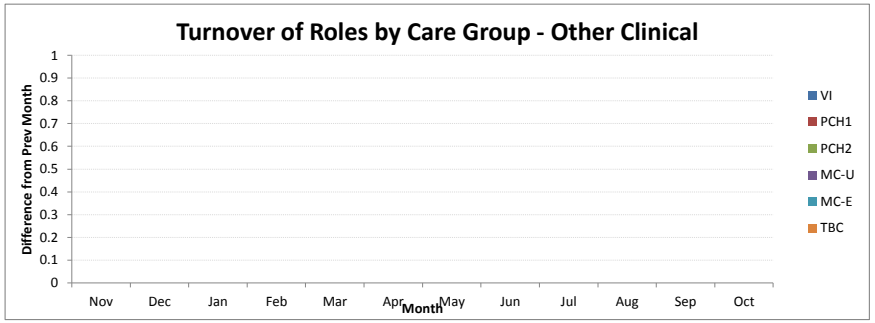
		2017/18											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Vacancies	Reception	0	0	0	0	0	0	0	0	0	0	0	0
	Admin	0	0	0	0	0	0	0	0	0	0	0	0
	Practice Manager	0	0	0	0	0	0	0	0	0	0	0	0
	Nurses	0	0	0	0	0	0	0	0	0	0	0	0
	GP	0	0	0	0	0	0	0	0	0	0	0	0
	Other - HCA	0	0	0	0	0	0	0	0	0	0	0	0
	Other - Social Worker	0	0	0	0	0	0	0	0	0	0	0	0
	Other - Care Navigator	0	0	0	0	0	0	0	0	0	0	0	0
	Other Physician Associate	0	0	0	0	0	0	0	0	0	0	0	0
	Social Prescribing	0	0	0	0	0	0	0	0	0	0	0	0
	Students (without supervision)	0	0	0	0	0	0	0	0	0	0	0	0
	Clinical Pharmacists	0	0	0	0	0	0	0	0	0	0	0	0
	Vacancies Total	0	0	0	0	0	0	0	0	0	0	0	0
	GP	0	0	0	0	0	0	0	0	0	0	0	0
	Other Clinical	0	0	0	0	0	0	0	0	0	0	0	0
	Non Clinical Staff	0	0	0	0	0	0	0	0	0	0	0	0

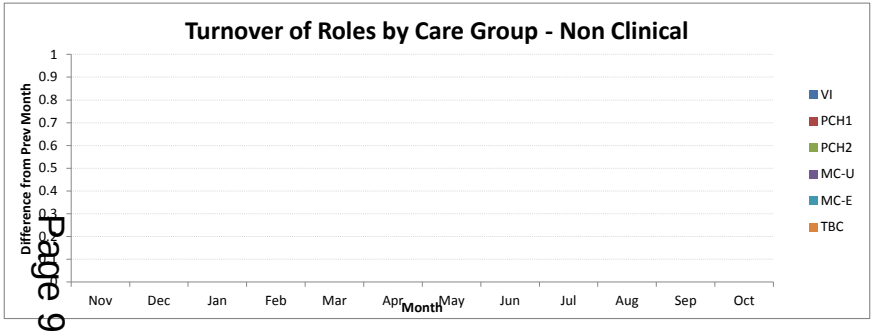
Overall percentage of vacancies

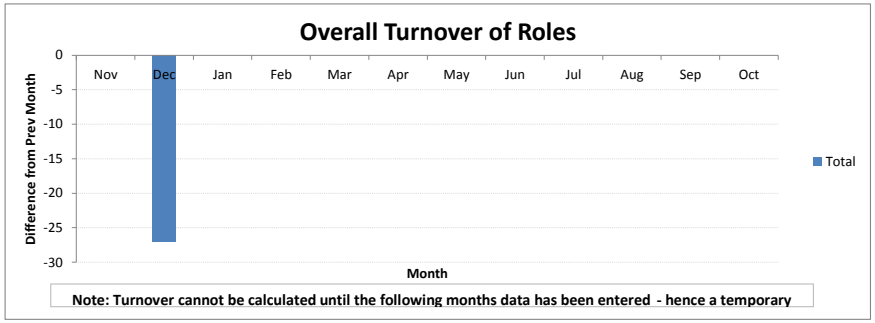


Turnover of Staff









Training

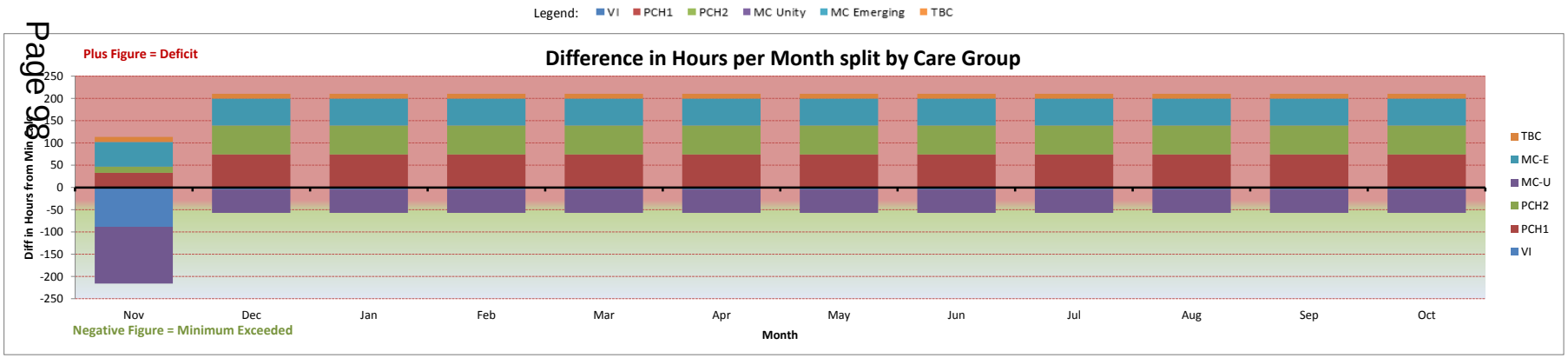
		2017/18											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Training	Vulnerable Practice Programme	0	0	0	0	0	0	0	0	0	0	0	0
	Practice Resilience Programme 17/18	0	0	0	0	0	0	0	0	0	0	0	0
	Time 2 Care	0	0	0	0	0	0	0	0	0	0	0	0
	Intro to Care Navigation (Admin)	7	0	0	0	0	0	0	0	0	0	0	0
	Competency Based Care Navigation (Admin)	0	0	0	0	0	0	0	0	0	0	0	0
	Triumvirate Leadership Programme	0	0	0	0	0	0	0	0	0	0	0	0
	Investment in Practice Manager Development	0	0	0	0	0	0	0	0	0	0	0	0
	Telephone Consultation Training	12	0	0	0	0	0	0	0	0	0	0	0
	Nursing Associate Training Programme	0	0	0	0	0	0	0	0	0	0	0	0
	Fundamentals of General Practice Nursing	0	0	0	0	0	0	0	0	0	0	0	0
	Advancing Clinical Practice	1	0	0	0	0	0	0	0	0	0	0	0
	Specialist Practice - General Practice Nursing	0	0	0	0	0	0	0	0	0	0	0	0
	Fundamentals of General Practice Nursing	0	0	0	0	0	0	0	0	0	0	0	0
	Practice Manager Diploma	1	0	0	0	0	0	0	0	0	0	0	0
	Training Total	21	0	0	0	0	0	0	0	0	0	0	0
	Overall Total	21											
	Overall percentage of workforce	*100.00%*											

Pharmacist Dashboard

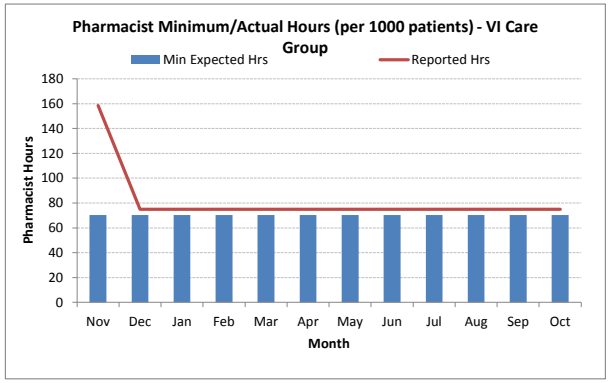
		2017/18											
		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Pharmacist Dashboard	Registered Population	278416	278416	278416	278416	278416	278416	278416	278416	278416	278416	278416	278416
	No of hours of pharmacist time(AS PER GP 5 Year forward Minimum of 1 WTE CP per 30, 000 patients = 1.25 hours per 1000 patients)	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02
	Pharmacist time already employed by practice	450.5	195	195	195	195	195	195	195	195	195	195	195
	Difference of number of hours of pharmacist time as per GP 5YFV minimum calculation	-102.48	153.02	153.02	153.02	153.02	153.02	153.02	153.02	153.02	153.02	153.02	153.02
	Overall Percentage of Registered Population	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Percentage of Pharmacist Time	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Overall Totals	Registered Population	278416	278416	278416	278416	278416	278416	278416	278416	278416	278416	278416	278416
	No of hours of pharmacist time(AS PER GP 5 Year forward Minimum of 1 WTE CP per 30, 000 patients = 1.25 hours per 1000 patients)	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02	348.02
	Pharmacist time already employed by practice	12	0	0	0	0	0	0	0	0	0	0	0
	Difference of number of hours of pharmacist time as per GP 5YFV minimum calculation	-102.48											

*Please note that where there has been no sumbission of Pharmacists time already employed, the formula will assume that there no pharmacist employed and therefore will report the minimum hrs required (eg a positive figure = poor position). In this calculation, a negative figure is a positive position.



*Please note that where there has been no sumbission of Pharmacists time already employed, the formula will assume that there no pharmacist employed and therefore will report the minimum hrs required (eg a positive figure = poor position). In this calculation, a negative figure is a positive position. The data above the zero axis line has a deficite of pharmacist hours (or have submitted no data).


Pharmacist Minimum/Actual Hours (per 1000 patients) - VI Care Group
Min Expected Hrs
Reported Hrs
Pharmacist Hours
0
20
40
60
80
100
120
140
160
180
Nov
Dec
Jan
Feb
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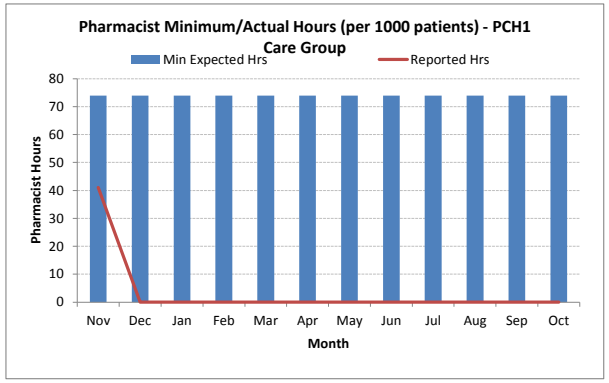
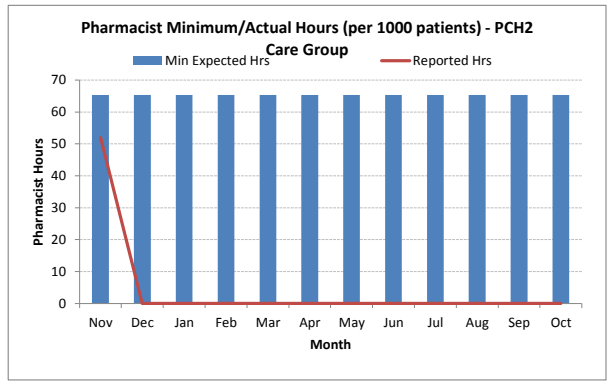
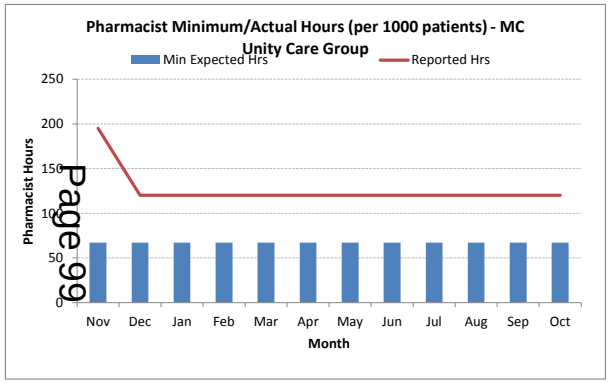
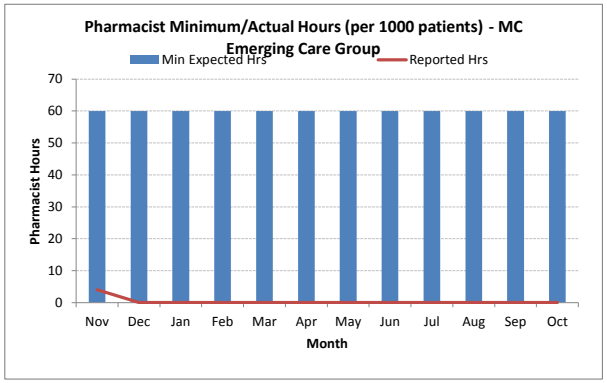
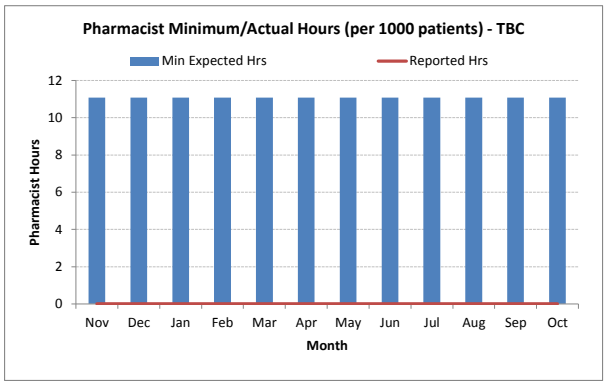
Oct
Month


Pharmacist Minimum/Actual Hours (per 1000 patients) - PCH1 Care Group
Min Expected Hrs
Reported Hrs
Pharmacist Hours
0
10
20
30
40
50
60
70
80
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Month


Pharmacist Minimum/Actual Hours (per 1000 patients) - PCH2 Care Group
Min Expected Hrs
Reported Hrs
Pharmacist Hours
0
10
20
30
40
50
60
70
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Month


Pharmacist Minimum/Actual Hours (per 1000 patients) - MC Unity Care Group
Min Expected Hrs
Reported Hrs
Pharmacist Hours
0
50
100
150
200
250
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Month


Pharmacist Minimum/Actual Hours (per 1000 patients) - MC Emerging Care Group
Min Expected Hrs
Reported Hrs
Pharmacist Hours
0
10
20
30
40
50
60
70
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Month


Pharmacist Minimum/Actual Hours (per 1000 patients) - TBC
Min Expected Hrs
Reported Hrs
Pharmacist Hours
0
2
4
6
8
10
12
Nov
Dec
Jan
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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12 December 2017

TITLE OF REPORT:	**Communication and Participation update**
AUTHOR(s) OF REPORT:	Sue McKie, Patient and Public Involvement Lay Member Helen Cook, Communications, Marketing & Engagement Manager
MANAGEMENT LEAD:	Mike Hastings – Director of Operations
PURPOSE OF REPORT:	This report updates the Governing Body on the key communications and participation activities in November 2017.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the **public** domain
KEY POINTS:	The key points to note from the report are: 2.1.1 **Minor Eye Conditions Service (MECS)** 2.1.3 **Winter Campaign** 2.1.4 **Extended opening in Primary Care**
RECOMMENDATION:	• **Receive** and **discuss** this report • **Note** the action being taken
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others.
2. Reducing Health Inequalities in Wolverhampton	• Involves and actively engages patients and the public. Uses the Engagement Cycle. – Commissioning Intentions. • Works in partnership with others. • Delivering key mandate requirements and NHS Constitution standards.
3. System effectiveness delivered within our financial envelope	• Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework.

1. BACKGROUND AND CURRENT SITUATION

1.1. To update the Governing Body on the key activities which have taken place November 2017, to provide assurance that the Communication and Participation Strategy of the CCG is being delivered effectively.

2. KEY UPDATES

2.1. Communication

2.1.1 Minor Eye Conditions Service (MECS)

The MECS campaign has continued its web and social media presence following its launch in September. We have seen a lot of interest in our MECS campaign, both with public and patient interest. See below a screen shot of a tweet.

This month (14/11/17) we held a public event and saw more than 300 people at Bentley Bridge Sainsburys. The vast majority were really interested in the service, and hadn't heard of it, and three people said they had used the service. It was interesting to hear from a large number of people how they have regular contact with their optician because of diabetes.

During the day event we also engaged with local stakeholders, such as GP reception staff, health centre staff members and two A&E nurses, who were again very interested in the scheme and took information to share.

Full details on MECS at https://wolverhamptonccg.nhs.uk/your-health-services/eye-care-service-mecs

2.1.2 Press Releases

Press releases since the last meeting have included: Awards highlight outstanding work by Wolverhampton care homes; Detect and protect yourself against risk of strokes – Global AF

Aware Week 20-26 November; Look out for the elderly in the Black Country this winter; Number of asthmatics being vaccinated against flu at dangerously low level; Embracing Self Care for Life; Confused about cold or flu?; Six things you should do for your health and home this winter and How does the NHS in England work? An alternative guide.

2.1.3 **Winter Campaign – Stay Well**

The winter campaign has started its national focus on stay well messages.

Press releases and tweets have been issued on the Black Country footprint for the STP and locally we have planned two public events for early December.

Planning is underway for our outreach events in December, January and February to enable us to spread the messages into the community and talk to people about how to stay well in Wolverhampton and access services most appropriately over the winter period.

See our Stay Well website pages for more information
https://wolverhamptonccg.nhs.uk/your-health-services/stay-well-this-winter

2.1.4 **Extended opening in Primary Care**

We are working with our colleagues in Primary Care and Pharmacy to promote their extended opening hours, particularly for cover over the Christmas and New Year holidays. There will be a series of newspaper advertising, leaflets and information on our website to inform people of GP opening over the holiday time and beyond.

2.2. Communication & Engagement with members and stakeholders

2.2.1 **GP Bulletin**

The GP bulletin is a fortnightly bulletin and is sent to GPs, Practice Managers and GP staff across Wolverhampton city.

2.2.2 **Practice Nurse Bulletin**

The November edition of the Practice Nurse Bulletin included the following topics:

- Charges to overseas visitors
- West Midlands Strategic Migration Partnership e-bulletin
- Clinical Academic Training Scheme
- Clinically Enhanced Independent Prescribing Programme
- West Midlands Integrated Urgent Care Alliance
- Become an Antibiotic Guardian
- Unscheduled / Incomplete Individual Immunisation status for update
- Healthwatch
- WIN
- Fire safety guidance

2.2.3 **Practice Managers Forum**
The PM Forum planned sessions covered the following topics in November:

- Care Navigation
- 10 High impact actions
- Future working together across the city and within our groupings for Practice Managers.

3. CLINICAL VIEW

GP members are key to the success of the CCG and their involvement in the decision-making process, engagement framework and the commissioning cycle is paramount to clinically-led commissioning. GP leads for the new models of care have been meeting with their network PPG Chairs to allow information on the new models, and provide an opportunity for the Chairs to ask questions. All the new groupings have decided to meet on a regular quarterly basis.

4. PATIENT AND PUBLIC VIEWS

Patient, carers, committee members and stakeholders are all involved in the engagement framework, the commissioning cycle, committees and consultation work of the CCG.

Reports following consultations and public engagement are made available online on the CCG website. 'You said – we did' information is also available online following the outcome of the annual Commissioning Intentions events and decision by the Governing Body.

4.1 The PPG Chair / Citizen Forum meeting took place this month and heard about Child and Young Persons mental health services and plans for commissioning in Wolverhampton. Attendees discussed the changes in Primary Care and the new groupings of the Practices. There were also presentations on Housing and the Genome Project. There was also feedback from the members on the Out of Hours Service experience and it was agreed that this would be an agenda item at the next meeting in Feb.

5. LAY MEMBER MEETINGS – attended:

5.1 The newly appointed Lay Member is Sue McKie.

6. KEY RISKS AND MITIGATIONS

N/A

7. IMPACT ASSESSMENT

7.1. ***Financial and Resource Implications*** - None known

7.2. ***Quality and Safety Implications*** - Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.

7.3. ***Equality Implications*** - Any engagement or consultations undertaken have all equality and inclusion issues considered fully.

7.4. ***Legal and Policy Implications*** - N/A

7.5. ***Other Implications*** - N/A

Name: Sue McKie
Job Title: Lay Member for Patient and Public Involvement
Date: 30 November 2017

ATTACHED: none

RELEVANT BACKGROUND PAPERS
NHS Act 2006 (Section 242) – consultation and engagement
NHS Five Year Forward View – Engaging Local people
NHS Constitution 2016 – patients' rights to be involved
NHS Five year Forward View (Including national/CCG policies and frameworks)
NHS The General Practice Forward View (GP Forward View), April 2016
NHS Patient and Public Participation in Commissioning health and social care.2017. PG Ref 06663

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REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	**n/a**	
Public / Patient View	**n/a**	
Finance Implications discussed with Finance Team	**n/a**	
Quality Implications discussed with Quality and Risk Team	**n/a**	
Equality Implications discussed with CSU Equality and Inclusion Service	**n/a**	
Information Governance implications discussed with IG Support Officer	**n/a**	
Legal/ Policy implications discussed with Corporate Operations Manager	**n/a**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**n/a**	
Any relevant data requirements discussed with CSU Business Intelligence	**n/a**	
Signed off by Report Owner (Must be completed)	**Sue McKie**	**01 December 2017**

NHS
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MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 10th OCTOBER 2017, COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON SCIENCE PARK.

PRESENT:	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Jim Oatridge	-	Interim chair WCCG
	Marlene Lambeth	-	Patient Representative
	Alicia Prive	-	Patient Representative
	Reena Bajaj	-	PWC IA Observation
	Peter Price	-	Independent Member
	Steven Forsyth	-	Head of Quality & Risk
	Sukhdip Parvez	-	Quality & Patient Safety Manager
	Kerry Walters	-	Public Health
	Danielle Cole	-	Administrative Officer
APOLOGIES:	Manjeet Garcha	-	Executive Director of Nursing & Quality

1. APOLOGIES & INTRODUCTIONS

Introductions were made and the above apologies were noted by members.

2. DECLARATIONS OF INTEREST

No declarations of interest were raised.

3. MINUTES & ACTIONS OF THE LAST MEETING

3.1 Minutes of the 12th September 2017

The minutes of the meeting held on the 12th September 2017 were approved as an accurate record with the exception of the following amendments:

SF stated page four, first paragraph reword to state 'SF highlighted the Trust has reported a serious incident yesterday (Monday 11th September 2017) with regards to a mother who had a intrauterine death at 31 weeks.

SF stated page four, fourth paragraph reword to state 'SF stated there have been three Never Events to date. The Never Event described in the report was thought to be at this stage of the RCA investigation to be influenced by human error (this could be STC).

RR requested to remove the action 5.1 from the log as she doesn't feel it is appropriate to write into Quality Matters as the risk is not specifically related to her practice.

JO stated page 8 item 7.1a second paragraph to state 'JO asked is there a public record of what key decisions have been made and when and the effective date of those decisions'.

3.2 Action Log from meeting held on the 12th September 2017

Key actions from the action log were discussed as follows and an updated version of the action log would be circulated with the minutes:

Action 4.1 - SP stated he has liaised with NHSE and unfortunately the contact is off on long term sick however, NHSE advised the data will be sent as soon as possible. Action remains open.

Action 5.1 - Action remains open – an update to be provided at the next meeting.

Action 6.1 – JO confirmed the action was discussed at Governing Body. Action remains open as there is a decision to be made as to whether purchase the moderning datix or continue to use the current datix.

Action 6.1 - Agreed to close action. SF stated RWT have provided assurance on the Heart and Lung Fire risk through CQRM. Ultimately the risk sits with the provider.

Action 5.1 – Agreed to close action. RR stated she doesn't feel it is appropriate to write into Quality Matters as the risk is not specifically related to her practice.

Action 5.1 – Agreed to close.

Action 5.4 – Action remains open.

Action 7.1a – Agreed to close.

Action 7.2 – SF stated SP has been in contact with the family who do not wish to take the event further. Agreed to close.

4. MATTERS ARISING

No Matters Arising was raised.

5. ASSURANCE REPORTS

5.1 Monthly Quality Report

Report was noted by all present. SF provided a brief summary of the report.

Urgent Care Provider

SF stated there have been key areas of development. The staffing areas which were a key risk in terms of clinical triage and home visiting are slowly starting to improve. Vocare have recruited eight GPs which are in the process of on boarding and two nurse practitioners. Three advance nurse practitioners have also applied for posts.

SF added there has been a significant change in management, Vocare have recruitment a number of key members of staff in order to drive improvements.

A key risk that has been identified is the NQR10 (clinical triage within 10 to 15 minutes) Vocare have realigned the staffing rotas in order to match the demand profile.

SF stated the issue around enough members of staff being able to see a paediatric patient especially under ones has now been resolved; four regular members of staff are scheduled to attend a Paediatric Minor Illness and Injury course in October and as interim solution Vocare have identified in principle with RWT that if a situation arose where the UCC is not manned and every option has been explored the patient would be redirected to RWT.

SF highlighted Vocare has worked closely with Wolverhampton's Quality and Safety Team and a serious incident workshop was held on Thursday 21st September at Vocare's request. The workshop was attended by Governance staff (governance assistants, clinical support managers and clinical governance leads) from across the country as well as Vocare's Organisational Medical Director, Director of Quality and Nursing and the majority of Vocare's Department of Quality, Compliance and Assurance. The workshop was well received and has resulted in actions which will now form part of a national work plan to build continuous improvement in the identification and management of serious incidents.

There have been two NHS England scrutiny meetings held to date. The last meeting was held on Thursday 5th October 2017 and the outcome of that meeting was the UCC was deescalated from the enhanced surveillance meeting, as NHSE were assured with the mitigations and plans being taken forward.

A coordinated unannounced visit to Wolverhampton UCC in conjunction with Stafford and Cannock, East Staffordshire, South East Staffordshire, Seisdon and Peninsula, North Staffordshire and Stoke CCG took place on the evening of Thursday 5th October. The aim of this visit was to explore staffing across the patch. . Key elements identified from the Wolverhampton unannounced visit were that clinician productivity is not good however, the UCC was very well staffed. Vocare have been asked to provide an action plan on clinical productivity. Home visiting was also highlighted as a concern in terms of the resource to manage; there was not a robust plan in place to allocate the GP to each home visit.

Maternity Performance Issues

SF highlighted the number of women booking to give birth at RWT has increased significantly in the last 12 months. The midwife to birth ratio has deteriorated from 1:29 in April 2016 to 1:32 in August 2017. Midwifery sickness rate has increased and is currently at 5.8%. In recent months there has been a number of SIs reported. A letter was sent to all Chief Executives and Accountable Officers in the Black Country asking for a meeting to discuss RWT capping births and how to move forward. The meeting has taken place there were extensive discussion with NHSE and NHSI who advised RWT to work collaboratively with local providers to reach an amicable solution.

Step down provider

SF noted an improvement board was held on Wednesday 5th October and was aiming to bring the board to a close due to seeing a number of improvements however, at the recent visit there were still a number of issues in terms of fundamental care. The CCG have requested the provider to address the following key actions; oversight in the home to mitigate risks further, the home have been asked to base a senior manager from the accord group to increase input and to also source a new clinical nurse who will provide supervisory capacity in order to help the current manager. The care home has also been asked to review the current action plan.

SF noted the LeDeR programme is now live. Deaths of patients with a learning disability will have a mortality review undertaken; this is being coordinator by the University of Bristol.

PP noted he's encouraged the CCG are closely monitoring on various areas where improvement is required however, the concern is if the CCG are focusing on those areas what happens to the work that is planned for the future which is increasing the quality of its service provision that the CCG are not able to undertake due to capacity reasons. SF responded work capacity and key priorities is monitored weekly. The team are currently on top of their workload however, the team is stretched. The Quality team are looking at their resources on a weekly basis.

RR asked for the meaning of 'achieved caseness as first assessment AND not at last assessment' on page 42 reference 34. SF agreed to speak with Sarah Fellows to clarify.

Action:- SF to speak with Sarah Fellows to clarify reference 34 on the combined IAPT Scorecard 'achieved caseness as first assessment AND not at last assessment'.

5.2 August Primary Care report

The report was noted by all present.

PP highlighted the report includes the figures each month for friends and family test submissions however, does not state what is being learnt from the data and how that data is being used in terms of moving forward. SF responded discussions are had regarding the FFT comments at PPG. PP added as the remit of this meeting is quality it would be useful to have more information on how the data is used. SF agreed to look in to this.

Action:- SF agreed to look at including further information on how FFT data is used to improve quality.

5.3 Information Governance Report

Peter McKenzie (PMcK) provided an over of the report stating;

- The focus of the IG team work is to ensure WCCG is compliant with IG tool kit. The latest version of the IG tool kit has now been released and a detailed action plan is being worked through.
- Training dates for three face to face GDPR training sessions have now been placed in the corporate calendar and communicated to staff at the 13th September team meeting.
- The IG team have produced a briefing paper on the designation of a Data Protection Officer for the CCG, which is a new requirement under GPDR. The management team have reviewed the briefing and feel that, due to the fit with existing duties the Corporate Operations Manager should be designated as the organisation Data Protection Officer. The committee were in agreement for Corporate Operations Manager to also be the designated Data Protection Officer.
- Business Case with screening questions stating that a full Privacy Impact Assessment is required for a Weight management service.

JO asked if the training element should be a feature at the development session. JO queried how the training is brought to the provider's attention. PMcK responded Sarah Hirst wrote a brief article that was added to the GP bulletin from the CCG that signposted all providers to their IG provider.

5.4 Freedom of Information Report

PMcK provided a brief overview of the report stating;

- The report provides details of the Freedom of Information requests received by the CCG during the second quarter of the 2017/18 financial year.
- From 1 July to 30 September 2017, the CCG has received 69 Freedom of Information requests. At the time of writing the report the CCG had responded to 61 of the requests, 59 of which had received a response within the statutory 20

working days. The CCG worked with the requesters whose responses were not sent within the statutory deadline to agree extensions. For the year to date the CCG has responded to 98% of requests within the statutory time limit.

- The eight requests awaiting responses are well within the 20 day timeframe and we expect to provide a response in line with the requirement.
- Although FOI requests may be made by anyone and the CCG responses does not differ based on the source of the request. The bulk of the CCGs requests come in from people who are representing an organisation from the press, charities, pressure groups and parliamentary groups for specific conditions.
- PMck highlighted the information requests that have been received during this quarter.

5.5 Equality and Diversity Quarterly Report

Juliet Herbert highlighted key points from the report stating;

- As part of the review of performance for people with characteristics protected by the Equality Act 2010, The Governing Body agreed that there needed to be a dedicated focus for moving the CCG from 'Developing' to 'Achieving' this is due to some areas of work around equality and inclusion was applied rather than explicit. The Equality Delivery System2 (EDS2) year one action plan starts to focus on those areas enabling the CCG to move forward.
- There may need to be some revision around the responsible officers so that the CCG is correctly positioned to move forward and enhance an inclusive practice.
- Three Equality Analysis training dates for staff have now been scheduled between October 2017 and November 2017.
- There are currently nine Equality Objectives which is excessive therefore these have been reviewed, closed down and will be published on the CCG website. The new objectives will be developed and published March 2018 as part of the new Equality Strategy. There will be a maximum of four objectives.
- The new Regulations where reporting schedule for publication of information and equality objectives has been changed to 30th March annually, and the usual up to four years for Equality Objectives.
- Wolverhampton CCG has completed their WES template. Due to the size of the workforce (easily identifiable information), the CCG have taken a different approach this year and published a statement of commitment to the WRES.
- An action plan will be developed to address the gaps identified on the WRES template.

5.6 Quality & Risk Work Plan

The work plan was noted by all.

PP asked as to whether the issues relating to quality, safety and performance at Vocare had impacted on the team's workload. SF responded by informing the committee that this work plan is a key enabler that allocates work for each quarter, this is articulated in a way as such that cross cover is possible. SF highlighted that it is also important to note that the team have weekly check in and out meetings. This is to ensure that not only the work plan, which is a static document, is covered but also urgent issues that are emerging or have landed in the quality work stream are allocated within the team based on skill, knowledge and capacity. Monthly supervision also is a key enabler to ensure productivity and staff morale is considered.

SF highlighted the plan demonstrates the teams priorities and direction. The action plan sits beneath the Quality Strategy and Plan on a Page which are two key documents.

5.7 Health & Safety Performance Quarterly Report

The report was noted by all

SF stated the key components of the Health and Safety work that has been undertaken this quarter is around ensuring that all staff have got a home DSE assessment. The CCG have provided a training session for staff to self-assess their DSE working environment at home. Another key issue highlighted is the cladding on the Science Park, this has been identified as a low risk as the building is not occupied during the night, there is 24 hour security and building fire alarms installed therefore the cladding will not be changed at this stage.

JO highlighted between quarters one and two there is still evidence of trailing cables, this is an area that is preventable. SF responded staff are daisy chaining which is a severe fire risk. This has been raised with the business operations team to provide fixed electrical points in certain departments within the CCG.

JO pointed out the cleanliness of the toilet facilities within the Technology Centre are not up to standard. SF stated this issue has been raised with the Science Park who has informed the cleaning regime has been changed.

Action:- SF to draft a letter on behalf of JO in relation to the cleanliness of the Technology Centre toilet facilities.

5.8 Quality Assurance in CHC Quarterly Report

Report was noted by all. Maxine Danks provided a brief overview stating;

- WCCG continue to meet requirements of the National Framework and Quality Premium.
- The National Framework requires new referrals to be assessed and a decision made within 28 days following receipt of a positive checklist.
- A CHC deep dive was undertaken in summer 2017 by NHSE. The feedback from the review was positive.
- As in previous reports the number of referrals continues to rise and the workload remains significant. On-going training is provided and scrutiny of the checklists and Fast Tracks by the Lead Nurse continues.
- The ICT receive a minimal number of complaints regarding the assessment process from individuals or their families; one in the last 12 months which was not substantiated. The CCG do receive complaints from Legal firms disputing the outcome which is part of the appeals process, rather than a complaint. These are often raised with the PMSO and to date one was partially upheld regards time taken to request notes. This resulted in a payment to the family.
- Personal Health budget continues to be challenging.
- The number of patients in step down average between 20-25 per week. The contract taken out with the Local Authority to provide therapy services is positively impacting on patients outcomes and the patients in step down are now receiving timely intervention from therapists. It has been noted that there are an increased number of patients returning home with reablement services since the introduction of the new therapy support.
- The department of Health are still to advise regarding the date that the cut off for CHC consideration for previously unassessed periods of care will be. MD confirmed no information has been received to date.

RR pointed out in regards to fast track the CCG are a significant outlier when considered against our comparator CCGs. The CCG have provided significant amount of training however, does not mention GPs which is a concern. MD responded training was provided for Team W and unfortunately only 10 delegates arrived for the training which was disappointing. If the CCG receives a fast track from GPs and doesn't feel the information is suffice the CCG will contact the practice. MD added the CCG are more than happy to provide the training. RR suggested a brief summary to be included on the monthly GP news bulletin.

JO suggested the table in paragraph 2.3, it would be useful to add a further two columns highlighting the number of decisions upheld and the numbers which are overturned this will demonstrate the vast majority of decisions taken are maintained. MD agreed to add the additional columns.

Action:- MD to produce a brief summary on fast track and to include in the monthly GP news bulletin.

Action:- MD to add a further two columns to the table in paragraph 2.3 of the report

to highlight the number of decisions upheld and the numbers which are overturned to future reports.

6. RISK REVIEW

6.1 Quality and Safety Risk Register

PS highlighted at present there is a total of eight risks attributed to the committee. One extreme, four high, two moderate and one low.

Extreme

Risk 466 - Out of Hours Provider – inaccurate reporting of performance data/quality assurance. PS stated close monitoring continues with Governing Body scrutiny. Three month target for improvement of priority areas expires on the 16th November 2017, however, poor performance against KPIs has seen little or no improvement. Further consideration taking place regarding additional contract performance notices in relation to poor response times.

High

Risk 489 – Inappropriate arrangements for a named midwife – RWT. PS stated the circumstances remain the same. The Head of Safeguarding is in discussion with the Head of Midwifery on how this can be progressed.

Risk 312 – Mass Casualty Planning - PS noted 'on call' staff including Directors have received refresher training on Mass Casualty Planning. The CCG are awaiting a handbook from the Regional EPRR Lead. A further review is expected in November 2017.

Risk 492 – Maternity Capacity and Demand – PS highlighted the risk is currently rated as a 12.

Risk 439 – PTS Poor Performance – PS stated the risk continues to be managed through CRM. A Remedial Action Plan is in place and the actions are being monitored accordingly. The risk remains at 12 as performance KPIs remain below the required standard.

Moderate

Risk 476 – Named Dr for LAC – PS noted RWT have successfully appointed a Community Paediatric Consultant who will be in post early November 2017, it is anticipated the appointee will take on the Named Dr LAC role.

Risk 414 – Quetiapine – Optimising use within the Health Economy. PS noted the risk is awaiting confirmation regarding closure from Sarah Fellows. Risk to be closed prior to next meeting.

Risk 321 – Safe working practices – PS stated scoping has been completed to identify those staff employed by WCCG that require a DBS. Numbers are much lower than previously required due to changes in guidance. A paper is currently being prepared for presentation to SMT. WCCG staff who provide a direct service to children, young people and adults' with care and support needs all have a current DBS. The paper has been delayed due to the capacity of the Designated Nurse. The risk has been reduced to a three however, until the paper has been to SMT the risk remains on the register.

SF highlighted no new risks have been added to the register and no closures post the last committee.

7. ITEMS FOR CONSIDERATION

7.1 Policies for ratification

7.1a Complaints Policy

The Complaints policy was noted by committee. The policy has been ratified.

Action:- SP to chase RWTs quarterly report of the Maternity reportable trigger list incidents.

7.1b Serious Incidents Policy

The Serious Incidents Policy was noted by committee. The policy has been ratified.

7.2 Learning Disabilities Mortality Review (LeDeR) Programme.

Report was noted by committee.

8. FEEDBACK FROM ASSOCIATED FORUMS

8.1 Draft CCG Governing Body Minutes

The minutes were noted by the committee.

8.2 Health & Wellbeing Board Minutes

No Minutes Available

8.3 Quality Surveillance Group Minutes

No Minutes Available

8.4 Draft Commissioning Committee Minutes

The minutes were noted by the committee.

8.5 Primary Care Operational Management Group Minutes

No Minutes available.

8.6 Clinical Mortality Oversight Group Minutes

No minutes were available for the meeting.

9. ITEMS FOR ESCALATION/FEEDBACK TO CCG GOVERNING BODY

No items for escalation.

10. ANY OTHER BUSINESS

No items raised

11. DATE AND TIME OF NEXT MEETING

Tuesday 14th November 2017, 10.30am – 12.30pm; CCG Main Meeting Room.

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NHS
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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

Minutes of the meeting held on 31st October 2017
Science Park, Wolverhampton

Present:

Mr L Trigg	Independent Committee Member (Chair)
Mr T Gallagher	Chief Finance Officer
Mr M Hastings	Director of Operations
Dr D Bush	Governing Body GP, Finance and Performance Lead

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr G Bahia	Business and Operations Manager
Mr V Middlemiss	Head of Contracting and Procurement

In attendance

Dr M Asghar	Governing Body GP, Deputy Finance and Performance Lead (part meeting)
Mr P McKenzie	Corporate Operations Manager
Mrs H Pidoux	Administrative Team Manager
Mr E Cooke	Auditor, PriceWaterhouseCooper (Observer)

1. Apologies

Apologies were submitted by Mr Marshall.

2. Declarations of Interest

FP.209 There were no declarations of interest.

3. Minutes of the last meetings held on 26th September 2017

FP.210 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.211

- Item 110 (FP.185) – Dermatology Service capacity issues – an update was given following the contract review meeting. Workforce issues continue and a contract review process has highlighted that community services are not being utilised to the full capacity. Communications are being sent to RWT stating that referrals should be directed to the community provider where appropriate.

  Assurance was given that there is no increased financial risk to the CCG due to these issues.

  It was noted that a cancer recovery plan received from RWT stated that the CCG was responsible for working with the community provider to ensure work is going through that pathway. It was agreed that RWT should be reminded that it is their responsibility to liaise with the provider and that this should be reflected in the recovery plan.

  Action: closed.

- Item 113(FP.203) – Invoice from RWT in respect of Physician A model – previous information submitted to be considered and legal advice sought – Mr Gallagher confirmed that the CCG is maintaining the stance that there is no case to answer, is not supportive of an arbitration process and will not be submitting any papers.

  The previous information submitted had been reviewed and additional detail added. Legal advice had not been sought as the contract is explicit that only work undertaken is covered not work that is not undertaken.

  The CCG's Governing Body and the NHS England (NHSE) Director of Finance are supportive of the CCG's stance on this matter. Future updates will be given to this Committee as required.

  Action: Closed

- Item 114 (FP.204) – Letter to be sent to Wolverhampton City Council clarifying the CCG's position on the BCF Risk Share Arrangement for 2017/18 – Mr Gallagher confirmed that a formal letter had been sent which included a working example of how this would work in practice. There is a risk cap of £250k which is significantly different to last year. Receipt of the letter had been acknowledged and a formal response was awaited. This will be followed up if not received shortly.

- Item 115 (FP.205) – Impact of NHS Digital Referral Assessment Service (RAS) in primary care to be checked - deferred to next meeting.

5. Matters Arising from the minutes of the meeting held on 26th September

FP.212 There were no matters arising to discuss from the last meeting.

6. Finance Report

FP.213 Mrs Sawrey introduced the report relating to month 6 and noted that as this is the end of Quarter 2 these are the figures that NHSE will recognise for forecast outturns going forward to year end.

The following key points were highlighted and discussed;

- The CCG is anticipating meeting all its statutory duties in 2017/18 and in doing so has utilised all its contingency reserves.
- Programme Costs are forecast to overspend which is partially compensated for by underspends on Running Costs
- The CCG's cash performance has improved in September and is expected to be back in line in October. Monthly payments will now be made to the Local Authority.

Dr Asghar joined the meeting

- The financial position had been scrutinised in M6 (Q2 review) and following a review of assumptions the recurrent overspend has decreased to an estimated £900k forecast outturn (FOT) which is currently offset by non-recurrent underspends and the use of reserves. This has serious implications for 18/19 onwards particularly as the QIPP target will increase.

- Additional QIPP had been identified over and above M5 and the CCG is reporting achieving its QIPP target. However, actual achievement of reduced activity levels associated with QIPP schemes are not materialising and are manifesting themselves in overspends, largely within the Acute portfolio.

  It was acknowledged that achieving the QIPP target will be harder going forward as all the 'quick' wins have been utilised. The challenge of meeting the target had been identified early in the year so that all opportunities can be explored. Options to draw money out of contracts will be considered during the contract review process.

  It was reported that the NHSE Area Team had reviewed the Decommissioning Policy of all CCGs and the CCG is required to review the options.

- Royal Wolverhampton Trust (RWT) is giving concern as the M5 activity is indicating a potential forecast out turn (FOT) of c £1.5-2m. The CCG is seeing new HRGs codes being used as a result of the expansion of codes in 17/18, many of which carry a higher tariff e.g. Sepsis.

- Other Providers such as University Hospitals Birmingham (UHB) and Dudley Group are also over performing which appears to be linked to new HRGs and Specialist activity now in the CCG portfolio. Modelling across other CCGs and CSUs is under way.

- Mental Health Complex cases are continuing to over perform. Assurances have been given by the Mental Health Commissioner that spend will reduce and fall back in line with budget as cases are reviewed and costs reduced.

- Within Delegated Primary Care there is some flexibility to in bring forward plans and commit recurrent spend.

- Expenditure on GP prescribing has decreased significantly compared to Month 5. A lot of work has been undertaken to address this issue with pharmacist involvement. The movement includes savings in relation to Pregabalin partially offset by increased costs for NCSO drugs.

It was noted that there has been a change in reporting requirements to NHSE. The CCG is carrying a recurrent risk, particularly in the Acute portfolio, which is being offset by non-recurrent solutions.

A further potential risk not included in the finance position or the risk schedule relates to the outstanding issue with RWT, £4.8m for lost income relating to Non Elective admissions as discussed earlier in the meeting.

In summary the CCG is reporting to achieve the control total in each scenario except the worst case scenario.

It was raised that when a shared approach is agreed across the Black Country regarding the modelling for the HRG relating to Sepsis. A letter will be sent to the Provider setting out this methodology.

Mr Trigg asked for clarification in relation to an underspend of £550k against other GP services. It was confirmed that this was due to an

accrual made by NHSE in 2016/18 which has been released in part non-recurrently. There are plans in place to utilise this resource.

A query was raised regarding a discrepancy in the running cost reporting of pay for Governing Body members and the Chair and non executives. It was agreed to review these figures

Resolved: The Committee noted;

- the contents of the report
- discrepancy in the running cost reporting of pay for Governing Body members and the Chair and non executives to be reviewed.

7. Performance Report

FP.214 Mr Bahia highlighted the key points of the Executive Summary relating to Month 5 performance, which were considered as follows;

- RTT – the original STF trajectory has been revised and the trajectory for recovery to 92% is March 2018. There are a series of concerns with capacity issues remaining the main cause. Failing specialities include ENT, General Surgery, Ophthalmology, Oral Surgery, Plastic Surgery, Trauma and Orthopaedics and Urology.

  It was noted that a change in the STF payment structure was implemented in September 2017 meaning that only the A&E standard has to be met to achieve 30% payment.

  Paediatric orthopaedic activity will transfer from Walsall Manor Hospital to RWT as of 1st October 2017. This includes 146 new patients and 113 follow up patients. 53 patients are over the 18 week target which will have an immediate impact on RTT performance. This will be closely monitored. A data quality/validation exercise is underway to attain accurate numbers. RWT are holding 14/15 additional clinics to clear backlog. Children's complex cases will still go to Birmingham Children's Hospital.

- A&E Urgent Care Performance – Performance is slightly ahead of STF trajectory. It was highlighted that there has been an increase in activity.

  NHS Improvement and NHSE have written out to all providers and CCG's to capture all unreported activity on UEC pathways to aid consistency of activity reporting.

  A potential 12 hour trolley breach included in the report had since been de-escalated.

- 62 day cancer waits – this continues to be a challenge across the region. A 6.13% increase in referrals has been seen year on year. Of 8 tertiary referrals received by RWT 5 were after day 32.

  The Trust has submitted a Cancer Transformation bid for £100k and this money will be transferred to them when received by the CCG.

  From 23rd October RWT are supporting a 70/30 split of the Oncology and Gynaecology Oncology work from City/Sandwell. The City work (70%) will go to University Hospital of Birmingham (UHB) and Birmingham Women's Hospital with Sandwell work (30%) going to RWT. UHB and RWT are putting in a joint bid to take on Gynaecology oncology from December. Initial projects are 150 patients, however, this is likely to be 250/300 patients. The impact on cancer 62 day performance is unknown as yet; however, there is a likely to be a decrease in performance.

  RWT has meetings to address cancer wait performance, which the CCG now attends and RWT have a series of actions to address. This includes improving the utilisation of clinics and additional work to validate patient lists including those who cancel. This is high on the STP agenda.

  Mr Hastings reported that correspondence from Alison Tongue, Director of Commissioning Operations - West Midlands, had been received requesting joint working together across the Black Country and for weekly reporting. A profile of waiting lists was also requested, which had been requested from RWT and this will be followed up if not received.

  It was felt that there was a need to ensure that the CCG's Governing Body is aware of the risk associated to the maternity capacity issues at RWT which are likely to get worse before getting better. Mr Hastings agreed to continue to contact RWT for the figures, to increase the level of risk reported and to add this to the operational risks that are taken to the Governing Body meeting.

- Delayed Transfer of Care (DToCs) – The Trust is performing relatively well although failing to achieve target. Concerns continue relating to Social Care transfers. A significant number of the delays are from Staffordshire. Further information will be brought back to the next meeting.

- E-Referral – Appointment Slot Issues (ASI) rates – an improvement was seen in August and performance is slightly ahead of the recovery trajectory.

- C. Diff – there have been 4 cases reported in August. The year to date remains in breach due to the number of breaches in previous

months (17 cases against a threshold of 15 cases). However, this is significant improvement year on year.

- Never Events – 1 Never Event occurred in August, a total of 3 for the year.

- MRSA – a breach occurred in October, this is the first for over 900 days.

- Carbapenemase Producing Enterobacteriaciae (CPE) – the increase in cases is being closely monitored by RWT as this had been an issue in the North West of the country previously. There has been a steady increase in cases over the last 3 years. As infected patients have to be treated in isolation this impacts on capacity.

- Mental Health – the CCG is taking steps to fully assure against the impact of the CAMHS Transformation Plan. IAPT targets continue to be achieved.

Resolved: The Committee noted
- the content of the report

8. Contract and Procurement Report

FP.215 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

It was confirmed that since the report was written discussions had taken place with RWT in relation to serious incidents being reported within 48 hours of occurrence and when this time period should be measured from. Following these discussions sanctions had been set at £6,650 for Month 4.

Total sanctions for Month 5 (17/18) totalled £22,350. This was a significant increase attributed to ambulance handover time breaches. It was noted this is a volatile and unpredictable performance target.

Sepsis Counting and Coding Change – RWT had not complied with the request from the CCG to provide their analysis of this coding. Therefore, the CCG will provide the Trust with the analysis provided by Arden and Gem CSU on its behalf for their consideration and feedback.

Activity Transfer from Walsall Manor – A co-hort of paediatric orthopaedic activity will be transferring from Walsall Manor Hospital to RWT on the basis of clinical and safety concerns for patients. The CCG, as host commissioner, will be completing a contract variation to reflect the change.

Dermatology – Workforce issues have stabilised in the short term with additional staff recruited in recent months at Cannock and New Cross sites.

Work is planned with other Providers to stabilise pathways and ensure that the community provider's capacity is being optimised.

Contract Round 2018/19 – this process will be a refresh of the contract for 2018/19 agreed last year. The timetable setting out key milestones has been shared with RWT. Fortnightly meetings with the Trust have been set up to take forward these discussions, with every second meeting widened to include executives.

Black Country Partnership Foundation Trust

A letter is due to be sent setting out the commissioning intentions for 2018/19 including the process to be followed for the contract refresh. This will be a joint process with Sandwell and West Birmingham CCG and Walsall CCG.

City of Wolverhampton (CWC) becoming associates to WCCG Contract - it was confirmed that CWC has a direct relationship for 1 element of CAMHS, the CCG commission the remaining services and this would have brought together the commissioning arrangements. Whether this change goes ahead or not there is minimal risk to the CCG as there are robust processes in place.

Urgent Care Centre (UCC)

The Provider of the UCC, Vocare, has been acquired by Totally PLC and the change of ownership confirmed. Clarification was given that the contractual and commissioning arrangements with the CCG remain the same. The Provider remains under close scrutiny through the Improvement Board and monthly Contract Review Meeting.

Probert Court Nursing Home

The suspension to the service at this Home (Step-down facility) has been lifted, as the Provider had demonstrated satisfactory improvement, and this had been confirmed to the Home in writing.

During the suspension the CCG incurred additional costs in paying for alternative arrangements for patients discharged from RWT who would have been suitable for Probert Court. These costs have been closely monitored during the suspension period and arrangements are being made for this total amount, £48k, to be recovered. The Provider had been made aware of this.

Individual Placement Support (Thrive into Work) Service

The procurement process had been completed for this Service. The CCG had actively supported the West Midlands Combined Authority, as host commissioner, in this process. A draft contract is being developed for the CCG to review and the aim is for contract sign off by 1st November. It was noted that this is an ambitious timeframe and there is a risk of slippage.

Resolved – The Committee:

- noted the contents of the report and actions being taken.

9. Any other Business

FP.216 Risk Report

Mr McKenzie tabled for consideration a first overview of the risk profile for the Committee including Corporate and Committee level risks following a review of the CCG's risk management arrangements**.**

Any additional risks identified at future meetings will need to be added to the register.

10. Date and time of next meeting

FP.217 Tuesday 28th November 2017 at 11.00am, Dunstall Park, Wolverhampton

Signed:

Dated:

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee Meeting (Public)
Held on Tuesday 5th September 2017, Commencing at 2.00 pm in the in the Stephenson Room, Technology Centre, Wolverhampton Science Park

MEMBERS ~
Wolverhampton CCG ~

		Present
Pat Roberts	Chair	Yes
Dr David Bush	Governing Body Member / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	No
Dr Salma Reehana	Locality Chair / GP	No
Steven Marshall	Director of Strategy & Transformation	Yes
Manjeet Garcha	Executive Lead Nurse	Yes
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	Yes

Independent Patient Representatives ~

Jenny Spencer	Independent Patient Representative	No
Sarah Gaytten	Independent Patient Representative	No

Non-Voting Observers ~

Katie Spence	Consultant in Public Health on behalf of the Health and Wellbeing Representative	Yes
Elizabeth Learoyd	Chair - Wolverhampton Healthwatch	No
Dr Gurmit Mahay	Vice Chair – Wolverhampton LMC	No
Jeff Blankley	Chair - Wolverhampton LPC	No

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Jim Oatridge	Interim Chair (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Jo Reynolds	Primary Care Development Manager (WCCG)	Yes
Tally Kalea	Commissioning Operations Manager (WCCG)	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

Welcome and Introductions

WPCC108 Ms Roberts welcomed attendees to the meeting and introductions took place.

Apologies for absence

WPCC109 Apologies were submitted on behalf of Tony Gallagher, Dr Helen Hibbs, Jeff Blankley and Sarah Gaytten.

Declarations of Interest

WPCC110 Dr Bush declared that, as GP he had a standing interest in all items related to primary care.

As these declarations did not constitute a conflict of interest Dr Bush remained in the meeting whilst these items were discussed.

RESOLVED: That the above is noted.

Minutes of the Primary Care Commissioning Committee Meeting Held on the 1st August 2017

WPCC111 RESOLVED:

That the minutes of the previous meeting held on 1st August 2017 were approved as an accurate record.

Matters arising from the minutes

WPCC112 Mr Oatridge asked if the following three patient experience reports shared at the previous meeting could be circulated to all GPS so they are aware of the results;

- Healthwatch Wolverhampton GP Access: Patient Experience April 2017
- Healthwatch Wolverhampton Urgent Care Centre: Patient Experience May 2017
- National NHS England GP Patient Survey: Wolverhampton CCG results

RESOLUTION: That the above patient experience reports are to be circulated to GPs

Committee Action Points

WPCC113 **Minute Number PCC302 – Premises Charges (Rent Reimbursement)**
The CCG are still awaiting the cost directives. Action to remain open.

Minute Number WPCC93 - Governing Body Report/Primary Care Strategy Committee Update
Mrs Southall confirmed that she had met with Ms Roberts regarding the bank holiday opening and how this is being advertised. Action closed.

Minute Number WPCC93 – Governing Body Report/Primary Care Strategy Committee Update
Miss Russell confirmed the amendments to the structure chart within the Task and Finish Groups terms of reference have been completed. Action closed.

Minute Number WPCC95 – Primary Care Operational Management Group Update
Update to be provided within the Private Primary Care Commissioning Committee meeting. Action closed.

RESOLVED: That the above is noted.

Primary Care Quality Report

WPCC114 Ms Gracha presented the quality report to the Committee which provides an overview of activity in primary care and assurances around mitigation and the actions taken when issues have arisen.

The following was highlighted to the Committee;

- ***Infection prevention -*** the service is provided by Royal Wolverhampton Hospitals and the most recent visits and audit ratings were shared with the Committee.
- ***Medicines Alert –*** further information regarding assurance on how the process is undertaken will be included within the next report.
- ***Friends and Family Test -*** the Quality Team and Contracts Team are working together to review the data in particular when data has not been submitted or supressed. It has been highlighted some practices can evidence submitting data but the system is not registering the data and the system is being investigated.
- ***Quality Matters –*** the majority of current incidents relate to information governance breaches and is being reviewed in depth by the Quality Team.
- ***Risk Register –*** There are currently no low risks, 4 moderate risks, 13 high risks and no extreme risks. Ms Roberts queried when the Committee were going to be presented with the full register so the committee can discuss the risks in more detail. Ms Garcha agreed that a snapshot of the risks could be circulated to the Committee.
- ***Workforce –*** a working group has been set up to develop effective communication and engagement including a video promoting primary care in the City and the development of the primary care web pages.

Mr Oatridge asked in future reports where tables/graphs are used could this be provided within a time series to display the data in a more meaningful way.

RESOLUTION:

Ms Garcha agreed that a snapshot of the risks could be circulated to the Committee.
Ms Garcha agreed to ensure that the tables/graphs within the report provide a time series of information so data can be reviewed in a more meaningful way.

Primary Care Strategy Committee Update

WPCC115 Mrs Southall shared with the Committee the minutes of the Primary Care Strategy Committee which took place on the 17th August 2017. Mrs Southall provided an overview of each of the Task and Finish Groups programmes of work and reported upon the GP Five Year Forward View training tracker.

RESOLVED: That the above was noted.

Primary Care Operations Management Group Update

WPCC116 Mrs Southall informed the Committee of the discussions which took place at the Primary Care Operational Management Group meeting on the 22nd August 2017 and highlighted the following points;

- The contract for the caretaking arrangements for Ettingshall Medical Practice has now been signed by The Royal Wolverhampton NHS Trust.
- A contract monitoring visit has been arranged with Tettenhall Medical Practice, Lower Green Health Centre due to the CQC rating of 'requires improvement'.
- Castlecroft Medical Practice is the next practice to be scheduled to migrate to EMIS Web.
- Following the introduction of the new infection prevention audit tool which is a more thorough process, practices have received a lower rating than previous years.
- It was highlighted that treatment for minor eye conditions can now be accessed through pharmacists, GP appointments, community optometrists and hospital appointments if urgent.

RESOLUTION: That the above was noted

Provision of Services post Dr Mudigonda Retirement from a Partnership to single handed contract – Business Case

WPCC117 Ms Shelley presented to the Committee a report regarding Dr N Mudigonda and Dr V Mudigonda requesting a decision of Dr N Mudigonda retirement and

removal from the GMS contract, resulting in Dr V Mudigonda being the sole contract holder.

Dr N Mudigonda and Dr V Mudigonda are father and son and hold a GMS contract to provide primary medical services from Bilston Health Centre holding c3,800 patients. Dr N Mudigonda has submitted an application to retire from the practice and provided a business plan identifying the proposal for clinical cover following his retirement.

The practice proposal for clinical cover following Dr N Mudigonda's retirement includes the following;

- Dr N Mudigonda has already reduced his clinical commitment in the practice from 9 sessions to 5 sessions per week in October 2013, and a salaried GP has been covering these sessions since then.
- An additional salaried GP has been employed for 4 sessions per week with a view to this GP becoming a partner on the contract in the future.
- The practice has a robust nursing team in a health care assistant and advanced nurse practitioner (ANP).
- The practice is also a training practice and have part time female registrar who will be in the practice for 2.5 years and while it is understood she is a trainee and supernumerary she will be able to offer some continuity and additional choice to those patients who wish to see a female GP in the immediate future.

The business case plan also highlights that they are in active discussions with one of the Primary Care Home groups with a view of joining them in the future. As well as taking on an extra salaried doctor with a view to making them partner in the near future. Mr Marshall asked if they have a timeframe of securing a new a new partner onto the contract. Discussions took place regarding the timeframe and the Committee agreed to request in line with the business case they should meet the expectation of reporting back in 12 months' time regarding the appointment of a partner and aligning to a new model of care.

The Committee agreed to the recommendation that the committee give approval for Dr V Mudigonda to continue as a sole contract holder following the removal of Dr N Mudigonda given the assurance provided by the practice. The Committee also agreed that the practice have 12 months to secure a new partner onto the contract and be aligned to a new model of care. Ms Shelley agreed to report back to the practice.

RESOLUTION: Ms Shelley agreed to report back to the practice that the Committee request in line with the with the business case they meet the expectation of reporting back in 12 months' time that they have a partner on the contract and that they have aligned to a new model of care

Any Other Business

WPCC118a The Committee highlighted there were no new risks identified during the discussions of the meeting.

WPCC118b Mr Oatridge on behalf of the Committee acknowledged that this was Ms Roberts last meeting as Chair of the Committee before her retirement at the end of month. Ms Roberts was thanked for all her hard work and commitment to the Committee and CCG and was wished all the best for her retirement.

RESOLVED: That the above is noted.

WPCC119 **Date, Time & Venue of Next Committee Meeting**
Tuesday 3rd October 2017 at 2.00pm in PC108, 1st Floor, Creative Industries Centre, Wolverhampton Science Park.

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group
Audit and Governance Committee

Minutes of the meeting held on 18 July 2017 commencing at 11.00am
In Armstrong Room, Science Park, Wolverhampton

Attendees:

Members:

Mr P Price	Chairman (Interim)
Mr D Cullis	Independent Lay Member
Mr L Trigg	Independent Lay Member

In Regular Attendance:

Mr J Oatridge	Interim Chair of the Governing Body
Mr P McKenzie	Corporate Operations Manager, WCCG
Miss M Patel	Administrative Support Officer, WCCG (minute taker)

In Attendance:

Mr T Gallagher	Chief Finance Officer, WCCG and Walsall CCG
Ms J Watson	Senior Internal Audit Manager, PwC
Mr N Mohan	Senior Manager, LCFS, PwC
Mr M Stocks	Partner, External Audit, Grant Thornton
Mr V Sarjan	Audit Manager, E&Y LLP

Apologies for attendance:
AGC/17/62 Apologies for absence were submitted by Mr Grayson and Ms Garcha.

Declarations of Interest
AGC/17/63 There were no declarations of interest to be declared.

Minutes of the last meeting held on 23 May 2017
AGC/17/64 The minutes of the last meeting were agreed as a correct record.

Matters arising (not on resolution log)
AGC/17/65 There were no matters arising.

Resolution Log
AGC/17/66 The resolution log was discussed as follows;

- Item 79 (Item b/f from private session) – Review results of Coding Audit at Nuffield; arranged via CCG Contracts Team –

independent checks had been carried out by CHKS for the Nuffield. Mr V Middlemiss to provide information once received.

- Item 90 (AGC/17/29) – Internal Audit mid-year review 2017/18 to be bought back as an agenda item to the September Audit and Governance Committee meeting - on agenda for review.
- Item 94 (AGC/17/54) – Ms Watson to speak to Mr Mohan and Mrs Tongue about an analytical review of National Fraud Initiative Accounts Payable by the next meeting – Mr Mohan had met with Mr Gallagher.
- Item 95 (AGC/17/59) – Mrs Skidmore to ask Mr Hastings to align his briefing on the recent cyber-attack alongside guidance from NHS Digital – on agenda.

Briefing on Recent Cyber Attack

AGC/17/67 Mr Hastings presented to the group a paper on the Cyber attack which took place on Friday 12 May 2017.

The paper outlined details the incident that occurred and the steps undertaken in response by Mr Hastings and his team alongside the IT department at The Royal Wolverhampton NHS Hospital, which provided IT services for the CCG and Wolverhampton GP practices. Mr Hastings provided the Committee with reassurance that the CCG had weekly meetings with the Trust regarding technical support and monthly Service Level Agreement Meetings. This meeting was attended by the Director of IT, Head of IT and other Senior IT staff from the Trust. All computers received regular patches which ensured that software was kept up to date. The compliance level was at 95% with the remaining 5% due to a number of computers at The Trust which were not physically manned but ran specific equipment, patching for these machines was being looked at.

Due to the diligence and good working between colleagues of the CCG and the Trust no machines were affected by the attack and no patient services were impacted.

Mr Cullis asked Mr Hastings where this was ranked on the Risk Register. Mr Hastings advised that it was not rated as a high risk on the register as it was with other organisations due to the strong mitigation in place but would remain on there as this would always be a risk.

RESOLUTION: The Committee:

- Noted and received assurance from the report.

Mr Hastings left the meeting.

Internal Auditor Progress Report

AGC/17/68 Ms Watson reported on progress made since the last Audit and Governance Committee meeting and informed that she had met with Mr Gallagher to discuss the existing plans which were risk assessed. This meant that the plan included a follow up on Risk Management following last year's audit findings. Ms Watson had also liaised with Mr Steven Marshall and Mr Hastings on the proposed plan for the year.

The table on page 4 of the document listed changes to dates in the plan. This had received approval from the Executive team and was now seeking approval from this Committee.

Mr Oatridge asked with regards to the timing of the planned review of QIPP if enough information would be received in Quarter 3 to react to any actions arising from the review in year. Mr Gallagher advised that the reason for using Quarter 3 is that that there would be more monitoring undertaken and the challenge of QIPP increasing. Although more QIPP schemes were being identified there was still the challenge of meeting the £2.2million QIPP delivery and suggested that he meet with Mr Oatridge outside of the meeting to discuss.

Ms Watson asked if the CCG would benefit from meeting with Specialists in cost reduction in a round table exercise as they had seen success with other organisations taking up this offer. Mr Price and Mr Gallagher felt that this might be a good idea and offered to discuss outside the meeting.

Mr Cullis suggested looking at lessons learnt from last year's QIPP to use towards how QIPP was looked at this year.

In respect of the proposal to delay planned work on public engagement, Mr Oatridge stated that although the CCG had been noted as being exemplar in public engagement, he had concerns that the Lay Member for Public and Patient Engagement was retiring from the Board in September and that this had not been identified in the report and would potentially leave a gap in the organisation. Mr Price also asked for clarification within public engagement around communication especially regarding external communications. Ms Watson explained that last year they had looked at the CSU delivery against the statement of work for the CSU. The findings were fed into the CCG's engagement strategy. Mr McKenzie had been advised that NHS England had identified the CCG as an exemplar in this area following their consideration of a self-assessment tool which formed part of the CCG's assurance arrangements last year. This had particularly identified the CCG's strong public engagement framework which was effectively embedded into the CCG's operations. Mr Oatridge felt that if this position wasn't filled that this may impact the rating. Mr Cullis asked if a management summary report could be prepared to look at planned activities and consider the potential risk. This was taken as an action by Ms Watson.

Mr Trigg asked how the Internal Audit team liaised with the City of Wolverhampton Council regarding the BCF programme and whether there was an overview of the whole programme and not just the view of the CCG. Ms Watson advised that any CCG concerns could be voiced through the Health and Wellbeing Board. Mr Trigg felt that it might be an action for the Management at this committee to monitor the CCG's contribution to the BCF programme. Ms Watson was not involved in the audit work with the Council as she was currently a Governor at a Wolverhampton School and it had been deemed as a potential conflict of interest at PwC.

Mr Price asked if IT security would be covered. Ms Watson informed Mr Price that this was covered last year as part of a broader piece of work using an IT diagnostic tooll and she would be happy to share the findings with Mr Price and Mr Gallagher. The CCG had robust arrangements in place through its Service Level Agreement with the Trust.

With regards to Risk Management, proposals for 2017/2018, there were concerns raised last year around the Risk Register and the Board Assurance Framework. The actions that should have been completed by now were delayed and would be discussed in more detail later on the agenda.

The appendices in the document referenced Declarations of Interest implementation across 13 CCGs and where WCCG was and also General Data Protection Regulation (GDPR) which will begin in May 2018. Mr McKenzie outlined that an action plan was being looked at with the help of the Information Governance Team at the CSU. The Quality and Safety Committee monitored this through reports from the IG Team.

RESOLUTION: The Committee:

- Agreed with the plan subject to QIPP timing this year
- Public Engagement – having a paper around the Lay Member leaving and any implications.
- Ms Watson to circulate IT summary Mr Price and Mr Gallagher.

Internal Audit Charter

AGC/17/69 The Internal Audit Charter was an annual report. It had been brought to the Audit and Governance Committee meeting for approval and then sighted at the Governing Body Meeting for information.

Mr Cullis as under 'reporting and monitoring' – there was nothing specific on following up on actions and asked if this could be approached more robustly. Ms Watson to amend document to reflect this.

RESOLUTION: The Committee:

- Accepted the report.
- Ms Watson to provide an update on actions at the next meeting.

Counter Fraud Progress Report

AGC/17/70 Mr Mohan presented to the Committee the Counter Fraud Progress Report. Mr Mohan had met with Mr Gallagher to review risks and how they were being managed.

The team were also assisting the CCG to help with the National Fraud Initiative.

RESOLUTION: The Committee:

- Noted the report.

WCCG LSMS Progress Report July 2017

AGC/17/71 Mr McKenzie presented the report on behalf of Mr Grayson and advised that work continued to progress following the action plan being presented at the April Audit and Governance Meeting. Mr Grayson had attended a recent Staff Meeting in June to raise staff awareness and that planned actions were in place. He also advised that Mr Grayson would be coming to the Science Park to meet with contractors to do a security risk assessment and seek assurance around the premises.

RESOLUTION: The Committee:

- Noted the report.

Annual Audit Letter

AGC/17/72 Mr Sarjan presented the Annual Audit Letter and advised that the content remained unchanged and that a certificate had been issued to WCCG stating that Ernst and Young had provided an unqualified opinion.

RESOLUTION: The Committee:

- Noted the report.

Risk Register Reporting/Board Assurance Framework

AGC/17/73 Mr McKenzie presented the report on behalf of Ms Garcha. This report is in response to the findings last year from an audit conducted by the Internal Audit team. Mr McKenzie was asked to support Ms Garcha to identify strategic risks and the structure of the Board Assurance Framework (BAF).

Mr McKenzie was asked to concentrate on the top risks that the Governing Body needed to be made aware of. There were 60 risks to review. The Datix system which is used to monitor risks only allows at present a single layered view of risks identified across the organisation. Mr McKenzie's review of the risks identified 8 as corporate level risks and 4 further risks were identified as composite risks from linked risks described on the system which were relevant to the Governing Body. The next step would be to discuss at the Senior Management Team meeting that the risks were correctly aligned to the CCG's objectives to support the population of the CCG BAF. Work continued to be ongoing.

Mr Price asked Ms Watson if she felt that this was an accurate reflection of work be undertaken currently at the CCG. Ms Watson advised that although the CCG continued to make progress, it was not in the position that had been anticipated at following the Internal Audit Review. Ms Watson also raised a concern with the BAF-Risk Management Project Implementation Plan point 1.2 (Once strategic objectives have been reconfirmed, the Governing Body will populate the BAF, setting out risks

with clear lines of responsibility and actions) which had been marked as complete as she felt that it had not been actioned. In order to achieve this it would have been anticipated that the Governing Body had approved the BAF which it had not been done.

Mr Oatridge also raised that there would be Governing Body elections shortly and this could lead to a change in the current members of both this committee as well as the Governing Body.

Mr Stocks remarked that it was unusual to not have an approved BAF in place.

Ms Watson remarked that although the CCG was risk aware that the documentation relating to BAF did not reflect this and that more emphasis needed to be made on agendas relating to this.

The group also asked if this would be reflected in the annual governance statement.

It was agreed that it would be good to have a more in depth discussion around Risk at a Governing Body Development Session potentially in September 2017 with further development once the new Governing Body was elected in October 2017. Risk would also feature as an agenda item at the SMT meeting due to take place next week.

RESOLUTION: The Committee:

- Noted the report
- Asked that reporting was reviewed as timelines had still not been achieved
- That information in the Implementation Plan was reviewed
- More in depth discussion needed with the Governing Body in September and once elections had taken place and a new Governing Body had been elected.

Review of Performance against Whistleblowing Policy

AGC/17/74 Mr McKenzie informed the group that the Whistle Blowing Policy had been formally approved at the Remuneration Committee and that he had been nominated as the CCG Speak Up Guardian.

No formal disclosures had been made so far. The policy was due to be reviewed at the next Remuneration Committee in November with the only minor changes made relating to contact information.

New NHS guidelines had been issued since the last time the policy had been presented at this Committee.

Mr Cullis raised concerns around the fact that there was no reference to disclosures being made by external parties and no provision in place for external stakeholders/suppliers/contractors/ex-partners. He also asked if there was currently a route for informal concerns to be raised and if not was this something that should be looked at. He also felt that the CCG policy should address the protection of whistleblowers identities in case of civil suits being raised. Mr McKenzie advised that, as the policy was due for review in November 2017, these comments could be taken on board as part of the review.

RESOLUTION: The Committee:

- Noted the report
- That the policy could be subject to the comments around disclosures being made by external parties and protection of whistleblowers identities.

Conflict of Interest Guidance

AGC/17/75 Mr McKenzie presented to the Committee the report on Conflicts of Interest following the publication of national guidance from NHS England. Changes had been outlined under 2.3 in the document.

Mr Oatridge left the meeting.

The group discussed 4.2 in the report around the declaring of interests by 'decision making' staff with relation to staff at Agenda for Change Band 8d. Mr Trigg asked if it was part of statutory requirement for staff to declare an interest on the register. Mr McKenzie confirmed that currently it was. Mr Trigg asked about the publishing of data with regards to the Data Protection Act and Mr McKenzie advised that the policy included a provision for staff to redact details in the register if they were concerned about them being in the public domain.

Mr Mohan spoke from a counter fraud perspective and felt that all declarations were a beneficial thing for the CCG.

RESOLUTION: The Committee:

- Noted the report.
- That the policy remained the same at present but that staff consultation should be undertaken.

Losses and Compensation Payments – Quarter 2 2017/18

AGC/17/76 Mr Gallagher presented this report and advised the Committee that there had been no losses or special payments during quarter 2 of 2017/2018.

RESOLUTION: The Committee:

- Noted the above.

Suspension, Waiver and Breaches of SO/PFPS

AGC/17/77 Mr Gallagher noted that there have been no suspensions of SO/PFPs in quarter 2 of 2017/18.

8 waivers were raised during quarter 2.

RESOLUTION: The Committee:

- Noted the above.

Receivable/Payable Greater than £10,000 and over 6 months old

AGC/17/78 The Committee noted that as at 30 June 2017 there were:

- No sales invoice greater than 10k and over 6 months old.
- 5 purchase ledger invoices greater than £10k and over 6 months old.
- The £4.8m invoice sent by RWT continued to be disputed by the CCG. NHSE and NHSI are aware of the situation.

RESOLUTION: The Committee:

- Noted the above.

Any Other Business

AGC/17/79 There were no items to discuss under this agenda item.

Date and time of next meeting

AGC/17/61 Tbc

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP COMMISSIONING COMMITTEE

Minutes of the Commissioning Committee Meeting held on Thursday 26th October 2017 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~

		Present
Dr J Morgans	Chair	Yes

Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Chief Finance Officer	Yes
Maxine Danks	Interim Executive Director Nursing & Quality	Yes
Sarah Smith	Interim Head of Commissioning - WCC	No
Julie Grainger	Public Health Commissioning Manager – WCC	No

In Attendance ~

Liz Hull	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Ranjit Khular	Primary Care Development Manager	Yes
Peter McKenzie	Corporate Operations Manager	Yes
Ed Cooke	Auditor, PWC (Observing)	Yes
Clare Barratt	Solutions & Development Manager	Yes

Apologies for absence

Apologies were submitted on behalf of Juliet Grainger and Sarah Smith.

Declarations of Interest

CCM632 Dr Morgans declared an interest as a member of Vertical Integration.

RESOLVED: That the above is noted.

Minutes

CCM633 The minutes of the last Committee meeting, which took place on 24th August 2017 and 28th September were accepted as true and accurate records.

RESOLVED: That the above is noted.

Matters Arising

CCM634 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

CCM635 (CCM589) Contracting and Procurement Update: Views of the functionality of the Community Services – Vic Middlemiss provided an update and reminded the Committee that the action is related to the services being provided by Concordia, in the context of Dermatology capacity that RWT were experiencing. A meeting has been set up between the CCG, RWT and community providers in Wolverhampton and Staffordshire, to review how the community providers work with RWT to support delivery of the Service Specification.

RESOLVED: That the above is noted and action closed.

(CCM592) Contracting and Procurement Report – Improvement Board (Vocare): Hard copies of the Improvement Board minutes to be sent to Max Reynolds and Cyril Randles. Action closed.

RESOLVED: That the above is noted and action is closed.

(CCM624) GP Representation – Scrutiny process for service redesign: Jane Woolley to attend the Committee in November.

RESOLVED: That the above is noted and the action is closed.

(CCM625) MSK Service – Wolverhampton Health Network: Peter McKenzie confirmed that the MSK Service is included.

RESOLVED: That the above is noted and the action is closed.

Review of Risks

CCM636 Peter McKenzie explained the work undertaken to realign the Risk Management Process with the Governing Body Assurance Framework and the CCG's strategic objectives. A document was circulated which included a snap shot of some of the risks assigned to Commissioning Committee and advised that more detailed information should be available for the next meeting.

RESOLVED: That the above is noted.

Contracting Update Report

CCM637 Vic Middlemiss provided the Committee with an overview of the CCG's contract performance, significant contract issues and actions being taken to address these. The Committee was asked to note that procurement updates will be covered in a separate report submitted to the Private Commissioning Committee.

Royal Wolverhampton NHS Trust

Contract Performance - No specific activity information was provided due to Month 4 data being repeated at the September CRM.

The main issues were noted as follows:

- Performance recorded in Month 4 indicates an over performance on activity of 1.46% and 0.11% on the finances.
- Elective activity is the largest under-performing Point of Delivery area at (£663k) which continues to give concern for the achievement of Referral to Treatment (RTT) time targets.
- Non-elective activity continues to overheat and the CCG is seeing new HRGs being used e.g. relating to Sepsis where before activity was not recorded.
- Outpatient first attendances are on plan in activity and money and this position is also reflected in the reduction of referrals seen.
- Outpatient follow ups continue to over perform and the CCG is working with RWT to understand the causes and key specialties.

Performance sanctions for July 2017 were confirmed as £29,000

Sepsis Counting & Coding Change:

- Due to a national change in the coding guidance for Sepsis, the CCG advised RWT that this will have a cost neutral impact to the CCG during FY 2017/18. The Trust has a different interpretation of the national guidance. However, CCG intentions have been made clear.
- Tony Gallagher advised the Committee that the CSU is pulling together a report to put the CCG's case forward to the Trust. It was agreed that Vic Middlemiss would check that the CSU are adopting the same methodology across all CCG's

before our response is sent to the Trust.

Activity Transfer from Walsall Manor:

- The CCG has been made aware that a cohort of paediatric orthopaedic activity will be transferred from Walsall Manor Hospital to RWT, on the basis of clinical and safety concerns for patients. The CCG has not yet been sighted on the activity numbers and will continue to liaise with RWT and Walsall CCG, particularly with regards to the impact on RTT.
- Walsall Manor Stroke Services – Max Reynolds raised a query with regards to Walsall Manor closing their Stroke Service. Steven Marshall clarified that this proposal is only at consultation stage.

Urgent Care/ Ambulance/ Patient Transport

Urgent Care Centre:

- Vic Middlemiss reported that Totally PLC have announced their intention to buy Vocare and the acquisition was due to be completed by the 24th October 2017. The sale has been confirmed by Vocare in its own recent press release, which confirms their full support. The change of ownership is not expected to impact on the contractual and commissioning arrangements the CCG has in place i.e. the existing contract will continue in its present form. It is therefore not a contract novation. In this scenario, the NHS Standard Contract requires the provider to notify the commissioner of a Change of Control, as per General Condition 24, once the acquisition is confirmed.
- The provider remains under close scrutiny through the Improvement Board and monthly Contract Review Meeting. The Vocare Improvement Board has issued the provider with a three month timeframe to make specific improvement in areas of concern. Two Contract Performance Notices and an Information Breach Notice remain in force.
- The Committee was reassured that the main concerns revolve around KPI's and although some clinical issues do exist, they are not major ones.

WMAS – Non-Emergency Patient Transport (NEPT):

- The performance of the NEPT service in Wolverhampton and Dudley is currently below the required standard. A Contract Performance Notice has been served for all of the KPIs that are underperforming and WMAS are working to a Remedial Action Plan.
- Two Potential Serious Incidents (SIs) – Clare Barratt confirmed that one incident has been confirmed not to be an SI and the other one is still being discussed between quality teams at the CCG and WMAS.

Other Contracts

Probert Court Nursing Home:

- The suspension to the service at Probert Court Nursing Home (Step-down facility) has been lifted as of 4th October 2017. This follows an intense period of scrutiny which has included weekly inspections and agreement that the provider Accord has demonstrated satisfactory improvement to warrant a return to normal operational

service.

- As a result of the suspension, bed utilisation at the home has been very low. This means poor value for money on the block contract (which is circa £880k) and the CCG paying for alternative arrangements for patients discharged from RWT who would have been suitable for Probert Court. These costs have been closely monitored by the Continuing Healthcare Team during the suspension period and arrangements are being made for this total amount to be recovered accordingly.

Individual Placement Support:

- As per paper to the September Governing Body (private session), a procurement process has been completed for Individual Placement Support service which the CCG is actively supporting West Midlands Combined Authority on, in the role of host commissioner. A draft contract is being developed for the CCG to review week commencing 16th October, aiming for contract sign off by 1st November. This is an ambitious timeframe and there is a risk of slippage.

RESOLVED: That the above is noted and the following action agreed:

- Sepsis Coding Proposal by the CSU - Vic Middlemiss to check that the CSU are adopting the same methodology across all CCG's before our response is sent to the Trust.

Primary Care Counselling Service

CCM638 The Committee was presented with a report by Ranjit Khular to request that approval be given to extend the current Primary Care Counselling Service Contract to the end of March 2018.

The key features of the service are to provide counselling support to patients with very low level anxiety and depression within a Primary Care setting for patients who do not meet the criteria for Healthy Minds.

Ranjit Khular confirmed that the uptake of the service and its outcomes are positive, hence the recommendation to extend the current contract until 31st March 2018.

RESOLVED: The Committee supported the request to extend the Primary Care Counselling Service until 31st March 2018 and the following actions were agreed:

- Ranjit Khular and Vic Middlemiss to liaise about the procurement process separately.

- Ranjit Khular to obtain a sample of outcomes and monitor the frequency of GP attendances following access to the service.

Any Other Business

Dermatology Service

CCM639 Clare Barratt gave assurance in relation to the effectiveness of the Dermatology Pathway. Max Reynolds and Cyril Randles were provided with a copy of the pathway which sets out the triaging assessment and treatment protocol.

RESOLVED: That the above is noted.

MSK Service

CCM640 Max Reynolds expressed concern about delivery of the MSK Service, following an event he attended, hosted by Health Watch Wolverhampton, where it was inferred that there were insufficient resources to deliver the service. Clare Barratt advised that she had not been made aware of this and that the provider are working well within the set Key Performance Indicators.

RESOLVED: That the above is noted and an action agreed for Clare Barratt to raise concerns about waiting times at the next Contract Review Meeting.

Commissioning Committee Chair

CCM641 Steven Marshall informed the Committee that Dr Kainth has been appointed as the Chair for the Committee, with effect from November 2017. There will also be an additional GP that forms part of the membership.

On behalf of the Committee and the CCG, Steven thanked Dr Morgans for his input as Chair, over the last few years.

RESOLVED: That the above is noted.

Date, Time and Venue of Next Meeting

CCM642 Thursday 23rd November 2017 at 1pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 19th October 2017

Members:
Dr David Hegarty – Chairman, Dudley CCG (Chair)
Helen Hibbs – Accountable Officer, Wolverhampton CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Angela Poulton - Programme Director – Joint Commissioning Committee
Matthew Hartland – Chief Operating & Finance Officer, Dudley CCG and Interim Strategic Finance Officer, Walsall CCG
Peter Price – Lay Member, Wolverhampton CCG (part)
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Salma Reehana – Chair, Wolverhampton CCG

In Attendance:
Laura Broster, Communications, Dudley CCG
Jackie Eades – Executive Assistant Note taker

Apologies:
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG
Dr Anand Rischie – Chairman, Walsall CCG
Prof. Nick Harding – Chairman, Sandwell & West Birmingham CCG Jim Oatridge – Interim Chair, Wolverhampton CCG
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. Welcome and Apologies

1.1 Welcome and apologies as above.

2. Declarations of Interest

2.1 Angela Poulton is collating all declarations of interest and a reminder given to members to return as soon as possible.

3. Minutes & Actions from the last Meeting

3.1 Minutes from the meeting held on 28th September 2017 were agreed as an accurate record of the meeting.

3.2 ACTION:

The action register was reviewed and actions delivered were confirmed and others taken within the agenda.

4. Sustainability & Transformation Plan (STP) Update

4.1 Andy Williams gave a brief update following the STP meeting on Monday 16th October. There was good attendance from Health members but limited from

Councils. The agenda focused on winter preparations across the Black Country. Currently all areas are undertaking telephone conference calls to ensure local arrangements are in place. A clinical leaders meeting is being convened led by Diane Wake, CEO Dudley Group of Hospitals. The Black Country is under pressure from external health economies with regards to Delayed Transfer of Care (DTOC) issues in Staffordshire. Paul Maubach stated that our Regulators must be made aware of this. Andy Williams is meeting with Councils as an ambassador of the STP. Paul Maubach put it to the JCC that he would like to see the plans the 4 Acute Trusts have around the big ticket issues impacting upon the system, such as what collaborative work they are undertaking with acute networks and what system efficiencies are being undertaken including Transforming Care Together (TCT).

4.2 Andy Williams met with colleagues from TCT to discuss the alignment between the work they are undertaking and the STP. Within the discussions there are four areas for clinical integration which include mental health, learning disabilities, children and families and integration of physical and mental health, the aim being to realise both financial and better quality of care benefits for the patients across the region.

4.3 James Green added that there are requirements for organisations to achieve 2% efficiency and 1% reductions in demand management which requires collaboration, and the STP is not sorting this to avoid the view forming that this is where this is being sorted. There was discussion about providers taking actions to deliver their elements which are then accounted for against their CIPs rather than the system. It was agreed that a paper would be brought back to a future JCC setting out where there had been successes in achieving the 1% reduction in demand management.

4.4 With regards to TCT, Peter Axel will be explaining the financial model that will deliver back office efficiencies and a contribution to the STP as part of the price/activity reconciliation exercise work being led by Tony Gallagher. It was agreed that the 4 CCG's place based care models need to be communicated to TCT. It was agreed that Matt Hartland, James Green and Peter Axon should meet with TCT colleagues to discuss the JCC and STP arrangements. Technical aspects need to be discussed in terms of funding for Mental Health services and where these sit.
ACTION: Matt Hartland & James Green and Peter Axon to meet to discuss alignment of JCC and STP.

5. Update from Clinical Leadership Group

5.1 There was no update given, as the meeting did not take place.

6. Future Commissioning in the Black Country

6.1 The 3 Accountable Officers met and produced the paper attached as item 6. The paper will be considered at today's JCC and if agreed will be taken to all respective Governing Bodies for approval. This will be used to update the staff on the direction of travel and the work that needs to be undertaken.

6.2 Matt Hartland stated that under section 3.2 more clarity is required to work through the financial aspects in relation to West Birmingham. Andy Williams confirmed this work has commenced.

6.3 James Green asked for further clarification on 4.4. The explanation was given that any staff that are currently working as part of the STP now, will not automatically be in line for the job once the STP is fully established. These roles will not be ring-fenced for these people. It was suggested that the wording is changed to say that anyone working in STP or JJC roles currently will be "neither privileged or disadvantaged" through having an interim position. This was agreed.

6.4 Andy Williams confirmed that NHS England have aligned some staff to the STP, including a Jo-anne Alner, a project manager and business support.

6.5 Andy Williams shared a diagram used at a SWB CCG staff protected learning time event which depicts the individual health and care organisations and the relationship with the STP. It shows how organisations operate in their own right as a statutory body but can collaborate through structures created such as the JCC. The diagram was agreed as being very useful and should be shared to members. Jackie Eades to send out with the notes.

ACTION: Jackie Eades to send out the diagram showing the constituent health and care organisations and structures for collaboration in the STP

6.6 Discussions then turned to the terminology of the task and finish groups, as some groups many be long term, it was agreed that these groups should be re-named as subgroups of the JCC. Angela Poulton felt that given mental health commissioners have already been collaborating that it would make sense to request the delegation for the work programme to commence now to strengthen the mandate. Members felt work could continue collaboratively.

6.7 The paper set out a set of recommendations that the members need to agree prior to the paper being presented at Governing Body meetings.

- 9.1 The members to consider the paper for presentation at Governing Body meeting.
- 9.2 A work stream around aligning our CCG Governance structures over time by establishing a common route map for how our CCG Governance will change as each of our ACS arrangements are established.
- 9.3 Seek confirmation from Sandwell and West Birmingham CCG on its plans for West Birmingham and subsequently change the TOR of the JCC accordingly.
- 9.4 Starting now in 2017/18, give delegated authority to act on behalf of the 4 CCGs: in the oversight of the LD TCP agenda to ensure that we have a coherent plan for the care of LD patients and a clear mechanism for reviewing individual cases.
- In the oversight of MH Services where we have the opportunity to collectively bid for new, shared development opportunities.
- Establish a joint policy forum to review the opportunities and mechanism for decommissioning
- Establish a joint acute contract group to develop the terms and conditions we are seeking from a new contractual relationship with our acute providers
- Confirm a ‘seat at the table’ arrangements for specialised services and actively start to work with NHS England to put these arrangements into place.
- Confirm that the JCC will oversee any transfer of NHS England assurance/performance functions/resources.
- 9.5 From April 2018: Be given delegated authority to establish a joint work programme to look at how we commission MH services together from TCT from April 2019.
- Be given delegated authority to explore the options for devolution/integration of Primary Care commissioning with NHSE should that become a realistic proposition.

The JCC members resolved to agree these recommendations.

6.8 Matt Hartland pointed out that we need to be mindful of the commissioning intentions that are being developed currently that will form the contracts for 2018/19 and take into consideration the financial aspects of the mental health integration plans. A meeting is being arranged.

6.9 Paul Maubach pointed out that there has been no representation from Simon Collings from Specialised Services in the last 2 meetings, therefore we require an urgent update of the planned arrangements which include financial risk.

6.10 Laura Broster would like to develop a slide pack for staff for information following the Governing Body's recommendations. This was agreed.
ACTION: Laura Broster to develop a slide pack for staff following the respective GB meetings.

7. Reports from the Task & Finish Group reports

7a. Governance Task & Finish group

The report was noted for information.

7b. System Design & Contractual Frameworks (SD&CF) Task & Finish Group

This group was set up to look at the Place Based Models of Care for each CCG and how this forms part of each ACO/ACS. Concerns still remain around Primary Care buy in and also the lack of clinical management/leadership due to vacancies for medical director posts in across some Acute Trusts. There was discussion around Wolverhampton being involved with Walsall as within the Place Based Care models there is significant patient flow between Walsall and Wolverhampton. This work is complete and the remit of the subgroup will change to look at the Acute Contracts and the potential to move away from PBR.

7c. CCG Collaboration Task & Finish Group

This group will look at the 7 priority areas agreed by the Clinical Leadership Group and the de-commissioning policies across the 4 CCGs.

7d. Infrastructure and IM&T Task & Finish Group

Work is continuing to discuss infrastructure. In terms of IT Mike Hastings produced a paper detailing a funding bid for file sharing across the four CCGs that has been submitted via the ETTF scheme. If the funding is favourable it will be for 1 year. Detailed in the report are costs for licenses for 400 staff members across the Black Country. After a brief discussion it was agreed that the subgroup will remain working on taking the recommendations forward.

7e. Communications & Engagement Task & Finish Group

Meetings are on-going and the Group has been asked by Staff Side to produce more information.

7f. Finance Task & Finish Group

James Green produced and gave a brief summary of the report. A performance dashboard is being developed for the STP Sponsorship Group. It will be challenging to get the work completed due to capacity and day to day working commitments. Issues remain around cross boundaries. Joint control totals are being discussed but this is in its infancy due to maturity. James Green stated that there is a meeting tomorrow between all CFOs to discuss financial risks in the system. More feedback will be given in due course as part of the regular finance subgroup updates, as this meeting may steer the work for the JCC and STP in terms of the finance. Andy Williams reminded the members that we need to set out our Black Country plans and communicate this to our Regulators to ensure that we get our share of the STF money.

It was agreed that the JCC is meeting after the STP meetings and this needs to be reversed. Jackie Eades to look at moving the JCC to ensure it falls before the STP sponsorship meetings.
ACTION: Jackie Eades to look at the JCC meeting dates.

8. Specialised Commissioning

8.1 In the absence of Simon Collings, as in the recommendation for delegation Paul Maubach stated that the JCC should pursue as a priority gaining delegated financial control via Angela Poulton. Work needs to be undertaken to scope areas for potential delegation, determine the financial value, identify risk and commence discussions regarding specialised services staff to support the work. The item was deferred to the November's meeting and Angela Poulton agreed to try to contact Simon Collings.
ACTION: Angela Poulton to contact Simon Collings for an update on Specialised Commissioning and to progress the ambition for delegation where appropriate.

9. JCC Executive Development Day

9.1 After a brief discussion Thursday 18th January was agreed. Jackie to send an electronic invite to all members.
ACTION: Jackie Eades to send out new Exec away day date 18th Jan 2018 electronically to all attendees.

10. Any Other Business

10.1 Jim Oatridge stated that a Joint Governance Group of CCG Audit Chairs met on Monday and a Terms of Reference agreed and circulated. These will now be presented at each CCGs Audit Committee. It was agreed that Jim should bring the agreed final TOR to the next appropriate JCC.
ACTION: Jim Oatridge to present the ratified Joint Governance Group Terms of Reference at the next appropriate JCC meeting.

Date and Time of Next Meeting
Thursday 14th December, 1-3pm at Room 1 Jubilee House.

JCC Action Log

No.	Date	Action	Lead	Status Update
030	22 June 17	Andy Williams to write to DASs to invite them to a meeting at the end of July.	Andy Williams	Completed, invite sent to Paula Furnival
051	17 August 2017	Simon Collings to confirm in writing to Kiran Patel that Specialised Services position have no concerns regarding current Vascular Services delivery	Simon Collings	To confirm status at October meeting
054	17 Aug 2017	Steve Marshall/Sarah Fellows to present a revised proposal for collaborative Mental Health commissioning to November JCC	Steve Marshall/Sarah Fellows	Not ready for Nov meeting
056	28 Sept 2017	David Hegarty to request via the Clinical Leadership Group that all clinicians take the opportunity to discuss A & E issues at forums in which they participate	David Hegarty	Meeting was cancelled therefore still outstanding
057	28th Sept 2017	Helen Hibbs to explore whether the Royal Wolverhampton's Medical Director would chair a clinical summit to specifically focus on how the Black Country system can work collectively to enable all acute providers to achieve the A&E standard	Helen Hibbs	Agreed for this to happen therefore update required
061	28th Sept 2017	Cancer performance to be added to the October agenda	Jackie Eades	November's agenda
062	19 Oct 2017	Matt Hartland and James Green to meet with Peter Axon re TCT and alignment with JCC and STP	Matt Hartland and James Green	
063	19th Oct 2017	Jackie Eades to send out the diagram showing the constituent health and care organisations and structures for collaboration in the STP	Jackie Eades	
064	19th Oct 2017	Laura Broster to develop a slide pack for staff once all GB's have agreed future of commissioning paper	Laura Broster	
065	19th Oct 2017	Jackie Eades to look at re-arranging the JCC meeting dates	Jackie Eades	
066	19th Oct 2017	Angela Poulton to contact Simon Collings for an update on Specialised Commissioning and to progress the ambition for delegation where appropriate	Angela Poulton	
067	19th Oct 2017	Jackie Eades to send out new Exec away day date 18th Jan 2018 electronically to all attendees	Jackie Eades	
068	19th Oct 2017	Jim Oatridge to present the ratified Joint Governance Group Terms of Reference at the next appropriate JCC meeting	Jim Oatridge	

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 18 October 2017

Attendance

Members of the Health and Wellbeing Board

Councillor Roger Lawrence	Chair (Labour)
Councillor Val Gibson	Cabinet Member for Children and Young People
Councillor Paul Sweet	Cabinet Member for Public Health and Well Being
Bhawna Solanki	University of Wolverhampton
David Watts	Director of Adult's Services
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Elizabeth Learoyd	Healthwatch Wolverhampton
Emma Bennett	Director of Children's Services
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Jo Cadman	Black Country Partnership NHS Foundation Trust
Mark Taylor	Strategic Director - People
Sarah Smith	Head of Strategic Commissioning
Steven Marshall	Wolverhampton Clinical Commissioning Group
Superintendent Harvi Khatkar	West Midlands Police

Employees

Brendan Clifford	Integrated Project Director
Glenda Augustine	Consultant in Public Health
Helen Tambini	Democratic Services Officer
Julia Nock	Head of Assets
Madeleine Freewood	Development Manager - City Health
Margaret Courts	Children's Commissioning Manager
Sarah Fellows	Mental Health Commissioning Manager

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence**

Apologies for absence were received from Councillor Sandra Samuels OBE, Councillor Paul Singh, Chief Superintendent Jayne Meir, David Loughton, Dr Alexandra Hopkins, Helen Child, Susan Milner and Tracy Taylor.

Councillor Jasbir Jaspal also sent her apologies in her capacity as the Chair of the Health Scrutiny Panel.

2 **Notification of substitute members**

Superintendent Harvi Khatkar attended on behalf of Chief Superintendent Jayne Meir and Bhawna Solanki attended on behalf of Dr Alexandra Hopkins.

3 **Declarations of interest**

There were no declarations of interest made.

4 **Minutes of the previous meeting - 20 September 2017**

Resolved:

That the minutes of the meeting held on 20 September 2017 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**

David Watts, Director of Adults Services referred to the Better Care Fund and confirmed that the plan had been submitted within the timescale but rejected by the NHS as the Delayed Transfers of Care (DTOC) target would not be met within the given timeframe. Improvements had been made over the months and the Wolverhampton Clinical Commissioning Group (CCG) was looking to identify if it could off-set the shortfall by lowering NHS delays. The plan had been resubmitted on that basis and agreed by the NHS. Last week the Secretary of State for Health issued three letters; the first to the 32 poorest performing authorities, the second to the 20 best performing authorities and the final letter to the remaining authorities confirming that their performance would continue to be monitored. Authorities that were meeting targets would be allowed to decide how funding was spent, it was therefore very important that projected targets were achieved.

6 **Health and Wellbeing Board Forward Plan 2017/18**

Glenda Augustine, Consultant in Public Health presented the report and highlighted key points.

The Chair referred to the recent flu outbreak in New Zealand and asked that the Board received an update on the local plans in place to respond to any potential outbreaks in Wolverhampton.

Councillor Sweet referred to a recent local school closure and the poor communication with Public Health England which had exacerbated the problem.

In response to a question regarding flu vaccinations, it was confirmed that vaccination was taken as compulsory for NHS employees. The vaccination was also being promoted to Council staff, with details on City People.

Resolved:

1. That the Board approved the current Forward Plan.
2. That a briefing note on the local plans and response to outbreaks be circulated to the Board.

7 **Mental Health Strategy 2017-19**

Sarah Fellows, Mental Health Commissioning Manager, Wolverhampton CCG had been delayed and in her absence Brendan Clifford, Integrated Project Director presented the report and highlighted key points. He referred to the Combined Authority 'Thrive' initiative and using that as a spur and the establishment of a Strategic Development Group and he suggested that an update be brought to the Board at its meeting in April 2018. The achievements covered in the "Direction of Travel" document were noted as presented at the attendance of Claire Murdoch, National Director for Mental Health from NHS England in August 2017.

David Watts, Director of Adults Services confirmed that the Council was supportive of the work undertaken so far, as it was more structured than before and felt positive.

Sarah Smith, Head of Strategic Commissioning advised that work was underway to implement the NHS Improvement Plan. There had previously been underinvestment and now was the opportunity to help to influence and support colleagues.

Jo Cadman, Black Country Partnership NHS Foundation Trust advised that from a Black Country perspective, work had been undertaken in collaboration with commissioners through the Black Country STP and it was important to deliver a sustainable service.

Resolved:

1. That the Board note the actions being taken regarding the development of a joint Mental Health Strategy including the next steps.
2. That an update report be submitted to the Board in April 2017.

8 **CAMHS Transformation Plan Refresh 2017-20**

Margaret Courts, Children's Commissioning Manager, Wolverhampton CCG presented the report and highlighted key points. She confirmed that the plan had been refreshed against the original milestones and key lines of inquiry that needed to be addressed and would be submitted to NHS England by 31 October 2017.

In answer to a question regarding the involvement of Scrutiny, Margaret Courts confirmed that Scrutiny had already been involved and further involvement would be welcomed.

Resolved:

That the Health and Wellbeing Board accepted the refresh of the CAMHS Local Transformation Plan.

9 **Development Session**

The following topics were considered at the Development Session:

1. Combined Authority opportunities.
2. Use of estates and shared premises more productively.
3. Workforce planning issues in the health and social care sector including Brexit and skills shortage.
4. Place Based Commissioning (Social Care and Accountable Care Systems).

The following actions were agreed:

1. That an update on the work of the West Midlands Combined Authority Board be submitted to the Board in April 2018.
2. That details of the next phase for the use of estates and shared premises more productively be submitted to the Board in April 2018.
3. That an update on the workforce issues be submitted to the Board in April 2018.
4. That an update on progress regarding Place based Commissioning be submitted to a future meeting of the Board.

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