

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 10th April 2018 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 13 February 2018
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 R Rajcholan

Board Member

Management

Mr T Gallagher

Chief Finance Officer – Walsall/Wolverhampton

Mr M Hastings

Director of Operations

Dr H Hibbs

Chief Officer

Ms S Roberts

Chief Nurse Director of Quality

Lay Members/Consultant

Mr P Price

Lay Member

Ms H Ryan

Lay Member

Mr L Trigg

Lay Member

In Attendance

Ms H Cook

Engagement, Communications and Marketing Manager (part)

Ms S Gill

Health Watch representative

Mr J Denley

Director of Public Health

Ms K Garbutt

Administrative Officer

Mr M Hartland

Chief Finance Officer – Dudley CCG (Strategic Financial
Adviser)

Mr P McKenzie

Corporate Operations Manager

Mr H Patel

Deputy Head of Medicines Optimisation

Apologies for absence

Apologies were received from Mr J Oatridge, Mr S Marshall, Dr J Parkes, Mr Chandock, Dr D Watts and Ms S McKie

Declarations of Interest

WCCG.2035 There were no declarations of interest declared.

RESOLVED: That the above is noted.

Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing

WCCG.2036 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 12 December 2017 be approved as a correct record.

Matters arising from the Minutes

WCCG.2037 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2038 **Minutes WCCG.1969 Chief Officer Report**

Mr P Price confirmed that data sharing relating to care records will be raised at the Audit and Governance Committee meeting on the 20 February 2018.

RESOLVED: That the above is noted.

Chief Officer Report

WCCG.2039 Dr Hibbs presented the report. She highlighted that Wolverhampton Clinical Commissioning Group (WCCG) has had an initial moderated rating of Good (Green) by NHS England against the Integrated Assessment Framework (IAF).

Dr Hibbs referred to the Accountable Care Alliance Development Locally. Work continues with GP leads, provider organisation, the Local Authority and Public Health to develop a new way of working together in Wolverhampton.

A review is currently being undertaken of the governance arrangements for the Black Country Sustainability Transformation Plan and a recommendation for the appointment of an independent chair is being worked on. Dr D Bush asked if there was a budget for this appointment. Dr Hibbs stated that the finance directors are looking at the running cost and there is also an allocation from NHS England.

Dr Hibbs pointed out the projects that are taking place ~

- Safer Provision and Caring Excellence (SPACE)
- Empowerment of Hard to Reach Communities in the Prevention of Violence against Women and Girls
- GP Domestic Violence Training and Support Project

RESOLVED: That the above is noted.

Items which should not routinely be prescribed in Primary Care

WCCG.2040

Mr H Patel presented the report. NHS England has run a national consultation and have made a set of recommendations around 15 items which should not be routinely prescribed in Primary Care and another 3 items which should not routinely be prescribed but include a series of exceptions. The guidance aims to reduce unwarranted variation by providing clear guidance to CCG's on items that should not be prescribed to ensure that best value is obtained from prescribing budgets. He referred to the feedback from the Members meeting regarding the outcome of the consultation and local implementation. Dr Hibbs expressed concerns regarding the possibility that items could be replaced with a more expensive item. Dr Bush added that clinical effectiveness is being balanced and asked what the rationale was in suggesting we have for banning items of medication.

Dr Gulati arrived

Dr Asghar asked if we always need to go for the cheaper option and stated that we need to have choice as the cheaper option may not work. He added that dealing with patients is difficult when changing medication. Dr Hibbs stated we need to encourage GP's not to prescribe these items. Dr Reehana added it would put some GP's in a difficult position.

A discussion took place and the recommendation would be to seek further advice regarding GP concerns and local implementation before taking these items off the local formulary.

RESOLVED: That the above is noted Mr Patel to return to the Governing Body with further information.

NHS England consultation: conditions for which over the counter items should not routinely be prescribed in Primary Care

WCCG.2041 Mr Patel presented the report which stated that NHS England have begun a consultation on conditions for which over the counter items should not be routinely prescribed in Primary Care. The report seeks the Governing Body's views on the consultation document.

He pointed out the feedback from the members meeting which took place on the 31 January 2018. Dr Bush pointed out that many of the items are relatively cheap. He added the way forward is education. Dr Hibbs stated we want people to be educated regarding self-care which is really important and helps empower them as well as protecting GP appointments for other conditions.

Mr M Hartland added that any financial benefit should be retained locally and the saving would be a proportion in the QIPP saving. A discussion took place. There are concerns around how we implement this in a fair way. It would be difficult to implement and savings would not necessarily be met. Patients should not be refused an appointment to be seen by a GP. One suggestion was that through Care Navigation patients could be directed through to pharmacy as an alternative option to a GP appointment. A review has been made at a national level and there is a significant variation both across areas and clinicians within areas.

It was suggested Mr Patel is to respond to the consultation on the CCG's behalf along the lines of the views expressed at the members meeting which mirror the views expressed around the Governing Body.

Mr Patel left

RESOLVED: That the above is noted and Mr Patel responds to the national consultation.

Board Assurance Framework

WCCG.2042 Mr P McKenzie presented the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register for the Governing Body's consideration. The updated GBAF gives an update on the risk profile against each of the defined Corporate Objectives. An assessment has been reached for each objective of the overall risk of it not being achieved.

The Strategic Risk Register is outlined in appendix 2. This gives an update on each of the identified risks, including details from the Governing Body Committee's reviews of the risks assigned to them. He pointed out that additional staff capacity has been approved in the Operations Team to further support the implementation of the risk management strategy, in particular supporting staff to ensure committee risk registers are kept up to date.

Mr Price stated this is part of the business process and is a good idea to come to the Governing Body. However we need trajectories included. Mr McKenzie confirmed this will be part of the development of the document. Ms S Roberts stated this had been discussed in the Quality and Safety Committee and is a really good system. Mr McKenzie stated we are capturing the outcome of the discussions taking place at meetings. Mr M Hastings confirmed that our auditors, Price Waterhouse Cooper have reflected this in their report.

RESOLVED:

- (a) That the Governing Body considered the Assurance Framework.
- (b) That the Governing Body noted the improvement/progression of the high level risks.

Commissioning Committee

WCCG.2043 Dr M Kainth gave an overview of the report. He pointed out the Social Prescribing Service Commissioning Intentions. The Committee was presented with a proposal to continue the Social Prescribing Service for a further 12 months from April 2018 to March 2019.

He pointed out WMAS Non-Emergency Patient Transport (NEPT). National contract variation discussions are taking place. Mr Hastings confirmed collaborative work is being carried out around this.

The implementation of the electronic referral system was discussed and Mr Hastings confirmed that practices will still be able to refer patients to a named consultant.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2044 Dr R Rajcholan welcomed Sally Roberts to the meeting and introductions took place.

Dr Rajcholan presented the report. She highlighted Vocare and an unannounced visit by WCCG which took place in January 2018 and a number of serious concerns were identified during the visit. This will be raised at the next Quality and Safety meeting.

She pointed out that the key performance indicators on the maternity dashboard were a growing concern which was impacting on the quality and safety of patients. This has been escalated.

Dr Rajcholan highlighted that there had been a delay in a patient requiring fast referral. A revised process will be established for fast track referral with cancer services and will be communicated to all staff.

Ms Helen Cook arrived

Ms H Ryan pointed out a problem within her practice regarding referrals through the ICE Health System that there is no mechanism in place for rejection which had delayed some treatment for patients. Mr Hastings confirmed he will look into this issue.

Dr Hibbs expressed concerns regarding pressure ulcers and the importance of monitoring this. Ms Roberts confirmed this will be reflected in the next report.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.2045 Mr Gallagher presented the report. He referred to the finance position on page 3 of the report which indicates one amber relating to Quality, Innovation, Productivity and Prevention (QIPP). The CCG is achieving its QIPP target as shortfall is being covered by reserved and other under-spends.

He referred to the risk and mitigation on page 27 of the report. 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 9, and continues to report a nil net risk. He highlighted key risks relating to funded nursing care and making provision for additional costs. Planning guidance makes it clear that we need to buy more than forecast outturn and make provisions for next winter and consume the consequences of increased costs in nursing care.

Mr Hastings gave an indication of the performance measures ~

- Referral to Treatment (RTT) 18 week wait rated as amber
- Diagnosis testing is back on target
- A&E wait - November 87.5%, December not too bad, January 73.1%
- 52 week wait which is on target at zero
- There was a 12 hour breach in November relating to a child requiring a bed
- Delayed transfer of care good news, health and social care trajectory is on track to deliver
- Mental Health missing a couple of targets but work is ongoing in this area.

RESOLVED: That the above is noted

Primary Care Commissioning Committee

WCCG.2046 Mr Hastings presented the report. He pointed out that the Committee received an overview of the activity in primary care and it was noted that the infection prevention standards and scores have improved since the new audit format was introduced.

He stated that the Workforce Plan continues in line with the Primary Care Strategy, Sustainability and Transformation Plan and national drivers.

RESOLVED: That the above is noted

Primary Care Programme Milestone Review

WCCG.2047 Mr Hastings stated he is happy to take any questions regarding the report which is for assurance. Alternatively please email Jo Reynolds jo.reynolds2@nhs.net.

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.2048 Ms H Cook gave a brief overview of the report. She pointed out that the Minor Eye Conditions Service (MECS) campaign has continued its web and social media presences following its launch in autumn last year.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.2049 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2050 RESOLVED: That the minutes are noted.

Minutes of the Primary Care Commissioning Committee

WCCG.2051 RESOLVED: That the minutes are noted.

Minutes of the Commissioning Committee

WCCG.2052 RESOLVED: That the minutes are noted.

Minutes of the Health and Wellbeing Board

WCCG.2053 RESOLVED: That the minutes are noted.

Black Country and West Birmingham Commissioning Board Minutes

WCCG.2054 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.2055 RESOLVED: That the above is noted.

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

WCCG.2056 RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2057 The Board noted that the next meeting was due to be held on **Tuesday 10 April 2018** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.50 pm

Chair.....

Date

Wolverhampton Clinical Commissioning Group Governing Body

Action List

10 April 2018

Date of meeting	Minute Number	Action	By When	By Whom	Status
13.02.18	WCCG.2040	Items which should not routinely be prescribed in Primary Care – Hemant Patel to return to the Governing Body with further information.	10 April 2018/ 8 May 2018	Hemant Patel	
13.02.18	WCCG.2041	Conditions for which over the counter items should not routinely be prescribed in Primary Care - Hemant Patel responds to the national consultation	10 April 2018/ 8 May 2018	Hemant Patel	

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WOLVERHAMPTON CCG
GOVERNING BODY
10 APRIL 2018

Agenda item 6

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:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	<ul style="list-style-type: none"> • Wolverhampton CCG is increasingly looking to work in a more integrated way with other organisations. • Recruitment in Primary Care is a key risk and focus work in this area is progressing.
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	<p>This report provides assurance to the Governing Body of robust leadership across the CCG in delivery of its statutory duties.</p> <p>By its nature, this briefing includes matters relating to all domains contained within the BAF.</p>
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 (WCCG).

2. CHIEF OFFICER REPORT

2.1 Primary Care Workforce

- 2.1.1 WCCG has launched a recruitment campaign to attract GPs and general practice staff to come and work in Wolverhampton.
- 2.1.2 Over the last few months, WCCG has started a series of roadshows to discuss the benefits of living and working in the city with prospective students. In October 2017, staff members involved in primary care attended Wolverhampton University's Annual Recruitment Fair to raise awareness of career opportunities in primary care.
- 2.1.3 Wolverhampton offers a wide mix of patients in the city with its diverse population and locally respected acute trust, The Royal Wolverhampton NHS Hospital Trust.
- 2.1.4 The CCG's GP recruitment campaign is part of a national recruitment programme to address staffing shortages in primary care.

2.2 Sustainability and Transformation Plan (STP)

- 2.2.1 The Black Country STP continues to meet and is currently reviewing its governance. Recruitment of an Independent Chair is in progress. The Clinical Leadership Group is reviewing the clinical priorities across the STP. The work programme will be reflecting areas that provide added value when viewed across a wider footprint.

2.3 Black Country and West Birmingham Joint Commissioning Committee (JCC)

- 2.3.1 Black Country and West Birmingham Joint Commissioning Committee is meeting regularly. Particular areas of work include Mental Health and work around Learning Disabilities. A variety of clinical areas are also being reviewed and a project looking at the management of hypertension is being scoped.

2.4 Transforming Care Partnership

- 2.4.1 This programme of work involves ensuring that people living with a Learning Disability are provided with the optimum care and support and where possible, are enabled to live in the community. To ensure that this happens, more community based services are being commissioned and the number of hospital based services are being reduced. This piece of work is being done collaboratively across the Black Country with commissioning organisations, Local Authorities and providers of services.

2.5 Local Joint Working

2.5.1 The CCG is working in partnership with our local GPs, The Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust and the Local Authority to agree how we will work in a more integrated way in Wolverhampton. Clinicians have been meeting together to agree the pathways of care that we will look at in the first instance.

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: 21 March 2018

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	21/03/18

WOLVERHAMPTON CCG

 Governing Body
 10th April 2018

Agenda item 7

TITLE OF REPORT:	Commissioning Committee Summary Report
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 February and March 2018.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> 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 February and March 2018.

2. MAIN BODY OF REPORT

2.1 Risks

Corporate level risks – there were no issues to bring to the Committee’s attention.

Committee level risks:

CC08 RITS Capacity - The Committee approved a recommendation to reduce the risk score from 20 to 12.

Action - That Governing Body notes the update provided.

2.2 Service specification for online counselling service for Children/Young People (CYP)

Approval was requested from the Committee to agree the service specification for the online digital counselling service for Children and Young People aged 11-18 to commence in April 2018.

Provision of this service will support Wolverhampton CCG to meet access targets for CYP. The target, set by the Government, is that at least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS funded service by 2020/21. This includes online counselling and face to face provision via Tiers 2 and 3.

The Committee approved the service specification and agreed for the procurement of the service to commence.

Action - That Governing Body notes decision made by the Committee.

2.3 Revised Quality Prescribing Service Specification

The CCG Medicines Optimisation Team wishes to continue to offer a prescribing incentive scheme to its GP practices for 2018/19 and requested approval to progress. This has been supported by the Modernisation Medicines Optimisation and Primary Care Programme Board.

The CCG has historically offered a GP Quality Incentive Scheme to support the QIPP agenda. The Medicines Optimisation Team is proposing to continue the scheme with a revised offer.

Payments are made based on a population of 270,000. No additional funds are required beyond the current budget of £450K to incentivise change in prescribing. It is an invest-to-save scheme with the knowledge that payment is only made on the successful achievement of the scheme. This approach was agreed in principle by a group consisting of the CCG Chair, GP Prescribing Lead and locality leads in 2015/16.

The scheme will deliver patient level benefits which are not accounted for in financial terms. These benefits and potential harm avoidance are realised from lower use of NSAIDs, inhaled corticosteroids as well as the long term effects on antimicrobial resistance with appropriate use of antibiotics. It should be noted that savings from certain items are not accounted for, such as Quality Premium payments.

The Committee approved the amendments to the Quality Prescribing Scheme for 2018/19 and supported the Work Plan.

Action - That Governing Body notes the decision made by the Committee.

2.4 Contracting Update

Royal Wolverhampton NHS Trust

The contract with the Royal Wolverhampton Hospital NHS Trust has been agreed for 2018/19, which includes an agreement with the Staffs CCG at £94.2m. Staffs CCG are continuing to have regular meetings with the Trust, with the view to potentially agreeing a risk/gain share model on some elements of the contract. There is a deadline of 20th April to reach a conclusion on these discussions and if an agreement cannot be met, normal National Tariff terms will continue to be applied to the contract.

Contract Performance Issues

Contract Performance (Activity and Finance)

Over-performance – The contract is over performing by £674k at month 9 for all commissioners. Wolverhampton CCG is over performing by £345k.

Rheumatology Referrals – It has been agreed that the CCG will pay an enhanced tariff for new outpatients exceeding plan for the period of 1st April to 30th December.

Care Quality Commission Unannounced Visit – Overall, feedback was positive. However, one area of concern was identified in relation to the significant delays in the Discharge Lounge. A follow up visit has taken place and feedback has been very positive.

Contract Performance (Key Performance Indicators/Quality)

Referral to Treatment – Performance was slightly below the agreed trajectory, in January, due to Winter pressures, which resulted in cancellation of some elective procedures to ease bed pressure. Discussions are taking place with clinical staff to increase capacity and reduce backlogs.

Cancer Two Week Wait (Breast Symptoms) – A 20% increase in referrals, during December, resulted in the Trust failing to meet the key performance indicator.

Cancer 62 Days – Performance has dropped for the third consecutive month. The Trust has submitted an Exception Report which confirms continued capacity issues in Urology, Radiology and Gynaecology.

Performance Sanctions

Sanctions agreed for Month 9 are £84,900.

Black Country Partnership Foundation Trust (BCPFT)

Performance/ Quality Issues

Data Quality Improvement Plan (DQIP)

Work with the DQIP is progressing and reporting of long term conditions is now being provided by the Trust.

There is an issue with IAPT access rates and the Trust has advised that they may struggle to achieve against target.

Urgent Care/ Ambulance/ Patient Transport

Urgent Care Centre

The Provider has been given a revised two month timeframe which ceases in April 2018 by which certain improvements are expected. As part of the two month improvement plan weekly updates are provided by Vocare and feedback is generally positive.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

Wolverhampton and Dudley CCGs have welcomed a proposal from WMAS, suggesting a number of changes; financial payment process (no funding change), data processing, quality report, contract review meeting ToR, exception reporting and key performance indicators. Both CCGs are, in the main, supportive and assurance has been provided by WMAS that such revisions will improve the management and performance of the contract, and lead to an improved service for our patients.

Approval of these changes was supported by the Committee.

An agreement is currently in place with E-Zec Medical Transport Services Ltd, to transport Wolverhampton CCG patients to and from Cannock Hospital. Following consideration by the CCG and discussion with WMAS, it is recommended that the agreement is resolved from 1st July 2018. No formal contract is in place so there is no minimum notice period.

The Committee approved this change.

Action - That Governing Body notes the decision made by the Committee.

3. RECOMMENDATIONS

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

Name: Dr Manjit Kainth

Job Title: Lead for Commissioning & Contracting

Date: 29th March 2018

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**WOLVERHAMPTON CCG
Governing Body
Tuesday 10th April 2018**

Agenda item 8

TITLE OF REPORT:	Executive Summary and Quality and Safety Committee report (April 2018)
AUTHOR(S) OF REPORT:	Annette Lawrence, Designated Adult Safeguarding Lead on behalf of Sukhdip Parvez, Quality and Patient Safety Manager Sally Roberts Chief Nurse
MANAGEMENT LEAD:	Sally Roberts Chief Nurse
PURPOSE OF REPORT:	To provide the Governing Body detailed information collected via the clinical quality monitoring framework pertaining to provider services. Including performance against key clinical indicators (reported by exception). A summary is provided and the April Quality and Safety Committee report is included in Appendix 1
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report is confidential due to the sensitivity of data and level of detail.
RECOMMENDATION:	Provides assurance on quality and safety of care, and inform the Governing Body as to actions being taken to address areas of concern
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	<ol style="list-style-type: none"> 1. Improving the quality and safety of the services we commission 2. Reducing Health Inequalities in Wolverhampton

	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
Urgent Care Provider	<p>Vocare has been rated inadequate for the March 2017 CQC visit. A further announced focused inspection was carried out by CQC on 26 October 2017 in relation to the warning notices issued in July 2017. An unannounced visit by WCCG in January 2018 highlighted further concerns, pertaining to triage, performance and paediatric triage arrangements.</p> <p>The CQC re-visited Vocare in February 2018 and whilst full report is awaited some improvements were noted. An 8 week improvement plan has been agreed between CCG and Vocare and weekly reviews have been ongoing.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Vocare Improvement Board meetings • Announced and unannounced visits by WCCG • Continuous monitoring for Serious Incidents, Complaints or any other emerging quality issues, with no emerging themes or trends. • Positive meeting with RWHT and Vocare with regards a process mapping review of streaming and triage arrangements, to be undertaken by CCG. • Senior oversight of improvement plan in place by Vocare, with improvements noted in performance targets for triage response. 	

	<ul style="list-style-type: none"> • Workforce review undertaken by Vocare and active recruitment now underway. • Move to local arrangements for some infrastructure arrangements, will ensure more timely and responsive arrangements for staffing and dispatch activities. • Appointment of senior operations manager has provided local leadership and oversight. 	
Maternity Performance Issues	<p>The Provider has currently capped the maternity activity for the Trust (capping where the Trust takes referrals from), this does not apply to Wolverhampton women. The current Midwife to birth ration is 1:31, with national rate standing at 1:28. <i>Caesarean rates:</i> Elective rate 12.6% (target is less than 12%) and Emergency rate 20.6% (target is less than 14%)</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining to maternity, no emerging themes or trends have been identified. • Maternity activity capped by provider • Midwifery vacancy rate reported as 0.3% for Feb 2018. • Awaiting outcome of review by National Team (Birth Rate Plus) – the Trust is expected to receive this at the end of March/beginning of April 2018, formal feedback will be provided at May CQRM. • RWT undertaking an internal review of caesarean section performance, findings will be presented at a future CQRM. 	
Non-Emergency patient transport service issues	<p>There are performance issues with this provider with a potential for its impact on quality. The provider has failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality reporting and current performance is not at the level expected.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for Serious Incidents, complaints or any other emerging quality issues with consideration to any themes or trends that may arise, no emerging themes at present. • Strengthening of commissioning arrangements underway, with KPI's being reviewed by WCCG/DCCG based on a proposal by WMAS 	

<p>Mortality</p>	<p>The estimated SHMI for November 2016 to October 2017 was 117.4 and banded higher than expected. At the next NHS Digital publication, the SHMI for RWT for the period October 2016 to September 2017 is estimated to be 1.18 and again banded higher than expected. RWT is a national outlier for this performance. The crude mortality trends have not seen any significant changes, the expected mortality rate for RWT continues to be lower than England's. The actual crude mortality for in-hospital deaths is lower in 2018 compared with the previous three years at the trust.</p> <p>For the period April 2017 – January 2018 there were 1651 adult inpatient deaths at the Trust. Of these 67.4% had an initial mortality review by the end of January and 46.7% had a review using the SJR methodology, which was introduced in August 2017.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Clinicians have been trained to undertake Stage 2 reviews and a working group has been set up to set out a method for allocating cases for stage 2 reviews in accordance with the established policy. • Work is in progress to implement the changes in the creation of finished consultant episodes on admission to AMU. • Changes have been made to clerking documentation to improve the clarity of primary diagnoses and comorbidities on admission to hospital, thus aiding richer coding. • The Head of Coding and Data quality has drafted a plan to address education and collaborative working between coders and clinicians with the aim to improve documentation accuracy. • Further understanding and more detailed work is required to identify concrete measures for monitoring progress and improvements. • To further explore a local system approach to mortality, with specific reference to patient 	
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	deaths within 30 days of hospital discharge, ensuring end of life pathways are robust.	
Increased number of NEs 16/17	<p>6 Never Events reported by RWT for 2017/18 year to date. There have been no never events reported in the last reporting period since previous Governing Body.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues • Scrutiny and challenge via bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present • Robust scrutiny of all Never Events before closure on STEIS (Strategic Executive Information System) • WCCG have requested a RWT/CCG Clinical Board to Board meeting to be held in April 2018 – Never Events will be discussed as the key agenda item. • RWHT have requested further support from AFPP to review culture and practice within clinical theatre environment, including application of WHO checklist, to be reported back to CCG once review completed. 	
Safety, experience and effectiveness	<p>Continuous scrutiny of Pressure Injuries, Serious Incidents, Falls, FFTs, Surveys, NICE and IPC.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present. • WCCG attends weekly PILLA (Pressure Injury Lesson Learned Accountability) meetings. • Continued improvements seen in avoidable pressure injuries, CDiff and falls. • No patient falls causing Serious Harm in February 2018 • Significant reduction in the number of avoidable pressure injuries • Significant reduction in the prevalence of Stage 3 and 4 pressure injuries • WCCG attends RWT monthly Pressure Injury Steering Group. 	
Improving primary care services	Continuous monitoring of Infection Prevention ratings, Friends and Family Test, Quality Matters, Complaints, Serious Incidents , NICE, and Workforce.	

<p>Cancer Performance</p>	<p>Cancer performance for the trust remains an area requiring further assurance. In particular 62 and 104 day cancer performance requires further assurance to ensure any potential or actual impact of harm for patients is understood and mitigated.</p> <p>Risk Mitigation:</p> <p>Chief Nurse has written to Chief Operating Officer and Medical Director at the trust and requested a meeting to clarify:</p> <ul style="list-style-type: none"> • Individual patient by patient harm review, including independent review and consideration being made for actual/potential harm as well as consideration of psychological impact of harm. • Is duty of candour considered and enacted as a result of harm review? • Some of the reasons pertaining to 104 waits have been identified as pertaining to patient choice, is this informed choice by patients and are they fully aware of the consequences of decision. • Access to diagnostics appears to be one of the reasons stated; further clarity is required, specifically where this may relate to commissioning. • Late tertiary referrals being cited WCCG are keen to work with RWHT to raise the issue across the system on the basis of poor quality of care provision. • One case required anaesthetic review prior to surgery, it would be helpful to understand why this meant 104 day breach • The revised RAP has been rejected by the CCG with regards the trajectory set by the trust and a discussion with regards revised trajectory is now required. • Current meetings taking place at RWT include the weekly PTL meeting where all patients 	

	<p>are reviewed, a weekly performance meeting although this is not specific to cancer performance and a monthly cancer improvement meeting. The priority and purpose of the proposed meetings is to see recovery by May 2018 (agreed on 16/3/18).</p> <ul style="list-style-type: none">• WCCG have requested to see a report on the work that has been done by Millar Bowness for head and neck pathways and to ascertain if some of the improvements would be transferrable to other cancer sites.• Analysis work being undertaken by the trust in diagnostics to review capacity and demand with the aim to identify bottlenecks.• Additional capacity has been identified in radiotherapy for CT scanning although workforce may be challenging to support this.	
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Cancer Waiting Times

Cancer Target Compliance

	Target	Q3 2017/18			Q4 2017/18			
		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Jan-18
2 Week Wait Cancer	93%	94.85%	93.54%	88.57%	90.79%			Excluding Tertiary Referrals
2WW Breast Symptomatic	93%	97.45%	93.39%	53.00%	93.33%			
31 Day to First Treatment	96%	97.51%	97.82%	97.35%	96.27%			
31 Day Sub Treatment - Anti Cancer Drug	98%	100.00%	100.00%	100.00%	98.39%			
31 Day Sub Treatment - Surgery	94%	94.59%	94.55%	85.71%	71.15%			
31 Day Sub Treatment - Radiotherapy	94%	97.58%	98.04%	96.05%	96.81%			
62 Day Wait for First Treatment	85%	76.99%	76.34%	73.94%	70.12%			73.08%
62 Day Wait - Screening	90%	100.00%	82.46%	74.19%	63.04%			63.64%
62 Day Wait - Consultant Upgrade (local target)	88%	93.20%	93.53%	89.47%	88.44%			91.40%

62 Day Target by Cancer Site

Site	Total Patients	Breaches	%
Breast	10	1	90.00%
Colorectal	9.5	4.5	52.63%
Gynaecology	6	1.5	75.00%
Haematology	3	1	66.67%
Head & Neck	7	5	28.57%
Lung	2	0	100.00%
Other	2	0	100.00%
Sarcoma	1	0	100.00%
Skin	12	0	100.00%
Upper GI	3.5	1.5	57.14%
Urology	26	10	61.54%
Total	82	24.5	70.12%

2 Week Wait - There are 124 patient breaches in month, these are largely down to patient choice (knock on effect from Christmas and New Year), however, this also includes capacity issues in Breast & Gastro due to significant rise in referrals numbers. This rise is being investigated by the commissioners.

31 Day Sub Surgery - 7 patient breaches in month - all capacity issues.

62 Day Traditional - 28 patient breaches in month - 7 x Tertiary referrals received between days 46 and 109 of the patients pathway (operating guidelines state referrals should be made within 42 days), 6 x Capacity Issues, 10 x Patient Initiated, 1 x Patient unfit for surgery and 4 x Complex Pathways. Of the tertiary referrals received 0 (0%) were received before day 42 of the pathway, and 3 (43%) were received after day 62 of the patient pathway.

62 Day Screening - 10 patient breaches in month - 7 x capacity issues and 3 x complex pathways.

Patients over 104 days - There are currently 23 patients at 104+ days on the cancer waiting list (compared with 15 reported in December), all of these patients have had a harm review and no harm has been identified.

Please see Appendix 1 for a full copy of the Monthly Quality and Risk Report – Quality and Safety Committee 10th April 2018 (February data)



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WOLVERHAMPTON CCG
Quality and Safety Committee
Tuesday 10th April 2018
Agenda item 8

TITLE OF REPORT:	Monthly Quality and Risk Report
AUTHOR(s) OF REPORT:	Annette Lawrence, Designated Adult Safeguarding Lead and Molly Henriques Dillon, Quality Nurse Advisor Team Leader on behalf of Sukhdip Parvez, Quality and Patient Safety Manager M Boyce, QAC P Strickland, QAC
MANAGEMENT LEAD:	Sally Roberts, Chief Nurse and Director of Quality
PURPOSE OF REPORT:	To provide evidence and assurance of the management and monitoring of the clinical quality framework and where assurance cannot be provided to share mitigation or seek escalation from committee of further actions that may be required. The report includes, performance against key clinical indicators for the reporting period February 2018 (reported by exception).
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report is confidential due to the sensitivity of data and level of detail.
RECOMMENDATION:	Submitted for assurance to the Quality and Safety Committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1. Improving the quality and safety of the services we commission 2. Reducing Health Inequalities in Wolverhampton

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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	Risk Mitigation	RAG	Page number in report
Page 33 Urgent Care Provider	Vocare has been rated inadequate for the March 2017 CQC visit. A further announced focused inspection was carried out by CQC on 26 October 2017 in relation to the warning notices issued in July 2017. An unannounced visit by WCCG in January 2018 highlighted serious concerns. The CQC has recently re-visited Vocare on 6 th February 2018 and a visit outcome is still awaited, although verbal feedback has been received	<ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • 6 weekly Vocare Improvement Board meetings • Announced and unannounced visits by WCCG • An 8 week turnaround plan has been negotiated with the provider. A recent CQC follow up visit has been completed and verbal feedback has been provided with evidence of some improvement • Continuous monitoring for Serious Incidents, Complaints or any other emerging quality issues • Escalation to NHSE, CQC and WCCG Chief Officer 		24
Maternity Performance Issues	The key performance indicators on the maternity dashboard are concerning. This has been escalated to NHSI, NHSE, LMS and	<ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining 		16

	<p>the Maternity STP. The Provider has capped the maternity activity for the Trust. The Midwife to birth ration is 1:31 – this is driven by the number of births</p>	<p>to maternity</p> <ul style="list-style-type: none"> Escalated to NHSE/NHSI/LMS & Maternity STP Maternity activity capped by provider Midwifery recruitment is continuing for minimum vacancy Awaiting outcome of review by National Team (Birth Rate Plus) 		
<p>Non-Emergency patient transport service issues</p>	<p>There are performance issues with this provider with a potential for its impact on quality. The provider has failed to meet reporting requirements i.e. Serious incidents, KPI's, Quality reporting and current performance is not at the level expected</p>	<ul style="list-style-type: none"> Monthly CQRM/CRM meetings Continuous monitoring for Serious Incidents, complaints or any other emerging quality issues with consideration to any themes or trends that may arise Escalated to WCCG Chief Officer/NHSE KPI's are currently being reviewed by WCCG/DCCG based on a proposal by WMAS 		<p>25</p>
<p>Mortality</p>	<p>The current published SHMI July 2016 to June 2017 for the trust is 1.16 (benchmark = 1, higher than expected) The number of deaths in excess of expected has increased by 34 (from 337 to 382, July 2016 – June 2017) The Trust continue to be an outlier when compared to all Trusts. There is a difference between mortality during the week than weekends – statistically higher than the National average – 115 Weekday and 125.3 Weekends</p>	<ul style="list-style-type: none"> Trust action plan in place Independent coding, diagnostic, palliative and case note reviews undertaken Continuous monitoring for SI's, complaints or any other emerging quality issues Consideration of a City wide Mortality Strategy 		<p>18-20</p>

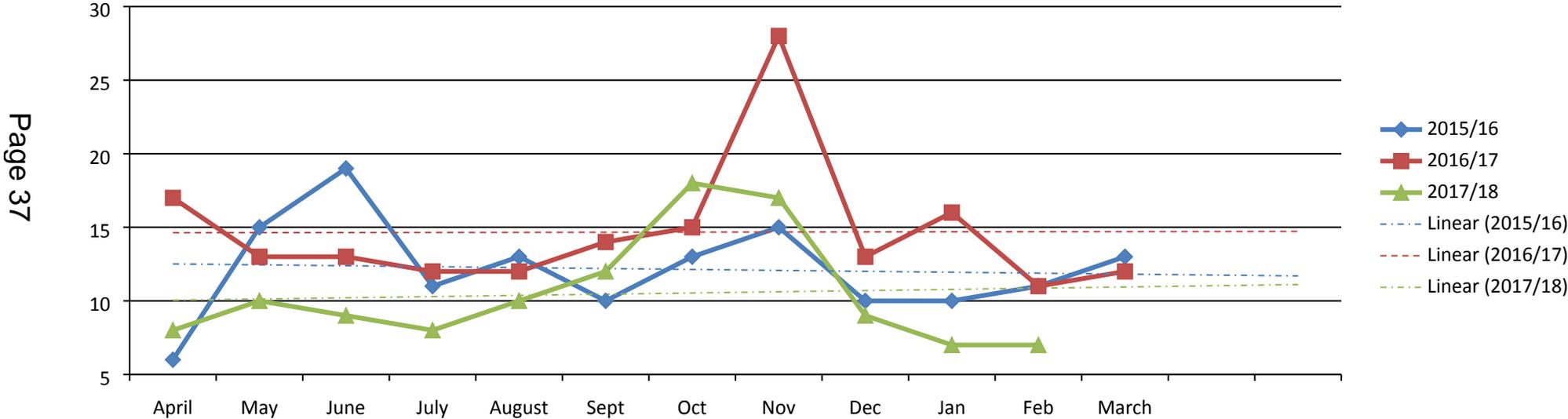
<p>Increase in number of Never Events 2017/2018</p> <p>Page 35</p>	<p>6 Never Events reported by RWT for 2017/18 year to date.</p>	<ul style="list-style-type: none"> • Monthly CQRM/CRM meetings • Continuous monitoring for SI's, complaints or any other emerging quality issues • Scrutiny and challenge via bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present • Robust scrutiny of all Never Events before closure on STEIS (Strategic Executive Information System) • WCCG/RWT Board to Board meeting to be held in April 2018 – Never Events is on the agenda • RWHT have requested further support from AFPP to review culture and practice within clinical theatre environment, including application of WHO checklist, to be reported back to CCG once review completed • No Never Events in February 2018 		<p>15</p>
<p>Safety, experience and effectiveness</p>	<p>Continuous scrutiny of Pressure Injuries, Serious Incidents, Falls, FFTs, Surveys, NICE and IPC.</p>	<ul style="list-style-type: none"> • Bi-monthly SISG (Serious Incident Scrutiny Group) meetings with provider present. • WCCG attends weekly PILLA (Pressure Injury Lesson Learned Accountability) meetings. • Improvements seen in avoidable pressure injuries, CDiff and falls. • WCCG attends RWT monthly pressure injury steering group. 		<p>Throughout the report</p>

		<ul style="list-style-type: none"> • Joint QRV (quality review visits) 		
<p>Improving primary care services</p>	<p>Continuous monitoring of Infection Prevention ratings, Friends and Family Test, Quality Matters, Complaints, Serious Incidents , NICE, and Workforce.</p>	<ul style="list-style-type: none"> • Monthly assurance report was provided to Q+SC in February 2018 • QAC attends Primary Care Operational Management Group; Primary Care Commissioning Committee and Workforce Task and Finish Group • QAC also attends Practice Collaborative Contracting visits • Liaison with Public Health around vaccine and screening uptake 		<p>N/A</p>

2. ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

Serious Incidents

RWT Incidents 2015-2018 (excluding PI's)



7 Serious Incidents were reported in February 2018, which is again the lowest number of SI's recorded in the past three years. No Never Events were reported in February 2018.

Slips/trips& falls – none for 2 consecutive months

Infection Prevention - 1

Diagnostics delay – 4 (one of which was reported by ED)

Increase prevalence of Diagnostic & Treatment delay Serious Incidents at RWT Emergency Department

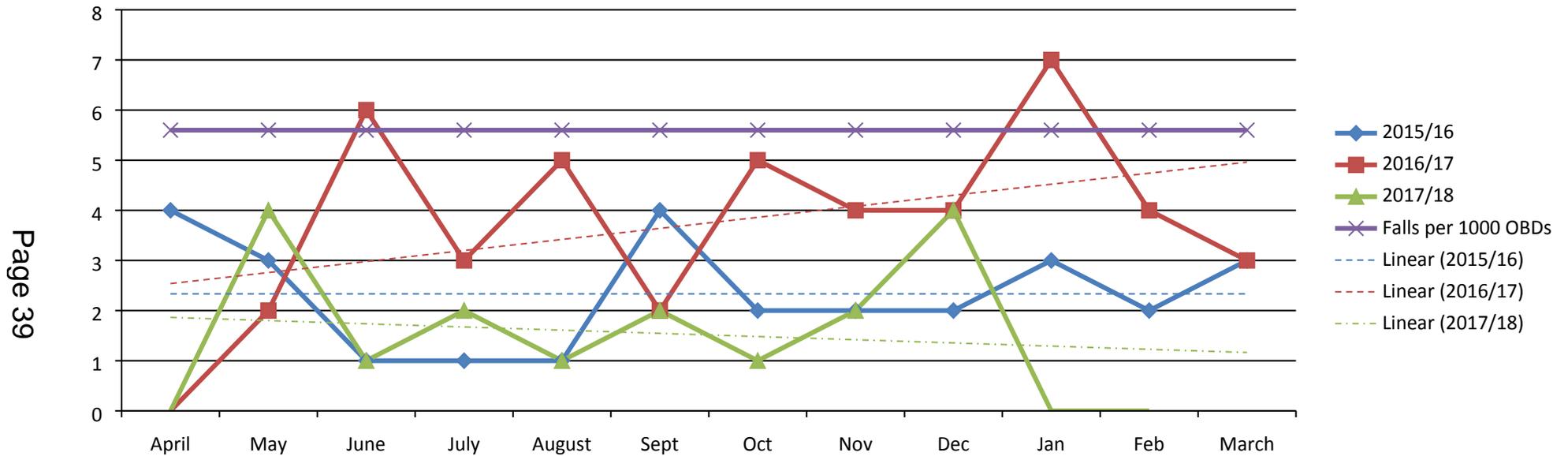
The SBAR (Situation, Background, Assessment, Recommendation) that was raised in November 2017 with the provider due to an increase in the number of diagnostic and treatment delay SI's reported by Emergency Department at RWT has been responded to as reported to Q+SC in February 2018. However, further challenge has been provided (see below) and a response is awaited.

WCCG has also asked the provider to consider the following actions to mitigate and prevent the reoccurrence of similar serious incidents:

- Tracking and review of diagnostic results by a responsible clinician prior to patient discharge from ED
- Robust clinical supervision/clinical support mechanism process for all junior doctors
- Empowering nurses and junior doctors to improve patient outcomes
- Shared decision making regarding patient care treatment plan and discharge from ED
- Consultant sign off for any patient who returns to ED within 72 hours
- Improving staff awareness and access to ED Sop's, policies and clinical pathways
- Improving critical aspects of ED documentation and communication by all clinicians
- Improving staff awareness of IG practices in ED
- Regular audits to check overall compliance

Slip Trip and Patient Falls SI's (RWT)

RWT - Slip Trip Falls, 2015-2018

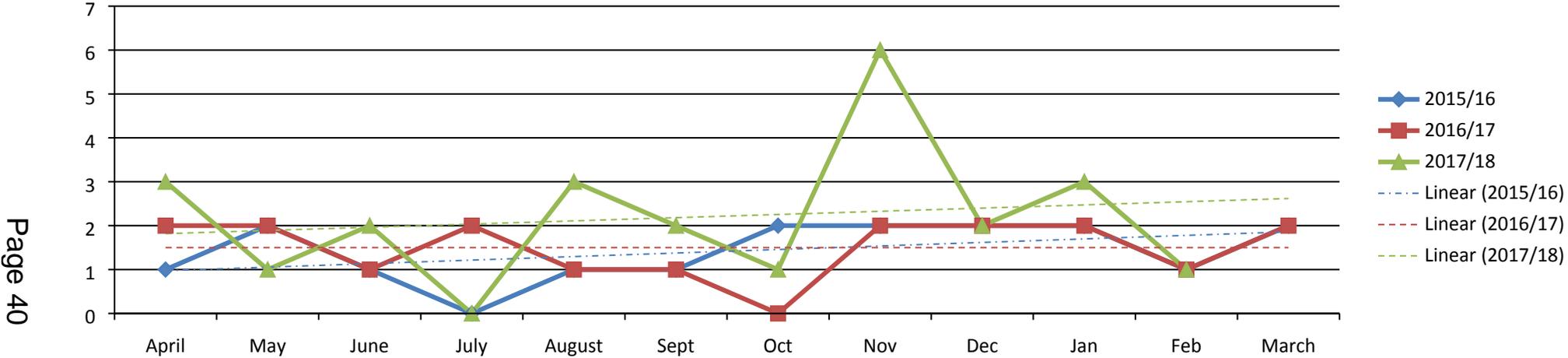


Slips, Trips and fall's SI's:

There were no patient falls with serious harm reported in February 2018, for the second consecutive month.

Infection Prevention

RWT HCAI/Infection control incidents 2015-2018



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No C-diff outbreaks were reported in February 2018.
 The Infection Prevention Incident that was reported (2018/5086) was on Ward A5 – Trauma and Orthopaedics – 3 bays affected with Norovirus (confirmed):
Actions taken immediately:
 Bay closed and visiting minimised to one visitor with no change over
Identified issues:
 Initial symptomatic patient was moved from closed bay into a side room
Contributory factors:
 None Known

Recommendations:

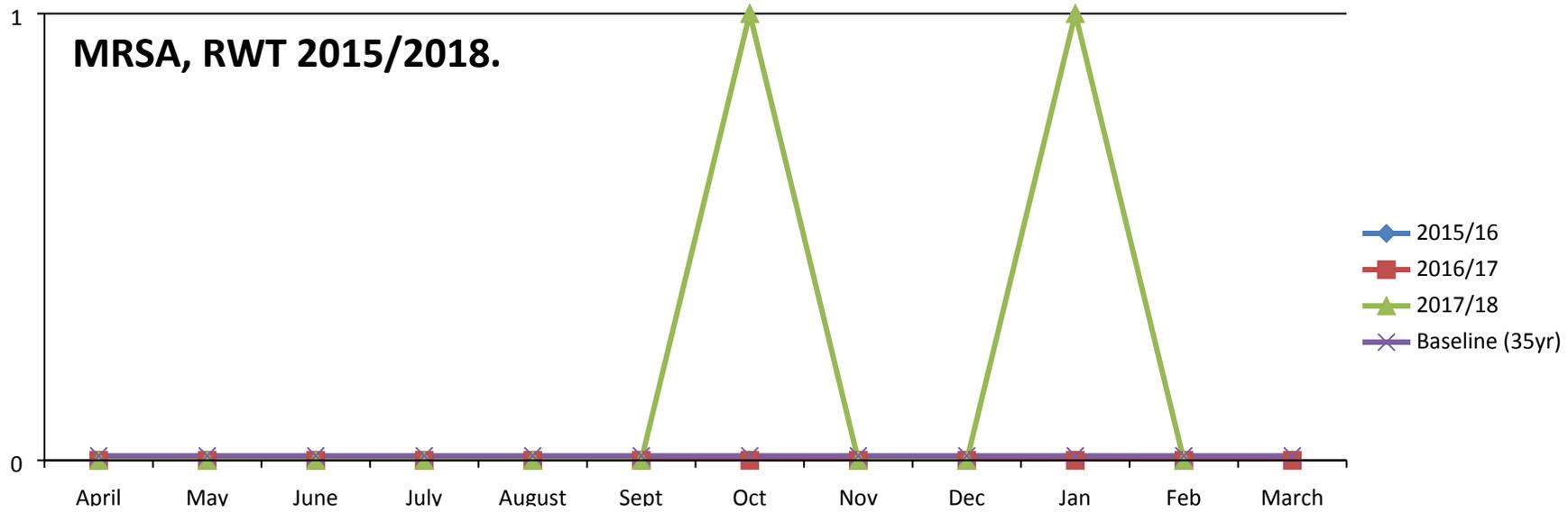
1. Review increased incidences promptly if they occur
2. Dissemination of lessons learned and actions from IP meeting across the Health Economy

Arrangements for shared learning:

Reinforce shared learning across Health Economy via training and reports to key meetings

WCCG attends the RWT monthly IPCG (Infection Prevention Control Group) and RWT monthly PSIG (Patient safety Improvement group) meetings to seek assurance that the Trusts Infection Prevention and Control Strategy is fully implemented, and that policies are in place to ensure best practice and to reduce HCAs. The WCCG Quality Team also attends regular QRV's (Quality Review Visits) to clinical areas to monitor staff compliance with all IP practice.

MRSA Bacteraemia

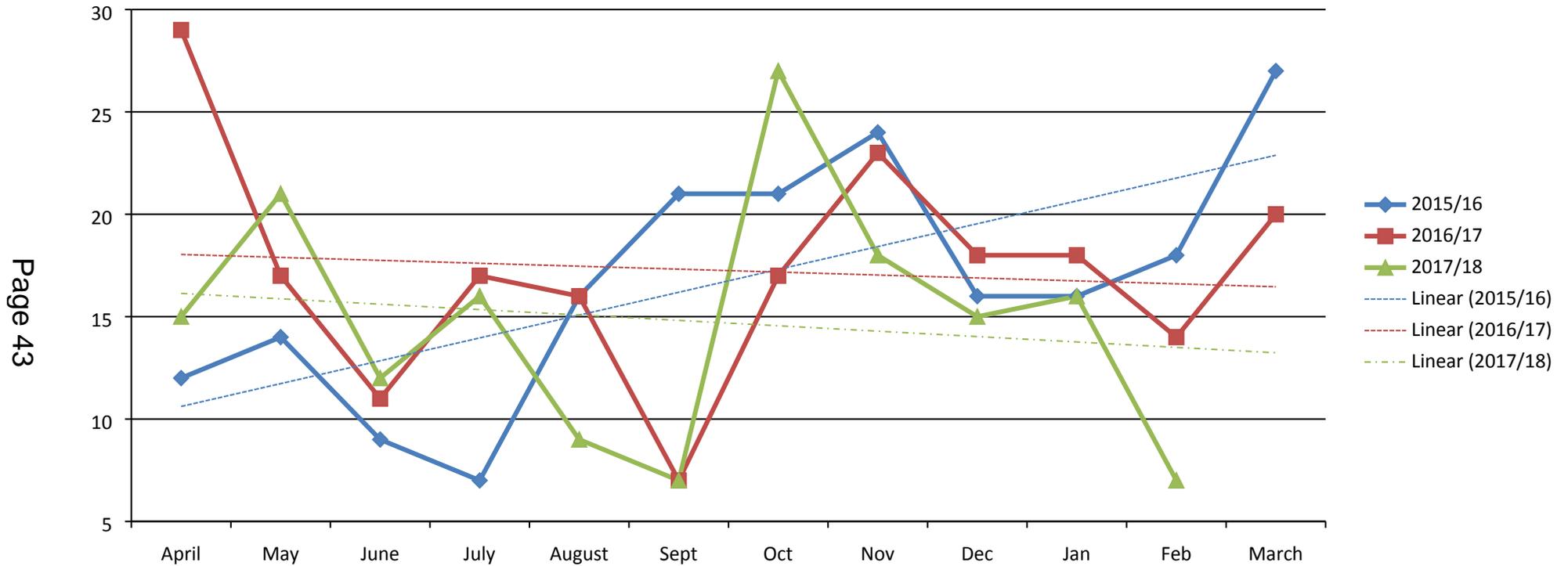


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No MRSA Bacteraemia cases were reported in February 2018.

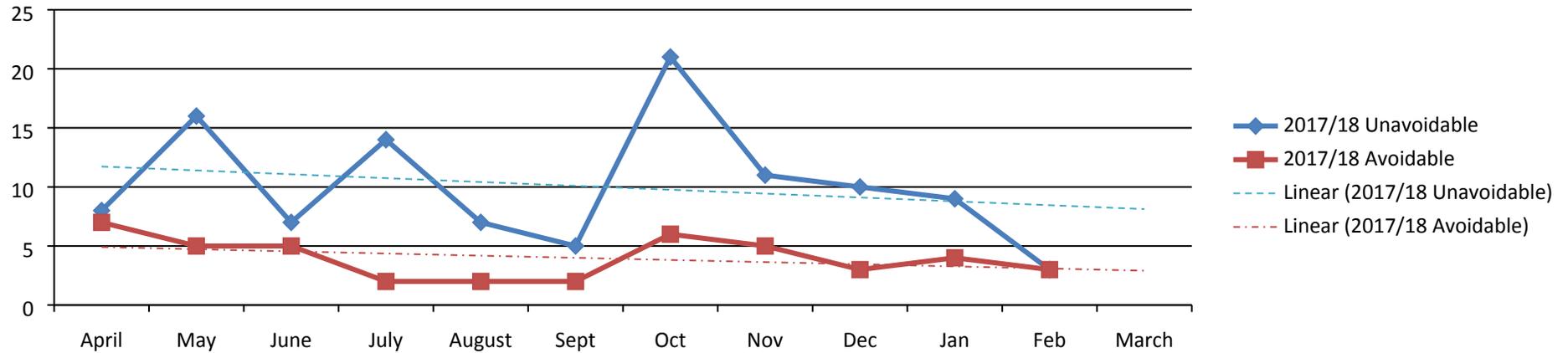
Pressure Injury Serious Incidents

RWT Pressure incidents G3/4, 2015-2018



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2017/18 PI Scrutiny Outcomes



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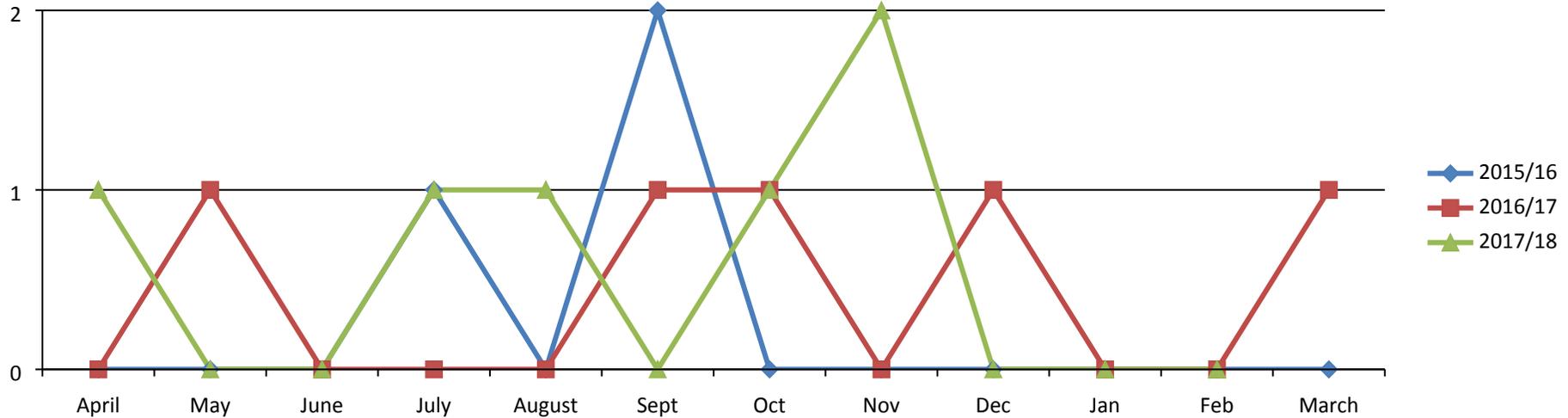
7 pressure injury incidents were reported in February 2018. No Stage 4 pressure injuries were reported in February 2018 (ongoing since October 2017). Themes for avoidable pressure injuries continue to include gaps in repositioning, failure to escalate concerns and inconsistency in wound assessments.

Trust actions:

- Ward areas with an increase of incidents or recurrent avoidable incidents have had bespoke training on pressure injury prevention
- Pressure injury policy due to be agreed by 21st March 2018

RWT Never Events

Never Events at RWT 2015-18.



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Apr17	1	Retained foreign object post-procedure
July17	1	Wrong site surgery
Aug17	1	Wrong site surgery
Oct17	1	Retained foreign object post-procedure
Nov17	2	Wrong site surgery

No Never Events were reported by RWT in February 2018. A WCCG/RWT Board to Board meeting is due to take place in April 2018, Never Events is on the agenda for discussion.

Maternity

No maternity incidents were reported in 2018.
The maternity dashboard highlights the following:

	Target	Q3 Results 2017/18			Q4 Results 2017/18		
		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Adms of Full Term Babies to Neo Natal Unit	0	3	0	1	0	1	
Elective C-Section Rates	<12%	13.4%	11.0%	9.9%	11.4%	12.6%	
Emergency C-Section Rates	<14%	12.9%	17.4%	16.1%	17.0%	20.6%	
Maternal Deaths	0	0	0	0	0	0	
Midwife to Birth ratio	< /= 30	31.5	31.0	31.0	31.0	31.0	
Bookings at 12+6 weeks	>90%	92.2%	93.6%	92.8%	90.5%	89.6%	
Babies being cooled (Born here)	0	2	0	0	0	1	
Breast Feeding Initiated	>64%	63.8%	68.1%	62.2%	61.0%	62.6%	
Early Neonatal Death (born here)	3	4	0	0	3	0	
Number of Mothers Delivered	< /= 416	448	482	434	428	374	

Unexpected Term Admissions to NNU requiring level 3 care (including cooled baby)

1 - Term baby born on MLU, meconium aspiration - had active cooling and spent 10 days on NNU before going home.

Caesarean Section Rates

Elective rate 12.6%
Emergency rate 20.6%

Midwife to Birth Ratio

Midwife to birth ratio 1:31., this is driven by the number of births. Midwifery recruitment is continuing for minimum vacancy.

Women booked by the service by 12 weeks and 6 days gestation:

Booking by gestation 12+6 = 89.6%.

Assurance

- Monthly discussion at CQRMs for assurance on actions i.e. recruitment plans, HR activity to address sickness, supervision and support for new staff.
- Current escalated Maternity commissioner meetings with RWT.
- Escalation to NHSE and NHSI
- Escalation meetings with RWT to discuss options and plans on maintaining safety. The Trust is providing assurance via adverse incident reviews, sickness, and recruitment activity.
- RWT and CCG entry on risk register.
- WCCG to attend RWT Maternity QRV visit planned for March 2018.

Mortality

Mortality Indicators: The Royal Wolverhampton NHS Trust

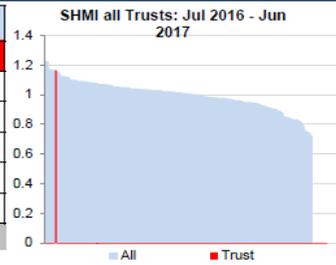


Published SHMI (HSCIC): Oct 2013 - Sep 2014 to Jul 2016 - Jun 2017

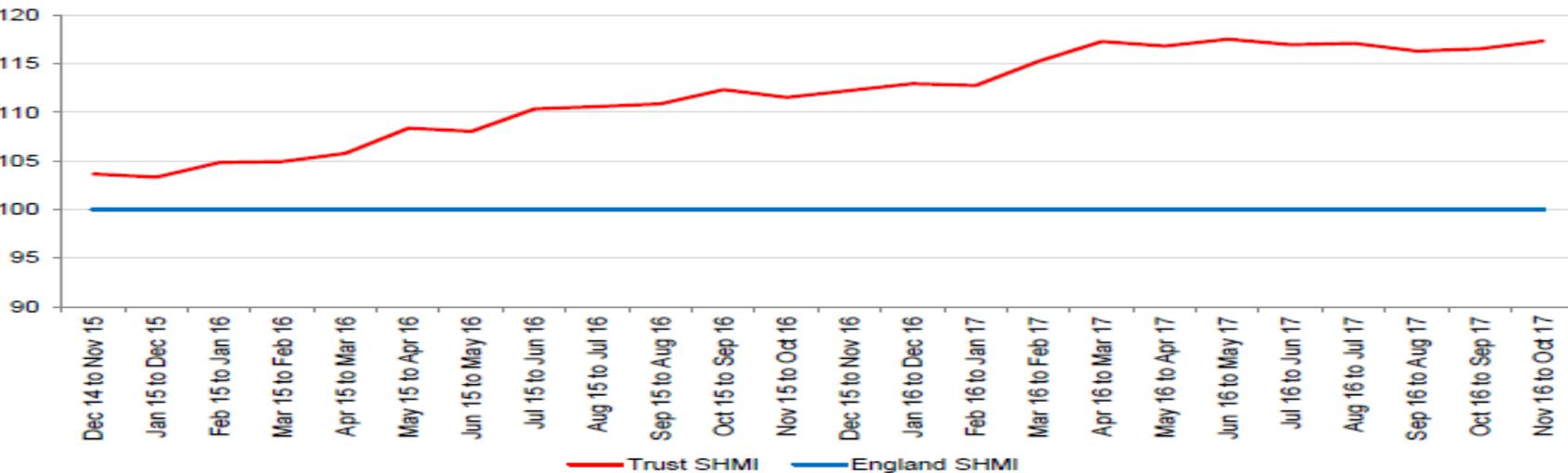
Data	Oct 2013 - Sep 2014	Jan 2014 - Dec 2014	Apr 2014 - Mar 2015	Jul 2014 - Jun 2015	Oct 2014 - Sep 2015	Jan 2015 - Dec 2015	Apr 2015 - Mar 2016	Jul 2015 - Jun 2016	Oct 2015 - Sep 2016	Jan 2016 - Dec 2016	Apr 2016 - Mar 2017	Jul 2016 - Jun 2017
SHMI	0.98	0.98	0.99	1.00	1.00	1.04	1.06	1.10	1.12	1.11	1.15	1.16
Crude Mortality Rate	3.4%	3.4%	3.6%	3.6%	3.6%	3.7%	3.6%	3.6%	3.6%	3.6%	3.7%	3.7%
England Crude Mortality Rate	3.1%	3.1%	3.1%	3.3%	3.3%	3.3%	3.3%	3.2%	3.2%	3.2%	3.3%	3.3%
Deaths in excess of expected	0	0	0	0	11	96	144	231	272	249	337	362
Lower Limit	0.90	0.91	0.91	0.90	0.91	0.90	0.90	0.89	0.89	0.90	0.89	0.89
Upper Limit	1.11	1.10	1.10	1.11	1.10	1.11	1.11	1.12	1.12	1.12	1.12	1.12

*Values for forecast SHMI are multiplied by a factor of 100, ie a published SHMI score of 0.95 equates to a forecast SHMI score of 95

High Outlier Low Outlier



SHMI (rolling 12 month) to Oct 2017



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SHMI (HED) - Weekday and Weekend mortality: to Oct 2017

Time of week	SHMI	SHMI95% CI Lower	SHMI95% CI Upper	Expected number of deaths	Number of observed mortalities	Excess deaths
Weekday	115.0	109.9	120.2	1690.2	1943	252.8
Weekend	125.3	115.8	135.3	514.0	644	130.0



Statistically higher than average

The current published SHMI July 2016 to June 2017 for the trust is 1.16 (benchmark = 1, higher than expected)
 The number of ‘deaths in excess of expected’ has increased by 34 (from 337 to 382, July 2016 – June 2017)
 The Trust continue to be an outlier when compared to all Trusts
 There is a difference between mortality during the week than weekends – statistically higher than the National average – 115 Weekday and 125.3 Weekends

The trust has undertaken the following actions to date to respond to the increased SMRs:

- Actions were agreed to investigate data variation and provide assurance in relation to clinical care and robustness of directorate mortality reviews
- External clinical review – completed, findings were shared with directorates. Clinicians to look at the recommendations and stage 2 reviews to be scheduled for the cases identified by the review
- External review of Pneumonia pathway – completed, awaiting final report
- Internal work on data variation, review of processes, improvement of documentation and coding – in various stages of completion
- Responding to the CQC alert for Pneumonia mortality; internal audit completed

External data review

- The auditors highlighted that the Trust's actual mortality rate has not increased and it is in the lower quartile nationally.
- The reason behind increased SMRs is the lower expected death rate for the Trust, which is impacted on by data variation.
- The report highlights the palliative care coding rate being lower than the national average, which could contribute to the increase in HSMR by approximately 7-8 points.
- The decrease in ordinary admissions and changes in patient case mix and/ or coding are mentioned as other potential explanations for the raised SMRs. The auditors estimated that for every 1000 extra emergency admissions the SHMI would decrease by approximately 0.7 points.
- The report also mentions the rate of admissions coded with signs and symptoms as primary diagnosis, which would contribute to a lower expected death rate. It is recommended that this area is further explored to ensure robust procedures and adherence to best practice in coding.

External coding review

- A review of coding for a sample of 200 emergency admissions was undertaken by an external auditing company. The report was presented and discussed at the mortality committees. The findings of the audit were generally positive and recommendations were made in order to further improve the quality of data.

Items to Note from CQR Meeting – March 2018

Cancer Waiting Times/Cancer Target Compliance

Site	Total Patients	Breaches	%
Breast	16	1	93.75%
Colorectal	5	2	60.00%
Gynaecology	8.5	3.5	58.82%
Haematology	3	1	66.67%
Head & Neck	8.5	4.5	47.06%
Lung	3	2	33.33%
Other	0	0	
Sarcoma	0.5	0.5	0.00%
Skin	10	1	90.00%
Upper GI	13	6.5	50.00%
Urology	24.5	8.5	65.31%
Total	92	30.5	66.85%

31 Day Sub Surgery - 5 patient breaches in month - all capacity issues.

62 Day Traditional - 39 patient breaches in month - 12 x Tertiary referrals received between days 33 and 104 of the patients pathway (operating guidelines state referrals should be made within 42 days), 15 x Capacity Issues, 4 x Patient Initiated and 8 x Complex Pathways. Of the tertiary referrals received 3 (25%) were received before day 42 of the pathway, and 5 (41.7%) were received after day 62 of the patient pathway.

62 Day Upgrade - 14 patient breaches in month - 2 x tertiary referrals, 8 x capacity issues, 3 x patient initiated and 1 x patient unfit.

Patients over 104 days - There are currently 21 patients at 104+ days on the cancer waiting list (compared with 23 reported in January), all of these patients have had a harm review and no harm has been identified.

RWT were predicting possible failure of the 31 Day Sub Surgery, 62 Day Upgrade and 62 Day wait for first treatment for February, validation is on-going. Final cancer data is uploaded nationally 6 weeks after month end. Specific actions are:-
 Review of tertiary and 2WW referral forms to standardise information across the region.
 Undertake local review of MDT process and function, in conjunction with national RCP led review.
 Undertake some pathway reviews to identify opportunities for improved performance.

Total Time Spent in Emergency Department (4 hours)

	Target	Q3 2017/18				Q4 2017/18		
		Oct-17	Nov-17	Dec-17		Jan-18	Feb-18	Mar-18
New Cross	95%	86.88%	80.54%	78.41%		73.80%	76.08%	
Walk in Centre		100.00%	100.00%	99.40%		100.00%	100.00%	
Cannock MIU		100.00%	100.00%	100.00%		100.00%	100.00%	
Vocare		94.76%	92.12%	94.67%		93.90%	96.29%	
Combined		91.55%	87.43%	87.03%		84.73%	86.27%	

Ambulance Handover

Comments: The fine for Ambulances during February was £48,400,00. This is based on 102 patients between 30-60 minutes @ £200 per patient and 28 patients >60 minutes @ £1,000 per patient.

There were 2 patients who breached the 12 hour decision to admit target during February 2018.

	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	99	122	199	102	
Number over 60 minutes	0	1	2	5	0	5	2	1	9	21	66	28	

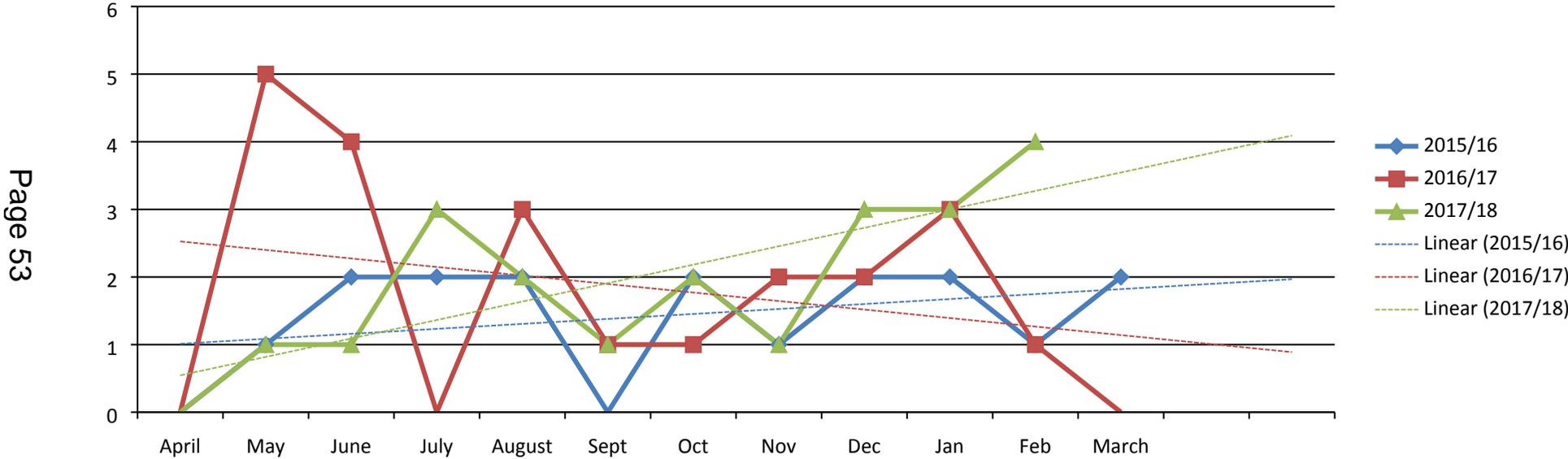
Please refer to **Appendix 1** for Month 11 RWT SQPR.

3. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

The Committee is asked to note the following:

a) Serious Incidents

BCPFT Incidents 2015-2018



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There were 4 serious incidents reported by Black Country Partnership Foundation Trust in February 2018 compared to 3 SI's reported for January 2018. Full RCA's are in progress:

- Pending Review – unexpected death of an Inpatient (respiratory arrest)
- HCAI – Norovirus outbreak
- Apparent/actual suspected self harm – burns following attempted suicide

- Slip/trip/fall – fractured arm following a fall

BCPFT CQRM

- b) Please refer to **Appendix 2** for Month 11 BCPFT SQPR.

Items to note from CQRM held on the 6th March 2018 (theme: CAMHS)

- 23 incidents were reported across the CYPF Division for the reporting period.
- There were no medication error incidents reported during January 2018. (January data used due to BCP reporting cycle)
- There were no STEIS reportable incidents or Never Events reported during January 2017 across the CYPF Division.
- There were currently 14 active risks for CYPF services.
- The audit plan had been agreed by the Division including the NICE guidelines baseline audits. This plan had been actively monitored by the Clinical Effectiveness Group. CQUINs are monitored separately with regular meeting with commissioners.
- Across the Division, sickness rates are below the KPI, even though there had been a slight increase in both short-term & long term sickness. The Trust had met its KPIs for Safeguarding Training, Specialist Mandatory Training, and Mandatory training.

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4. PRIVATE SECTOR PROVIDERS

Vocare

There were no serious incidents reported by Vocare in February 2018

Assurance due to ongoing concerns:

- Monthly CQRM/CRM meetings
- 6 weekly Vocare Improvement board meetings

- Announced and unannounced visits by WCCG
- WCCG weekly Vocare progress review meetings
- 8 week turnaround plan has been negotiated with the provider. A recent CQC follow up visit has been completed and verbal feedback provided with evidence of some improvement
- Continuous monitoring for SI's, complaints or any other emerging quality issues
Escalation to NHSE, CQC and WCCG Chief officer

NEPTS (Non-emergency Patient Transport Services) - WMAS

As previously reported to Q&SC that there was difference of opinion between the CCG and WMAS as to whether an incident that took place in March 2017 was reportable due to patient harm threshold, this was escalated to NHSE in December, and a decision remains outstanding at the time of reporting.

Assurance:

- Monthly CQRM/CRM meetings
- Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining to the service, considering any themes/trends that may arise
- Escalated to chief officer/NHSE
KPI's are currently being reviewed by WCCG/DCCG based on a proposal by WMAS

Nuffield

The Never Event reported by Nuffield has now been received for closure by WCCG and is awaiting scrutiny.

Compton Hospice

1 Serious incident was reported by Compton Hospice in February 2018:

Confidential information breach - Whilst in the community a Clinical Nurse Specialist (CNS) had a collision with another car and upon leaving the vehicle to discuss the accident was threatened with a knife. CNS's car was then stolen. The CNS had a prescription pad and information relating to two patients (full records) that the CNS was due to visit. A work mobile was also stolen. The police have been informed and are investigating, NHSE were

advised about the stolen prescription pads, CQC were informed. The relatives of the patients notes that were stolen were informed. A full RCA is in progress.

5. CHILDRENS SAFETY

5.1. Safeguarding Children

No exceptions – February exceptions already presented at Marchs Quality & Safety Committee.

Level 3 Training Compliance - RWT

Safeguarding Children - Mandatory Training Compliance												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level 3	84.3%	87.3%	85.3%	87.7%	86.4%	83.9%	80.2%	82.4%	83.7%	82.3%	84.1%	

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5.2

LAC Update

The CCG were informed in March of a medication error on a looked after young man who the CCG tri-partite fund through the External Placement Panel. He was given an unintentional increase of his Sertraline from 50mg to 100mg. Following a thorough investigation by children’s social care, a number of actions were taken, including notifying Ofsted, and recommendations were made.

The young man involved suffered no negative side effects.

The Designated Nurse for Looked After Children will be conducting a quality visit on the 28th April to review the health files in order to offer assurance to the CCG that appropriate actions have been taken.

6. ADULT SAFETY

6.1 Care Homes

Serious Incidents (SI)

Three SIs were concluded and closed at February SISG.

One categorised as a slip, trip and fall. However there was no history of resident sustaining a fall prior to the identification of a fracture. Investigation therefore was inconclusive; however, potential contributing factors included use of slides sheets whilst resident in bed and no staff had training in moving and handling. The resident was also known to have Osteoporosis and low Vitamin D. Immediate action required the care home ensured 100% staff trained in moving and handling by March SISG.

Two Pressure Injury Stages 3/4. Both were deemed avoidable due to the gaps in care. Improvement action plans are with the care home managers which will be monitored by the respective QNA.

Five new SIs were reported in February. Four acquired stage 3 or 4 pressure injuries and 1 slip, trip and fall (resident fell from shower chair and fractured her knee).

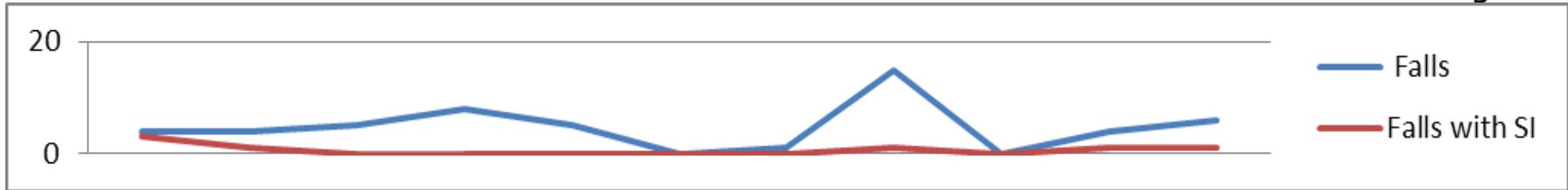
Final RCAs for the above SIs are due to be presented at May SISG.

Performance Data

15 homes participated in the Survey Monkey Care Home questionnaire in February, compared to 22 in January 2018.

Of these, 11 homes are also participating in the SPACE programme and consistently provide data on a monthly basis. Therefore, the figures appearing below are based on the data collection from the 11 SPACE homes, in order to give a true comparison.

There were 52 falls across 11 care homes during February, resulting in 7 falls with injury requiring GP attendance or visit to A&E. This is up on January when 42 falls during January, however it should be noted that less homes (8) submitted data in January compared with the 11 who took part in February.



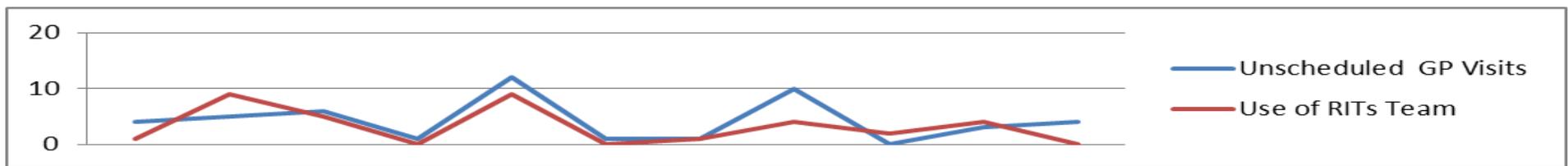
The care home reporting the highest numbers (15) of falls in the month is seen a reduction of 40% in falls since October 2017.

Two Stage 2 and 1 Stage 4 pressure injuries were acquired within the homes during the month. This is slightly down in January when 2 Stage 3 PIs were reported.

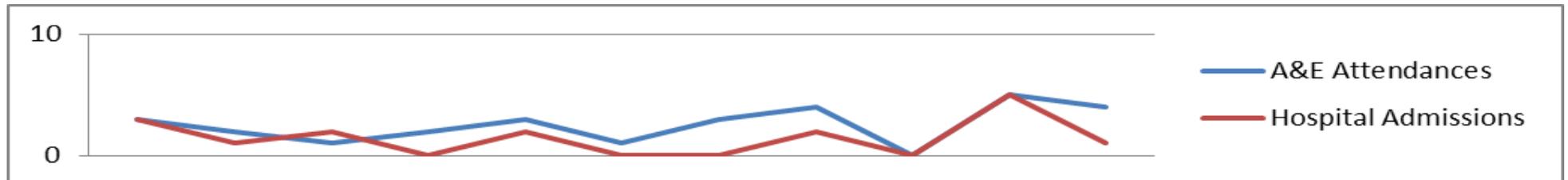
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Good use of the RITs Team continues with 35 separate referrals from care homes. This is up on January when 23 separate referrals were made based on 8 care homes providing data.



Of the 28 A&E/AMU attendances during February, 16 care home residents were admitted to RWT. The main reasons for admission were Falls (5), Chest Infection (3), Heart Problems (3). Other reasons for admission were Catheter complications, suspected DVT, breathlessness, palliative care complication due to Influenza Type B. Chest infections, falls and heart problems continue to be the recurring themes for attendances and admissions.



Safeguarding Referrals

Six safeguarding referrals were made to the QNAT for February. Two were for S42 enquires related to poor care and 10 deaths over a 6 week period and 4 were related to quality concerns. Outcome of which will be reported in subsequent reports. One residential care home remains in suspension.

Outbreaks in care homes

Eight care homes reported closure as a consequence of outbreaks during February. Seven of the outbreaks related to influenza and 1 related to D&V. Four (50%) of the care homes 3 nursing and 1 resident were located on or around the Penn Road in the South West of the City.

Quality Improvement - SPACE

Seventeen care homes continue to engage well with the programme and taking the lead in identifying and initiating quality improvement initiatives supported by the QI facilitator. To date 338 staff have received quality improvement training. During February this training was extended to include colleagues from the QNA team, CHC and local authority quality assurance officers. One care home corporate group has rolled out a quality improvement initiative tried and tested in one of its home in Wolverhampton to its sister home in Walsall. At the request of care home managers and staff a sharing event is being hosted on 24th April 2018 to show case all the initiatives that are happening in care homes across Wolverhampton.

Themes identified through performance monitoring data are being fed into and informing the QNA work plan.

6.2 Adult Safeguarding

- No exceptions – February exceptions already presented at Marchs Quality & Safety Committee.

LeDeR update:

- LeDeR Bristol (University) will continue to support the programme until 31st May 2019
- LeDeR Knowledge Hub forums have now been set up, and one for the LeDeR programme as a whole. Knowledge Hub is a way in which staff can connect digitally with colleagues, share knowledge and ideas, invite comments on draft documents, and learn from others' experiences. Access to the site can be gained by emailing the LeDeR team at: leder-team@bristol.ac.uk, stating which forums you would like to join Please put 'Knowledge Hub access' in the head of your email. The Midlands and the East forum is already 'live'. It is anticipated that the other forums will go 'live' from 1st April.
- The LeDeR training team will be working with an external company to develop a range of e-learning materials to support local areas to train reviewers using blended learning approaches (e.g. e-learning and shadowing an existing reviewer)
- As part of the LeDeR programme a repository of anonymised summaries of Safeguarding Adult Reviews, Serious Case Reviews, and Serious Incident Reports pertaining to people with learning disabilities is available. The themes arising from these reports have now been updated. You can find the latest summary at: <http://www.bristol.ac.uk/sps/leder/repository/summary-of-themes/>
- The programme will be publishing its Annual Report at the end of March 2018. The report will demonstrate trends and themes (initial themes are deaths from aspiration and constipation)
- The Black Country has 26 people who have completed training to qualify them to undertake reviews for this programme, only 13 have registered on the website. (Once training is completed the reviewer has to register on the LeDeR website to be able to complete a review). This is being managed by the LeDeR Steering Group, hosted by Dudley CCG
- Further training dates for reviewer training have been made available
- There have been 27 deaths allocated to the Black Country for reviewing, only 8 have been allocated
- One child death is currently going through the CDOP process and one adult review has been completed. RWT and WCCG reviewers are currently completing allocated reviews
- There are still unresolved issues around IG and reviewers being able to access patient records. Dudley CCG have said they will develop a Memorandum of Understanding to allow access
- The LeDeR programme is now included in Refreshing NHS Plans for 2018/19 Published by NHS England and NHS Improvement

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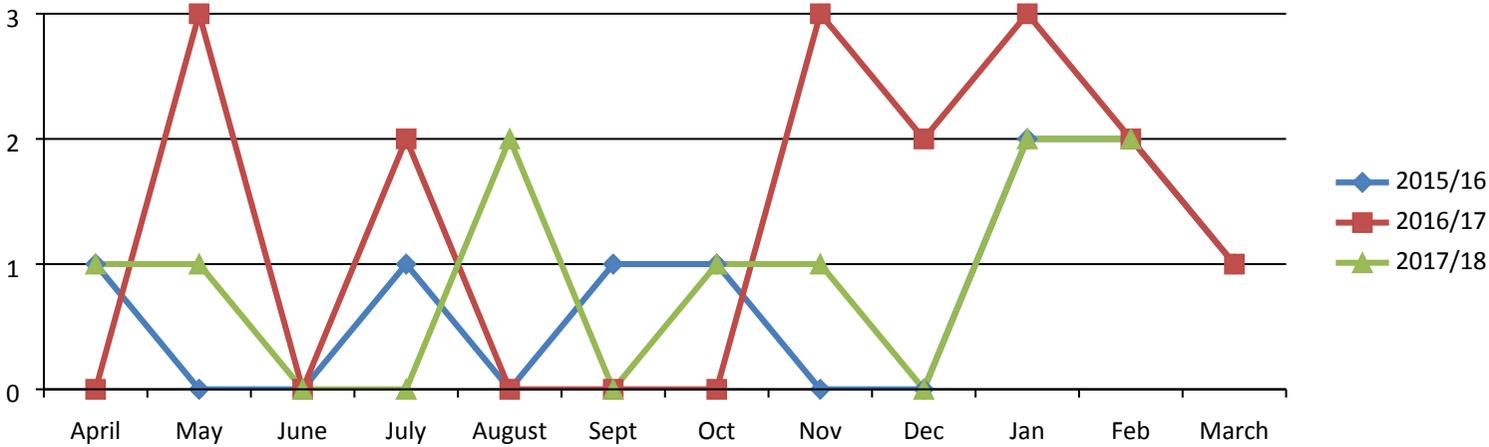
Level 3 Training Compliance - RWT

Safeguarding Adult - Mandatory Training Compliance												
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Level 3	80.0%	80.0%	86.7%	93.3%	93.3%	93.3%	92.9%	92.9%	92.9%	92.9%	92.9%	

7 USER AND CARER EXPERIENCE

7.1 Formal Complaints.

CCG Formal Complaints



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Within February 2018 there were two new formal complaints registered by the CCG. One of the complaints was investigated and closed; the other complaint is ongoing within timeframe.

The CCG has also registered 9 concerns or complaints for other commissioned providers where the complainant has contacted the CCG in the first instance, in all 9 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.

There is one formal complaint ongoing in total at the end of February 2018.

7.2 NICE Assurance

The next NICE Assurance Group meeting will be held in May 2018.

8. HEALTH AND SAFETY

Health & Safety Management within the organisation is currently under review with further information to follow in the coming months.

The Quarter 4 Health & Safety report is due to be discussed at April’s Quality & Safety Committee and JNCC.

9. BOARD ASSURANCE FRAMEWORK/RISK REGISTER

a) Number/Breakdown of Risks on Datix:

1st November 2017	TOTAL
Open Risks	39
Extreme	4
High	20
Moderate	14
Low	1

Please refer to **Appendix 3** for a breakdown of risks pertaining to the Quality and Safety Committee.

The Quality Team continues to give assurance to the Governing Body, delivery boards and individual committees that risks are being managed effectively and in a timely manner.

Risk register is now a standing item on agendas for delivery boards and committees.

10. RECOMMENDATIONS

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: Annette Lawrence/Molly Henriques Dillon

Job Title: Designated Adult Safeguarding Lead / Quality Nurse Team Leader

Date: 7th March 2018

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.

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



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WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 9

Title of Report:	Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee - 30th January 2018
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	<ul style="list-style-type: none"> • 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

	Constitutional Standards.
Relevance to Board Assurance Framework (BAF):	
<ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Domain2: Performance – delivery of commitments and improved outcomes 	The CCG must meet a number of constitutional, national and locally set performance targets.
<ul style="list-style-type: none"> • 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	£404.034m	£404.034m	Nil	G
Revenue Administration Resource not exceeded	£5.535m	£5.342m	(£0.19m)	G

Non Statuory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance £'000	351	209	(142)	G
Maximum closing cash balance %	1.25%	0.74%	-0.51%	G
BPPC NHS by No. Invoices (cum)	95%	100%	-5%	G
BPPC non NHS by No. Invoices (cum)	95%	97%	-2%	G
QIPP	£7.96m	£7.85m	£0.11m	A
Programme Cost £'000*	288,986	290,714	1,729	G
Reserves £'000*	1,602	0	(1,602)	G
Running Cost £'000*	4,151	4,004	(147)	G

- The net effect of the three identified lines (*) is a small underspend of £20k.
- 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 M9 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, (section 7).
- Programme Costs are forecast to overspend which is partially compensated for by under-spends on Running Costs.
- The financial position has been scrutinised in M9 and following the adoption of a series of assumptions informed by Budget Managers the recurrent overspend has reduced to £381k FOT which is currently offset by non-recurrent under-spends and the use of reserves. This has very serious implications for 18/19 onwards most importantly the level of QIPP will have to increase, (section 3).
- The key cause for the improving recurrent position is the movement of NCSO pressures to non recurrent as per NHSE guidance.
- The Main areas of deterioration can be identified as comprising Mental Health and Acute including NCAs.
- Royal Wolverhampton Trust (RWT) is giving concern as the M8 activity is indicating a potential forecast out turn (FOT) of c £2.5m.
- Other Providers such as Dudley Group are also over performing which appears to be linked to new HRGs and Specialist activity now in the CCG portfolio and the financial impact appears to have worsened after a period of stability in M8,
- 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. This is now unlikely to occur thus increasing the pressure on budgets.
- Within Delegated Primary Care there is some flexibility to utilise in bringing forward plans and commit recurrent spend.
- Expenditure on GP prescribing has stabilised. The CCG continues to incorporate into the financial position the worst case position for NCSO drugs. NHSE have advised CCGs that pressures emanating from NCSO should be treated as non-recurrent. This has been reflected in the overall reporting.
- CHC/FNC continues to report an overall forecast under-spend but this has reduced again in month 9.

- No additional QIPP has been identified in M9. 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, 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 M09									In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o(u)
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var% o(u)	FOT Actual £'000	FOT Variance £'000	Var% o(u)					
Acute Services	194,561	145,921	147,120	1,199	0.8%	196,615	2,054	1.1%	●	587	1,466		
Mental Health Services	36,079	26,987	27,515	527	2.0%	36,584	505	1.4%	●	275	231		
Community Services	48,547	36,341	35,929	(412)	(1.1%)	47,965	(582)	(1.2%)	●	9	(591)		
Continuing Care	14,484	10,863	10,633	(230)	(2.1%)	14,178	(307)	(2.1%)	●	(20)	(286)		
Primary Care Services	52,253	39,190	39,512	322	0.8%	52,615	362	0.7%	●	(450)	812		
Delegated Primary Care	35,301	26,476	26,362	(114)	(0.4%)	34,801	(500)	(1.4%)	●	0	(500)		
Other Programme	4,277	3,208	3,644	436	13.6%	4,727	449	10.5%	●	(308)	757		
Total Programme	385,503	288,986	290,714	1,729	0.6%	387,485	1,981	0.5%	●	93	1,888		
Running Costs	5,535	4,151	4,004	(147)	(3.5%)	5,342	(193)	(3.5%)	●	(93)	(100)		
Reserves	3,866	1,602	0	(1,602)	(100.0%)	2,077	(1,788)	(46.3%)	●	0	(1,788)		
Total Mandate	394,904	294,739	294,718	(21)	(0.0%)	394,904	(0)	(0.0%)	●	(0)	(0)		
Target Surplus	9,130	6,847	0	(6,847)	(100.0%)	0	(9,130)	(100.0%)	●	0	(9,130)		
Total	404,034	301,586	294,718	(6,868)	(2.3%)	394,904	(9,130)	(2.3%)	●	(0)	(9,130)		

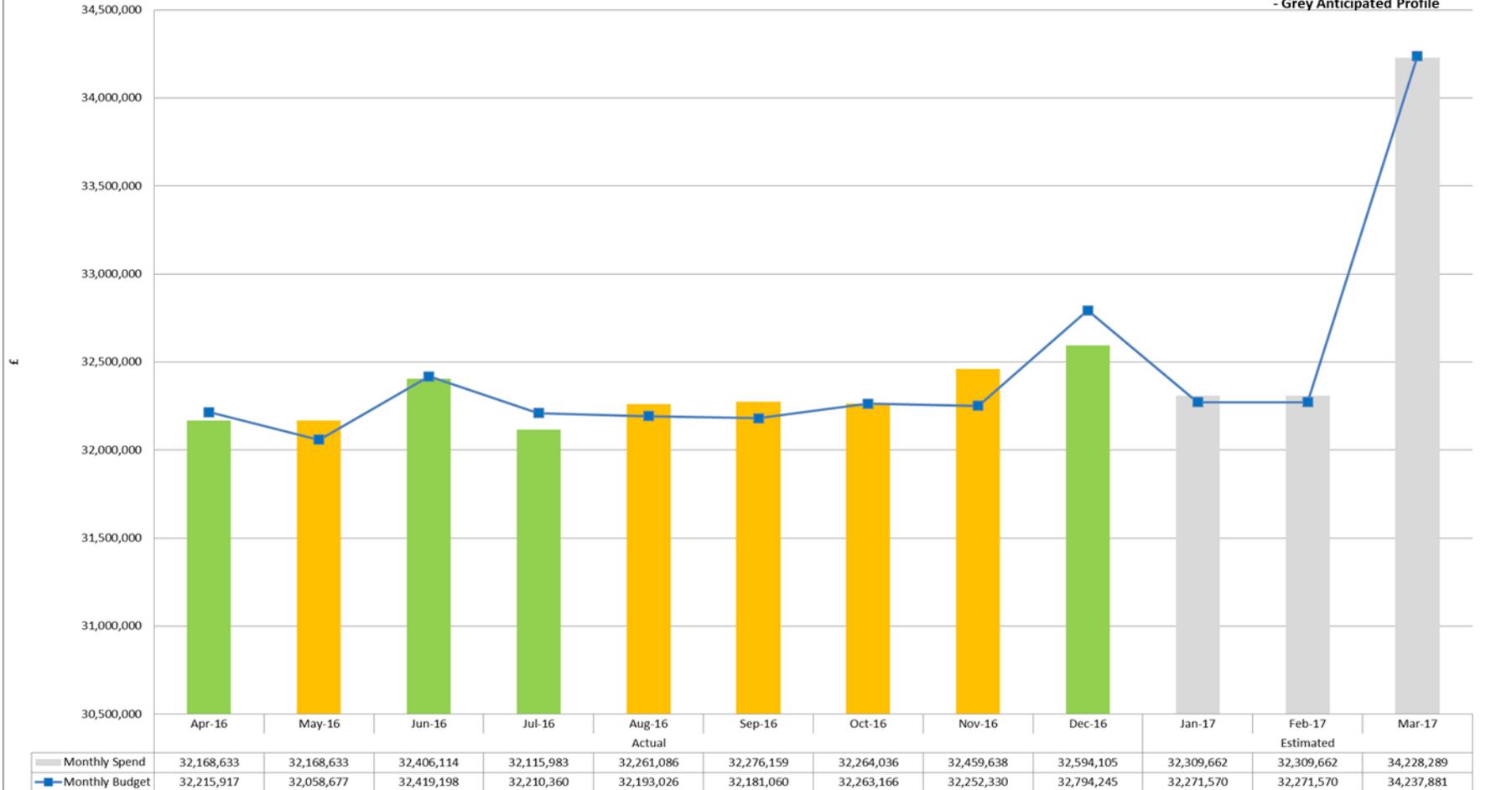
	Annual Budget £'000	Yr End Forecast £'000	Yr End Variance Total £'000 o(u)	Yr End Variance Recurrent £'000	Yr End Variance Non Recurrent	Yr End Variance %
Acute Services	194,561	196,615	2,054	2,312	(258)	0
Mental Health Services	36,079	36,584	505	235	270	0
Community Services	48,547	47,965	(582)	(390)	(192)	(0)
Continuing Care	14,484	14,178	(307)	(305)	(1)	(0)
Primary Care Services	52,253	52,615	362	(1,332)	1,694	0
Delegated Primary Care	35,301	34,801	(500)	0	(500)	(0)
Other Programme	4,277	4,727	449	6,369	(5,920)	0
Total Programme	385,503	387,485	1,981	6,890	(4,909)	0
Running Costs	5,535	5,342	(193)	0	(193)	(0)
Reserves	3,866	2,077	(1,788)	(1,788)	0	(0)
Total Mandate	394,904	394,904	(0)	0	0	(0)
Target Surplus	9,130	0	(9,130)	0	(9,130)	(1)
Total	404,034	394,904	(9,130)	5,102	(14,232)	(0)
Recurrent/Non Recurrent Adjustment				(4,721)	4,721	
Removal of Target Surplus					9,130	
Residual Position				381	(381)	

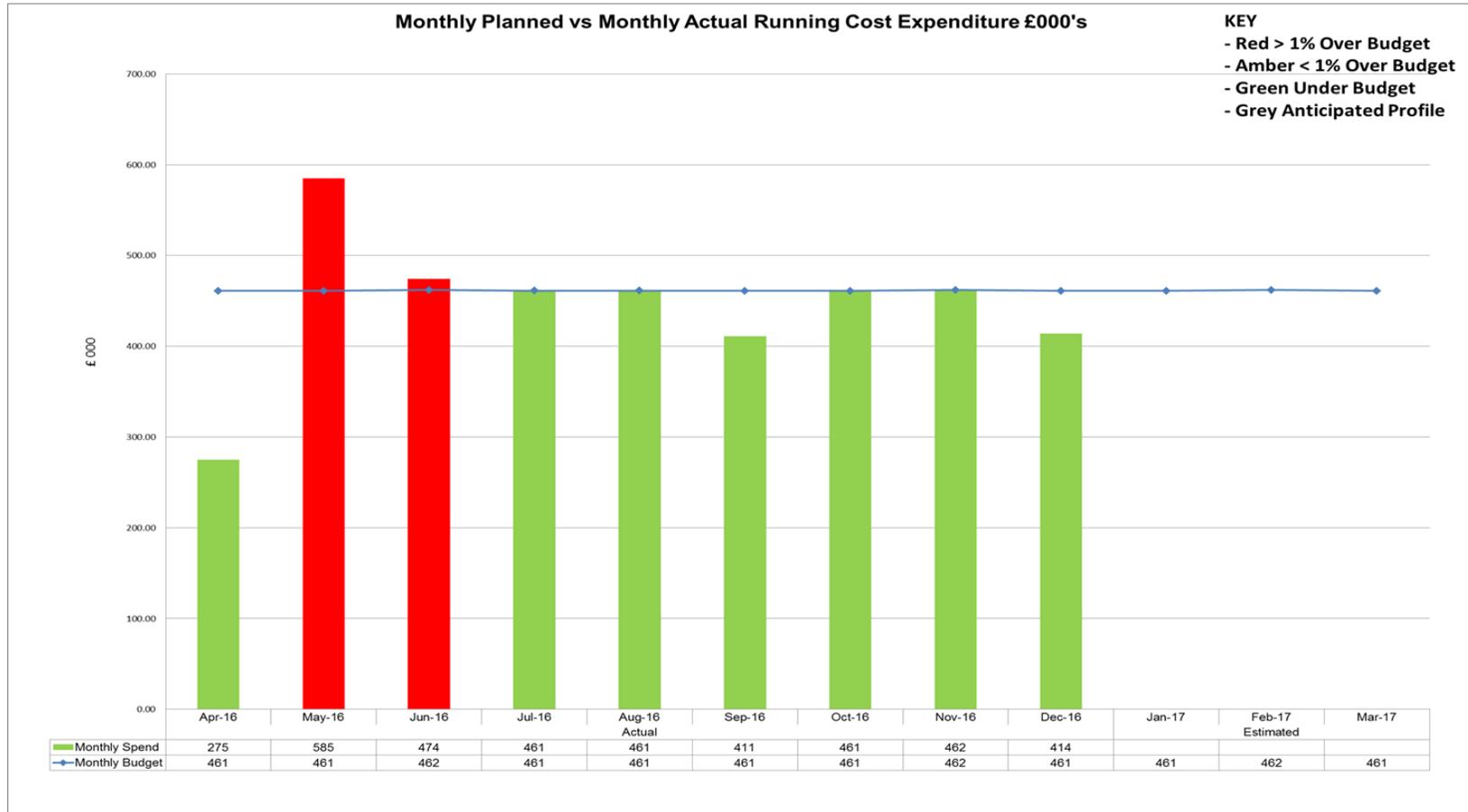
- Of the recurrent year end variance, £4.721m is a consequence of recurrent spend being offset by a non-recurrent allocation in relation to HRG4+ and IR (national coding and costing changes which impacted upon the 17/19 contract). The CCG will have a non-recurrent allocation again in 18/19 thereafter 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 £381k a decrease of £1.1m mainly as a result of moving the NCSO overspend to non-recurrent as per NHSE.
- 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)

Monthly Planned vs Monthly Actual Programme Expenditure

KEY
 - Red > 1% Over Budget
 - Amber < 1% Over Budget
 - Green Under Budget
 - Grey Anticipated Profile





- 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 M09 are £35.649m. The forecast outturn is £35.149m delivering an under-spend position.

- The table below shows the revised forecast for month 09;

	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	15,751	15,789	38	21,002	21,002	0	●	0	0
General Practice PMS	1,357	1,349	(8)	1,809	1,809	0	●	0	0
Other List Based Services APMS incl	1,724	1,906	183	2,298	2,298	0	●	0	0
Premises	2,013	1,988	(25)	2,684	2,684	0	●	0	0
Premises Other	68	45	(22)	90	90	0	●	0	0
Enhanced services Delegated	634	626	(8)	845	845	0	●	0	0
QOF	2,716	2,692	(25)	3,622	3,622	0	●	0	0
Other GP Services	2,083	1,966	(117)	2,777	2,277	(500)	●	0	(500)
Delegated Contingency reserve	131	0	(131)	174	174	0	●	0	0
Delegated Primary Care 1% reserve	261	0	(261)	348	348	0	●	0	0
Total	26,737	26,362	(375)	35,649	35,149	(500)	●	0	(500)

The forecast outturn shows an under-spend of £500k against other GP services which relates to the release of an accrual previously managed by NHSE. The benefit is non recurrent in nature. The 0.5% contingency will be committed 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.

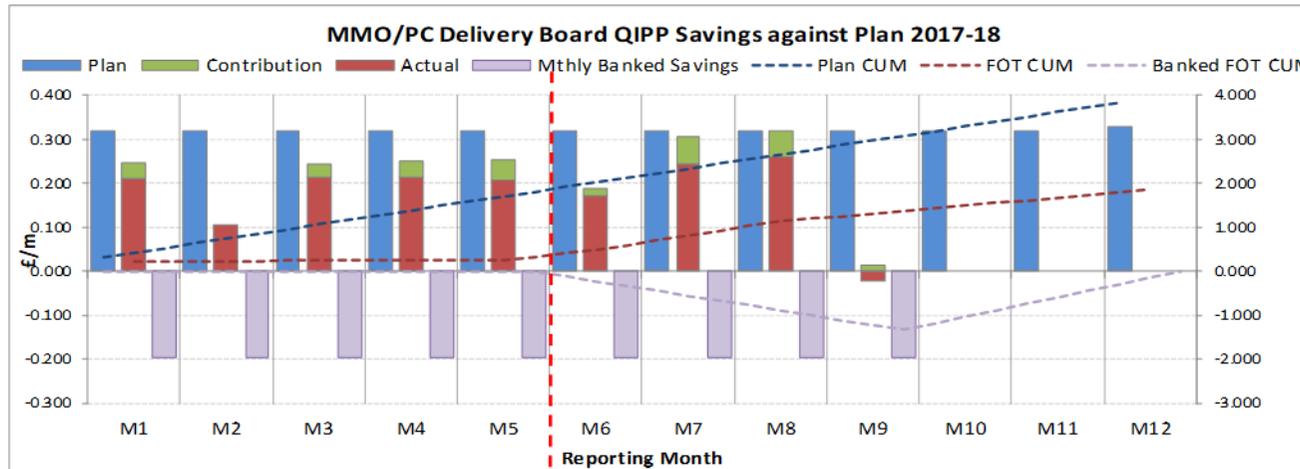
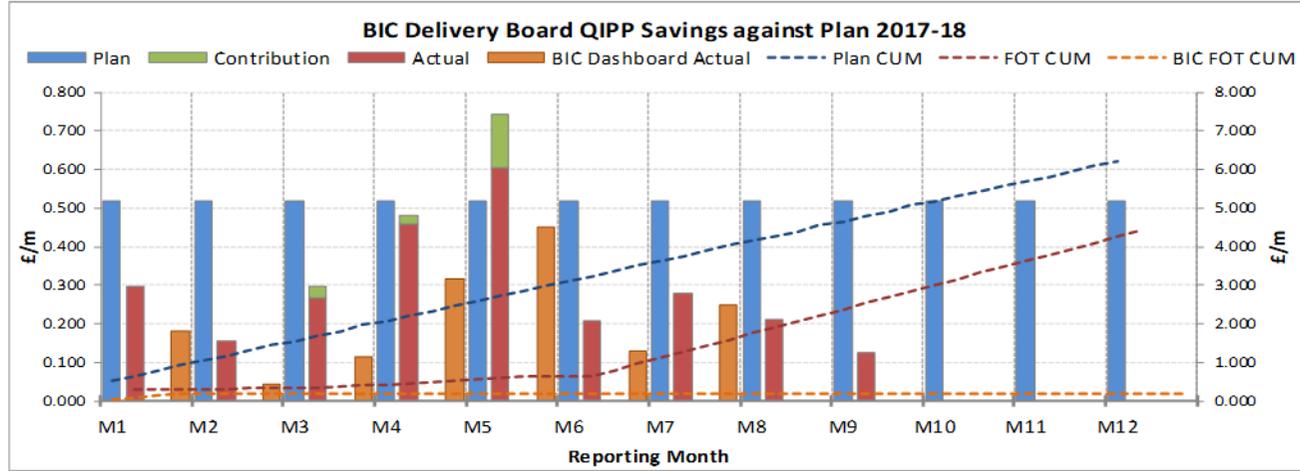
3. QIPP

The key points to note are as follows:

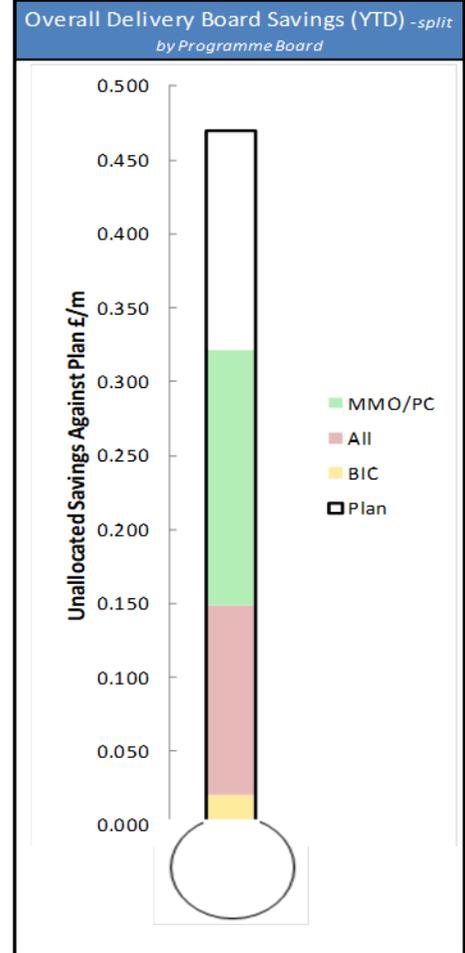
- Following the finalisation of the year end figure the plan QIPP target of £10.62m increased to £11m. As a result, the level of non-contracted QIPP without plans increased to £1.519m as £616k has identified plans.
- No additional QIPP has been identified in M9.
- Any non-recurrent QIPP will potentially be carried forward into the 18/19 target although the CCG is covering undelivered QIPP in its recurrent reported position.

QIPP Programme Delivery Board

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



<Merger of Boards from M6, monthly figures now include PC Investment



4. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 31st December 2017 is shown below.

	31 December '17 £'000	30 November '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	1,870	1,865	5
Cash and Cash Equivalents	209	133	76
	2,079	1,998	
Total Assets	2,079	1,998	
Current Liabilities			
Trade and Other Payables	-32,258	-31,251	-1,007
	-32,258	-31,251	
Total Assets less Current Liabilities	-30,179	-29,253	
TOTAL ASSETS EMPLOYED	-30,179	-29,253	
Financed by:			
TAXPAYERS EQUITY			
General Fund	30,179	29,253	926
TOTAL	30,179	29,253	

Key points to note from the SoFP are:

- The CCG has achieved its cash target this month with an outturn of 0.74% 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);

5. PERFORMANCE

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

Executive Summary - Overview

Nov-17

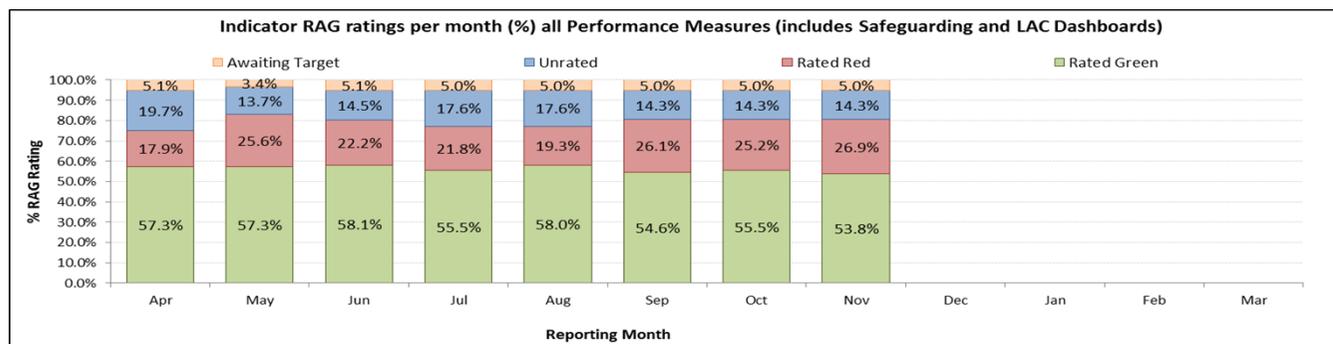
Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	13	13	11	11	0	0	0	0	24
Outcomes Framework	7	7	9	9	10	10	0	0	26
Mental Health	26	24	5	7	5	5	0	0	36
Safeguarding - RWT	8	8	5	5	0	0	0	0	13
Looked After Children (LAC)	0	0	0	0	0	0	6	6	6
Safeguarding - BCP	12	12	0	0	2	2	0	0	14
Totals	66	64	30	32	17	17	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	54%	54%	46%	46%	0%	0%	0%	0%
Outcomes Framework	27%	27%	35%	35%	38%	38%	0%	0%
Mental Health	72%	67%	14%	19%	14%	14%	0%	0%
Safeguarding - RWT	62%	62%	38%	38%	0%	0%	0%	0%
Looked After Children (LAC)	0%	0%	0%	0%	0%	0%	100%	100%
Safeguarding - BCP	86%	86%	0%	0%	14%	14%	0%	0%
Totals	55%	54%	25%	27%	14%	14%	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.

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

October 2017 : Submissions from Black Country Partnership Foundation Trust have been split to show the Wolverhampton responsible figures from M7.



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																														
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sept</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>YTD</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td style="background-color: #C00000; color: white;">91.07%</td> <td style="background-color: #C00000; color: white;">91.50%</td> <td style="background-color: #C00000; color: white;">91.01%</td> <td style="background-color: #C00000; color: white;">91.09%</td> <td style="background-color: #C00000; color: white;">91.07%</td> <td style="background-color: #C00000; color: white;">90.80%</td> <td style="background-color: #C00000; color: white;">91.12%</td> <td style="background-color: #C00000; color: white;">91.23%</td> <td></td> <td></td> <td></td> <td></td> <td style="background-color: #C00000; color: white;">91.11%</td> <td style="background-color: #D9E1F2; color: black;">92.00%</td> </tr> </tbody> </table>	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	91.07%	91.50%	91.01%	91.09%	91.07%	90.80%	91.12%	91.23%					91.11%	92.00%	
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target																	
91.07%	91.50%	91.01%	91.09%	91.07%	90.80%	91.12%	91.23%					91.11%	92.00%																	

The performance data for headline Referral To Treatment (RTT - 18wks) Incompletes has seen an increase to 91.23% against the 92% target (92.10% STF target). When compared to the previous years performance, the validated National Unify2 figures show that there has been a 2% increase in the number of incompletes waiting (Nov16 = 91.08%, 2882 breaches out of 32312, Nov17 = 91.12%, 2900 breaches out of 33072). Failing specialties include : ENT (87.86%), General Surgery (89.60%), Ophthalmology (88.29%), Oral Surgery (81.47%), Plastic Surgery (81.17%), Trauma & Orthopaedics (89.44%) and Urology (83.57%). The Trust continue to focus on reducing the backlog where possible with monthly prediction reports circulated detailing priority patients and expected activity numbers for each month with targeted meetings with Directorates to discuss poor compliance/recording of outcomes. All specialty group managers have a plan in place to achieve a target in order for the headline performance target to be met by March 2018 with weekly activity versus plan reports shared with the Directorates and presented at Performance meetings.

The Trust have had to cancel some elective procedures in line with national guidance to ease bed pressure due to winter pressures within the system (including A&E and bed capacity). The majority of operations (approximately 80%) are currently Day Cases, with the majority of electives taking place at Cannock Hospital. The Trust have advised that they will know the overall urgent and time to recover performance after the end of January 2018.

Following an increase in referrals for diagnostic tests, the Trust have confirmed that challenges continue within Radiology (centred around CT and MRI Heart) and the Commissioner will continue to monitor performance and the impact on RTT. The Trust have confirmed that they are expecting the number of Elective procedures in January to fall due to Christmas and New years effect which is likely to impact performance. Early indications for the December performance have not been made available for inclusion within the F&P papers deadline.

Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
98.88%	99.06%	99.48%	99.58%	99.20%	99.22%	99.06%	98.92%					99.18%	99.00%



The performance for Diagnostic Tests has seen a decline in November and has failed to achieve the 99% in month target (98.92%) and relates to 71 breaches (out of 6,563). All diagnostic test areas were at 100% in November with the exception of Computed Tomography (CT = 53 breaches out of 664 = 92.02%) and Magnetic Resonance Imaging (MRI = 18 breaches out of 1,533 = 98.83%). Challenges continue within Radiology and are centred around CT and MRI Heart following an increase in referrals for these diagnostic tests near the end of the month. Additional sessions were utilised during November and December to accommodate the rise in referrals and in turn reduce the backlog. The Trusts Integrated Quality and Performance Report (IQPR) for November confirmed that there were 7 radiation incidents reported (including 5 near misses) against 24,612 examinations. Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. Management of any serious incident is in line with the Serious Incident Framework (2015) which requires a Root Cause Analysis (RCA) and agreement of closure by the CCG once satisfied that the RCA investigation report and action plan meets required standards. As a Commissioner, the November performance calculates as 98.81% (49 breaches out of 4132) of which 46 relate to the Royal Wolverhampton NHS Trust, 3 to other Providers (compared to 32 breaches at the end of October):

Computed Tomography (CT) x 46 (all 36 x The Royal Wolverhampton)

MRI x 12 (2 x Birmingham Women's and Children's Hospital and 10 x The Royal Wolverhampton).

Early indications are that the December performance has seen an improvement to 99.12% and is therefore GREEN.

RWT_EB4

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%	91.55%	87.43%					92.04%	95.00%

The November performance has seen a decrease from the previous month to 87.43% and has failed to achieve the National Target (Type I and All Types) of 95% and the agreed 17/18 STF Trajectory for November of 92%. The performance can be split into the following : Emergency Department Type I (New Cross) - 80.54%, Walk-in Centre Type 4 - 100%, Cannock Minor Injury Unit (MIU) Type 3 - 100% and Vocare Type 3 - 92.12%.

When comparing the Nationally validated number of attendances from the previous year, there has been a 2.8% increase (Nov16: 18,791 - 92.08% compliance, Nov17: 19,314 - 87.43% compliance). The number of ambulance conveyances has also seen an increase of 5.1% (Nov16 = 3729, Nov17 = 3920).

The daily number of attendances increased over the course of the month with an average of 352 attendances per day with the maximum of 436 attendances occurring on Monday 20th November 2018. The Trust have submitted an Exception Report which confirms reasons for under performance as bed availability, issues with patient flow (decision making) and ambulances arriving in batches and therefore creating queues within the system. Actions highlighted include:

Active recruiting for substantive Emergency Department consultants. Bed meetings 3 to 5 times a day. Daily discharge levels sent across the Trust to ensure adequate patient flow and minimise breaches due to bed shortages with pre-admission bay opened to free cubicles of patients waiting for bed allocation. Staff are to ensure that To Take Out (TTO's - Prescription medication) and discharge summaries are completed as part of ward rounds with proactive use of the discharge lounge to prevent delays and bed blockers. New ambulance offload area to replace corridor offload. Influenza has increased pressure on the wards and the Flu Plan is in action with flu cases contained on wards C18 and C19 (respiratory) with flu testing available on site 7 days a week.

Continued overleaf.

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 - Continued

Key Commissioner actions identified are :

Co-ordinated communications across the CCG, Trust and Primary Care regarding system capacity and pressures (including regional newspaper listings of GP Practice opening hours over the Holiday season, extended hour clinics (late and weekend clinics).

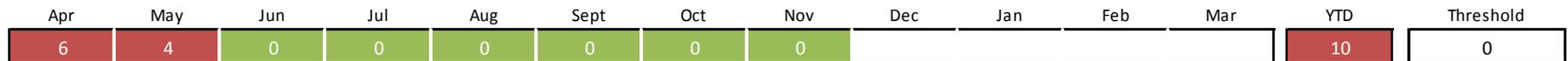
Rapid Intervention Team (RiTs) contacted to raise awareness of Primary Care Communications and potential of increased referrals.

The Commissioner brokerage team (Continuing Health Care) have been notified to be on standby for increased referrals and the Integrated Discharge Team are aware that all Medically Fit For Discharge (MFFD) patients are to be discharged as quickly as possible to clear backlogs. The Sustainability and Transformation Fund (STF) Payments guidance has been released and the Trust have confirmed that they will have failed payment due to the 95% 4hr target failures (part1). The Streaming section of the STF payment (part2) requires further clarification regarding the Type 3 activity inclusion as the Wolverhampton system classifies all Vocare activity as streamed. Early indications are that December has seen a decrease to 87.03% and therefore remains RED however, there has been positive progress with Vocare working closely with both the Trust and Commissioner to move more activity from the Emergency Department to the Urgent Care Centre and alleviate pressure, this includes additional funding from the Commissioner for additional staff within Vocare.

RWT_EB4

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Zero tolerance RTT waits over 52 weeks for incomplete pathways



This indicator has breached the Year End zero threshold for 52 week waiters due to the April and May breaches for Orthodontic patients. The M8 performance confirms that there were no patients waiting over 52 weeks during November, 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 December.

RWT_EBS4

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	1					1	0



The performance for the number of Trolley waits in A&E (not longer than 12 hours) has breached the zero threshold for the first time since June 2015. The CCG Quality and Safety Team liaise with Trusts involved (Royal Wolverhampton NHS Trust) to establish a timeline and assess if an indicator breach has occurred and if the incident also meets the Serious Incident Framework (2015) criteria. The Trust have since confirmed that the breach relates to a child awaiting a Paediatric Intensive Care Bed (PICU).

RWT_EBS5

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%	1.49%	1.66%					1.62%	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 both the 2.2% threshold in-month (excluding Social Care) reporting 1.66% for November and the 3.5% combined threshold (3.44%).

National DTOC submission data from the Unify2 collection system confirms that there were 807 total delay days for November at the Royal Wolverhampton Trust (of which 278 x Wolverhampton, 414 x Staffordshire, 65 x Walsall, 42 x Dudley and 8 x Shropshire). As a Commissioner, November delays days totals were : 278 x Royal Wolverhampton NHS Trust, 30 x South Staffordshire and Shropshire Healthcare, 2 x University Hospitals Birmingham, 143 x Black Country Partnership and 42 x Dudley Group of Hospitals. Following the new guidance the Director of Adult Social Services is to sign off all Delayed Transfers of Care and a DToc Directory has been developed with contact details of key individuals. 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, however the July reports confirm the combined performance as 5.09% and therefore RED. The Trust have indicated the following delay reasons for November:

- 22.6% - Delay Awaiting Assessment (prev 30.2% - decrease)
- 7.6% - Delay awaiting further NHS Care (prev 9.5% - decrease)
- 24.5% - Delay awaiting domiciliary package (prev 28.4% - decrease)
- 8.5% - Delay awaiting family choice (prev 4.3% - increase)
- 12.3% - Delay awaiting equipment/adaptations (prev 7.8% - increase)
- 0.9% - Delay awaiting public funding (prev 0.9% - 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 been achieved for October (3.44% combined delays).

Early indications are that the December performance is 1.11% and remains below the 2.2% 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%	27.22%	25.55%					30.80%	10.00%



Performance for this indicator has achieved the 40% recovery trajectory threshold for November, achieving 25.55%. The National validated performance has since been confirmed as 28.34% (32.78% 1st Outpatient only). Analysis of the year on year performance shows that the Month 8 performance relates to a lower number of referrals (16/17 denominator = 4634, 17/18 denominator = 4736, an increase of 102) with performance declining from that of the same period in 2016/17 (17.11%). The Trust have submitted an exception report which has confirmed that increased demands on services and reduced capacity in some specialties due to staff shortages effecting performance with Ophthalmology, Paediatrics, Urology and Orthopaedics the areas facing the biggest challenges. Planned actions include : Identification of routine clinic slots for conversion to e-RS slots, conversion of slots to match sub-specialty requirements and demands, service review to identify any e-RS service gaps and updating the Directory of Services accordingly and as part of the E-referral Service (ERS) Commissioning for Quality and Innovation (CQUIN) Scheme, work has been on-going with individual specialties to identify additional capacity and conversion to direct booking. 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 November reported figures= 1210/4736 (25.55%), whereas the NHS Digital confirmed data = 1342/4736 (28.34%). The initial response has indicated that the difference in performance figures related to Dermatology activity and the CCG are awaiting confirmation from the Trust are to confirm if these figures are included. The National Appointment Slot Issue report for November 17 allows us to benchmark performance :

- Walsall Healthcare NHS Trust - 51.71 (1,140 issues out of 2,228 bookings)
- Sandwell and West Birmingham - 67.73 (3,977 issues out of 5,872 bookings)
- Dudley Group of Hospitals - 33.81 (1,927 issues out of 5,699 bookings)
- Royal Wolverhampton - 28.34 (1,342 issues out of 4,736 bookings)

The National performance (Acute Trusts only) for November has been confirmed as 15.29, with the West Midlands (Acute Trusts only) currently performing at 34.21.

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*



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
100.00%	95.45%	92.31%	95.83%	100.00%	89.74%	91.89%	94.44%					94.96%	95.00%

The performance for this indicator has seen an increase from the previous month however remains below the 95% target for the third consecutive month (94.44%) with YTD currently below target at 94.96%. The Wolverhampton breaches for November relates to 2 patients (out of 36) that did not receive a follow up within 7 days from psychiatric in-patient care. An exception report has been provided by the Trust which includes details for each breach and actions taken to prevent future breaches. These include :

Meetings to be arranged to agree a more robust process for communication between wards and community staff.

A daily monitoring process established and relevant team contacted to prompt a 7 day follow up with the inclusion of escalation plan to ensure any system failures are communicated to Community Staff.

All staff in planned and urgent care have been contacted to ensure that they are following process (in line with the SOP) and issues with the lack of patient details on discharge needs to be addressed.

The Trust have confirmed the following reasons for breaching target :

1 x temporary network issues, discharge was not picked up within the 7 day timeframe, contact was made via telephone.

1 x patient self-discharged against clinical advice to move to London. Home Treatment Team in London contacted upon day of discharge to request a 7 day follow up, however was not due to take place until 11th December.

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



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
80.33%	83.88%	87.07%	85.85%	85.08%	85.25%	83.64%	84.22%					84.42%	85.00%

The performance for the IPC training programme is based on a quarterly target of 85%, however figures are received on a monthly basis to monitor performance. The November performance has seen an increase however remains below target both in-month (84.22%) and Year To Date (84.42%). The submitted data for this indicator is at a Provider level and includes both Wolverhampton and Sandwell figures. As a Quarterly performance indicator, an exception report is not provided each month and will only be available if the full Quarter fails to achieve. Performance is discussed at the CQRM and CRM meetings with the Trust and the CCG will continue to monitor the monthly performance. To achieve the Quarterly target, a minimum of 88% performance will be required in December.

BCPFT_LQGE06

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
4.88%	1.57%	4.11%	4.03%	3.18%	4.54%	3.89%	10.50%					4.58%	7.50%



The Delayed Transfers of care programme (DTC) has seen a significant increase in November (10.50%) and has breached the 7.5% threshold. This performance relates to Wolverhampton only, the Sandwell performance has been confirmed as 1.72% and therefore remains GREEN.

As delayed discharges remain a National issue, performance will be 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. The delayed discharges for Wolverhampton currently concern patients on our Older Adults Ward waiting for specialist nursing home beds and the Mental Health Commissioner is working with colleagues from the Continuing Health Care (CCG - CHC) Team and the Local Authority. The Trust have submitted an exception report for the November performance which confirms that the majority of delays are currently due to Older Adult patients awaiting placements (delays due to difficulty in finding providers, awaiting provider assessments, availability of placements and disputes between health care and social care). The Trust and Local Authority have completed a deep dive review of delayed discharges on the wards with findings leading to an agreement for a working group to be established to look at a multi-agency approach to systems to reduce delays in discharges. The Local Authority have provided a dedicated social worker to Penn Hospital who attends weekly reviews and engages with patients and Multi Disciplinary Teams (MDTs) for placements/housing and instigates early assessments for less complex patients to minimise assessment delays (limited to Adults rather than Older Adults).

Following the December Clinical Quality Review Meeting (CQRM), the Trust shared additional information regarding delays detailing timelines and actions taken. From April 2017 there has been a change to the methodology used for the submission of the National DTC 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 November National figures have been confirmed as follows for the Black Country Partnership (all commissioners) :

- NHS delay days = 2 and a 0.07 delayed bed day average (previously 52, 1.68 average)
- Social Care delay days = 70 and a 2.33 delayed bed day average (previously 22, 0.71 average)
- Both delay days = 112 and a 3.73 delayed bed day average (previously 7, 0.230 average)
- Trust Total = 184 delay days and a 6.13 delayed bed day average (previously 81, 2.61 average).

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%	58.65%	59.84%					56.87%	50.00%

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 59.84% of patients moving to recovery during November 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 Trust has met with the Commissioner regarding the variances in local and nationally reported performance. Small variances are expected due to differences in submission deadlines and performance methodologies (National performance is based on a rolling 3 month calculation whereas local data is in-month only), however other factors include the possible inclusion of Birmingham Mental Health Consortium (Herbert Road) of commissioner level data and possible data quality issues with the current system provider (PCMIS) downloads which was flagging discharged patients as still requiring a follow up and therefore included within the denominator calculation once uploaded to the Mental Health Minimum Data Set (MHMDS). Trust investigations have also highlighted that staff were not correctly discharging patients on the electronic systems and a new process document has been introduced to all staff who enter data onto the clinical system (including new and temporary staff) to confirm the exact process for discharging patients.

The CCG is assured that the Trust are taking appropriate actions to improve existing processes and data quality standards to ensure that any local and national data variances are minimised. As part of the assurance process, the CCG will continue to review the monthly local and national figures with the Trust to identify any unusual variances which require further investigation. The Trust have indicated that they are continuing efforts to minimise errors and ensure data is validated prior to future uploads and are working with the clinical system provider to do this. The Commissioner is also working with the Trust to look at options for an IAPT "Pop-up" shop in the city centre and/or University along with some additional communications to be developed to support the IAPT access target between now and the end of the financial year. The latest National data available is September 2017 and is currently reporting at 52.27% and is GREEN for the third consecutive month. 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.

The current positions of contract negotiations for 2018/19 were noted.

7. PLANNING FOR 2018/19

The Committee noted the 2018/19 planning submissions made by the CCG. Assurance was taken from the quality and financial considerations which have been taken into account during the planning round.

The Committee recommends to the Governing Body that it signs off the budget, noting the inherent risk.

8. RISK REPORT

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

9. 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 9, and continues to report a nil net risk.

The table below details the current risk assessment for the CCG' a risk of £2.0m with mitigations of £2.0m.

CCG RISKS & MITIGATIONS	Forecast Net Expenditure				RISKS (enter negative values only)						MITIGATIONS (enter positive values only)								TOTAL NET (RISK) / MITIGATION			
	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)	394.904																					
REVENUE RESOURCE LIMIT (CUMULATIVE)	404.034																					
Acute Services	193.678	195.732	(2.055)	(1.1%)	(0.700)	(0.300)				(1.000)				0.300						0.300	(0.700)	
Mental Health Services	36.079	36.584	(0.505)	(1.4%)																		
Community Health Services	48.547	47.965	0.582	1.2%																		
Continuing Care Services	14.484	14.178	0.307	2.1%																		
Primary Care Services	52.253	52.615	(0.362)	(0.7%)				(1.000)		(1.000)					1.000					1.000		
Primary Care Co-Commissioning	35.649	35.149	0.500	1.4%											0.400					0.400	0.400	
Other Programme Services	8.678	7.338	1.340	15.4%												0.300				0.300	0.300	
Commissioning Services Total	389.369	389.562	(0.193)	(0.0%)	(0.700)	(0.300)	-	(1.000)	-	(2.000)	-	-	-	0.300	1.400	0.300	-	-	-	2.000	-	
Running Costs	5.535	5.342	0.193	3.5%																		
Unidentified QIPP																						
TOTAL CCG NET EXPENDITURE	394.904	394.904	0.000	0.0%	(0.700)	(0.300)	-	(1.000)	-	(2.000)	-	-	-	0.300	1.400	0.300	-	-	-	2.000	-	
IN YEAR UNDERSPEND / (DEFICIT)	-	0.000	0.000	0.0%																		
CUMULATIVE UNDERSPEND / (DEFICIT)	9.130	9.130	0.000	0.0%																		

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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	£11.130	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	£7.130	Adjusted risks and no mitigations occur. CCG misses revised control total

10. Other Risks

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).

11. RECOMMENDATIONS

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

Name: Lesley Sawrey
Job Title: Deputy Chief Finance Officer
Date: 30th January 2018

Performance Indicators 17/18

Current Month:

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		
RWT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	RWT	92%	91.23%	R	91.11%	R	↑														
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	RWT	99%	98.92%	R	99.18%	G	↓														
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%	87.43%	R	92.04%	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%	93.57%	G	93.38%	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%	93.39%	G	95.31%	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%	97.39%	G	96.92%	G	↑														
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	RWT	94%	92.59%	R	89.86%	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%	98.04%	G	98.65%	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%	76.04%	R	75.45%	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%	81.82%	R	86.56%	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	1.00	R	↑														
RWT_EAS5	Minimise rates of Clostridium Difficile	RWT	Mths 1-11 = 3 Mth 12 = 2	2.00	G	23.00	G	↔														
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	99	R	446	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	9	R	25	R	↓														
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	RWT	0	1	R	1	R	↓														
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%	96.41%	G	95.53%	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%	99.89%	G	99.87%	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%	98.92%	G	98.97%	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%	96.47%	G	95.21%	G	↑														
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%	84.98%	R	86.54%	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%	1.66%	G	1.62%	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	0.00	G	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	5.00	R	17.00	R	↓	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.58%	G	0.38%	G	↓	
RWT_LQR11	% Completion of electronic CHC Checklist	RWT	Q1 - 86% Q2 - 90% Q3 - 94% Q4 - 98%	92.31%	R	94.56%	G	↓	
RWT_LQR12	E-Referral – ASI rates	RWT	10.00%	25.55%	R	30.80%	R	↑	
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	93.60%	G	91.66%	G	↑	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	83.78%	G	84.93%	G	↑	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	72.58%	G	74.07%	G	↑	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	92.50%	99.34%	G	99.55%	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%	93.71%	R	92.58%	R	↑	
RWT_LQR29	Infection Prevention Training Level 2	RWT	95.00%	95.87%	G	94.87%	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%	98.31%	G	97.28%	G	↑	
BCPFT_EB54	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	90.63%	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%	96.00%	G	96.12%	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%	100.00%	G	100.00%	G	→	
BCPFT_EB51	Mixed sex accommodation breach	BCP	0	0	G	0	G	→	
BCPFT_EB53	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	94.44%	R	94.96%	R	↑	
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%	100.00%	G	96.32%	G	→	
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge from secondary care. (NB: exclusions apply to patients who discharge themselves against clinical advice or who are AWOL)	BCP	100.00%	100.00%	G	98.13%	R	→	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	87.80%	G	90.83%	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%	0.84	R	0.84	R	↑	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	96.88%	G	96.62%	G	↓	
BCPFT_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	BCP	95.00%	100.00%	G	99.64%	G	↑	
BCPFT_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	BCP	7.50%	10.50%	R	4.58%	G	↓	
BCPFT_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	BCP	95.00%	99.31%	G	96.86%	G	↓	
BCPFT_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	BCP	85.00%	96.67%	G	92.46%	G	↓	
BCPFT_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	BCP	85.00%	98.06%	G	98.11%	G	↓	
BCPFT_LQGE15	Percentage of SULs that are reported onto STEIS within 2 working days of notification of the incident	BCP	100.00%	100.00%	G	100.00%	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_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%	50.00%	R	93.75%	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%	100.00%	G	81.25%	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%	59.84%	G	56.87%	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%	96.00%	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_LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,880 = 16.8% of prevalence.	BCP	1.40%	1.13%	R	1.42%	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%	96.55%	G	98.79%	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	→	

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WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 9

Title of Report:	Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 27th March 2018
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Recommendations:	<ul style="list-style-type: none"> • 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

	Constitutional Standards.
Relevance to Board Assurance Framework (BAF):	
<ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Domain2: Performance – delivery of commitments and improved outcomes 	The CCG must meet a number of constitutional, national and locally set performance targets.
<ul style="list-style-type: none"> • 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	£405.30m	£405.30m	Nil	G
Revenue Administration Resource not exceeded	£5.535m	£5.260m	(£0.28m)	G

Non Statutory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance	£340k	£87k	(£253k)	G
Maximum closing cash balance %	1.25%	0.32%	(0.93%)	G
BPPC NHS by No. Invoices (cum)	95%	100%	(5%)	G
BPPC non-NHS by No. Invoices (cum)	95%	98%	(3%)	G
QIPP	£9.73m	£9.66m	(£0.07m)	A
Programme Cost *	£354,334k	£356,545k	£2,211k	G
Reserves *	£1,958k	£0k	(£1,958k)	G
Running Cost *	£5,073k	£4,821k	(£253k)	G

- The net effect of the three identified lines (*) is break even.
- 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 M11 the level of risk has diminished. The CCG is continuing to maintain a nil net risk as mitigations match identified risks.
- Programme Costs are forecast to overspend which is compensated for by under-spends on Running Costs.
- The financial position has been scrutinised in M11 and following the adoption of a series of assumptions informed by Budget Managers and technical adjustments, the recurrent overspend has increased further this month to £1.387m FOT which is currently offset by non-recurrent under-spends and the use of reserves. This has very 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 M10 activity is indicating a potential forecast out turn (FOT) of c £2.8m as a result of higher than expected activity in January for NEL.
- Other Providers such as 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 had been given by the MH Commissioner that spend will reduce and fall back in line with budget as cases are reviewed and costs reduced. This is now unlikely to occur thus increasing the pressure on budgets.
- Within Delegated Primary Care there is a considerable level of flexibility. The CCG continues to try to bring forward plans and commit recurrent spend although the impact will now be minimal. Any unused budget can be used non-recurrently to support the financial position (if required) as the Delegated Primary Care budget is ring fenced on a recurrent basis.
- Expenditure on GP prescribing has increased slightly in month due to a recalculation of the spend profile by NHSBSA. Offset against this is an improvement in the position for NCSO drug.
- No additional QIPP has been identified in M11. 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 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 M11									
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)	In Month Movement Trend	In Month Movement £'000 o(u)	Previous Month FOT Variance £'000 o(u)
Acute Services	194,569	178,358	180,868	2,510	1.4%	197,453	2,883	1.5%	●	357	2,526
Mental Health Services	36,157	33,024	33,295	271	0.8%	36,396	239	0.7%	●	(193)	432
Community Services	48,547	44,417	43,819	(598)	(1.3%)	47,909	(638)	(1.3%)	●	(1)	(637)
Continuing Care	14,485	13,278	12,851	(427)	(3.2%)	14,020	(465)	(3.2%)	●	(142)	(323)
Primary Care Services	52,374	48,006	48,405	398	0.8%	52,668	295	0.6%	●	(77)	372
Delegated Primary Care	35,301	32,359	31,954	(405)	(1.3%)	34,511	(790)	(2.2%)	●	0	(790)
Other Programme	5,336	4,892	5,353	461	9.4%	5,876	540	10.1%	●	82	458
Total Programme	386,770	354,334	356,545	2,211	0.6%	388,834	2,063	0.5%	●	25	2,038
Running Costs	5,535	5,073	4,821	(253)	(5.0%)	5,260	(275)	(5.0%)	●	(25)	(250)
Reserves	3,866	1,958	0	(1,958)	(100.0%)	2,077	(1,788)	(46.3%)	●	0	(1,788)
Total Mandate	396,171	361,366	361,366	0	0.0%	396,171	0	0.0%	●	0	0
Target Surplus	9,130	8,369	0	(8,369)	(100.0%)	0	(9,130)	(100.0%)	●	0	(9,130)
Total	405,301	369,735	361,366	(8,369)	(2.3%)	396,171	(9,130)	(2.3%)	●	0	(9,130)

	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	194,569	197,453	2,883	1,902	981	0
Mental Health Services	36,157	36,396	239	842	(604)	0
Community Services	48,547	47,909	(638)	70	(709)	(0)
Continuing Care	14,485	14,020	(465)	(363)	(102)	(0)
Primary Care Services	52,374	52,668	295	(944)	1,238	0
Delegated Primary Care	35,301	34,511	(790)	0	(790)	(0)
Other Programme	5,336	5,876	540	6,388	(5,848)	0
Total Programme	386,770	388,834	2,063	7,896	(5,833)	0
Running Costs	5,535	5,260	(275)	0	(275)	(0)
Reserves	3,866	2,077	(1,788)	(1,788)	0	(0)
Total Mandate	396,171	396,171	0	0	0	0
Target Surplus	9,130	0	(9,130)	0	(9,130)	(1)
Total	405,301	396,171	(9,130)	6,108	(15,238)	(0)
Recurrent/Non Recurrent Adjustment				(4,721)	4,721	
Removal of Target Surplus					9,130	
Residual Position				1,387	(1,387)	

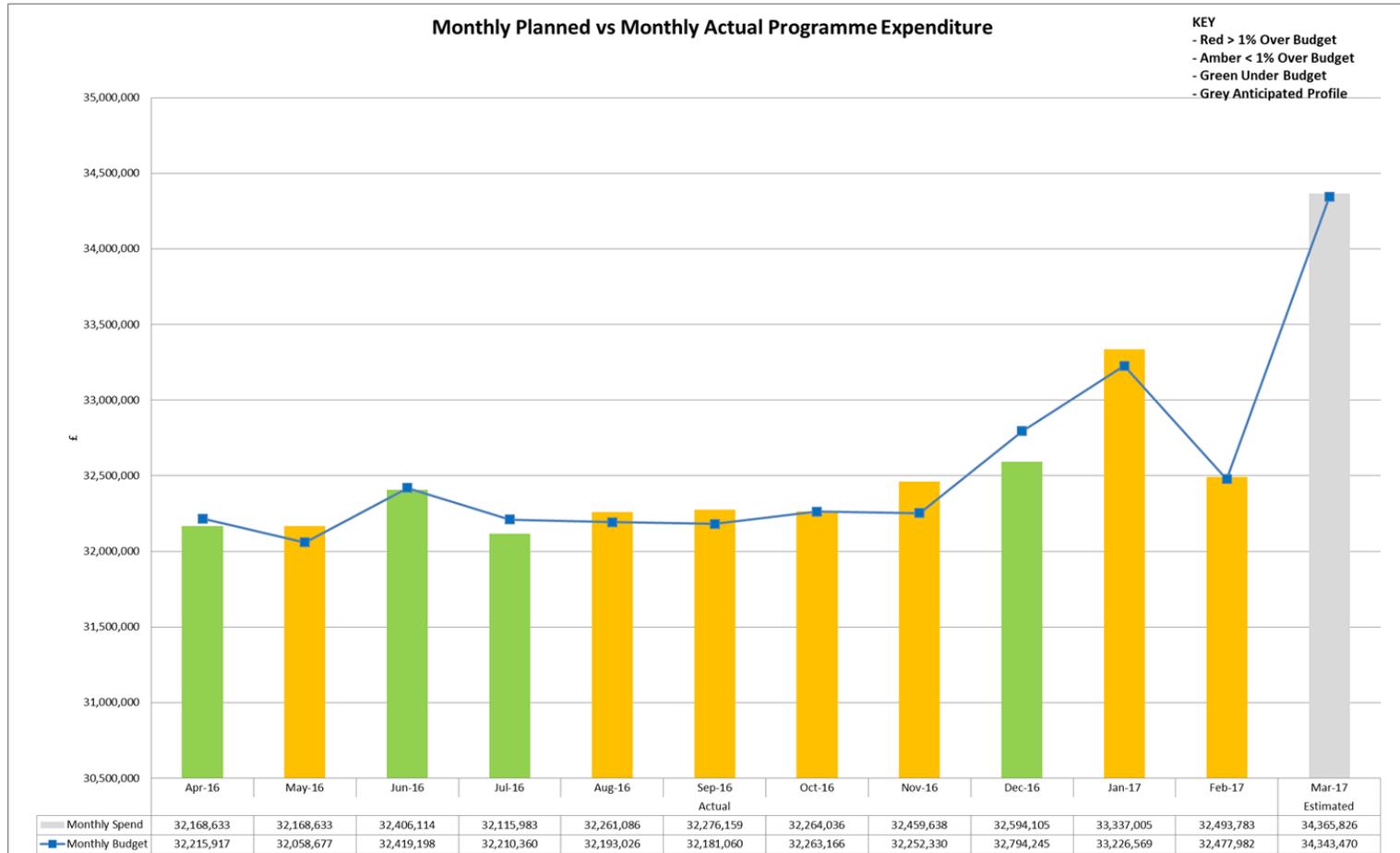
- Of the recurrent year end variance, £4.721m is a consequence of recurrent spend being offset by a non-recurrent allocation in relation to HRG4+ and IR (national coding and costing changes which impacted upon the 17/19 contract). The CCG will have a non-recurrent allocation again in 18/19. Thereafter 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 £1.387m as a result of small budget movements and technical adjustments in preparation for Final Accounts and 18/19 budgets.

- 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. This is clearly detailed in the following table.

	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)

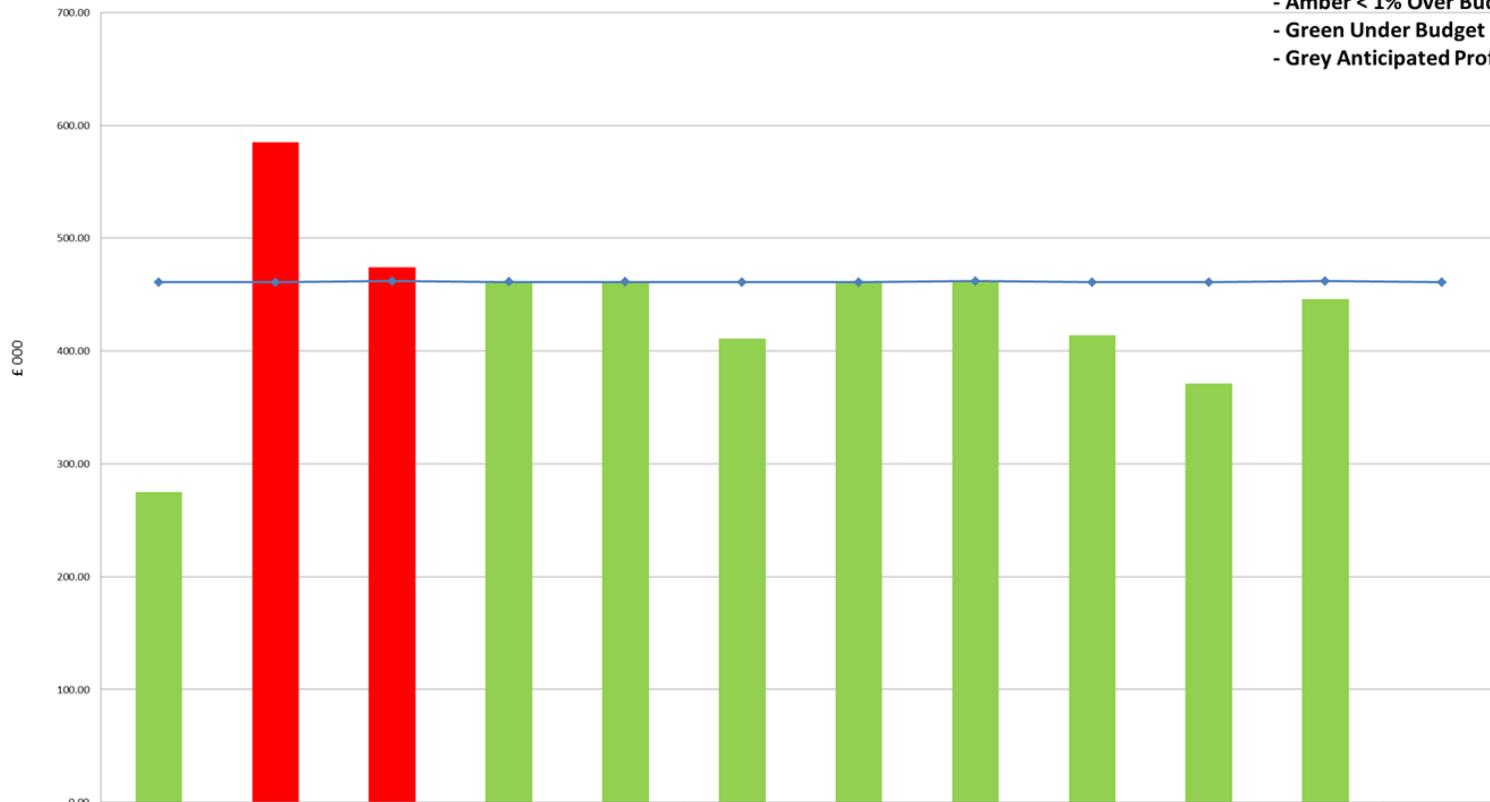
Monthly Planned vs Monthly Actual Programme Expenditure

KEY
 - Red > 1% Over Budget
 - Amber < 1% Over Budget
 - Green Under Budget
 - Grey Anticipated Profile



Monthly Planned vs Monthly Actual Running Cost Expenditure £000's

KEY
 - Red > 1% Over Budget
 - Amber < 1% Over Budget
 - Green Under Budget
 - Grey Anticipated Profile



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16 Actual	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17 Estimated
Monthly Spend	275	585	474	461	461	411	461	462	414	371	446	
Monthly Budget	461	461	462	461	461	461	461	462	461	461	462	461



- 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 forecast underspend of £275k is anticipated.

2. Delegated Primary Care

Delegated Primary Care allocations for 2017/18 as at M10 are £35.649m. The forecast outturn is £34.859m delivering an underspend position of £790k.

The forecast outturn shows an under-spend of £790k (and year to date under-spend of £659k), which relates to the release of an accrual previously managed by NHSE. The benefit is non recurrent in nature. The 0.5% contingency will be committed 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.

The table below shows the revised forecast for month 11:

	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	19,252	19,298	46	21,002	21,002	0	●	0	0
General Practice PMS	1,658	1,576	(83)	1,809	1,809	0	●	0	0
Other List Based Services APMS incl	2,107	2,330	224	2,298	2,298	0	●	0	0
Premises	2,460	2,542	82	2,684	2,684	0	●	0	0
Premises Other	83	57	(25)	90	90	0	●	0	0
Enhanced services Delegated	775	553	(222)	845	845	0	●	0	0
QOF	3,320	3,346	25	3,622	3,622	0	●	0	0
Other GP Services	2,546	2,253	(293)	2,777	1,987	(790)	●	0	0
Delegated Contingency reserve	160	0	(160)	174	174	0	●	0	0
Delegated Primary Care 1% reserve	319	0	(319)	348	348	0	●	0	0
Total	32,678	31,954	(724)	35,649	34,859	(790)	●	0	0

The 0.5% contingency will be committed 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

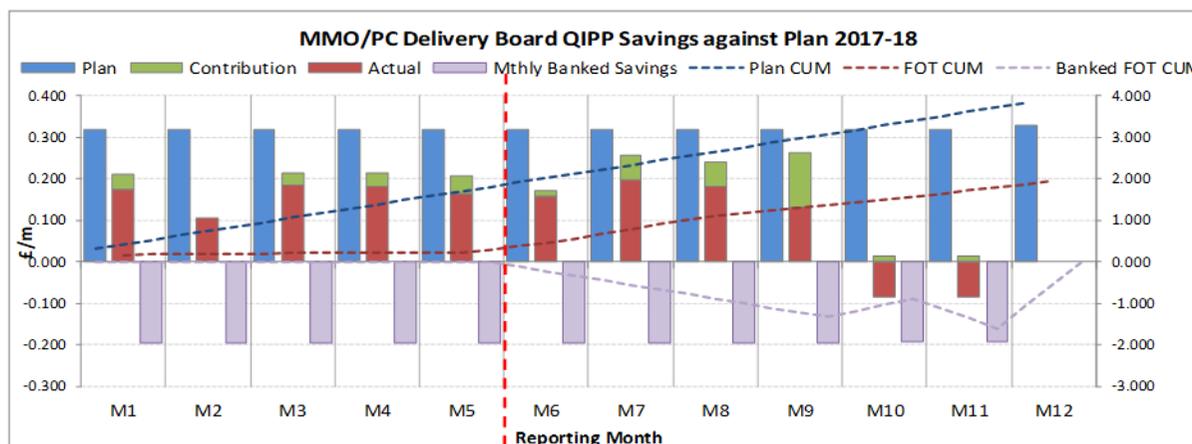
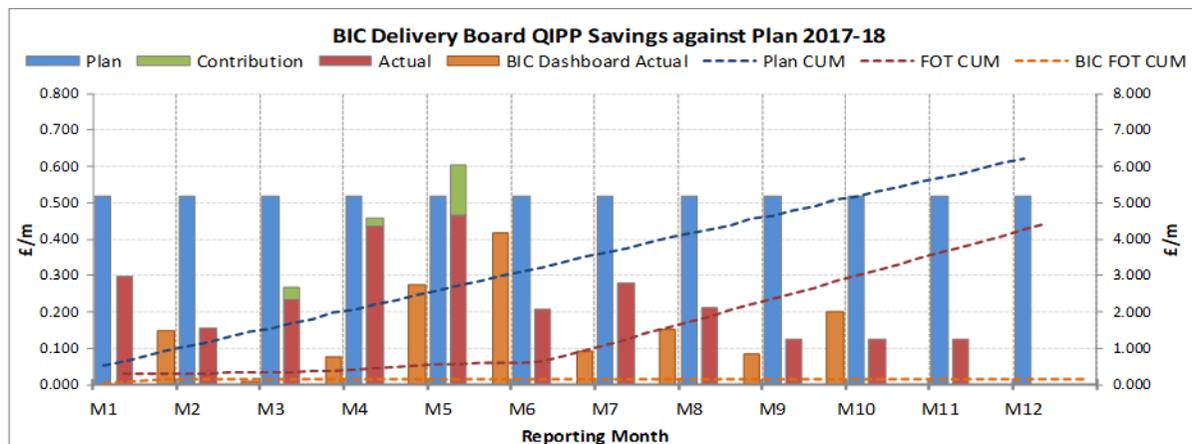
The key points to note are as follows:

- 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 M11.
- 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.
- There has been little change in the QIPP position and at this stage of the financial year there are unlikely to be further changes. The CCG is currently planning to cover any shortfalls in the QIPP Programme by underspends and the application of reserves such as Contingency.

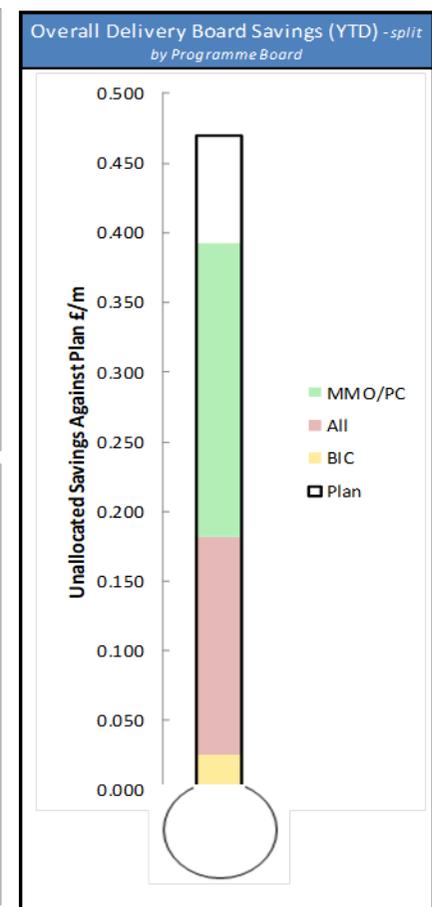
QIPP Programme Delivery Board

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

Mth 11 - Feb 17/18



<Merger of Boards from M6, monthly figures now include PC investment



4. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position (SoFP) as at 28th February 2018 is shown below.

	28 February '18 £'000	31 January '18 £'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	1,461	2,071	-609
Cash and Cash Equivalents	81	61	21
	1,543	2,132	
Total Assets	1,543	2,132	
Current Liabilities			
Trade and Other Payables	-35,130	-33,820	-1,310
	-35,130	-33,820	
Total Assets less Current Liabilities	-33,588	-31,688	
TOTAL ASSETS EMPLOYED	-33,588	-31,688	
Financed by:			
TAXPAYERS EQUITY			
General Fund	33,587	31,688	1,899
TOTAL	33,587	31,688	

Key points to note from the SoFP are:

- The CCG has achieved its cash target this month with an outturn of 0.32% 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, (98% for non-NHS invoices and 100% for NHS invoices).

5. PERFORMANCE

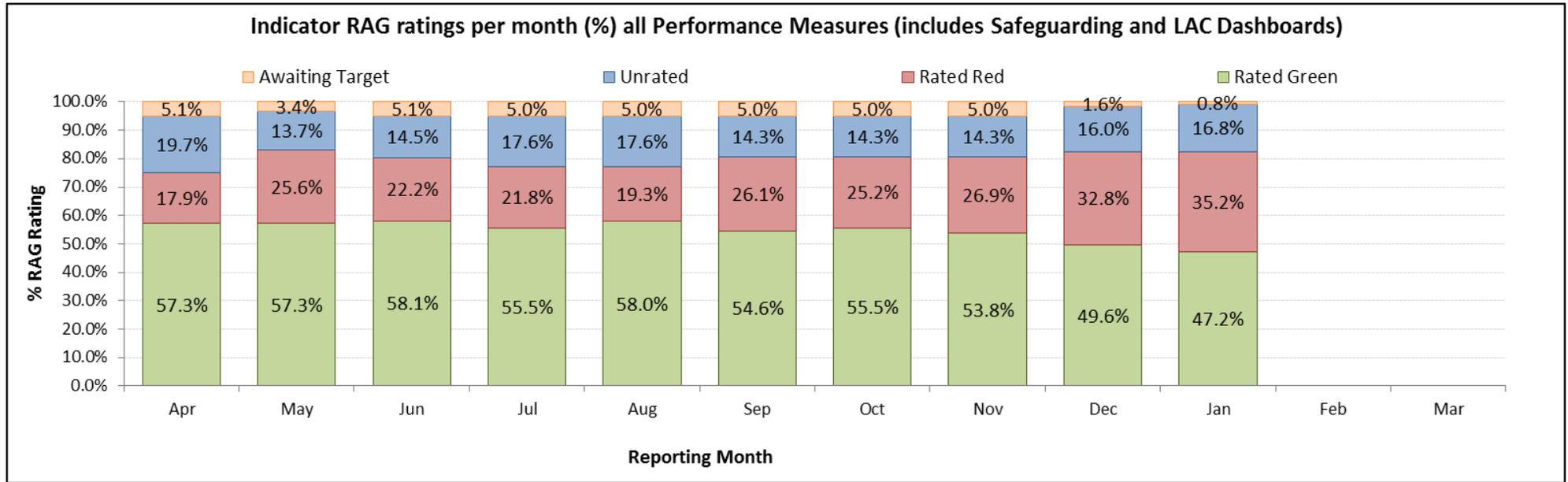
The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Jan-18

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	11	10	10	14	3	0	0	0	24
Outcomes Framework	6	6	10	8	10	12	0	0	26
Mental Health	26	25	11	11	4	5	0	0	41
Safeguarding - RWT	6	6	7	7	0	0	0	0	13
Looked After Children (LAC)	1	1	3	3	1	2	2	1	7
Safeguarding - BCP	12	12	0	0	2	2	0	0	14
Totals	62	60	41	43	20	21	2	1	125

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC or n/a *
NHS Constitution	46%	42%	42%	58%	13%	0%	0%	0%
Outcomes Framework	23%	23%	38%	31%	38%	46%	0%	0%
Mental Health	63%	61%	27%	27%	10%	12%	0%	0%
Safeguarding - RWT	46%	46%	54%	54%	0%	0%	0%	0%
Looked After Children (LAC)	14%	14%	43%	43%	14%	29%	29%	14%
Safeguarding - BCP	86%	86%	0%	0%	14%	14%	0%	0%
Totals	50%	48%	33%	34%	16%	17%	2%	1%



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



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
91.07%	91.50%	91.01%	91.09%	91.07%	90.80%	91.12%	91.23%	90.02%	90.26%			90.92%	92.00%

The performance for the headline Referral To Treatment (RTT - 18wks) Incompletes has seen an increase to 90.26% and has failed to achieve the 92% National Target, 92.1% STF Target and local recovery trajectory of 91.60%. When compared to the previous years performance, the validated National Unify2 figures show that there has been a 3.5% increase in the number of incompletes waiting (Jan17 = 90.59%, 2,929 breaches out of 31,110, Jan18 = 90.26%, 3,136 breaches out of 32,200). Failing specialties include: ENT (87.57%), General Surgery (86.79%), Ophthalmology (87.46%), Oral Surgery (79.90%), Plastic Surgery (70.56%), Trauma & Orthopaedics (87.05%) and Urology (84.28%). The Trust have submitted a Remedial Action Plan (RAP) which provides actions to improve performance by issue heading :

Waiting List Validation and Utilising : Daily and Weekly validations, reviews of patients on waiting lists, reviews of patients fit for surgery

Pathway Validation : Review of diagnostic waiting times and validation of all patients on the pathway to highlight errors and trends, forecast priority patients and identify bottle necks

Reporting/Monitoring : Continuation of inpatient prediction reports - show expected activity numbers, priority patients and current backlog with specialties to be issued with their own monthly trajectories to aid achievement of Trust compliance

Capacity/Demand : Day Case lists to continue on Saturdays, re-utilise all "cancelled/vacant" sessions and utilisation of Cannock theatres for appropriate cases

Training : E-learning competency/training package is to be agreed by the end of March 2018 and will be made mandatory for all PAS users with RTT responsibilities and access, departments with error trends as identified via the waiting list validation will receive 1:1 training. The Trust have confirmed that focus on reducing the backlog where possible and work closely with Directorates. Early indications are that the February performance has seen an increase to 90.38% and remains below recovery trajectory.

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%	91.55%	87.43%	87.03%	84.73%			90.81%	95.00%

The January performance has seen a decrease from the previous month to 84.73% and has failed to achieve the National Target (Type I and All Types) of 95% and the agreed 17/18 STF Trajectory for January of 92%. The performance can be split into the following : Emergency Department Type I (New Cross) - 73.80%, Walk-in Centre Type 4 - 100%, Cannock Minor Injury Unit (MIU) Type 3 - 100% and Vocare Type 3 - 93.90%.

When comparing the Nationally validated number of attendances from the previous year, there has been a 14% increase (Jan17: 18,368 - 86.36% compliance, Jan18: 21,016 - 84.73% compliance). The number of ambulance conveyances has also seen an increase of 0.6% (Jan17 = 4,142 , Jan18 = 4,166).

The daily number of attendances increased over the course of the month with an average of 362 attendances per day with the maximum of 431 attendances occurring on Monday 22nd January 2018. The Trust have submitted an Exception Report which confirms reasons for under performance as bed availability, issues with patient flow (decision making), ambulances arriving in batches (and therefore creating queues within the system) and, as nationally reported, A&E is under pressure across the country with the Trust feeling the same pressures and staffing capacity issues. Actions highlighted include : Bed meetings 3 to 5 times a day, Patient flow and first assessment (including improved signposting/triaging functions) and closer working with Vocare, actively recruiting for substantive Emergency Department consultants, daily discharge levels set across the Trust to ensure adequate patient flow and minimise breaches due to bed shortages and bed meetings 3-5 times a day. A new ambulance "offload" area has been implemented to replace corridor offload and a pre-admission bay opened to free cubicles of patients waiting for bed allocation. A phased implementation plan for a new Frailty Building sub department within the Emergency Department commenced in January with additional elements due to be implemented as the building is released for use. The Trust are to ensure that To Take Out's (TTO's - Prescription medication) and discharge summaries are completed as part of ward rounds with the proactive use of the discharge lounge.

Continued overleaf.

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_EB5

A&E performance continues to be discussed with the Trust at the A&E Delivery Board, Clinical Quality Review Meeting (CQRM) and Contract Review Meeting (CRM). The NHS National Statistics show that the January performance for the Royal Wolverhampton NHS Trust is above that of other local providers (The Dudley Group = 81.80%, Sandwell and West Birmingham = 82.51% and Walsall Healthcare = 76.39%) and the all Providers England Total = 85.28%. The West Midlands Ambulance service has reported a 9.5% increase in conveyances during January. Early indications are that February has seen an increase to 86.27% however remains RED, with the Trust reporting an escalation to level 4 (Emergency Management Solution highest grading) due to staffing gaps and potential safeguarding issues. The positive progress with Vocare continues with close working with both the Trust and Commissioner to move more activity from the Emergency Department to the Urgent Care Centre and alleviate pressure, this includes additional funding from the Commissioner for additional staff within Vocare.

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



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Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
94.59%	96.37%	95.02%	96.27%	94.21%	95.10%	97.47%	93.39%	53.06%	93.33%			90.88%	93.00%

RWT_EB7

The 2 week (breast symptoms) cancer performance failed to achieve the 93% target for the first time in December (reporting at 53.05%), however has seen a positive increase with January performance achieving 93.33%. The Year to Date is currently under target due to the low December performance. Compared to the previous year, there has been a 75% decrease in the number of patient seen during the month (Jan17 = 178 - 99.44%, Jan18 = 45 - 93.33%). The performance for this indicator is based on the number of women referred with breast cancer symptomatic symptoms (eg Cysts, breast pain etc) but not specifically cancer suspected, however is required to achieve the 2 Week Wait (2WW) rules and can be effected by referral numbers and activity for the 2WW Breast Suspected Cancer indicator (ref EB6). With the pressures of Christmas capacity (the same consultants see referrals for both EB6 and EB7 indicators) combined with patient choice issues and the significant increase in referrals with suspected cancer, the December activity and performance decreased significantly. The Trust have confirmed that the referral numbers for January have remained low, but capacity has returned to normal post-Christmas levels and therefore performance has seen a positive increase. Saturday clinics have been set up to replace lost activity due to the bank holiday season and monitoring of referrals is on-going to determine any area/practice trends and if a business case for additional resource is required. Early indications are that the February performance has increased to 95.33% and therefore GREEN.

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%	76.25%	76.04%	71.08%	70.12%			74.48%	85.00%

The performance for the 62 Day from Referral to 1st definitive treatment has failed to achieve both the 85% National target and the revised STF trajectory of 80% for January and has seen a decrease in performance to 70.12% in month (73.08% excluding tertiary referrals). The Trust have since confirmed via the Integrated Quality and Performance Report (IQPR) there were 28 patients that breached target during January (7 x tertiary referrals received between days 46 and 109 of the patients pathway, 6 x capacity issues, 10 x patient initiated, 1 x patient unfit for surgery and 4 x complex pathways. Of the tertiary referrals, none were received before day 42 (operating tertiary referral guidelines) and 3 were received after day 62 of the patient pathway and had therefore already breached standard. Analysis by Cancer site confirms the breaches are relating to : Head & Neck (5 breaches out of 7 - 28.57%), Colorectal (4.5 breaches out of 9.5 - 52.63%), Upper GI (1.5 breaches out of 3.5 - 57.14%), Urology (10 breaches out of 26 - 61.54%), Haematology (1 breaches out of 3 - 66.67%), Gynaecology (1.5 breaches out of 6 - 75.00%), Breast (1 breach out of 10 - 90.00%), Lung (0 breaches out of 2 - 100%), Sarcoma (0 out of 1 - 100%) and Skin (0 out of 12 - 100%). The Trust have submitted an exception report and an updated recovery plan to include the potential impact of the Sandwell and West Birmingham increase in referrals which will be reviewed on a monthly basis. The reasons for under performance : Late tertiary referrals, Radiology capacity (increased demand has put additional pressure on the service to delivery reports and scans in a timely manner), Gynaecology Service capacity and significant increases in referrals to Head and Neck. Details of any breaches over 104 days (that have been subject to a harm review) are discussed at the Quality Surveillance Group (QSG), specific reasons for the January breaches included : 13 x Capacity, 2 x Patient Choice, 4 x Clinical Complexity and 4 x Late Tertiary Referral.

The Commissioner continue to review the weekly extracts of the Cancer Patient Tracking List (PTL) for 62 Day Cancer Waits at Executive level, 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.

The Trust have been requested to submit tertiary referral updates to the Commissioner which are to include details of referring Trust and patient pathway waits. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and January performance has been confirmed as 70.66% (24.5 patients breaching target out of 83.5) and therefore remains RED.

Percentage of Service Users waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
94.74%	84.62%	78.57%	82.50%	86.49%	83.78%	100.00%	81.82%	72.41%	58.70%			82.36%	90.00%

The 62 Day referral from an NHS screening service performance for January has seen a significant decrease to 58.70% and is the lowest performance to date. This indicator is affected by low numbers of breaches impacting on a small cohort of patients. In January, 9.5 patients breached the 62 day threshold from a total of 23 patients (includes tertiary referral shared breaches). The Trust have confirmed that the breaches relate to: 7 x capacity issues and 3 x complex pathways (with performance excluding tertiary referrals = 63.64%). Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and the January performance has been confirmed as 60.00% (10 breaches out of 25). Initial indications are that performance has seen a significant increase in February to 92.31% and is therefore GREEN. The 62 Day Cancer waits continues to be a National issue and is to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 90%.

RWT_EB13

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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	0	0	0	0			10	0

This indicator has breached the Year End zero threshold for 52 week waiters due to the April and May breaches for Orthodontic patients. The M10 performance confirms that there were no patients waiting over 52 weeks during January, 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. The National validated data for January confirms that there is a Wolverhampton patient breaching 52 weeks at the Royal Orthopaedic Hospital (Birmingham) which is a Trauma & Orthopaedic specialty breach. This brings the Commissioner Year to Date total to 13. Early indications are that there are no further Trust breaches during February.

RWT_EBS4

All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
33	69	54	27	48	70	46	99	122	199			767	0

The Ambulance handover delays have seen a significant increase in breach numbers during January with 199 handover breaches out of 4,165 conveyances (confirmed by the West Midlands Ambulance Service) during the month. Compared to the same month in 16/17, there has been a 10% decrease in the number of breaches (Jan17 = 221 breaches, Jan18 = 199 breaches) . There has also been a 0.6% increase in the number of conveyances (January 16/17 = 4,142, January 17/18 = 4,165). Activity numbers for January confirm that there were an average of 134 conveyances per day, the highest number of 170 ambulance conveyances was reported on Thursday 4th January 2018. Ambulance conveyance breaches continue to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. Variations in breach numbers between the Trust and the West Midlands Ambulance Service have been raised by the Commissioner and discussions on the completion of reported Handover Times are ongoing.

The fine for all Ambulance breaches during the month is estimated at £105,800 (£39,800 for 30-60 minute breaches (£200 per breach) and £66,000 for > 60 minute breaches (£1,000 for >60 minute breaches). Early indications are that the February performance has seen a decrease to 102 breaches.

RWT_EBS7a

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%	27.22%	25.55%					30.80%	10.00%

The January performance for Appointment Slot Issues (ASI) indicator was not submitted as part of the Month 10 return, however has since been confirmed as 17.26% and therefore remains above the 10% National threshold, however has achieved the 20% recovery trajectory. The CCG Quality Team have confirmed that the Trust are currently meeting the locally agreed ASI trajectory as part of the National E-Referral CQUIN for 2017/18, however the CQUIN measures ASI rate per 1st Outpatient booking not the rate per Direct Booking Service (DBS) as per the Local Quality Indicator (LQR). The national CQUIN currently expires at the end of March 2018, if it is not extended the Commissioner are proposing to replace with a LQR that reflects the milestones in the CQUIN. NHS England are due to publish updated CQUIN guidance for 18/19 shortly. The Trust have previously submitted an exception report which confirmed that increased demands on services and reduced capacity in some specialties due to staff shortages affecting performance with Ophthalmology, Paediatrics, Urology and Orthopaedics the areas facing the biggest challenges. Planned actions included : Identification of routine clinic slots for conversion to e-RS slots, conversion of slots to match sub-specialty requirements and demands, service review to identify any e-RS service gaps and updating the Directory of Services accordingly and as part of the E-referral Service (ERS) Commissioning for Quality and Innovation (CQUIN) Scheme, work has been on-going with individual specialties to identify additional capacity and conversion to direct booking. The National Appointment Slot Issue report for January 2018 allows us to benchmark performance :

- Walsall Healthcare NHS Trust - 35.98 (884 issues out of 2,457 bookings)
- Sandwell and West Birmingham - 52.70 (3,139 issues out of 5,956 bookings)
- Dudley Group of Hospitals - 18.55 (1,160 issues out of 6,254 bookings)
- Royal Wolverhampton - 17.26 (918 issues out of 5,319 bookings)

The National performance (Acute Trusts only) for January has been confirmed as 18.89, with the West Midlands (Acute Trusts only) currently performing at 24.32.

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.

Early indications are that the February performance has seen an increase to 20.39% and therefore remains RED.

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*



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
100.00%	95.45%	92.31%	95.83%	100.00%	89.74%	91.89%	94.44%	90.63%	95.24%			94.55%	95.00%

The percentage of service users (under adult mental illness specialties on CPA) receiving a follow up within 7 days of discharge has achieved the 95% target for January (95.24%), however due to previous below target performance (September to December), remains below Year to Date (94.55%). Previously submitted exception reports provided by the Trust indicated actions taken to prevent future breaches. These included :
A daily monitoring process established and relevant team contacted to prompt a 7 day follow up with the inclusion of escalation plan to ensure any system failures are communicated to Community Staff.

All staff in planned and urgent care have been contacted to ensure that they are following process (in line with the SOP) and issues with the lack of patient details on discharge needs to be addressed.

Ward staff are to double check telephone numbers and addresses on patients discharge.

Performance continues to be monitored and raised at the Contract Review Meetings with the Trust.

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



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
80.33%	83.88%	87.07%	85.85%	85.08%	85.25%	83.64%	84.22%	83.81%	87.77%			84.69%	85.00%

The performance for the IPC training programme is based on a quarterly target of 85%, however figures are received on a monthly basis to monitor performance. The January performance has seen an increase to 87.77% and is the highest reported performance this year however remains below target Year To Date (84.69%). A joint Contract Performance Notice with Sandwell CCG has been issued and the following has been confirmed by the Trust :

BCPFT_LQGE06

Training is provided by online input, Electronic Staff Record (ESR) and a paper version for staff to complete. The paper version was introduced in October 2017, however results have been slow to take effect. The Rapid Improvement Group have been engaged to support actions and focus on the quarterly compliance of this indicator by March 2018. Early indications are that the February performance has achieved target.

People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,880 = 16.8% of prevalence.



Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
1.53%	1.68%	1.46%	1.35%	1.44%	1.41%	1.39%	1.13%	0.75%	1.42%			1.36%	1.40%
1.53%	3.21%	4.67%	6.01%	7.45%	8.86%	10.25%	11.39%	12.13%	13.55%			13.55%	16.80%

(Cumulative)

This indicator is based on the number of people entering treatment as a proportion of people with anxiety or depression (a local prevalence - 29,880) with a Year End target confirmed Nationally as 16.8% (in month 1.399%). Performance had seen a decrease from September to December (with Month 9 reporting the lowest performance to date of 0.75%) however, the January performance has seen a positive improvement to 1.42% and is therefore above the in-month target. Due to the decline over Quarter 3, the Year To Date remains below the cumulative target (13.55% against 14.00% target). Previously the Trust have been confident of Year End achievement, however due to continued vacancy issues (4 x Band 5 WTEs) are now forecasting a below target performance of 16.1%. Recruitment is a national issue which has seen newly qualifying staff immediately taking the next training step rather than remaining within current roles. The Trust have met with the Commissioner to discuss options available to increase the access rate with potential participation in community events across Wolverhampton to boost March performance to achieve the 16.8% target. The Trust will need to achieve a minimum of 486 patients per month (1.62%) for each remaining month to achieve the year end target of 16.8%. An access rate forecast has been developed to 2020/21 to highlight the number of patients required each month to achieve the staggered target (18/19 = 19%, 19/20 = 21%, 20/21 = 25%) and includes a breakdown of Long Term Condition (LTC) splits required as part of the annual targets.

BCPFT_LQIA05

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
4.88%	1.57%	4.11%	4.03%	3.18%	4.54%	3.89%	10.50%	13.69%	7.68%			5.81%	7.50%



The Delayed Transfers of care programme (DTC) has seen a reduction of delays since December with January reporting 7.68%, however remains below the 7.5% threshold. This performance relates to Wolverhampton only, the Sandwell performance has been confirmed as 2.24% and therefore remains GREEN.

As delayed discharges remain a National issue, performance will be monitored via the 2017/18 Local Quality Requirements and remain an agenda item on both the CCG's monthly performance call with NHS England (NHSE) and the Trust's CQRM meetings. The delayed discharges for Wolverhampton predominantly concern patients on the Older Adults Ward waiting placements. Placement difficulties (resulting in delays) include : sourcing of providers, awaiting provider assessments, placement availability and funding disputes between Health and Social Care. The Trust have submitted an exception report for the January performance which confirms the following actions to resolve the current performance :

A weekly bed state meeting is held with both Local Authority and Commissioner to discuss delays and potential delays in order to agree multi-agency plans.

The Local Authority have provided a dedicated social worker for Penn Hospital who can attend weekly reviews and engage with patients and Multi-Disciplinary Teams (MDT) earlier for placements/housing. The social worker is to instigate early assessments for less complex adult patients to prevent delays however this excludes older adult patients. From April 2017 there has been a change to the methodology used for the submission of the National DTC 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 January national figures have been confirmed as follows for the Black Country Partnership (all commissioners) :

NHS delay days = 33 and a 1.06 delayed bed day average (previously 0, 0.00 average)

Social Care delay days = 50 and a 1.61 delayed bed day average (previously 84, 2.71 average)

Both delay days = 111 and a 3.58 delayed bed day average (previously 173, 5.58 average)

Trust Total = 194 delay days and a 6.26 delayed bed day average (previously 257, 8.29 average).

6. RISK and MITIGATION

The CCG continually reviews its levels of risk and as anticipated, as the financial year progresses the level of risk diminishes as issues are built into the financial position. As a result the level of reported risk for Month 11 has reduced to £500k which is mainly within the Acute portfolio. A residual level of risk has been included in the Acute portfolio to cover for the impact on NEL activity as a result of the bad weather and fluctuating temperatures.

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)	396.171																						
REVENUE RESOURCE LIMIT (CUMULATIVE)	405.301																						
Acute Services	193.686	196.570	(2.884)	(1.5%)	(0.200)	(0.300)				(0.500)												(0.500)	
Mental Health Services	36.157	36.396	(0.239)	(0.7%)																			
Community Health Services	48.547	47.916	0.632	1.3%																			
Continuing Care Services	14.485	14.020	0.465	3.2%																			
Primary Care Services	52.374	52.658	(0.285)	(0.5%)																			
Primary Care Co-Commissioning	35.649	34.859	0.790	2.2%																			
Other Programme Services	9.737	8.482	1.256	12.9%											0.500					0.500		0.500	
Commissioning Services Total	390.636	390.911	(0.275)	(0.1%)	(0.200)	(0.300)				(0.500)					0.500					0.500			
Running Costs	5.535	5.260	0.275	5.0%																			
Unidentified QIPP																							
TOTAL CCG NET EXPENDITURE	396.171	396.171	(0.000)	(0.0%)	(0.200)	(0.300)	-	-	-	(0.500)	-	-	-	0.500	-	-	-	-	0.500	-	-	-	-
IN YEAR UNDERSPEND / (DEFICIT)	-	(0.000)	(0.000)	(0.0%)																			
CUMULATIVE UNDERSPEND / (DEFICIT)	9.130	9.130	(0.000)	(0.0%)																			

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	£9.630	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	£8.630	Adjusted risks and no mitigations occur. CCG misses revised control total

7. 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.

8. RECOMMENDATIONS

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

Name: Lesley Sawrey
Job Title: Deputy Chief Finance Officer
Date: 29th March 2018

Performance Indicators 17/18

Current Month:

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			
RWT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	RWT	92%	90.26%	R	90.92%	R	↑															
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	RWT	99%	99.24%	G	99.18%	G	↑															
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%	84.73%	R	90.81%	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%	90.79%	R	92.63%	R	↑															
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%	93.33%	G	90.88%	R	↑															
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%	95.36%	R	96.79%	G	↓															
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	RWT	94%	71.15%	R	87.54%	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%	98.39%	G	99.84%	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%	86.17%	R	97.01%	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%	70.12%	R	74.48%	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%	58.70%	R	82.36%	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	2.00	R	↑															
RWT_EAS5	Minimise rates of Clostridium Difficile	RWT	Mths 1-11 = 3 Mth 12 = 2	3.00	G	28.00	G	↓															
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	199	R	767	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	66	R	112	R	↓															
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	RWT	0	0	G	2	R	↑															
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%	96.10%	G	95.60%	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%	99.55%	G	99.79%	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%	99.09%	G	98.95%	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%	96.12%	G	95.19%	G	↑															
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%	86.42%	R	85.35%	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%	1.02%	G	1.51%	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	0.00	G	7.00	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	4.00	R	24.00	R	↓	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.94%	R	0.49%	G	↓	
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	90.50%	G	91.66%	G	↓	
RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	80.00%	G	84.00%	G	↓	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	71.43%	G	73.23%	G	↑	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	92.50%	94.11%	G	99.00%	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%	93.31%	R	92.76%	R	↓	
RWT_LQR29	Infection Prevention Training Level 2	RWT	95.00%	95.16%	G	94.98%	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%	99.05%	G	97.64%	G	↑	
BCPFT_EB54	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%	50.00%	G	77.50%	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%	93.14%	G	95.96%	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%	98.04%	G	99.80%	G	↓	
BCPFT_EB51	Mixed sex accommodation breach	BCP	0	0	G	2	R	↑	
BCPFT_EB53	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%	95.24%	G	94.55%	R	↑	
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%	92.86%	G	95.62%	G	→	
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge from secondary care. (NB: exclusions apply to patients who discharge themselves against clinical advice or who are AWOL)	BCP	100.00%	100.00%	G	97.79%	R	↑	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	72.73%	R	88.27%	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%	0.88	G	0.85	R	↑	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	97.22%	G	96.74%	G	↑	
BCPFT_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	BCP	95.00%	100.00%	G	99.71%	G	→	
BCPFT_LQGE11	Delayed Transfers of Care to be maintained at a minimum level	BCP	7.50%	7.68%	R	5.81%	G	↑	
BCPFT_LQGE12a	% of Crisis assessments carried out within 4 hours (Wolverhampton Psychiatric Liaison Service Emergency)	BCP	95.00%	99.19%	G	97.33%	G	↑	
BCPFT_LQGE13a	% of Urgent assessments carried out within 48 hours (Wolverhampton Psychiatric Liaison Service)	BCP	85.00%	100.00%	G	93.97%	G	→	
BCPFT_LQGE14b	% of Routine assessments carried out within 8 weeks (Wolverhampton Psychiatric Liaison Service Routine Referral)	BCP	85.00%	100.00%	G	98.29%	G	↑	
BCPFT_LQGE15	Percentage of SULs that are reported onto STEIS within 2 working days of notification of the incident	BCP	100.00%	100.00%	G	100.00%	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_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%	50.00%	R	90.00%	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%	100.00%	G	85.00%	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%	60.00%	G	58.41%	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%	93.14%	G	95.96%	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%	98.04%	G	99.80%	G	↓	
BCPFT_LQIA05	People who have entered treatment as a proportion of people with anxiety or depression (local prevalence) [Target - Special Rules - 29,880 = 16.8% of prevalence.	BCP	1.40%	1.42%	G	1.36%	R	↑	
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	99.03%	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	→	
BCPFT_EH9	The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period	BCP	30.00%	19.18%	R	17.53%	R	↑	
BCPFT_EH10a	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (0-19 year olds)	BCP	85.00%	0.00%	R	50.00%	R	↓	
BCPFT_EH11a	Number of CYP with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (0-19 year olds)	BCP	85.00%	100.00%	G	100.00%	G	→	
BCPFT_EH10b	Number of patients with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral (19 year olds and above)	BCP	85.00%	100.00%	G	100.00%	G	→	
BCPFT_EH11b	Number of patients with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (19 year olds and above)	BCP	85.00%	100.00%	G	100.00%	G	→	

WOLVERHAMPTON CCG

Governing Body Meeting 10th April 2018

Agenda item 9

Title of Report:	CCG Finance Plan and Budget for 2018/19
Report of:	Tony Gallagher, Chief Finance Officer
Contact:	Tony Gallagher, Chief Finance Officer
Finance and Performance Committee Action Required:	<input checked="" type="checkbox"/> Decision <input type="checkbox"/> Assurance
Purpose of Report:	<ul style="list-style-type: none"> • To appraise the Governing Body of the finance plan and budget for 2018/19, noting the risks inherent in the position • To seek sign off of the 2018/19 budget for the CCG.
Recommendations:	<ul style="list-style-type: none"> • To receive and discuss the report • To note the level of financial risk associated with the proposed 2018/19 budget. • Sign off the 2018/19 budget • Support the CCG's Executive Team to continue to pursue avenues to close the gap in the QIPP plan and therefore reduce the financial risk.
Public or Private:	This Report is intended for the public domain
Relevance to CCG Priority:	Strong Financial Management and sound planning and performance
Relevance to Board Assurance Framework (BAF):	Supporting and delivery of the strategic direction of the CCG
<ul style="list-style-type: none"> • Domain 1: A Well Led Organisation 	– impacting on whether the CCG:



	<ul style="list-style-type: none"> • has strong and robust leadership; • has robust governance arrangements; • secures the best value for money; and has effective systems in place to ensure compliance with its statutory functions.
<ul style="list-style-type: none"> • Domain2: Performance – delivery of commitments and improved outcomes 	<p>A key focus of assurance will be how well the CCG delivers improved services, maintain and improve quality, and ensures better outcomes for patients. This includes progress in delivering key Mandate requirements and NHS Constitution standards. The financial plan is set with consideration for the delivery of NHS targets (both constitutional and otherwise) and with a view to supporting the CCG’s work to improve outcomes for its population</p>
<ul style="list-style-type: none"> • Domain 3: Financial Management 	<p>A robust financial model is essential to the CCG’s success. This paper sets out the resources available to the CCG for 2018/19; detailing the financial risks and challenges that the organisation faces. Financial management capability and performance, including an assessment of data</p>



1. Purpose of the paper

The purpose of the paper is:

- To present to the F&P Committee the draft financial plan for 2018/19, noting adherence to the revised 17/19 planning rules
- To highlight the risks contained within the financial position.

2. Context and Overview

2.1 Health and Social Care Economy Overview

- There continues to be significant financial challenges within the Health economy particularly as the main acute provider, RWT moves to a deficit position and BCPFT remains financially challenged which is exacerbated by a period of considerable organisational change.
- The Local Authority remains under significant financial pressure following the announcement of significant savings targets over the next 5 years being £123m over 2015/16 -2019/20.
- The Sustainability and Transformation Plan (STP) has worked to “size the total gap” for the Black Country and give a better view of the economy-wide issues that will need to be overcome over the coming years. WCCG is playing an active part in the development of these plans.
- In March 2017 CCGs were required this year to submit plans for 2 years, 2017-19.
- In February 2018 NHSE issued revised planning guidance for 2018/19.

2.2 NHS Funding settlement

In late 2015 NHSE issued allocations where growth was loaded into year 1 to 5 of the 5 year plan. Allocations were designated as confirmed for 2017/19 and indicative for 19/21.

In February the CCG received an updated allocation for 2018/19 as follows:

Programme	£'000
17/18 notified	344,217
Growth	6,839
Notified Jan 2016	351,056
adjustments	
recurrent to M9 17/18	1,716
HRG4+	5,171
IR	(518)
NHSPS Market Rents	198
	357,623
Additional Growth	2,978
Total Programme	360,601
Delegated Primary Care	36,552
Running Costs	5,515
Total Allocation	402,668



Planning assumptions for 2018/19 Budgets

3.1 The revised planning guidance and National Tariff headlines reconfirms the following key elements and requirements for CCG plans:

- Tariff inflation 2.1%
- Tariff efficiency 2%
- HRG4+ incorporated into tariff
- Marginal Rate Emergency Tariff remains unchanged at 70%/30%
- Current Market Forces Factor, MFF remains in place
- STP growth assumptions to be used

For planning purposes the Long Term Financial Model (LTFM) has incorporated the 2017/19 National Tariff published December 2016 which includes the efficiency and inflation assumptions stated above. The CCG has applied such percentages to spend as detailed below.

ONS POPULATION STATISTICS - MOST LIKELY			Other Factors impacting on contract growth - MOST LIKELY		
Demographic Changes (%)	0.55%	0.58%	Demographic Changes (%)	0.55%	0.58%
Demographic Changes (population)	257.3	258.8	Demographic Changes (population)	257.3	258.8
	17/18	18/19		17/18	18/19
Prescribing	0.55%	0.58%	Prescribing	5.10%	4.00%
Prescribing Other			Prescribing Other		
Reserves			Reserves		
Mental Health	0.55%	0.58%	Mental Health	1.60%	1.50%
Mental Health Income			Mental Health Income		
Non NHS MH	0.55%	0.58%	Non NHS MH	1.60%	1.50%
LD	0.55%	0.58%	LD	1.60%	1.50%
Community Contracts	0.55%	0.58%	Community Contracts	3.10%	3.00%
Community Other	0.55%	0.58%	Community Other	3.10%	3.00%
Continuing Care spend	0.55%	0.58%	Continuing Care spend	7.70%	7.60%
Secondary or Tertiary acute care	0.55%	0.58%	Secondary or Tertiary acute care	1.80%	1.80%
RWHT	0.55%	0.58%	RWHT	1.80%	1.80%
West Midlands Ambulance	0.55%	0.58%	West Midlands Ambulance	1.80%	1.80%
ETO Reserve			ETO Reserve		
Running Costs			Running Costs	1.80%	2.10%
Other CCG spend(no inflation)			Other CCG spend(no inflation)		
Other Primary Care	0.55%	0.58%	Other Primary Care	4.35%	4.72%
Other CCG spend	0.55%	0.58%	Other CCG spend	0.95%	0.92%
INFLATIONARY ASSUMPTIONS -			EFFICIENCIES ASSUMPTIONS -		
	17/18	18/19		17/18	18/19
Prescribing	0.00%	0.00%	Prescribing		
Prescribing Other			Prescribing Other		
Reserves			Reserves		
Mental Health	2.30%	2.00%	Mental Health	-2.00%	-2.00%
Mental Health Income			Mental Health Income		
Non NHS MH	2.30%	2.00%	Non NHS MH	-2.00%	-2.00%
LD	2.30%	2.00%	LD	-2.00%	-2.00%
Community Contracts	2.30%	2.10%	Community Contracts	-2.00%	-2.00%
Community Other	2.30%	2.10%	Community Other	-2.00%	-2.00%
Continuing Care spend	0.00%	0.00%	Continuing Care spend		
Secondary or Tertiary acute care	2.30%	2.10%	Secondary or Tertiary acute care	-2.00%	-2.00%
RWHT	2.30%	2.10%	RWHT	-2.00%	-2.00%
West Midlands Ambulance	2.30%	2.10%	West Midlands Ambulance	-2.00%	-2.00%
ETO Reserve			ETO Reserve		
Running Costs			Running Costs		
Other CCG spend(no inflation)			Other CCG spend(no inflation)		
Other Primary Care	0.00%	0.00%	Other Primary Care		
Other CCG spend	0.00%	0.00%	Other CCG spend		



Growth has been based on two elements, demographic (ONS) projections as provided by Public Health, and non ONS projections derived from trend analysis and local knowledge, the resulting uplifts are detailed below.

3.3 In addition to the elements above the planning guidance sets out additional specific activity growth percentages which the CCG has modelled and funded from the additional growth allocation of £2.978m;

- Non Elective and Ambulance growth to be 2.3% above FOT at M6, after QIPP
- Growth in A&E to be 1.1% above FOT at M6 after QIPP
- Elective growth to be 3.6% above FOT at M6 after QIPP
- Outpatient growth to be 4.9% above M6 FOT after QIPP
- GP referrals to be 0.8% growth above M6 FOT after QIPP

The above assumptions will consume c £1.8m of the additional growth monies

Guidance on Business rules which will need to be met are as follows:

- Commissioners must plan for a cumulative reserve (surplus) of 1%
- Commissioners must plan to draw down all cumulative surpluses above the 1% in the next three years,
- The requirement for CCG's to underspend 0.5% of their allocation has been lifted and is to fund local pressures and transformation plans.
- The requirement to use a further 0.5% of the CCG allocation solely for non-recurrent purposes has been lifted.
- Commissioners must set aside an additional 0.5% as contingency,
- Better Care Fund plans for 2018/19 must explicitly support reductions in unplanned admissions and delayed transfers of care and national guidance is awaited,
- CCGs must maintain the Parity of Esteem for Mental Health Services by ensuring growth in spend is at least the same as overall allocation increase .
- CCGs should ensure that parity is achieved for Primary Care spend. This is a new target.

3.4 Within the plan for 2018/19 the CCG control total set by NHSE gives explicit permission for the CCG to deliver a further non-recurrent £1.3m in year deficit. The table below is an extract from the M9 LTFM and demonstrates the CCG's planned and in year positions and the reduction of the cumulative surplus to 1% of the CCG's allocation as per national planning rules.

Allocations for 19/20 onward remain indicative only.



PLANNING ASSUMPTIONS				
	17/18	18/19	19/20	20/21
	£m	£m	£m	£m
<u>Income</u>				
Allocation Forecast	386.9	387.0	402.7	408.2
Previous Year Carry Forward	10.4	9.1	8.0	8.1
Growth	6.8	15.7	5.6	19.6
	404.0	411.8	416.3	435.9
<u>Expenditure</u>				
Forecast Expenditure (LTFM)	394.0	403.9	407.9	423.9
Inflation	5.3	5.5	5.4	8.1
Efficiencies	-5.0	-5.3	-5.4	-5.6
QIPP Savings	-15.7	-13.9	-15.6	-17.0
Growth (Demographic plus other)	9.5	10.2	10.8	10.4
Cost Pressures	6.9	3.4	5.1	7.8
	394.9	403.8	408.2	427.6
In Year Surplus / (Deficit)	-1.2	-1.1	0.0	0.2
Cumulative Surplus / (Deficit)	9.1	8.0	8.1	8.3

3.5 NHSE has also introduced more rigour in testing that CCGs are achieving the Mental Health Investment Standard and the Primary Care Parity of Esteem. As such the CCG is required to increase its spending on such services by at least the same percentage as growth received. For Wolverhampton CCG the targets in 17/18 and 18/19 are 2% and 1.99% respectively. The CCG is anticipating achieving these percentages in its plan.

4. QIPP

4.1 In order to submit a balanced, assured plan for 18/19 the CCG has included a QIPP programme of £13.9m, 3.5% of its allocation. This is an extremely stretching target. The table below summarises the CCG QIPP challenge.



Scheme Title	Net 18/19 value (£s) [as included in CCGs financial plan i.e. CCG risk assessed value]	Recurrent/Non Recurrent
NHS Funded Care	£ 400,000	R
Neuro Rehab Tariff Change	£ 138,000	R
Targeted Peer Review	£ 437,909	R
Diabetes Right Care	£ 348,000	R
Respiratory Right Care	£ 578,000	R
Paediatric Right Care	£ 339,472	R
Prescribing	£ 1,743,000	R
OTC Prescribing	£ 250,000	R
Prescribing Hub	£ 140,000	R
Clinical Assessment Service CAS	£ 101,880	R
EPP	£ 20,000	R
Estates Voids	£ 100,000	R
Falls	£ 238,000	R
Care Closer to Home	£ 3,231,550	R
MSK	£ 330,000	R
Running Costs	£ 115,000	R
CDU	£ 500,000	R
BCF Cap	£ 500,000	R
Childrens Equipment	£ 30,000	R
C22 Top up	£ 200,000	R
MH in Acute setting (High Volume attenders)	£ 250,000	R
IC and NCA reduction in LOS and placements	£ 500,000	R
Stepdown	£ 300,000	R
Specific MH client moving to Tier 4	£ 450,000	R
reablement budget not required	£ 100,000	R
Dermatology	£ 163,265	R
Avoided Admissions	£ 250,000	R
Unidentified QIPP	£ 2,192,814	R
	13,946,890	

As at 9.2.18

The QIPP programme is currently split as follows:

	£	% of QIPP
Acute-NHS	6,751,076	48.4%
Community-NHS	307,000	2.2%
CHC	400,000	2.9%
Prescribing	2,507,000	18.0%
EPP	20,000	0.1%
Estates	100,000	0.7%
Running Costs	115,000	0.8%
Community Other	574,000	4.1%
Childrens' Eqpt	30,000	0.2%
Mental Health	950,000	6.8%
Unallocated	2,192,814	15.7%
TOTAL	13,946,890	



4.2 Delivery of the portfolio of QIPP schemes presents a significant challenge and risk to the CCG and the Programme Boards continue to develop and agree schemes to deliver the target (see risk section). The level of unidentified QIPP is 15.7% of the overall QIPP programme. The CCG has benefited from most of the “quick win” schemes and has now to be creative in developing solutions to bridge the gap. This will be challenging and although difficult is considered achievable.

5. Budgets and budget sign off

5.1 Within the LTFM and the recent planning submission the CCG has developed its budgets to meet the planning requirements.. Below is an extract from the March 18 plan submission confirming the CCG is meeting the financial metrics and Business rules.

Revenue Resource Limit		
£ 000	2017/18	2018/19
Recurrent	386,981	402,668
Non-Recurrent	7,923	1,542
Total In-Year allocation	394,904	404,210
Income and Expenditure		
Acute	194,390	198,094
Mental Health	36,584	36,422
Community	37,015	38,632
Continuing Care	14,178	15,095
Primary Care	52,615	52,611
Other Programme	19,631	19,275
Primary Care Co-Commissioning	35,149	36,368
Total Programme Costs	389,562	396,497
Running Costs	5,342	5,515
Contingency	-	2,197
Total Costs	394,904	404,209
£ 000		
Underspend/(Deficit) In-Year Movement	0	1
In-Year (RAG)	GREEN	GREEN
Net Risk/Headroom		-
Risk Adjusted Underspend/(Deficit)		1
Risk Adjusted Underspend/(Deficit) (RAG)		GREEN
Underlying position - Underspend/ (Deficit)	3,829	8,054
Underlying position - Underspend/ (Deficit) %	1.0%	2.2%
Contingency	-	2,197
Contingency %	0.0%	0.5%
Contingency (RAG)		GREEN
Notified Running Cost Allocation	5,535	5,515
Running Cost	5,342	5,515
Under / (Overspend)	193	-
Running Costs (RAG)	GREEN	GREEN
Population Size (000)	276.2	279.5
Spend per head (£)	19.34	19.73



5.3 Budgets are currently based upon the Month 9 forecast outturn. It is acknowledged that there may be some movement between M9 and M12 and as such in the sign off process a statement has been included for Budget Holders to confirm that any material changes incurred between months 9 and 12 will be reflected before budgets are uploaded to the ledger.

5.4 Running Cost Budgets

Budget Holders have been fully engaged in setting budgets, confirming their establishment and non-pay requirements.

5.5 Programme Budgets

Programme budgets have been calculated based on the planning assumptions and known changes. Other Healthcare budgets have been discussed with Budget Holders and are in the process of sign off.

6. Risk and Mitigations

6.1 The CCG has identified risks included within the 2018/19 budgets which total £3.5m. The key risks are as follows:

- £2.0m related to potential level of overspend in the Acute Sector. This is an estimate as the main Acute contract with RWT has not been finalised. A verbal update will be given at the meeting.
- £500k associated with Prescribing and the volatility within this budget particularly around NCSO and QIPP
- £1.0m in relation to the uncertainty around FTA's (Financial Transfer agreements) and the future of TCP for LD services.

6.2 The CCG has identified mitigations for risks as detailed below.

- £2.00m - as in 2017/18 the CCG will utilise all of the Contingency reserve to offset overspends if they arise.
- £1.5m of the 1% reserve

2018/19		RISKS (enter negative values only)						MITIGATIONS (enter positive values only)										TOTAL NET RISK / MITIGATION	OF WHICH: RECURRENT	CCG Narrative (Provide details of risks and mitigations)
CCG RISKS & MITIGATIONS	Plan	Contract	Efficiency	Performance Issues	Prescribing	Other	TOTAL RISKS	Contingency Held	Contract Reserves	Investment in Innovation	Further Efficiency Extensions	How Recurrent Measures	Deliver / Reduce Investment Plus	Other Mitigations	Potential Funding	TOTAL MITIGATIONS	£000	£000		
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
REVENUE RESOURCE LIMIT (IN YEAR)	404,210																			
REVENUE RESOURCE LIMIT (CUMULATIVE)	7,831																			
Acute Services	198,094	(2,000)	0				(2,000)										(2,000)	2,000	Risk of overperformance	
Mental Health Services	36,422		0			(1,000)	(1,000)										(1,000)	1,000	Risk of CCG requiring to cover FT process in TCP	
Community Health Services	38,632		0				0										0	0		
Continuing Care Services	15,095		0				0										0	0		
Primary Care Services	52,811		0		(500)		(500)										(500)	500	potential overspend and NCCO impact	
Primary Care Co-Commissioning	36,558		0				0										0	0		
Other Programme Service	19,275		0				0	2,000					1,500				3,500	3,500	hold 1%	
Commissioning Services Total	395,661	(2,000)	0	0	(500)	(1,000)	(3,500)	2,000	0	0	0	0	1,500	0	0	3,500	0	3,000		
Running Costs	5,515		0				0										0	0		
Underfunded QIPP			0				0										0	0		
TOTAL CCG NET EXPENDITURE	402,196	(2,000)	0	0	(500)	(1,000)	(3,500)	2,000	0	0	0	0	1,500	0	0	3,500	0	3,000		

6.3 As a consequence of the risks and mitigations the CCG starts 2018/19 with nil net risk.

	Surplus £m	
Most Likely Case	7.83	No risks or mitigations, achieves control total
Best Case	11.33	Risks do not materialise and mitigations achieved, achieves control total
Worst Case	4.33	No mitigations achieved but risks materialise CCG misses control total

7. CONCLUSIONS

Whilst the CCG financial plan for 2018/19 meets all the planning requirements and can withstand the mitigation of a certain level of risk there are still a number of



variables that, without their resolution, place undue additional risk on the position that may make it undeliverable. In summary these are:

- Risk associate associated with continued NCSO
- Future funding of TCP and potential impact on the Local Authority

8. RECOMMENDATIONS

- To **receive** and **discuss** the report

In particular;

- To **note** the level of financial risk associated with the proposed 2018/19 budgets.
- **Sign off** the 2018/19 budget
- **Support** the CCG's Executive Team to continue to pursue avenues to close the gap in the QIPP plan and therefore reduce the financial risk.

Name Lesley Sawrey
Job Title Deputy Chief Finance Officer
Date: 20th February 2018

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**WOLVERHAMPTON CCG
 GOVERNING BODY
 10 April 2018**

Agenda item 10

TITLE OF REPORT:	Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 20 February 2017
AUTHOR(S) OF REPORT:	Peter Price – Interim Chair, Audit and Governance Committee
MANAGEMENT LEAD:	Tony Gallagher – Chief Finance Officer
PURPOSE OF REPORT:	<ul style="list-style-type: none"> To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	<ul style="list-style-type: none"> To provide an update of the WCCG Audit and Governance Committee to the Governing Body of the WCCG.
RECOMMENDATION:	<ul style="list-style-type: none"> 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 Audit Plan 2018/2019

The Senior Internal Audit Manager had met with the Executive Team to discuss the plan and any concerns they may have. Information collated would be used to draft the plan. The final plan will be considered for approval at the next meeting.

1.2 Internal Auditor Progress Report

The Senior Internal Audit Manager reported that good progress on risk had been made since the last Audit and Governance Committee meeting. Other work around areas such as Information Governance was ongoing.

1.3 External Audit Plan

The first Draft External Audit Plan was shared with the Audit and Governance Committee for comment.

1.4 Draft Counter Fraud Plan

The Draft Counter Fraud Plan was shared with the Audit and Governance Committee.

1.5 Risk Register/Board Assurance Framework

The Audit and Governance Committee were presented with a paper that had also been presented to the Governing Body. They were also presented with the Updated Risk Management Strategy Meeting for approval.

Members felt that good progress was being made in this area.

1.6 Annual Governance Statement

The Corporate Operations Manager presented the Draft Governance Statement to the Audit and Governance Committee for comment. The statement included reference to changes in risk management and the impact of the cyber-attacks and the CCG response.

1.7 Draft Committee Annual Report

The Corporate Operations Manager outlined an approach to developing the report for 2017/18 following a similar pattern from last year in terms of format and themes. The Committee also approved the changes to the Terms of Reference.

1.8 General Data Protection Regulation (GDPR)

The Corporate Operations Manager presented a paper on the GDPR which will come in force in May 2018 and the steps taken by the CCG to ensure that the organisation was compliant.

1.9 Feedback to and from the Audit and Governance Committee and Wolverhampton CCG Governing Body Meetings and Black Country Joint Governance Forum

The Chair of the Audit and Governance Committee and Chair of the Black Country Joint Governance Forum updated respectively from each committee.

1.10 Final Accounts and their preparation plan including update on submission of Month 9 accounts

The Audit and Governance Committee were presented with the draft accounts by the Director of Finance and the Head of Financial Resources. Work was going to plan and on target to be submitted on 29 May 2018.

1.11 Losses and Compensation Payments – Quarter 2 2017/18

There was 1 loss and no special payments were reported in quarter 3 2017/18

1.12 Suspensions, Waiver and Breaches of SO/PFPS

There were no suspensions of SO/PFPS in quarter 3 of 2017/18

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

The Committee noted that as at 31 December 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: 20 February 2018

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)		



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WOLVERHAMPTON CCG
GOVERNING BODY MEETING
10 APRIL 2018

Agenda item 11

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 6 February 2018
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 6 February 2018.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	<ul style="list-style-type: none"> The Committee agreed to the report recommendation that the CCG commission the Pharmacy First Scheme for all patients until March 2019.
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 6 February 2018. This report provides a summary of the issues discussed and the decisions made at those meetings.

2. PRIMARY CARE UPDATES

Primary Care Commissioning Committee – 6 February 2018

2.1 Services Out of Area Registration Scheme Report

- 2.1.1 Ms Southall presented a report to the Committee highlighting that there is a gap in commissioning services for patients living in the Wolverhampton area but who live outside their practice boundary and are therefore deemed out of area. The following points were highlighted:

- 2.1.2 NHS England originally commissioned this service for CCGs, these arrangements end on 31 March 2017.

- 2.1.3 The requirement for the CCG to commission such a service was not identified during the 'Preparing for Full Delegation' process. The CCG became aware of the gap in summer 2017 and following liaison with a variety of colleagues identified that draft guidance dated January 2017 existed.

- 2.1.4 Based on NHS England guidance, a local service specification has been developed for consideration in order to address the current gap in commissioning.

- 2.1.5 The Committee granted approval for expressions of interest from Practices / Groups and other local providers to be obtained in order to address this gap in commissioning.

2.2 Pharmacy First Scheme for all Patients

- 2.2.1 Mr Patel presented a report to the Committee seeking approval for funding to commission the Pharmacy First Scheme for all age groups from April 2018 until March 2019.

- 2.2.2 The CCG currently commissions a service for over 16's, however the service for under 16's is commissioned by NHS England, which will be decommissioned on 31 March 2018.

- 2.2.3 The activity for patients over the age of 16 for 2016/17 was 2,750 consultations. The consultation cost was £5. Therefore the cost of the consultations for the year was £13,750. In addition, the drug costs were £7,999. Total cost of the service in the last financial year was £21,749.
- 2.2.4 The activity for patients under the age of 16 for 2016/17 were 3,852 consultations. The consultation cost was £5. Therefore the cost of the consultations for the year was £19,260. In addition, the drug costs were £10,991. The total costs for under 16s were £30,251.
- 2.2.5 The risks of not continuing to commission the service would place greater demand on the GP Practices, Urgent Care, Walk in Centres and the A&E Department.
- 2.2.6 It was noted that a total budget of £60,000 will be required and this will be split between the primary care budget and the prescribing budget. Primary care will fund the consultation costs and drug costs will be funded from prescribing.
- 2.2.7 The Committee agreed to the report recommendation that the CCG commission this service until March 2019 and requested an update in 6 months' time.

The Committee received the following update reports:-

2.3 **Governing Body Report / Primary Care Milestone Review Board Update**

- 2.3.1 The Committee were informed that the report presented had been shared at the December 2017 Governing Body meeting and is based on November 2017 activity. The following points were also highlighted:
- The Care Navigation face to face training took place on 24 January 2018 and the programme has now launched. The second cohort of pathways are currently being identified and discussed.
 - The plans for Extended Access / Winter Opening were noted as being in place and offered appointments to patients every day except Christmas Day and New Year's Eve. The Winter Pressures Scheme is funded by the CCG with an aim to increase the number of appointments available to patients during December 2017 – March 2018.

2.4 Primary Care Operational Management Group Meeting

2.4.1 The Committee were updated around the Primary Care Operational Management Group Meeting which took place on 22 January 2018. The following points were highlighted:

- In relation to estates development, some Practices are signing agreements to start work at the end of the financial year. There have been implications with NHS Property Services around leases and cost directives.
- Programme of ongoing Practice merges were shared and discussed.
- It was noted that the CCQ has undertaken a number of inspections to GP premises and that the report for Dr Fowler had been published which received a rating of 'good'.

2.5 Other Issues Considered

2.5.1 The Committee met in private to receive an approval request for the retirement and removal of a GP Partner from the contract of 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: 19 March 2018



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	19/03/18



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WOLVERHAMPTON CCG

Governing Body
10th April 2018

Agenda item 12

TITLE OF REPORT:	Primary Care Milestone Review Board
AUTHOR(s) OF REPORT:	Jo Reynolds- Primary Care Development Manager
MANAGEMENT LEAD:	Sarah Southall- Head of Primary Care
PURPOSE OF REPORT:	To provide an update on the activities that have taken place for two key programmes of work (Primary Care Strategy and General Practice Forward View) since the last report, presented to the Governing Body on 13 th February 2018.
ACTION REQUIRED:	<input checked="" type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This report has been prepared for consideration and discussion at the Public Governing Body Meeting.
KEY POINTS:	The Milestone Review Board last met in January and meets at quarterly intervals this report confirms the continued pace of progress being sustained in response to both the Primary Care Strategy & General Practice Forward View.
RECOMMENDATION:	<p>The recommendations made to Governing Body regarding the content of this report are as follows:-</p> <ul style="list-style-type: none"> • Receive and discuss this report, and the programmes of work contained within it. • Confirm ratification of the Primary Care Workforce Strategy in order for implementation to commence. • Note the updates provided for each work programme. • Accept 3 exceptions reported for the Primary Care Strategy work programme.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	<p>1a Improving the quality and safety of the services we commission 2 Reducing Health Inequalities 3 System effectiveness delivered within our financial envelope</p>



1. BACKGROUND AND CURRENT SITUATION

1.1 The CCG has developed two programmes of work to enable implementation of the Primary Care Strategy and General Practice Forward View. Both programmes have been in place since 2016 the content of both is largely attributed to national direction & local improvement that seeks to achieve a sustainable primary care for the future. A full programme management office approach is taken for the Primary Care Strategy the GPFV programme and has been developed over a period of time based on guidance from NHS England.

1.2 Reporting of the programme of work is to the Milestone Review Board on a quarterly basis. Task and finish groups in all of the areas are held on a monthly basis to ensure progress.

2.0 Primary Care Programme(s) of Work

2.1 Primary Care Strategy

Task and Finish Group Updates are captured routinely via a series of workbooks have been submitted to the Programme Office and will continue to be subject to review at monthly intervals.

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:-

Practices as Providers Task & Finish Group
<ul style="list-style-type: none"> • Targeted Peer Review has been implemented, with all groups holding monthly sessions by the end of March 2018. • Frailty Pilot Review : mid-term review undertaken, full benefits realisation to be undertaken at the end of the 12 month pilot. • Back Office Functions Review has concluded. • The Risk stratification specification has been put on hold whilst wider discussions on multidisciplinary team working take place. A workshop is due to take place which will provide further clarity of the future direction. • The Sound Doctor continues to be utilised and monitored. • A centralised commissioned services dashboard has been introduced for monitoring and is being used at group level and CCG meetings. • Primary Care Counselling Service : Contract has been awarded to Relate, the incumbent provider. Mobilisation is taking place to up scale the activity in line with new contract requirements.



Primary Care as Commissioners

- Movement within practice groups has been facilitated and all relevant processes adhered to.
- Targeted Peer Review meetings have been held, with the findings reviewed with Group Leads (March).
- Delivery plans for Improving Access have been submitted by all groups, all achieving the target of 100% coverage by October 2018
- Practice groups have formulated a shortlist of services they are exploring with a view to delivering at scale, delivery plans are currently being prepared.
- Continued engagement with PPG Chairs & promotional advertising for the wider public regarding improving access, care navigation etc.
- New process developed for identifying & developing enhanced services/ investment in General Practice.
- Group Budget Statements introduced for ongoing discussion at Group Meetings.
- Commissioned Services Payment Template and procedure has been introduced to improve the payments process.
- Commissioned Services Dashboard in place (includes data for Quarters 1-3)
- The Practice Groups are regularly receiving group level data and are considering QOF report monitoring and other performance indicators.
- QOF+ Scheme has been developed and comments being sought from Group Leads, LMC etc.

Workforce

- Extensive programme of work continues to be deployed with oversight from the responsible Task & Finish Group.
- Primary Care Webpage continues to be developed, particular focus on recruitment & General Practice vacancies. A series of three Wolverhampton videos have been developed for use on the website and other promotional activities.
- Promotional activities have taken place with partner agencies, such as recruitment fayres, online advertising and increased presence on Linked In as a recruitment platform.
- Continued delivery of extensive programme of training for Admin & Reception staff, Practice Managers.
- HCA Development programme agreed & Practice Nurse Training Programme continues to be delivered in line with the Practice Nurse 10 Point Action Plan.
- Explored opportunities for introducing apprenticeships in primary care.
- Continued partnership working with stakeholders including Wolverhampton University, Royal Wolverhampton Trust & Health Education West Midlands, Black Country STP and NHS England.
- *The Primary Care Workforce Strategy is attached for ratification by the Governing Body.* Once the strategy has been ratified by the Governing Body this will move into the implementation stage and form part of the Task and Finish Group programme of work.
- STP Workforce Strategy which includes information about Wolverhampton has been partially assured by NHS England, an implementation plan will be developed to demonstrate how the strategy will be realised.
- The benefits realisation of all the training programmes delivered within the year is currently being undertaken. The findings/outcomes are due to be reviewed in March.
- Clinical Education Provider Network continues to increase numbers of mentors and placement sites.



<ul style="list-style-type: none"> • The Team W programme changes have been discussed by members and new programme will commence from April 2018. • Workforce data collection continues to take place, a citywide workforce dashboard will be available in March.
<p>Contracting Task & Finish Group</p> <ul style="list-style-type: none"> • Primary Care Contracting Strategy is currently being developed by the Task and Finish Group. • The Primary Care Advice, Support and Transformation Team (PCAST) Memorandum of Understanding has been agreed, which means that NHS England will carry on providing the same service into 2018/2019. • NHS England will continue to commission Direct Enhanced Services in 2018/2019. • Feedback received from the System Redesign and Contract Framework Group regarding Risk Gain share approaches across the Black Country have been considered by the Task and Finish Group and will form part of future discussion and contract arrangements.
<p>IT Task & Finish Group</p> <ul style="list-style-type: none"> • Shared Care Record - Funding from NHS England approved and quote received from Graphnet to continue development of the solution. • The migration planning and preparation has commenced for Dr Cowen's with a go live date scheduled for May 23rd 2018. • The Project Manager to deliver E-Consultations is now in post and has commenced development of project documentation to deliver online triage and video consultation within practices identified to participate in the pilot. • A schedule has been developed for facilitators to visit practices during March and April 2018 to encourage the uptake of patient online. • A review of activity and usage for Sound Doctor will be taking place.
<p>Estates Task & Finish Group</p> <ul style="list-style-type: none"> • North East BCF locality has a potential base identified the option is being discussed and driven through the Wolverhampton Local Estates Forum which has representation from The Council, Wolverhampton CCG, Royal Wolverhampton Hospital Trust and Black Country Partnership Foundation Trust. • ETTF developments are still awaiting lease sign off with NHSPS. There has been an agreement on the type of lease that will be offered however, practices are yet to receive leases to sign. Practices continue to work with NHSPS and meetings have been on-going with CCG support.

The Primary Care Milestone Review Board are due to reconvene in April and will review progression of the programme and forward plans for delivery that is anticipated in 2018/19.

There were however, 3 exceptions identified in February 2018 that deviate from anticipated completion dates defined in the wider programme of work, these include:-

Practices as Providers	<p>Home Visiting Service – Delay in finalising the service specification (December 2017) completed and approved by Primary Care Commissioning Committee in March 2018.</p> <p>The exception report advises that the pilot is anticipated to commence in May 2018, later than expected this has been further revised to June 2018.</p>
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General Practices as Commissioners	Enhanced Services at scale proposal - as a result of services being identified at group level the original timescale was partially achieved however delivery of preferred services will not be confirmed until later in April in line with the submission of delivery plans for the 2018/19 Transformation Fund. A revised completion date for this piece of work is 30 April 2018.
Estate Development	Primary Care Estates – Further delays experienced involving cohort 1 practices (ETTF bids) should completed by 1 April 2017. A new time scale of March 2019 for completion of these projects is anticipated.

2.2 General Practice Forward View

The forward view comprises of 5 strands of work spanning investment, workforce, workload, infrastructure and care redesign. Currently the programme has 85 projects defined these are reflective of the five chapters but also align with some of the work that had been identified within the CCGs Primary Care Strategy Programme of Work. By way of an overview the current programme has been broken down as follows:

GPFV Programme of Work	
Chapter	Total Number of Projects
1 Investment	7
2 Workforce	27
3 Workload	25
4 Infra-structure	21
5 Care Redesign	5
Total(s)	85

Appendix 1 provides a more detailed assessment of the full programme of work by chapter, in a self-assessment format providing an indication of individual project status and progress being made spanning all 5 chapters of the GPFV.

Many of the projects overlap with the work of some Task and Finish Groups, some have been completed many are now in progress.

2.2.1 General Practice Five Year Forward Live Project Updates;

Care Navigation

Care Navigation is now in practice; practices are navigating patients to the five points and recording their interactions on the clinical system.

Training sessions continue to be rolled out at practice level, and online training continues to be available to new personnel and those who were unable to attend in December/January.



Preparation for phase 2 underway this will enable further navigation points to be identified and included, these will be launched by July with staff, service user & stakeholder engagement throughout.

Online Consultation

In response to the availability of national funding a pilot project is due to take place which will enable both online consultations and video communication. Both projects are anticipated to be live by May 2018.

Practice Manager Training

Four practice managers have commenced the Practice Manager Diploma course in February, with a further 6 practice managers being accepted onto June and October cohorts. Additional support has been given to all candidates from Wolverhampton with sessions being held with tutors to understand the course requirements and a peer support network being established.

Additional funding has been received to support practice manager development and allocated as follows:-

- Practice Manager training sessions in employment law, Contract Management & Governance, Finance, Workforce Planning & Design
- 2 day coaching and mentoring workshop
- Fine tune your appraisal skills 2x half day workshops
- PM forum/ framework being developed

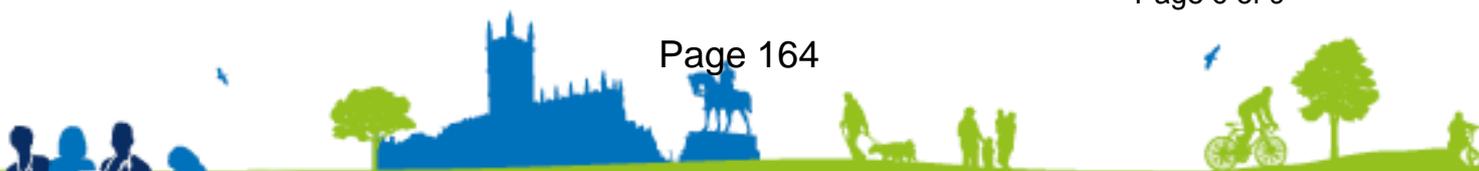
Improving Access

Delivery plans have been submitted by all groups in response to the access requirement set out in the Improving Access Specification. Negotiations are currently taking place with practice groups to determine if an earlier implementation of 100% coverage could be achieved before October 2018. Practice Groups had already planned this locally, so there is minimal change required for Wolverhampton. Additional funding has now been offered to move the inception of 100% coverage closer.

From April 2018 all practice groups will provide additional appointments, commencing over the Easter break. This has been promoted and publicised in local press and at group level & with Patient Participation Group chairs when they met earlier in March.

Transformation Projects 2018/19

Delivery plans are currently being prepared by practice groups to demonstrate how they will improve patient care / service delivery within their practice group(s), delivery plans are due by the end of April & projects anticipated to be up and running by the end of June. The delivery plans will also focus work pertaining to the 10 high impact actions and working at scale. Six of the high impact actions have been implemented in 2017/18 and will be maintained on an ongoing basis. The remaining 4 high impact actions will be implemented during 2018/19.



Two Way Texting (Mjog)

Two-way text messaging functionality is now installed in all practices. This will provide opportunities improved communication between practices & their patients. This will be used for obtaining feedback from patients, appointment reminders, appointments not attended and other messages relating to health and promotional campaigns.

Workflow Optimisation

Workflow optimisation is a training programme for clerical and administrative staff, to enable them to gain the skills and knowledge to effectively code and input correspondence onto the clinical system.

A specification has been drafted for this, and is currently going through the approval process. Once agreed, a procurement process will be followed with planned start date of June 2018.

2.3.7 Team W

Professional development is part of the GP forward view & as part of the CCGs ongoing commitment to protected learning time for it's GP's Team W has been reviewed. Following a series of discussions with GP colleagues a revised format and change of frequency will be introduced from April 2018. Sessions will be quarterly, partially focussed on mandatory training and will also incorporate other roles within the practice e.g. clinical pharmacists.

2.3.8 Pharmacy Peer Group

Representatives from a range of pharmacy settings met for the first time in March to explore how they can work better together to support patients at each stage in the care pathway. A series of priorities have been identified and 3 specific projects are due to commence shortly to begin work to improve patient experience and clinical effectiveness. Regular meetings will be taking place, the next meeting will be held in May.

2.4 Primary Care Workforce Strategy

A golden thread throughout both programmes of work is the availability of a suitable and sufficient workforce. A Primary Care Workforce Strategy has been developed to underpin achievement of a sustainable workforce for the future. The Workforce Task and Finish Group have been sighted on the development of this strategy and have provided a range of comments that have been incorporated into the document attached. Wider discussion has also been held with GP colleagues and Governing Body members too.

The final draft document is attached for approval, a detailed implementation plan and programme of work accompany the document. Governing Body should consider and confirm their endorsement. The strategy seeks to deliver our vision to ensure we have a sustainable primary care in Wolverhampton that is built around the needs of our population, which has the skills, knowledge and values to transform at scale and deliver high quality care.



3 CLINICAL VIEW

3.1 There are a range of clinical and non-clinical professionals involved in the delivery & oversight of both primary care programmes of work. Leadership decisions are clinically driven with representation at many Task and Finish Groups from clinicians from across the city.

4 PATIENT AND PUBLIC VIEW

4.1 The CCG has lay member involvement in a range of projects and forums pertaining to primary care. Patient Participation Group Chairs receive regular updates from the primary care team regarding up and coming projects & developments, their feedback is encouraged & valued. Plans are being finalised for engagement arrangements with the public for 2018/19, these will be underpinned by the CCGs Communications & Engagement Strategy.

5 RISKS AND IMPLICATIONS

Key Risks

5.1 The Milestone Review Board, who oversee this programme of work, 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.

Financial and Resource Implications

5.2 At this stage there are no financial and resource implications to consider, the resources needed have been discussed in the appropriate task and finish groups and at Milestone Review Board. All financial commitments have been allocated within the scope of the Primary Care resources, and finance colleagues are aware of the implications.

Quality and Safety Implications

5.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The quality team will be engaged accordingly as service design 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. The workforce task and finish group tracks the progress and effectiveness of the role.

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 Jo Reynolds
Job Title Primary Care Development Manager
Date 23/03/2018

Governing Body
10th April 2018



Appendix 1 GPFV Programme & Self Assessment 2018/19 (updated March 2018)

Appendix 2 Primary Care Workforce Strategy, Programme of Work & Implementation Plan

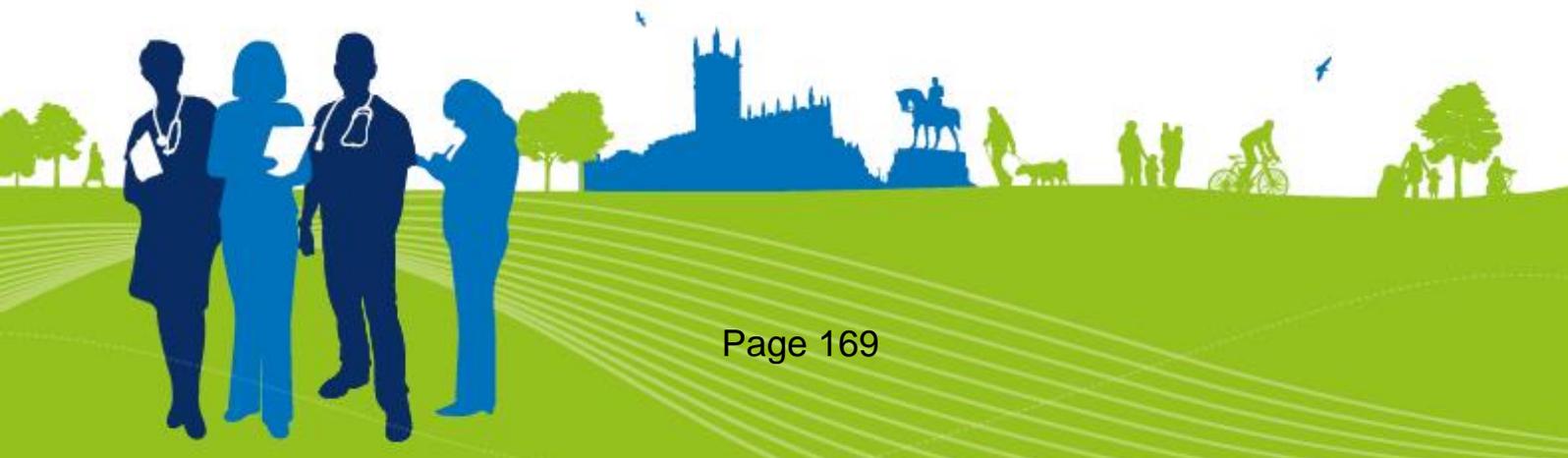
	Details/ Name	Date
Clinical View	S Reehana	
Public/ Patient View	S McKie	
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team	S Roberts	
Equality Implications discussed with CSU Equality and Inclusion Service	NA	
Information Governance implications 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)	S Marshall	29.3.18



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Draft – Wolverhampton CCG

Primary Care Workforce Strategy



DOCUMENT STATUS:	Draft for approval
DATE ISSUED:	12th January 2018
DATE TO BE REVIEWED	By January 2020

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
1	21/11/17	Comments from Task & Finish Group
2	30/11/17	Comments from Governing Body
3	February 2018	Final Draft for Approval at February Governing Body

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION
Workforce Task and Finish Group Leads		21.11.17	1
Governing Body		04.12.17	2
Workforce Task & Finish Group Milestone Review Board	Workforce Programme of Work Workforce Programme of Work	January 2018	3

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Workforce Task and Finish Group	30.11.17	V2
Governing Body via enclosure with Primary Care members monthly report	11.12.17	V2
Workforce Task and Finish Group	16.01.18	V3
Milestone Review Board	18.1.18	V3
Governing Body	13.2.18	V3

DISTRIBUTION

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Distributed To:	Distributed by/When	Paper or Electronic	Document Location
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Group Leads	Pending approval	Electronic	
Milestone Review Board	Pending approval	Electronic	

DOCUMENT STATUS

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS

These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION
		STP Workforce Strategy	
		Programme of Work	

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Introduction

The General Practice five year forward view (DH 2016) sets out a programme of work on how general practices can aspire, change and develop to deliver a new model of care. It outlines actions to support and develop the evolving workforce. The plan aims to achieve a net increase of 5000 WTE GP within the 5 year plan. Further development to fund new roles that include mental health therapists and clinical pharmacists in general practice. Development monies for practice nurses, physician assistants, receptionists and practice managers will be made available. The vision for Primary Care in Wolverhampton is to deliver universally accessible high quality out of hospital service that promotes health and wellbeing of our local community ensure that our population receive the right treatment at the right time and in the right place reduce early death and improve the quality of life of those living with long term conditions: and reduce health inequalities. (Primary Health Care Strategy 2016-2020) To have a workforce that is sufficient, responsive and adaptable and puts the patients at the centre of their care is the key to our success as a CCG. The right and sufficient workforce is an enabler for delivery of all new solutions for health care provision, paying particular attention to meeting patient expectations of access and care closer to home, with increased integration of service and greater provision of service over weekends and out of hours.

The workforce strategy provides a clear vision and objectives for the CCG which will align with the Strategic Transformation Plan.

Our focus is on the training and education of new and existing staff, recruitment to existing and new roles, retaining the skilled people that we have, coupled with managing demand and embracing a culture fit for the future we will change service delivery and meet the demand.

National Context

Over 90% of all contacts with the NHS occur within general practice, with the average member of the public seeing a GP six times a year, double the number of visits of a decade ago. Increasing demands have been placed on general practice, in part due to the growth in our population who are living longer, with more complex multiple health conditions. This has been compounded by a reduction in the proportion of funding for primary care and a lack of growth in the primary care workforce relative to the increase in demand.

By 2021, in excess of one million people are predicted to be living with dementia and by 2030; 3 million people will be living with or beyond cancer. By 2035 it is predicted that there will be an additional 550,000 cases of diabetes, 400,000 additional cases of heart disease and the number of people with multiple long term conditions will increase from 1.9 million in 2008 to 2.9 million by 2018. 18 million patients are estimated to suffer from a chronic condition, with the majority of these individuals being managed by GPs. Approximately 53% of patients in England report having long term health problems, many of which will have been treated by GPs as part of their care.

Within this context, the pressures on general practice will not reduce in the foreseeable future and therefore an immediate renewed focus on general practice has been required.

Five Year Forward View

Published by NHS England in 2016 the Five Year Forward View sets out a plan to stabilise and transform general practice through additional investment and support in relation to workload, workforce infrastructure and care navigation.

The Forward View acknowledges the need for a suitably skilled workforce to deliver these new models of care.

NHS England is investing £500 million in a national sustainability and transformation package to support GP practices, which includes additional funds from local clinical commissioning groups (CCGs).

It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development program to speed up transformation of services. They will be committing to an increase in investment to support general practice over the next five years.

The plan was developed with the Royal College of General Practitioners (RCGP) and Health Education England (HEE) and contains over 80 specific, practical and funded steps to:

- channel investment
- grow and develop the workforce
- streamline the workload
- improve infrastructure
- and support practices to redesign their services to patients

Our local implementation plan has been developed and approved by NHS England and is well underway.

Local Context

Wolverhampton has a model based on practices working in groups. The types of primary care groups currently operating are as follows:-

Both primary and secondary care and senior managers are committed to the following principles to pursue a Wolverhampton approach to Accountable Care.

Our proposals for an Accountable Care Alliance are set out in a Draft Prospectus and negotiations among stakeholders continue to take place. The vision for Primary Care is that it will be delivered at scale, across multidisciplinary integrated teams, 7 days per week offering prevention and treatment services.

Our strategy must be clinically led. The clinical workforce must be deployed effectively across the health system, removing artificial distinctions between “primary” and “secondary” clinicians. We will support the professional development of all existing staff. There is strong clinical support across the health system to work in this way

- We will create shared governance across the parties which will provide system leadership
- We will provide a clear vision for our system that will be our joint public commitment and hold ourselves mutually accountable for delivering this
- The alliance partnerships work will be patient-centred. We will focus services around the patient, developing innovative unified pathways that provide a more consistent quality of care across Wolverhampton
- We will shift resources from hospital to out of hospital services so that more patients are supported proactively in their home and communities
- We will focus on health, developing our approach to health promotion and disease prevention to support the wellbeing of our communities alongside the care that we already provide
- We must be financially sustainable, making the best use of the resources that we have collectively. This will mean amending the current payment methods as they do not always incentivise best practice

Vertically Integrated (VI) Practices

VI Practices are aligned to Royal Wolverhampton Hospital Trust. The model is one where a sub-contracting arrangement is in place between the named GP on the contract and the Trust. The principle behind this model is that care between the acute trust and primary care is better integrated, with patient pathways improved through being one organisation. There are currently 8 practices within Wolverhampton tied into this model.

Primary Care Home (PCH) Groups

The structure of the Primary Care Home Group model is based on National Association of Primary Care (NAPC) guidance. PCH groups work towards an integrated workforce, with a strong focus on:

1. Partnerships spanning primary, secondary and social care:
2. A combined focus on personalised care with improved population health outcomes.
3. Aligned clinical and financial drivers through a unified, capitated budget (a budget calculated per person) with appropriate shared risks and rewards.

4. Provision of care to a defined and registered population of between 30,000 and 50,000.

Medical Chambers

Medical Chambers follows this guidance, but operates under a MOU (Memorandum of Understanding) rather than forming a company limited by guarantee, as the home groups have done.

Wolverhampton currently has two primary care homes operating as Limited Companies. This constitutes 17 member practices aligned to the two PCH groups who work in line with NAPC Guidance to actively implement the Primary Care Home model. There are a further 18 practices also following NAPC Guidance who have chosen to form 2 Medical Chambers, each group is functioning in line with an agreed memorandum of understanding. A further 8 practices are aligned to the Vertical Integration Model; one of the contracts is an APMS that is held by the trust in a caretaking capacity. The remaining 7 practices have chosen to sub contract their GMS Contract(s) to the trust and operate in line with an integration agreement.

By following this model, primary care groups are better positioned to be working at scale, sharing workforce, and better positioned to develop teams within the group.

The CCG are committed to investing in Primary Care and General Practice to deliver the national benchmark to ensure that we have a sustainable PC.

Black Country STP

General Practice is the foundation of the NHS, but services are under significant pressure both locally and nationally. In order to address this issue, NHS England through the General Practice Forward View (GPFV) has set out an ambitious Strategy for General Practice focusing on 5 key areas - care redesign, workforce, workload, investment and infrastructure to increase the sustainability.

Black Country STP is made up of five places across four CCGs, with a population of 1.4 million and 236 GP practices providing care to our patients. The STP is one system, with one single strategy having 4 strong identities within it. Our Vision for Primary Care is that it will be delivered at scale, across multidisciplinary integrated teams, 7 days per week offering prevention and treatment services to reduce demand, integrated with partners and our Local Authorities.

The STP Primary Care Workforce Strategy sets out our vision for the workforce in General Practice and describes in detail how the STP and the LWAB will support and equip member practices with the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our local population: Recruit – Retrain and Transform.

Across the Black Country, 236 practices support over 1.4 million patients. Detail regarding disposition of age profiles for GPs as shown below.

Number of GPs and practices across Black Country STP

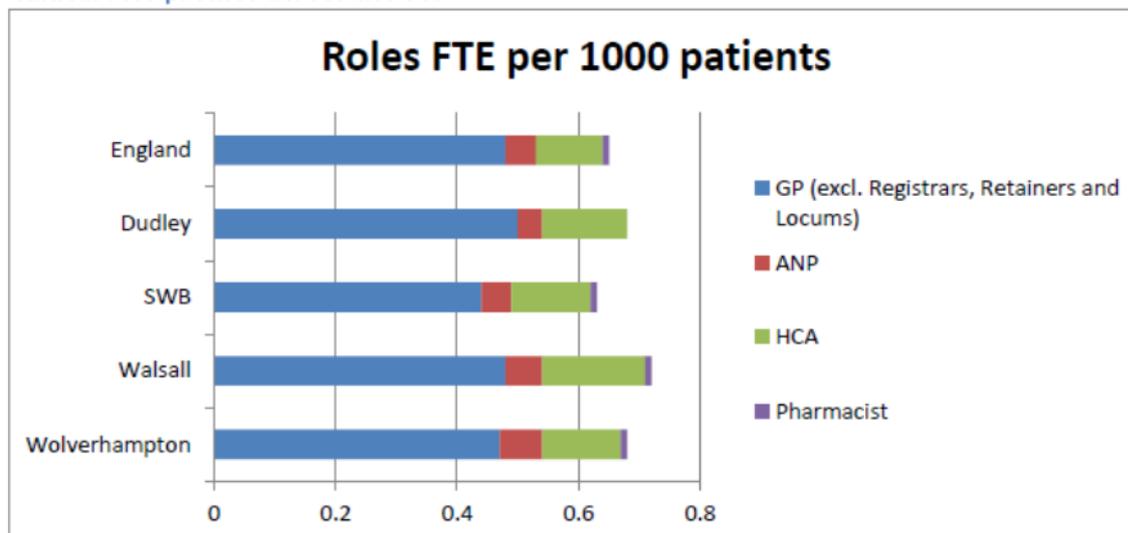
	Practices	Patients	GP Headcount	GP Headcount aged 55 or over	GP Headcount aged 60 or over	GP FTE
NHS Dudley CCG	45	318335	192	45	18	155.4
NHS Sandwell and West Birmingham CCG	88	563794	339	91	68	245.5
NHS Walsall CCG	59	283267	194	49	33	147.3
NHS Wolverhampton CCG	44	277006	157	31	17	133.3
Black Country STP	236	1442402	882	216	136	681.6

Further comparable data highlights the position of Wolverhampton within the local STP.

Patients per role FTE – taken from NHS Digital practice level indicators data

	GP (excl. Registrars, Retainers and Locums)	Nurse (incl. ANP)	ANP	HCA	Pharmacist
England	2,074	3,753	20,578	8,904	111,248
Dudley	1,984	3,659	23,039	7,286	504,915
SWB	2,282	3,884	20,128	7,887	85,409
Walsall	2,099	3,271	16,541	5,907	118,313
Wolverhampton	2,143	3,680	13,619	7,758	142,489

Clinical role profiles across the STP



Clinical roles FTE per 1000 pts

	GP (excl. Registrars, Retainers and Locums)	Nurse (incl. ANP)	ANP	HCA	Pharmacist
England	0.48	0.27	0.05	0.11	0.01
Dudley	0.50	0.27	0.04	0.14	0.00
SWB	0.44	0.26	0.05	0.13	0.01
Walsall	0.48	0.31	0.06	0.17	0.01
Wolverhampton	0.47	0.27	0.07	0.13	0.01

The Accountable Care System (ACS) involves leadership from all 18 STP partners focusing on delivering both strategic and operations transformation of the health and care system. Working together will ensure the future sustainability of the system through the local integration of health care.

Initiatives for Workforce Development

Practices coming together to form larger partnerships that, in turn, afford greater resilience to deliver through developing a shared workforce, underpinned by the range of new roles practices are being encouraged to adopt.

The Resilience Programme that has been used as a means to prevent practices falling over and planning for perceived shortfalls in delivery of their contract. Access to national allocations for this programme is helping practices to plan to prevent failure & alert CCGs to the need for help sooner. Learning from these events should also factor so that across the STP we are helping practices to identify what can go wrong, how to avoid it and to recognise how such problems can be mitigated

HEE Modelling suggests a gap of 222 GPs, 26% of anticipated demand by 2020. This modelling is based on assumptions of retirement of all GPs aged 55 and over within the next four years. A caveat to this is that there is a difference of 27.1 FTE GPs between the HEE baseline modelling and the June 2017 NHS digital experimental data. The local CCG Workforce data analysis suggests that no all GPs will retire within 4 years if aged 55 or over. The Black Country STP share is 127 GPs.

The HEE forecast supply modelling suggests 196 cumulative retirements by 2020 identified from a baseline assumption of 100% of GPs over 55 retiring. The HEE modelling allows for 80% of the over 55s retiring -157 retirements. The 80% assumption is more strongly supported than the 100% assumption based on previous analysis by the CCGs.

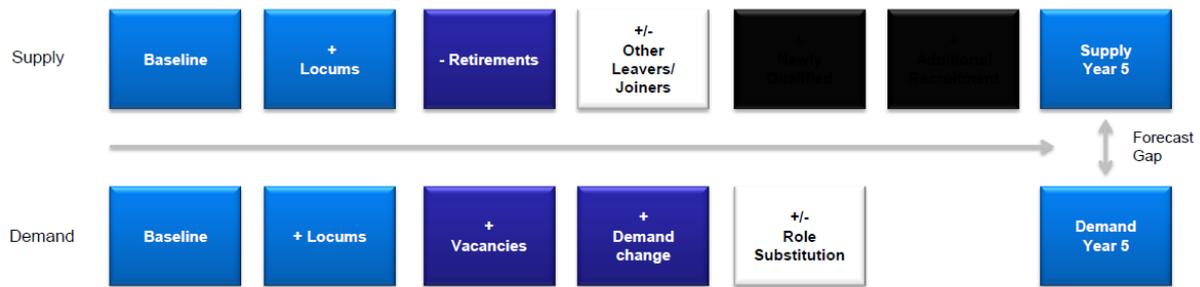
Our workforce dashboard will capture a clear picture of turnover of GPs and Practice Nurses to ensure that we are proactive in replacing and sustaining capacity within the general practice team.

Workforce Supply and Demand

NHS Digital workforce returns at practice level indicators together with HEE Midlands GP Supply forecast (September 2017) provided the workforce picture for the STP. However, there are reservations around accuracy of the workforce picture that this presents, including the age profile and assumptions based thereon.

Wolverhampton CCG have developed a workforce dashboard to capture the true workforce picture and have sight of the changes on a month by month basis to enable accurate planning and delivery of service to include clinical and non-clinical roles.

The dashboard will be monitored by the Group Manager(s) to ensure accuracy of data and continued compliance. This is a priority for group level meetings/board meetings and that where vacancies are foreseen that the respective group consider how they are replaced and the practice remains resilient.



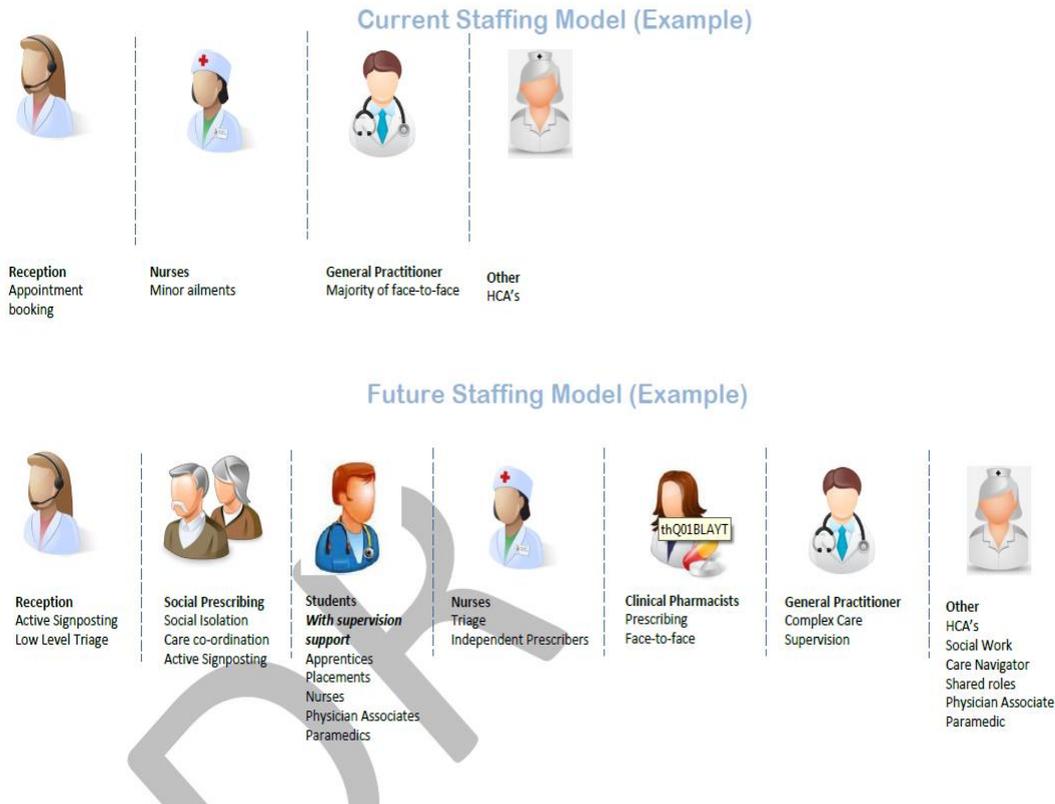
This must be owned at Group level through the upkeep of the workforce dashboard.

Our Vision

Our shared vision with recommendations from the GPFV 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

Our program of work sets out our robust plan to introduce the new roles that will lead to delivering our strategy.

As practice groups mature and the wider accountable care model develop the employment of personnel may not necessarily be by individual practices. A variety of employment opportunities can be explored including a nominated practice within a practice group or a joint venture organisation will provide expertise and may be a more cost effective solution to share the risk of employment as workforce structures develop across health and social care.



Our vision will be achieved through delivery of the Workforce programme over the coming years. (workforce delivery plan appendix 3)

Workforce Cost Impact

Consistent and sustainable funding is required from Health Education England (HEE) and NHS England over the next 3-5 years and is essential to the planning for the Black Country STP and for the continued investment in primary care. HEE have already made significant cuts in relation to a number of training schemes and has reduced the CEPN budget by 30%. If we are to achieve the ambitions of the GPFV and the new models of care, investment in other primary care roles and training must be continued to ensure sustainability for the future. Significant investment is required across the range of new roles and retaining current workforce including, but not limited to:

- Fundamentals of General Practice Nursing courses
- Advanced Clinical Practice MSc courses
- Mental health therapists
- Physicians Associates, including creation of PA Ambassadors
- Primary care fellowships

The STP intends to focus on the local refugee scheme in the first instance with a view to reviewing an application for International Recruitment by phase 3. If the STP is successful in its local scheme it would need financial support from the national GPFV fund to continue to support the local refugees into education, regulation and eventually back into practice. If the STP could tap into the international recruitment money for our local scheme, it is anticipated that this cost over five years would be £4.2 million (based on estimated costs of £25,000 per candidate).

Development of Current Workforce

In addition to the development of new roles and new ways of the working, workforce transformation can also occur through the investment and development of current staff. Investing in the current workforce will not only provide a positive working environment but is known to support the retention of the workforce. The below initiatives are currently being developed for roll out across the Black Country STP member practices, supported and led by the CCGs and CEPNs. It will be a priority of the CCG to make available training and re-training opportunities for existing GPs.

Care Navigation Training: pilot phase summer 2017, full rollout from year two, engagement with patient groups.

Effective Telephony Training: secured funding through NHS England's Practice Resilience programme for training for clinical and non-clinical staff.

Practice Manager Development Programme: transformation funds received from NHS England in March 2017, commissioned across the Black Country STP footprint, coordinated by Sandwell & West Birmingham CEPN, 22 modules June 2017-March 2018 with further continued investment in this training up to 2020.

Multi-disciplinary Team (MDT): support for practice groups to develop and run MDTs within multiple practices.

Nurse Mentorship: to increase nurse mentors, and thereby increase student nurse placements, by funding training and backfill.

Community Education Provider Networks (CEPNS)/Training Hubs

Local Community Education Provider Networks (CEPNs) are commissioned by Health Education West Midlands (HEWM) as a new way of developing the primary care workforce in response to the current health agenda. CEPNs work to enable primary care transformation through programmes of ongoing training and development for practice staff. The CEPN contract is held by Walsall Alliance in Wolverhampton. Partnership with the CEPNs is essential to the delivery of some of the proposals for role and workforce development in the GPFV. Re-procurement of the existing contract is anticipated early 2018 and likely to be on STP footprint.

Apprentices

Apprentices are becoming an increasingly important part of the workforce in many industries. The government sees apprenticeships as a key part of upskilling and developing the workforce to meet future needs. Some General Practices have, in the past, employed business and admin apprentices but until recently, clinical apprenticeships had not been available. However, apprenticeships now encompass both clinical and non-clinical roles. Local Higher Education Institutions (HEIs) have

Developed Nurse Apprenticeship programmes and the recently introduced Nurse Assistant role is set to become an apprenticeship. Other clinical apprenticeships due to be introduced include pharmacy technicians, Occupational Therapy and Physiotherapy assistants, paramedics and physician associates.

One of the key areas of work in Primary Care is around workforce planning to mitigate the number of practice staff who are due to retire within the next 20 years and also to broaden the range of staff within General Practice, needed to meet the challenges in Primary Care. The Queens Nursing Institute, in their report of 2015, General Practice Nursing in the 21st Century: A Time of Opportunity stated that nationally 33.4% of General Practice Nurses are due to retire by 2020. At the moment there are insufficient numbers of Newly Qualified nurses choosing to work within Primary Care. Steps are underway to rectify this situation, such as the introduction of the Fundamentals of General Practice Nursing programme, designed to support and skill up newly qualified nurses in Primary Care. The CCG and local HEIs have worked hard to encourage pre-registration students to undertake a placement in Primary Care. Anecdotal evidence collected from such students suggest that up to a third of students will seriously consider a career in General Practice following a successful placement.

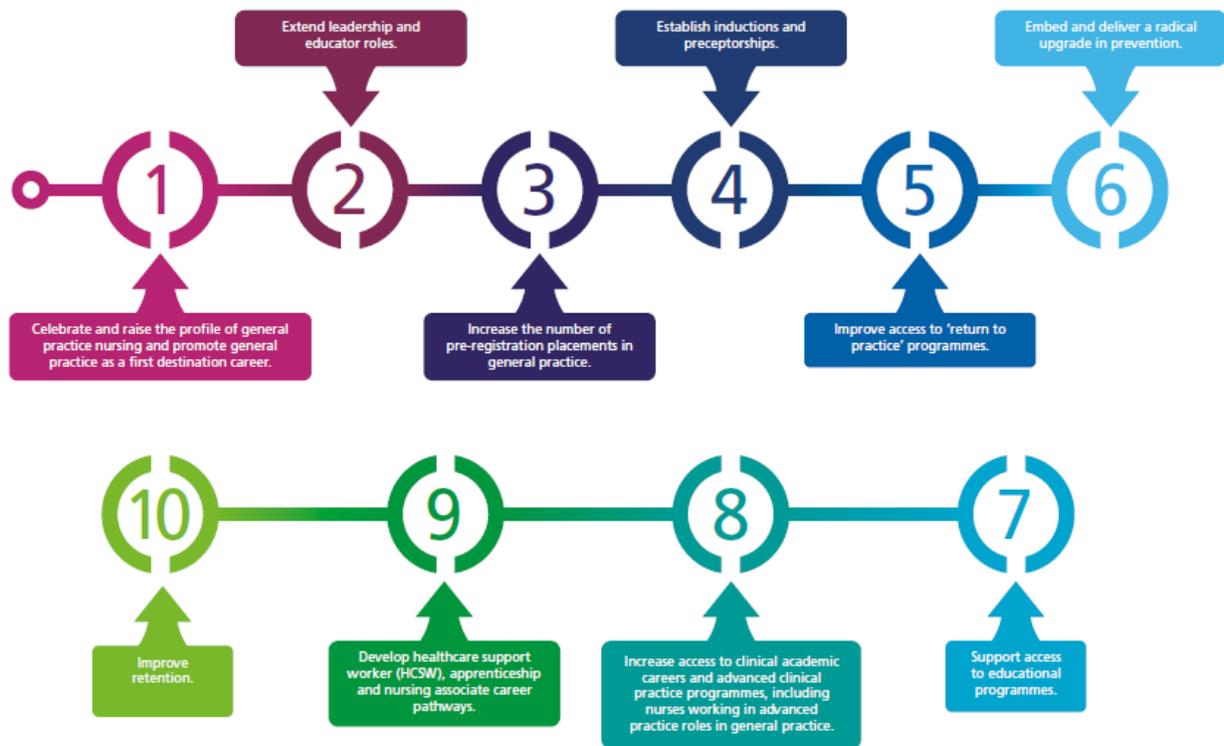
An option available to General Practice is to consider apprenticeships as a means of recruiting new staff and upskilling current staff to move into either different or expanded roles.

When the CEPNs (Community Education Provider Networks) were established in 2014, one of their KPIs was to increase the number of apprenticeships in Primary Care, as a means of supporting General Practices to improve resilience in order to meet future demand.

General Practice Nursing Ten Point Action

Health Education England published the Practice Nursing ten point action plans in July 2017. Promoting the importance of general practice nursing the report provides details of potential use, risk and recommendations to develop and support the workforce. Upskilling existing nurses, ensuring availability of student nursing mentors and placements are areas of importance so too are measures to retain existing staff remains a high priority. This implementation can ensure general practice nursing remains a vital component of the primary care workforce for the future (Appendix 3).

Ten point action plan



Introducing New Roles

The principles of the workforce development for primary care include:

1. Identifying and developing new roles
2. Review and redefine current ways of working
3. Expand opportunities for portfolio careers and flexible working options
4. Enabling digital technology innovations to better manage workload

New Roles

The workforce initiatives consider the total workforce in primary care that will support the management of the supply and demand of GP numbers as already identified.

Healthcare assistants (HCA)

Provide clinical support for GPs to enable them to allocate more time for patients with complex problems.

Health and wellbeing co-ordinators:

Enable patients to maintain their health and wellbeing and improve self-management of their condition.

Physician associates:

Work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.

Care coordinators/navigators:

Provide a central co-ordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

Medical Assistants:

This role will support doctors in the smooth running of their surgery. They will handle routine administration and some basic clinical duties, enabling the GP to focus on more complex patients.

Clinical pharmacists:

Work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. This includes providing extra help to manage long-term conditions, advice for those on multiple medications and better access to health checks. The role is pivotal to improving the quality of care and ensuring

Practice based Physiotherapists:

Using direct access to physiotherapy as an alternative to seeing a GP, patients would be given the option to book themselves an assessment directly with the MSK practitioner. This could take place either face to face or over the phone. During the assessment the practitioner, where appropriate, could provide: advice and exercises along with a self-management plan; referral for further physiotherapy; referral to an appropriate service e.g. podiatry. These roles could demonstrate cost savings to local health economies in terms of prescribing and placing patients on the correct pathway of care, investigations and secondary care referral, as well as easing the burden on the general practitioner workforce.

Nurse mentors:

Increasing the number of qualified mentors in the existing GPN workforce is anticipated to support an increase in the number of student placement learning opportunities for student nurses who express an interest in pursuing a career in primary care, strengthening the likelihood of those students considering a career in general practice.

Social Prescribing:

Recognised for the benefits it can bring for patients, including better quality of life, improved mental and emotional wellbeing, and lower levels of depression and anxiety. It also has the potential to reduce patients' reliance on NHS services, easing pressure on accident and emergency wards and hard-pressed GPs.

Mental Health Therapists:

The GPFV outlines that there will be 3,000 new fully funded mental health therapists nationally to work in general practice by 2021. This should help individuals to seek help at an early stage, noting that general practice staff has a role to play in recognising when early referral or treatment may be indicated for someone at risk of falling out of work.

Nurse Associates:

The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. ... Its introduction has the potential to transform the nursing and care workforce - with clear entry and career progression points.

Implementation of Strategy

Wolverhampton CCG will continue to support and enable primary care workforce development through new ways of working. Access to innovation funding, commission new roles, pilot new roles and building relationships with other partners to ensure workforce development is a key enabler for transformation. A detailed delivery plan with a focus on cultural change will assist us achieve the goals within the plan.

Group Managers will maintain the dashboard, monitor the delivery plan and share with the appropriate task and finish groups to ensure completion of the project. Group meetings will have sight of the plan and focus on any updates or actions at practice level that are required to ensure our information is accurate.

The CCG will encourage practices to invest in line with commissioned services to ensure sufficient capacity to serve patient population as recommended by the global sum, currently 0.58 WTE per 1000 patients.

Delivery Plan	Key Deliverables	Baseline Position	Action / Milestone	Action Owner (Organisation)	Milestone Delivery Date	Success Measure	KPIs / Plan Trajectory
Workforce							
Local Workforce Dashboard	Validate accuracy of Local Workforce Dashboard	First draft of local Workforce Dashboard	Meeting with WCCG November 2017	CCG Group Leads	March 2018	Understanding the gaps in local Workforce Dashboard to inform further development	All CCG understand gaps and agree plan to address
	Use the local Workforce Dashboard within Practices to model the gaps in existing and future Workforce and then develop an action	March 2018 and regular updates	Ongoing development of the primary care workforce plan at group level	Group Leads and Group Meetings	April 2018	Primary Care Workforce Implementation Plan in place	1st Draft to be developed by March 2018 and implemented thereafter
NHSE National Initiative; GP Retainer Scheme, GP Induction and Refresher and International Recruitment	Engagement with practices to promote awareness of availability of national schemes	Practices currently participating in the GP Retainer Scheme	Practice engagement International recruitment etc	CCG Primary Care Leads	On-Going	All practices aware of support available	100% of practices aware of national support offers through NHSE
Back Office functions and clinical leadership - please refer to Workload Delivery Plan		Workforce Task group meetings (monthly)	Monthly review	Director of Nursing	January 2018 onwards	Dashboard, Audit program of work	Dashboard
Workforce Task and Finish Group Programme of work	Primary Strategy and GPFV						

Delivery plan

The Workforce Task and Finish Group will be responsible for delivering the agreed program of work. (Appendix 1) They will establish and maintain strong links with stakeholder educational establishments for medical, nursing and non-clinical staff groups. Complete the clinical pharmacist model in line with national direction and monitor performance through the workforce dashboard. The Workforce Task and Finish Group will complete the reshape through the communications plan and sub groups that include the roles of practices and GP Managers. The CCG commissioned prescribing and advice and QIPP delivery. Further collaborative working with STP and GPFV will complete the plan.

Risks

The financial constraints and workload pressures now faced in general practice are acute. Release of staff for training is an issue for most practices as this often results in an impact on service provision or additional costs if the person goes out during working hours. Some practices still view training their workforce as a risk, that is, where they invest in skills development for individuals, neighbouring practices will 'poach' experienced and trained staff. The opportunity cost of staff development therefore needs to be recognised and supported for all practices. Evidence and experience shows where these obstacles have been overcome practices have seen the benefits of investing in training their workforces.

A further risk of assuming the point that GPs will retire is mitigated by the information provided within the workforce dashboard.

Improvement will be over a period of time in line with a national programme that is delivered locally/STP footprint and will also need to ensure that the introduction & implementation of new measures needs to be monitored to ensure benefits are realised and sustained.

WCCG recognises that workforce development is a responsibility that requires engagement, testing and evaluation. Recruitment to new roles remains the responsibility of our Contractors supported by their respective Group Manager(s).

Conclusion

It's important at this point to make the correlation with strategy implementation plan as well as the GP5YFV projects that have begun to be launched such as GP Resilience Programme / Vulnerable Practice Programme, Training for Admin & Reception staff, Time for Care and Practice Manager Development training. The extensity of both the GPFV and Primary Care Programme of Work will enable realisation of this Strategy.

Access to these will be overseen by the Primary Care Team within the CCG to ensure that all practices/groups are appropriately represented & the benefits realisation from taking part in these programmes is recognised and learning shared across the groups.

References and Bibliography

Five year forward view: Department of Health 2016
<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
GP five year forward view, Department of Health 2016
<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
Workforce Planning in the NHS: Kings Fund 2015
<http://www.kingsfund.org.uk/publications/workforce-planning-nhs>
Primary Care Health Care Strategy: WCCG 2016-2020

Enclosures

Local Workforce Dashboard
Programme of Work
Workforce Delivery Plan

GPFV Programme of Work					
Chapter	Total Number of Projects	Not Started	Achieved & Closed	In Progress within Timescale	Overdue and/or behind
1 Investment	7	0	5	2	0
2 Workforce	27	10	3	14	0
3 Workload	25	12	4	9	0
4 Infra-structure	21	6	6	9	0
5 Care Redesign	5	1	0	4	0
Total(s)	85	29	18	38	0

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within
Red	Overdue and/or behind

GPFV Project Timeline 2018-20

Project Title	Completed Projects	April to June 2018	July to September 2018	October to December 2018	January to March 2019	2019/20
Chapter 1 Investment	Monitoring & Investment Monitoring CCG Investment in General Practice Carr-Hill Formula Review	Messages down the finance route Development of Single LA/CCG Investment (BCF)				
Chapter 2 Workforce	Targetted financial incentives to GPs returning to work Further investment in leadership development Investment in practice nurse measures & access to mentorship training Extension of Clinical Pharmacy Scheme Care Navigation Practice Manager Development Service to prevent burnout	Increasing GPs into Training Practice Manager Development Programme/Diploma Investment in Leadership Development Refining GP Speciality Training National Recruitment Campaign (HEWM) International Recruitment Post CCT Fellowships Mental Health Therapists Medical Assistants Further Measure to Improve Work	National Recruitment Programme Investment in Leadership Development International Recruitment Campaign Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Mental Health Therapists Medical Assistants Multi-disciplinary training hub reprocured	National Recruitment Campaign International Recruitment Campaign Investment in Leadership Development Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Training for Physician Associates Mental Health Therapists Medical Assistants	National Recruitment Campaign International Recruitment Campaign Practice Manager Development Programme/Diploma Extension of Clinical Pharmacy Scheme Publication of evidence about retention	Val Wass work on Medical Schools Pharmacy Integration Fund Pilot Medical Assistant Role Publication of evidence about retention Nursing career framework & standards Investment in QNI education & practice standards
Chapter 3 Workforce	National programme of self care Reference to GPs influencing commissioning Programme to reduce burden of oversight Work & health measures including others to sign fit note	National Development Programme Consultant hotline advice (A&G) My NHS indicators Review of QOF & AUA DES Growth in mandatory trianing linked to appraisal & revalidation Social Prescribing Ambassador(s)	National Development Programme Consultant hotline advice (A&G) Standards for outpatient appointments My NHS Indicators Review of QOF & AUA DES EPS for Practice Hubs Issue guidance to HWBs for DH	National Development Programme Standards for outpatient appointments New software to automate tasks Simplified Data Reporting Incoming data from NHS providers all automated Accelerating moves to paper free NHS	New software to automate tasks Accelerating moves to paper free NHS Audit tool to help practices reduce demand Automated appointment measuring interface	Reformed 111 Service CQC Charges/Funding/Frequency of inspection Automated appointment measuring interface
Chapter 4 Infra-structure	Investment in practices to take up online consultations CCGs commission core GPIT WIFI Services in GP Practices Buying catalogue for IT goods/services Pharmacy summary care record Data & tools that benefit GPs	ETTF Programme Implement measures promised on premises Priority given to improve access (continuation of transformation fund & improving access fund) Apps & digital self care Work with supplier market choice of digital services Support groups to implement Hub level EMIS	ETTF Programme National framework for cost effective telephone/e-consult Support groups to implement Hub level EMIS Apps & digital self care Develop A&G Platform Online access for patients to accredited clinical triage systems	ETTF Programme Actions to support practices offer patients online self care & self management services Create innovative choice of digital services	ETTF Programme Implement measures promised on premises	ETTF Programme Funding to support education for patients & practitioners to utilise digital systems
Chapter 5 Care Redesign	Transformation Fund 2017/18 NMOC Contracting Options explored	National Development Programme Transformation Fund 2018/19 NMOC Contract Strategy Implemented Review of protected learning time arrangements for practice staff	National Development Programme Transformation Fund 2018/19 Review of protected learning time arrangements for practice staff	National Development Programme Transformation Fund 2018/19	National Development Programme Transformation Fund 2018/19	Deliver the access commitment Continuation of Transformation Funding Review NMOC/Contract

Chapter 1 Investment

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
1.1	Monitoring of Investment	Established liaison between NHSE & CCG at both primary care & finance level(s).		Allocations, spend & investment monitored via internal quarterly meetings to ensure funds are duly spent.	Sarah Southall	Dec-16	Dec-16	
1.2	Monitoring of CCG Investment in General Practice	CCG fully delegated since April 2017 & in receipt of delegated budgets.		As above quarterly monitoring meetings held to ensure spend is within budget limitations.	Sarah Southall	Apr-17	Apr-17	
1.3	Messages down the finance route	National Allocations are made via notification to CFO & where necessary assurance reporting requested via NHSE on specific allocations.		Allocations are being made on an ongoing basis, although some are to a nominated CCG within the STP resulting in invoicing the nominated CCG. Continue with existing arrangements.	Lesley Sawrey	Mar-18	Mar-18	Continue with existing arrangements & close liaison with Finance colleagues.
1.4	Carr-Hill formula review	Formula review undertaken at national level, new guidance published April 2016.		Allocations will be in line with new guidance, copy in folder for further reference.	Sarah Southall	Summer 2016	Jul-16	Ensure national allocations are in line with Carr Hill Formula Review.
1.5	PMS contract reviews	PMS contracts reviewed 2017, reducing values discussed with practices affected.		small number of PMS contracts remain.	Gill Shelley	Summer 2017	Summer 2017	
1.6	Indemnity	National review undertaken. Support schemes during winter pressures accessed by practices.		Monitor impact of indemnity premiums as practices continue to implement working at scale. Premium(s) tend not to be affected if clinicians have full access to the clinical record.	Sarah Southall	Jan-17	Jan-17	Practice information sharing agreements & configuration within EMIS enables full access to patient clinical records. Ensure when practice movements occur agreement & configuration arrangements are reviewed.
1.7	Development of single LA/CCG investment arrangements into general practice through BCF	Community Neighbourhood Teams development to include Social Workers, Mental Health & input from specialist teams.		Mental Health Therapists Social Workers Community Neighbourhood Team	Andrea Smith	2017-20		

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Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

Chapter 2 Workforce

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
2.1	Increasing GPs into training	GP training places increased, uptake to full compliment not achieved 2016 nor 2017		Continue to monitor uptake / fill rate for Trainees in training practices Wolverhampton. Retention to be reviewed & monitored. IGPR Application submitted February 2018. Network with Uni(s) established, placements encouraged. Linked to retention.	Marianne Thompson	2019/20		
2.2	Refining GP speciality training	Increase in GP speciality training places (linked to retention schemes).		GPSI opportunities to be revisited at group level. Competency requirements to be identified. Expressions of interest & specialities to be considered at Workforce TFG	Marianne Thompson	2019/20		
2.3	Val Wass work on medical schools	Choice not by Chance Report published November 2016		15 recommendations to be reviewed, report in folder	Sarah Southall	2018/19		
2.4	National recruitment campaign	Lead by HEWM		National advertising, events & campaigns implemented locally.	Marianne Thompson	2019/20		
2.5	International recruitment drive	First cohort commenced Feb 2017, report shared with WTFG Summer 2017, decision to defer till 2018.		Meeting due to be held STP level 8.12.17 STP Application submitted February 2018, outcome awaited.	Sarah Southall	2018/19		
2.6	250 Post CCT fellowships	GPs who wish to develop extended skills ie geriatric medicine, mental health etc also known as Portfolio Career. Training opportunities in in areas of poorest GP recruitment.		Identify Wolverhampton share & expressions of interest.	Marianne Thompson	2018/19		
2.7	Further measure to improve work	Simplify return to work routes new portfolio route to improve retention.			Sarah Southall	2018/19		
2.8	Increase financial compensation of current retainer scheme	Targetted financial support for GPs to remain in practice.			Sarah Southall	2018/19		
2.9	Targetted financial incentives to Gps returning to work	GP Retainer Scheme Induction & Refresher Schemes			Sarah Southall	2018/19		

2.1	Publication of evidence about retention	Address concerns of workload, financial & educational support.			Sarah Southall	2019/20		
2.11	Further investment in leadership development	Leadership programme(s) offered since 2016 (1 x 2015/16, 2 x 2016/17).		KM&T has begun working with 3 practices from PCH1 and one from PCH2, this will continue until march. RCGP will be providing two sessions which are scheduled for April and May, to enable lead PMs to become more effective and confident in the processes required for working at scale, and to enable delivery plans to be realised.	Jo Reynolds	Mar-18		Further leadership development to be identified & project review carried out. Will become business as usual. No interest has been declared by practices in the 2018/19 funding that is available, so no bid will be submitted.
2.12	Investment in practice nurse measures	10 Point Action Plan Primary Care Workforce Strategy (STP & W'ton)		Responsive local plan in place, monitoring via Workforce TFG Practice Nurse & HCA Development Plans approved & programmes due to commence	Liz	2018/19		nurse facilitator hours have been allocated from the LWAB hub to help progress this work
2.13	Extension of clinical pharmacy scheme	Funding scheme to support clinical pharmacists working in general practice. Coverage to be extended all Wolverhampton Practices as far as reasonably possible.		2016/17 One successful bid 2017/18 Two successful bids CPs in post across a number of practices (1:30,000 shared model) Benefits realisation & Case Studies monitored via Workforce TFG.	Hemant Patel	2018/19		
2.14	Pharmacy integration fund	Will be introduced to look at how pharmacists, their teams & community pharmacy fit into wider NHS services in the local area		Pharmacy Peer Group Forum due to be introduced (Feb 2018) Direct Commissioning discussions with NHSE 2018/19	Sarah Southall	2018-20		
2.15	Mental health therapists	Introduce new Mental Health Therapists practice based		Primary Mental Health Care Strategy Commissioning Mental Health Therapists on shared basis across practices as part of MDT working.	Sarah Fellows	2018/19		

2.16	Training of care navigators medical assistants reception & clerical staff	Admin & reception staff who are suitably skills to actively signpost patients & the public so that they see the right person in the right place. Reducing GP workload.		Cohort 1 pathways will go live February 2018. Cohort 2 pathways will be scoped & launched summer 2018	Jo Reynolds	Summer 2018		Cohort 2 pathways & continuous improvements from 2018/19
2.17	Pilot new medical assistant role	Support doctors in the smooth running of their surgery by handling routine administration & some basic clinical duties enabling the GP to focus on the patient. Medical Assistants will refer, arrangement appointments & follow ups.		Competency Framework awaited from HEE	Sarah Southall	2018-20		
2.18	Pilot new physiotherapy roles	Transforming out of hospital care through care navigation & direct access.		Care Navigation opportunity	Jo Reynolds	2018-20		Physio to be scoped as a care navigation point in phase 3 starting
2.19	Investment in practice manager development	National allocation 2016/17 £10k - training programme commenced May 2017.		Further funds anticipated before March 2018 assigned to LMCs	Jo Reynolds	Mar-19		Additional funding from CCG for PM Diploma £25k supported due to commence Feb 2018 & further cohort summer 2018
2.2	Roll out nursing career framework & standards for general practice nurses	10 Point Action Plan Primary Care Workforce Strategy (STP & W'ton)		Responsive local plan in place, monitoring via Workforce TFG Practice Nurse & HCA Development Plans approved & programmes due to commence	Liz	2019/20		number of mentors is being increased, more practice placement sites will be coming online following this. Practice nurse advocates are being developed with NHSE, these will be newly qualified nurses entering general practice. RCN leadership course, will be run throughout the year. Clinical academic careers, application has been sent out (non Dr clinician, clinical academic career) return to practice- UWLV have developed a programme and are ready to launch. HEE legacy programme, managment who want to move back to the shop floor, will be developed in the near future. RN and Nursing associate apprenticip has been sent out to all practices.

2.21	General practice nurse access to mentorship training	Availability of nurse mentorship training programme	Green	Nurse Mentorship Training commenced 2017, ongoing programme in place monitored via Workforce TFG in line with TNA.	Liz	2017/18	Dec-18	Group Level TNA in place to monitor & respond to demand.
2.22	Benefits for more committed locums	Improve attractiveness of partner & salaried positions.	Blue		Sarah Southall			
2.23	Locum rates	Standardise locum rates across practice groups through negotiation with agencies/supply chain & potential introduction of a locum bank.	Blue	Back office functions review may confirm this as a priority for practice groups.	Sarah Southall	2018/19		
2.24	National service for burn out	Occupational health service providing mental health support & wellbeing.	Green	Service introduced by NHSE 2017, publicised locally & information available on NHSE website.	Sarah Southall	2017/18	Sep-17	NHS England manage/monitor/review effectiveness of scheme.
2.25	Training 1000 physician associates	Investment by HEE in training of 1,000 Pas to support general practice.	Amber	Training provided locally in Wolverhampton & student placements hosted by some practices however limitations to role ie prescribing.	Marianne Thompson	2018/19		
2.26	Implement QNI voluntary education & practice standards	To provide a highly skilled nursing workforce in general practice includes investment to fund training & practice standards (Queens Nursing Institute).	Amber	Nurse 10 point action plan in place, actively monitored via Workforce TFG.	Liz Corrigan	2019/20		superceeded by the 10 point action plan, development plan it address this and align the competencies between the two
2.27	Multi-disciplinary training hubs in every part of England	Support the development of the wider workforce within General Practice.	Amber	SLA in place with Walsall CCG till March 2018. Funding extended 8 Months (April to November) 2018. HEWM will be procuring at STP level 2018	Sarah Southall	2018/19		Continuity of provision until November.

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

Chapter 3 Workload

Project Ref	Project Title	Progress	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
3.1	National development programme	Support training of reception clerical staff to play a greater role in care navigation & handling clinical paperwork.		Document Management Procurement due to commence Care Navigation Training concluding, roll out commencing February Cohort 1 Pathways	Jo Reynolds	2018/19		
3.2	National programme of self care	Every opportunity to support people to play a greater role in their own health.		Linked to Care Navigation Introduced the Sound Doctor & Transformation Fund 2017/18 promoted the importance of practices advocating self care.	Jo Reynolds	2017/18		Commissioned Services Dashboard TSD Benefits Realisation Report
3.3	Reference to GPs influencing commissioning	GPs involved in/influencing commissioning decisions.		Group Leads Meeting Members Meetings Governing Body Membership Clinical Reference Group Relationship with I MC	Sarah Southall	2017/18	Dec-18	Continued involvement in commissioning discussions/ decisions.
3.4	Reference to reformed 111 service	Hubs & reformed urgent care; a new voluntary contract supporting integrated primary & community services such as integrating extended access with out of hours & urgent care services, 111 & clinical hubs.		NHS111 & Practice Group Hub Working Bank Holiday Scheme/Saturdays Investment in clinical hub via NR ££ 2017/18 Improving Access Delivery Plans at Group Level 2018/19 Review Urgent Care Centre Contract delivery options 2018/19	Dee Harris	2019/20		

3.5	Practice resilience programme	Leadership programme(s) offered since 2016 (1 x 2015/16, 2 x 2016/17).		<p>KM&T has begun working with 3 practices from PCH1 and one from PCH2, this will continue until march.</p> <p>RCGP will be providing two sessions which are scheduled for April and May, to enable lead PMs to become more effective and confident in the processes required for working at scale, and to enable delivery plans to be realised.</p>	Jo Reynolds	Mar-18	May-18	<p>Further leadership development to be identified & project review carried out. Will become business as usual.</p> <p>No interest has been declared by practices in the 2018/19 funding that is available, so no bid will be submitted.</p>
3.6	New standards for outpatient appointments	More convenient access to care, a stronger focus on population health/prevention, more GPs and wider range of practice staff operating in more modern buildings & better integrated with community & preventative services, hospital specialists & mental health.		<p>Practice groups maturing to provide out of hospital services in fit for purpose premises.</p> <p>Development of Community Neighbourhood Teams</p>	Sarah Southall	2018/19		
3.7	New working group to look at hospital GP interface	BMA Guidance implemented April 2017		<p>Revised process implemented Oct 17</p> <p>Care Query Panel Meeting held fortnightly.</p> <p>Review meeting held with RWT February 18 including LMC, process working well, reduction in care queries, panel continues to meet regularly.</p>	Sarah Southall	Apr-18		<p>Extending good practice to Mental Health Provider - Mental Health Stakeholder Group.</p> <p>Continue to monitor review the effectiveness of the existing arrangements for RWT.</p>

3.8	Rapid testing programme on consultant hotline advice	Consultant Connect explored but declined by CRG.		Development of A&G & CAS currently being worked up via PAP TFG	Ranjit Khular	2018/19		Advice & Guidance Scoping report drafted for Primary Care Programme Board April. CASs Cardiology & Ophthalmology under development also.
3.9	New software to automate tasks	Automation of common tasks.			Steve Cook	2018/19		
3.1	CQC Charges - lead by CQC	Support to move to a 5 year inspection interval for good & outstanding practices.			CQC			
3.11	Funding for CQC	Streamlining the payment system			CQC			Check allocations / Contract
3.12	My NHS Indicators	A set of key sentinel indicators published July 2016.			Jo Reynolds	2018/19		
3.13	Review of QOF & future of AUA DES	AUA DES changed April 2017 to focus on Frailty. Internal Steering Group to develop QOF+ formed also.		Priorities identified & outlines for QOF+ due to be worked up via CSU - implementation April 2018 (£1m recurring revenue investment)	Ranjit	Apr-18		QOF monitoring arrangements being worked through with IM&T Facilitator Team. Further development of Group Level monitoring also being explored. QOF+ drafted, searches due to be created.
3.14	Simplified data reporting	Extraction of routine data to simplify reporting.			Steve Cook	2018/19		The CCG will look to use the Graphnet data repository to support reporting Requirements
3.15	Programme to reduce burden of oversight	Reduce the burden of hospital correspondence & GPs having to manage tasks for secondary care clinicians.		NHS Contractual requirement 2017/18 onwards Local process & arrangements for reimbursement in place.	Sarah Southall	Summer 2018	Oct-18	Process revised in light of further guidance & monitoring report due to be considered at meeting with RWT clinicians.

3.16	Review payments processes	CCG Payments process revised & shared with Practice Managers.		Template is in use and monitored for effectiveness	Jo Reynolds	Dec-17		Business as usual
3.17	Accelerating moves to paper free NHS	Assisting primary care become paper free not just within practices but across the wider health care system through interoperable systems		The Big Paper Switch Off i.e. E-referral	Steve Cook	2018/19		Wolverhampton CCG are fully engaged with the Acute provider to support paper switch off all referrals being sent via E-RS Event 11 April
3.18	Electronic prescriptions	EPS in place across all practices in the city.		EPS not available for hub working, yet to be resolved.	Steve Cook	2018/19		
3.19	Incoming data from NHS providers, all digital	Providers will submit data to a Strategic Data Collection Systems Portal using a downloadable proforma i.e. improving access.			Steve Cook	2018/19		
3..20	Audit tool to help practices identify how they can reduce demand	Audit of potentially avoidable appointments in General Practice will support reducing workload.			Steve Cook	2018-20		Project due to start in 2018
3.21	Automated appointment measuring interface	Making Time in General Practice Report			Steve Cook	2018-20		Project due to start in 2018
3.22	Growth in mandatory training & link to appraisal & revalidation	Funding & support schemes to help stabilise & improve the primary care workforce through training & recruitment of GPs & investment in staff.			Sarah Southall	2018/19		

3.23	Promote social prescribing & create national champion	Social prescribing initiatives supported by 35 national ambassadors & advocates promoting the GP role.		Champion being identified by Social Prescribing Service.	Jo Reynolds	2018/19		Social Prescribing funding has been extended to 2018/19, with an application for national funding being considered. Service will continue to be monitored and promoted through practices, with referral numbers being monitored to identify issues.
3.24	Issue guidance to HWBs for DH	DoH will issue guidance to Health & Wellbeing Boards asking them to ensure that joint health & wellbeing strategies include action across health, social care, public health and wider.			Sarah Southall	2018/19		
3.25	Work & health measures including others to sign fit note	GPs will not have to sign fit notes for hospital patients.		NHS Contract 2017-19 makes it mandatory for hospitals to write fit notes for patients that were admitted by hospital staff, discharged or attended an outpatient clinic.	Sarah Southall	2017/18	Oct-18	Primary Secondary Care Interface process working well & extending to Mental Health provider also. Care Query Panel meetings regularly.

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

Chapter 4 Infrastructure

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
4.1	Run estates & technology transformation fund	ETTF programme in place		3 year programme agreed/funded	Steve Cook	ongoing		The ETTF Bids that have been successful, are been run in line with PRINCE2 project management Methodology
4.2	Implement measures promised on premises	NHS England will fund stamp duty & land tax costs for practices signing leases with NHS PS from May 2016 till the end of October 2017			Tally Kalea			
4.3	Work with NHS PS to identify how we can underwrite lease agreements				Tally Kalea			
4.4	Work with CHP to mobilise public & private partnerships				Tally Kalea			
4.5	Investment for practices to take up online consultation systems	National allocations confirmed over 3 year period.		First allocation 2017/18 (Jan-18)	Steve Cook	Nov-17	Jan-18	See 4.14
4.6	Ensuring CCGs commission core GP IT services	Core GPIT Services		Commissioned by CCG	Steve Cook	2016	2016	The CCG have continued to provide core GPIT services via an SLA with Royal Wolverhampton Trust

4.7	Ensuring that priority given to things to help access	National & local funds fully utilised to assist with improved access Winter 2016 & 2017 Practice & hub delivery, including bank holidays has been pump primed via Transformation / A&E Delivery Board / Non Recurring Revenue		Delivery plan assured by NHSE March 2018 Group level delivery from April 2018→ have been submitted	Jo Reynolds	Mar-19		Delivery plans are in place for the year, on target to achieve 100% 8-8 weekday and weekend provision by October 1st 2018
4.8	WIFI services in GP practices	All practices have WIFI except Rosevillas.		Rosevillas will be relocating to the Croft in 2018.	Steve Cook	Feb-17	Mar-18	Project Complete
4.9	Apps & digital self care	New core requirements i.e. digital patient records, specialist support, outbound electronic messaging etc.		currently scoping options	Steve Cook & Jo Reynolds	Review Sept 2018		
4.10	Accredited catalogue & buying framework for IT products & services			provided by arden and GEM CSU proc dept	Steve Cook	complete		Working with Midlands and Lancs CSU to identify joint buying opportunities
4.11	Work with supplier market to create wide & innovative choice of digital services				Steve Cook	ongoing		Have worked with suppliers to identify opportunities to introduce innovative digital services
4.12	Complete roll out of pharmacy summary care record			Midlands and Lancs CSU	Steve Cook	complete		Project Complete
4.13	£45m programme to stimulate uptake of online consultation by every practice	As 4.5 above		Bid submitted to NHS Digital Dec-17 Project Team to be formed Jan-18	Steve Cook	Summer 2018	Jan-19	Project Manager has been appointed and hardware and software has been procured. EMIS Triage & Video Consultation pilot sites identified and discussions commenced March 2018.
4.14	Actions to support practices offer patients more online self care & self management services	National allocation £68k 2017/18 anticipated Jan 2018. Bid prepared & submitted Dec-17		Bid submitted to NHS Digital Dec-17 Project Team to be formed Jan-18	Steve Cook	Mar-20		see 4.13 above

4.15	Online access for patients to accredited clinical triage systems	EMIS Triage Solution & Video Consultation		in discussions with EMIS software available & keen to roll out to pilot sites.	Steve Cook	review sept 2018		Have agreed with Egton to have a trial of the EMIS Triage pilot sites will be Grove & Parkfields Practices, Video Consultation with both practices & care homes they are working with (Newlyn & Belvedere). NHSE Regional Lead is due to liaise with IT regarding progress of project. Data sharing & discussions with IG taking place, also visiting Belvedere as part of ongoing discussions (22.3.18)
4.16	The ability to access data & tools that aid GPs (and local commissioners)			is available within Graphnet	Steve Cook	Complete		Wolverhampton have a Shared Care Record that is being developed to support GP's and Commissioners while operating within Information Governance Guidelines.
4.17	Enhancements to the advice & guidance platform on the e-referral system	Develop advice & guidance beyond 6 specialties currently in use locally.		Currently 11 specialties live, not all well utilised.	Steve Cook/Ranjit Kular	Autumn 2018		
4.18	A national framework for the cost effective purchase of telephone & e-consultation tools	Framework yet to be defined by NHS Digital			Steve Cook	TBD		waiting for information from NHS Digital
4.19	Funding to support education & support for patients & practitioners to utilise digital services	Awaiting further clarification			Steve Cook	TBD		The CCG utilise its IM & T facilitator team to support patient and practices make use of the digital services. We are also looking get EMIS to provide additional support to the federated GP Groups

4..20	Support federated practices by enabling appointments in one practice	Practice groups already working at scale.		Phased roll out of hub level EMIS systems currently under way.	Steve Cook	Summer 2018	This is supported via the provision of the EMIS Remote consultation which supports practices booking appointments and holding consultations with patients who belong to practices within the federated GP Group
4.21	Let healthcare professionals from different settings inform & update a practice through sending/management	Awaiting further clarification			Steve Cook	TBD	The CCG are in the process of upgrading Docman to version 10. Patient data is also available through the shared care record.

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale
Red	Overdue and/or behind scheduled timescale

Chapter 5 Care Redesign

Project Ref	Project Title	Description	Current Status	Next Steps	Nominated Lead	Anticipated Completion	Closure Date	Continuity Arrangements
5.1	Deliver the access commitment	30 minutes per 1,000 patients 2018/19 45 minutes per 1,000 patients 2019/20		Delivery plan assured by NHSE March 2018 Group Delivery Plans have been submitted.	Jo Reynolds	2019/20		Delivery plans are in place for the year, on target to achieve 100% 8-8 weekday and weekend provision by October 1st 2018
5.2	Ensure CCGs provide £171m work of support	CCGs to provide £3.00 per patient transformational funding.		Year 1 Service Specification & Assurance Reports Year 2 Service Specification is authorised and with groups..	Jo Reynolds	2018/19		deliery plans form groups will be submitted by end of April 2018, with activity to start June 2018
5.3	New MCP Contract (NMOC)	MCP contracting explored, ACA preferred solution.		ACA Development Group meeting (Nov-Mar)	Sarah Southall	Apr-18		Shadow year to commence April-18→
5.4	National Development Programme	Releasing Time for Care Programme		STP Event held summer 2017 Priority areas were Document Management (procurement due to commence) & Leadership Training (sessions to be arranged for summer 2018)	Jo Reynolds	Sep-18		Document Management Spec awaiting approval, due to commence June 2018
5.5	Protected learning time for practices	Dedicated training sessions to allow general practice staff to attend training.		Review of Team W effectiveness currently underway. Monitoring via Group Leads.	Jo Reynolds	Summer 2018		Support from MT till late March

Legend for Current Status	
Blue	Not started
Green	Achieved & closed
Amber	In progress within timescale

Red Overdue and/or behind schduled timescale

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WOLVERHAMPTON CCG

Governing Body
10 April 2018

Agenda item 13

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 February and March 2018.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> 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 Easter opening in Primary Care
RECOMMENDATION:	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients



envelope	that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework.
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1. BACKGROUND AND CURRENT SITUATION

To update the Governing Body on the key activities which have taken place December 2017 and January 2018, 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 autumn last year. We have seen a lot of interest in our MECS campaign, both from public and patients.

Two more events have been held to promote the MECS service:

- On 16 February, staff spent the day at Morrisons in Bilston. Even though it was a cold day, staff were able to engage with more than 200 people during the event. The literature, materials and stress balls were really popular!
- 23 March saw staff sharing information about the MECS service at Asda, Molineux.

All the MECs printed materials, postcards, posters and window stickers have now been distributed to opticians and GP practices.

MECS continues to be a popular subject on Twitter, with figures from early March showing that we've sent out 232 tweets, had 90 likes and 108 retweets.

2.1.2 Press Releases

Press releases since the last meeting have included:

- Be prepared – stock up your medicine cabinet now!
- Stay Well roadshows in Wolverhampton to help residents stay well over winter
- Visit your pharmacist first with minor health concerns
- Keep children well this half term
- Cold weather warning for Wolverhampton residents: UPDATED
- Child abuse – if you think it, report it
- Why Wait? - Eating Disorders Awareness Week
- Cold weather warning: people urged to take care in Wolverhampton
- Easter 2018 Pharmacy opening in Wolverhampton
- City makes pledge to become Autism Friendly
- Easter 2018 GP opening in Wolverhampton

2.1.3 Winter Campaign – Stay Well

The winter campaign has continued 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 had two public events in February at Morrisons in Bilston and Wolverhampton Swimming and Fitness Centre. Planetary Road.



Unfortunately, due to snowy weather, our planned engagement with youth membership of Healthwatch Wolverhampton was cancelled. We await the new date to return to that meeting to share with young people the importance of accessing the appropriate local health services.

2.1.4 **Extended Easter opening in Primary Care**

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

For the full details please see our webpage: <https://wolverhamptonccg.nhs.uk/news/606-easter-2018-gp-opening-in-wolverhampton>

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 March edition of the Practice Nurse Bulletin included the following topics:

- Practice Makes Perfect Forum
- Healthy Lifestyles Service (HLS) and GP Smoking Cessation
- Public Health - PGD
- Training
- NHS STP news
- Café Neuro – Wolverhampton
- Changing Our Lives – campaign about postural care
- CCG Bulletin
- Public Health changes

2.2.3 **Members Meeting**

The GP Members Meeting took place on 31 January. Members discussed how Team W meetings could work more effectively for them in the future. They also received updates on QOF+ schemes, Primary Care Workforce and Targeted Pier Review work. Following the updates, Members debated and put forward their views on the two national NHSE Primary Care Prescribing consultations. Their contributions to the consultation have now been submitted to NHSE.

We have started planning for the next members meeting in early May.

2.2.4 **Practice Managers Forum**

The PM Forum has not met yet this year, but has started planning for discussion topics and the schedule of meetings in 2018.



2.2.5 Annual Report

We have started to compile this year's Annual Report.

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 in March with an attendance of 16 members. The meeting commenced with a primary care update from Sarah Southall, it was noted that there are still changes to the groupings being made. This was followed by feedback from each of the practice / forum representatives. It is clear that there remains some significant variations in how the PPGs operate and get engagement and members that are struggling were encouraged to speak to PPG chairs that are having some successes. As agreed at the January meeting the group were presented with an amended version of the Terms of Reference. This amended version saw a split between members in terms of content and length. It was agreed that a small working group would meet in April to go through the differences of opinion.

It was also agreed that Dee Harris would return again to provide more detail about the urgent care centre referral pathways with staff from this service on hand to answer any questions. The update on the urgent care centre was presented in a more pictorial form which helped the members to understand the complexity of the entry routes into the service.

A presentation on the falls service was deferred until the next meeting. The last few minutes of the meeting were used to discuss the May meeting and the opportunity for the group to be consulted on the CCGs commissioning intentions.

5. LAY MEMBER MEETINGS – attended:

- 5.1 Primary Care Commissioning Meeting
CCG Governing Body Meeting



CCG Governing Body Development meeting
Quality and Safety Meeting
1:1 Induction meetings



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: 28 March 2018

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



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	28 March 2018



WOLVERHAMPTON CCG
Governing Body
10 April 2018
Agenda item 14

TITLE OF REPORT:	CCG Annual Equality report 2018
AUTHOR(s) OF REPORT:	David King
MANAGEMENT LEAD:	Sally Roberts
PURPOSE OF REPORT:	This report has been produced to showcase the CCG's annual Equality activity and for publication to meet the CCG's legal duties.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	<ul style="list-style-type: none"> • Annual report showing progress <ul style="list-style-type: none"> ○ EDS2 ○ Equality Objectives • Summary of CCG's position and key areas for work
RECOMMENDATION:	GB to review and note for assurance.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	The report sets out how the CCG is making effective progress around Equality, Inclusion and Human Rights.
1. Improving the quality and safety of the services we commission	Summaries areas of work and progress made.
2. Reducing Health Inequalities in Wolverhampton	Summaries areas of work and progress made.
3. System effectiveness delivered within our financial envelope	Summaries areas of work and progress made.

Governing Body

10 April 2018

Page 1 of 4

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N.B. Please divide the rest of the report into Paragraphs, using numbering for easier referencing.

1. BACKGROUND AND CURRENT SITUATION

- 1.1. This report includes the relevant information for the CCG to meet its publication duty. It includes a full EDS2 report and details of the CCG's new Equality Objectives. It also summarises a review of progress and key focuses for the coming year.

2. NEXT HEADING

The report is divided into the following sections:

- **Foreword**
- **EDS2**
- **Equality Objectives**

3. CLINICAL VIEW

N / A

4. PATIENT AND PUBLIC VIEW

- 4.1. Public engagement is planned on the EDS2 outcomes during 2018.

5. KEY RISKS AND MITIGATIONS

- 5.1. No risks have been identified in the report, though failure to publish by 30th March would be a risk since the CCG would not have met its legal duty to publish.

6. IMPACT ASSESSMENT

Financial and Resource Implications

- 6.1. N/A



Quality and Safety Implications

6.2. There are no implications within the report since it is retrospective and no issues have been identified.

Equality Implications

6.3. No negative impacts are identified and the report showcases the work done.

Legal and Policy Implications

6.4. Publication is a legal requirement, report has been published on the CCG website.

Other Implications

6.5. N / A

Name: David King
Job Title: EIHR Manager
Date: 5/3/18

ATTACHED:

- Annual report

RELEVANT BACKGROUND PAPERS

N/ A

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	Within report	
Finance Implications discussed with Finance Team	N/A	
Quality Implications discussed with Quality and Risk Team	Within report	
Equality Implications discussed with CSU Equality and Inclusion Service	Within report	5/3/18
Information Governance implications discussed with IG	N/A	

Governing Body

10 April 2018



Support Officer		
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)	David King	5/3/18



Equality & Inclusion Annual Report

2017 – 2018

Foreword

This report has been produced to set out a summary of the activity Wolverhampton Clinical Commissioning Group (CCG) has undertaken during the 2017/18 financial year with regard to Equality, Inclusion and Human Rights (EIHR). This report includes details of how the CCG has met its obligations under the Equality Act 2010 and the Public Sector Equality Duty, including the specific publication duties.

This report has been produced by the Arden & Greater East Midlands Commissioning Support Unit EIHR team on behalf of the CCG.

The report is split into the following sections:

- An overview of the CCG's approach to Equality
- The CCG's NHS Equality Delivery System 2 (EDS2) template update
- An update on the CCG's newly adopted Equality Objectives

Included within the CCG's EDS2 template is an overview of the population the CCG serves and relevant health inequalities that exist for the CCG's patients.

Additional information and reports can be found via the following link:

<https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2018>

This includes the CCG's NHS Workforce Race Equality Standard (WRES) publication history.

'Wolverhampton Clinical Commissioning Group is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity'

Wolverhampton Clinical Commissioning Group (WCCG) believes that equality and diversity should include addressing health inequalities as well as being embedded into all commissioning activity. Equality and diversity are central to commissioning plans, where everyone has the opportunity to fulfill their full potential. WCCG also believes that equality is about creating a fairer society and diversity is about recognising and valuing difference in its broadest sense.

Forty six GP practices in the city are members of the CCG and this provides us with the opportunity to work with our patients to improve services and the overall health of the city. Our GP practice membership will ensure the needs and priorities of our population are clearly identified and addressed by delivering the right care in the right place, at the right time by the right people.

This annual report sets out how the Clinical Commissioning Group has performed in meeting its legal duties set out in the Equality Act 2010 and the Human Rights Act 1998.

Summary of Progress

While the report and EDS2 table sets out in detail the CCG's activity and demonstrates that it is meeting its legal duties, this section highlights areas of particular good practice. The CCG's progress is in line with other CCGs and has fully met the requirements of the Public Sector Equality Duty in ensuring services are delivered equitably. The CCG has self assessed its progress as a mix of developing and achieving, in line with the principles of the EDS2 framework. It is intended that the CCG will seek a public / lay review of the relevant evidence and outcomes during 2018 with a view to gaining independent feedback. NHS England has announced a full review of EDS2 and the CCG will thus have due regard to the outcome of these changes in further work. The CCG's Equality Objectives are interlinked with the EDS2 and set out key areas of focus for the CCG however these areas can be set out as follows:

- Enhancing access to services for vulnerable groups
 - Homeless people
 - Those with language or communication support needs
- Ensuring that patient's transition between services including between NHS and Local Authority support is seamless and effective
- Robust assurance around Equality, Inclusion and Human Rights from those who provide services on the CCG's behalf
 - Access to services
 - Information for patients – provide in appropriate formats
 - Services are available when needed
 - Complaints / concerns are identified and lessons learned are acted on
- CCG staff are engaged, supported and protected
- The CCG is a visible system leader within the black country, setting best practice and ensuring the best outcomes for patients.

As a key foundation in delivering these areas of work, the CCG has established a strong robust Equality Analysis process that ensures that all decisions made by the CCG are undertaken with all the information, relevant impacts understood and any negative impact is mitigated where possible. This places the CCG in a strong position to ensure equitable high quality services for all patients. Evidence of this best practice approach can be seen in the published Equality Impact Assessments on the CCGs website. Further examples of specific services can be found in this report (EDS2 section) and previous reports, demonstrating year on year improvement.

The CCG is also pleased to note the positive feedback from staff received in the annual staff survey, the CCG has built a positive culture, with visible accessible leaders and supportive policies as showcased under Goal 3 and 4 of the EDS2 section. This combined with the findings of the NHS Workforce Race Equality Standard illustrate that the CCG's Organisational focused activity on Equality is to continue the current approach as there are no key issues outstanding.

EQUALITY DELIVERY SYSTEM 2 (EDS2)

- Introduction to EDS2
- Overview of CCG population information
 - Overview of CCG health inequalities
 - CCG approach to Equality

If you require this document in an alternative version such as 'Easy to read', Large print, Braille or help in understanding it in your community language please email us at:

Evidence portfolio

Date of publication

30/03/18



Introduction to the Equality Delivery System2 (EDS2)

The EDS2 was first launched by the NHS Equality and Diversity Council in 2011 and was refreshed as EDS2 in November 2013. Although it is not a legal requirement, EDS2 allows the CCG to clearly evidence what actions they are taking as a commissioning organisation to address equality and health inequality issues which are part of the responsibilities under the Health and Social Care Act 2012. Also, it is expected by NHS England (NHSE) that all CCGs will continue to implement it as a mandatory requirement. From April 2015, EDS2 implementation by NHS organisations was made mandatory in the NHS standard contract.

There are four sections: population health outcomes, individual patient experience, supported workforce and inclusive leadership. The key role of CCGs is to work with partners to improve the health and well-being of its population. Over time, the various improvements in health care services, social care, public health, wider environmental and economic factors have served to significantly improve the population's life expectancy and health status. This subsequently means that CCGs as commissioners of health care services have statutory and moral responsibility to put in place measures to improve potential patient and patient experience and satisfaction levels with, the healthcare services they commission for them.

The EDS2 framework was designed by the NHS to support NHS commissioners and providers to meet their duties under the Equality Act. The EDS2 has four goals, supported by 18 outcomes as detailed in the table below. NHS Wolverhampton CCG has used the EDS2 as a tool kit to meet the requirements (Public Sector Equality Duty) under the Equality Act 2010 and in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. Furthermore we have linked the EDS2 to Human Rights, listed below are the Articles.

The **Equality Act 2010** requires all Clinical Commissioning Groups (CCGs) to annually publish information which demonstrates their performance and progress against the requirements of the Public Sector Equality Duty (PSED), for people with characteristics protected by the Equality Act 2010. The nine characteristics are as follows:

- Page 223
- Age
 - Disability
 - Gender re-assignment
 - Marriage and civil partnership
 - Pregnancy and maternity
 - Race (national and ethnic origin)
 - Religion or belief
 - Sex
 - Sexual orientation

Other disadvantaged groups include people who are:

- Homeless
- Live in poverty
- Stigmatised groups i.e. prostitution
- Misuse drugs
- Geographically isolated

The EDS2 was developed by the NHS for the NHS to help NHS organisations, in discussion with their local partners and local people, review and improve their performance in respect of people with a protected characteristic.

The **EDS2 framework** identifies four over-arching goals with 18 outcomes.

- Better health outcomes for all
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership.

Human Rights

Human rights and principles of equality should never be a secondary consideration in the provision of NHS services or in the development of the workforce. The five principles are referred to as FREDA:

Fairness – at the heart of recruitment and selection processes (Goal 3)

Respect – making sure complaints are dealt with respectfully (Goal 2)

Equality – underpins commissioning (Goal 1)

Dignity – core part of patient care and the treatment of staff (Goal 2 & 3)

Autonomy – people should be involved as they wish to be in decisions about their care (Goal 2)

(Goal 4 would be a golden thread as part of all outcomes)

These have been developed to provide general principles that NHS should aspire to.

The Public Sector Equality Duty (PSED)

Using the EDS2 will help organisations respond to the PSED, and demonstrate their continued activities to meet the requirements to:

eliminate unlawful discrimination;

advance equality of opportunity between different groups and;

foster good relations between different groups;

The goals and outcomes of EDS2		
Goal	Number	Description of outcome
Better health outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
	2.3	People report positive experiences of the NHS
	2.4	People's complaints about services are handled respectfully and efficiently
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	3.3	Training and development opportunities are taken up and positively evaluated by all staff
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	3.6	Staff report positive experiences of their membership of the workforce
Inclusive leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Articles of the European Convention on Human Rights

The key human rights articles have been considered:

- Article 2 Right to life
- Article 3 Freedom from torture and inhuman or degrading treatment
- Article 4 Freedom from slavery and forced labour
- Article 5 Right to liberty and security
- Article 6 Right to a fair trial
- Article 7 No punishment without law
- Article 8 Respect for your private and family life, home and correspondence
- Article 9 Freedom of thought, belief and religion
- Article 10 Freedom of expression
- Article 11 Freedom of assembly and association
- Article 12 Right to marry and start a family

- Article 14 Protection from discrimination in respect of these rights and freedoms
- Protocol 1, Article 1 Right to peaceful enjoyment of your property
- Protocol 1, Article 2 Right to education
- Protocol 1, Article 3 Right to participate in free elections
- Protocol 13, Article 1 Abolition of the death penalty

Wolverhampton CCG Equality Objectives

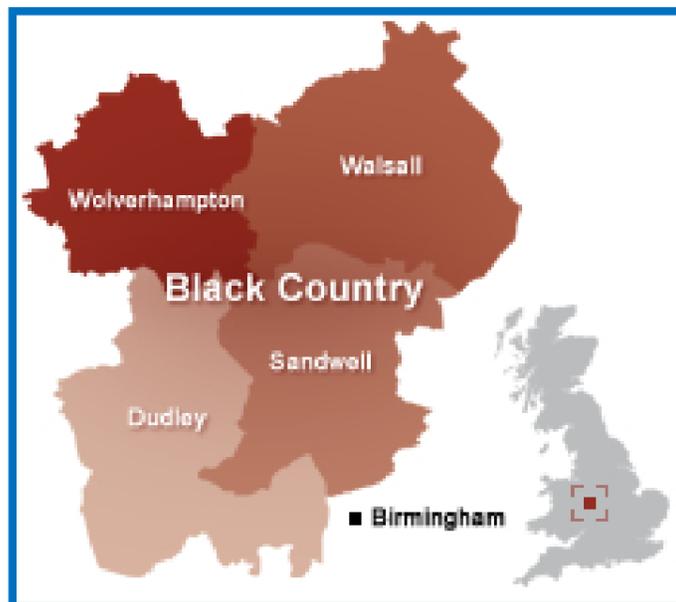
1. The CCG to work towards a comprehensive understanding of the barriers to accessing services experience by patients. To work to reduce the barriers identified with partner organisations and stakeholders.
2. The organisation will ensure that Due Regard is given to the needs of the CCG's population during service change, including vulnerable groups, through effective engagement focused to the profile of the population affected by particular changes.
3. The organisation will use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive supportive values and competencies across the workforce.
4. The CCG's Leadership will, as system leaders continue to visibly champion improved outcomes for vulnerable groups and tackling health inequalities across Wolverhampton and the Black Country.

Vision

Our vision is to provide the right care in the right place at the right time for all of our population. Our patients will experience seamless care, integrated around their needs and they will live longer with an improved quality of

Wolverhampton CCG wants everybody to receive the highest quality and appropriate care for their needs, delivered from the right service, when the patient needs it. The CCG have a range of strategies to help us achieve this. Some might mean the CCG look to change how services work in order to meet the current needs and expectations of local patients. Others, for example, will look to help patients make the right decisions about getting care. An example of this is the CCG's 'choose well' campaign, which you may have seen on buses and in newspapers. This aims to inform patients of all the urgent and emergency care options available to them.

CCG region



Overview of CCG population information

Wolverhampton CCG is committed to design and implement policies, procedures and commission services that meet the diverse needs of the local population and workforce, ensuring that none are placed at a disadvantage over others. As the leader of the local NHS, Wolverhampton CCG, are responsible for spending almost £1m a day on healthcare for the city's 262,000 registered patients. The CCG commission (buy and monitor) everything from emergency/A&E care, routine operations, community clinics, health tests and checks, nursing homes, mental health and learning disability services. As a commissioner, it is the role of the CCG to ensure that the services brought from the many providers of care, including The Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust is of the highest quality and appropriate for the health needs of our city. Wolverhampton CCG, are a clinically-led organisation comprising of 46 member GP practices within the city. This means that local family doctors can use all their experience of the needs and wishes of local patients to make decisions about local health services.

Wolverhampton is one of the four local authorities in the Black Country sub-region. Wolverhampton has a documented history dating back to 985AD. In 2000, Wolverhampton was granted city status. The first Census in 1801 shows Wolverhampton's population as 12,500, in 1901 94,187 and by 1951 the population stood at 162,672. Wolverhampton is now one of the most densely populated local authority areas in England, with a population of 249,470 people (Census 2011) living in its 26.8 square miles, equating to a population density of 3,447 per square kilometre. The latest Indices of Deprivation (2010) indicates that Wolverhampton is more deprived than it was three years ago and represents a relative decline, from the 28th most deprived to the 20th most deprived local authority (out of 326 local authorities). The equalities profile of the borough focuses on the following:

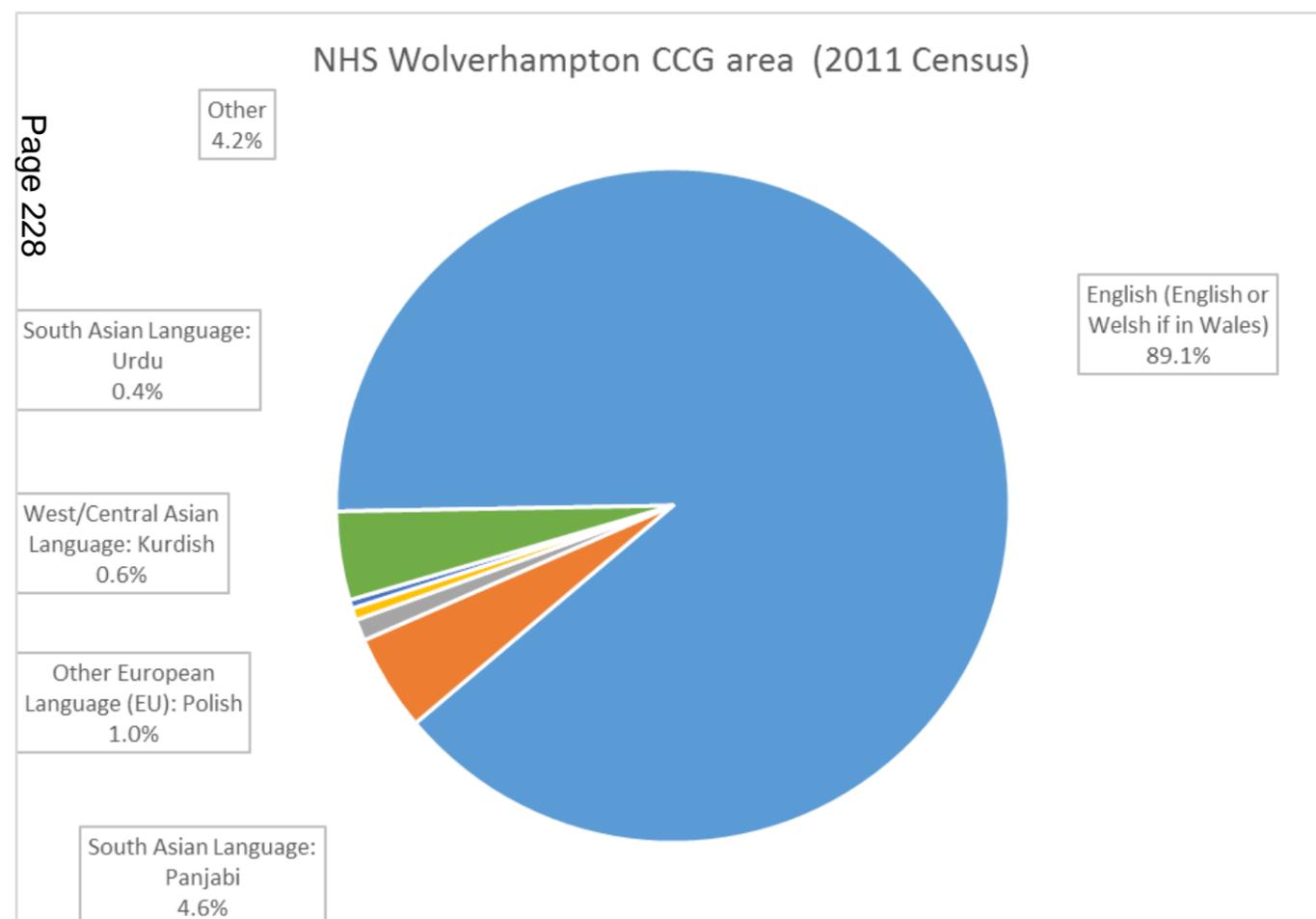
Table 1: The ethnicity profiles of England and NHS Wolverhampton CCG's area based on the 2011 Census (all usual residents)

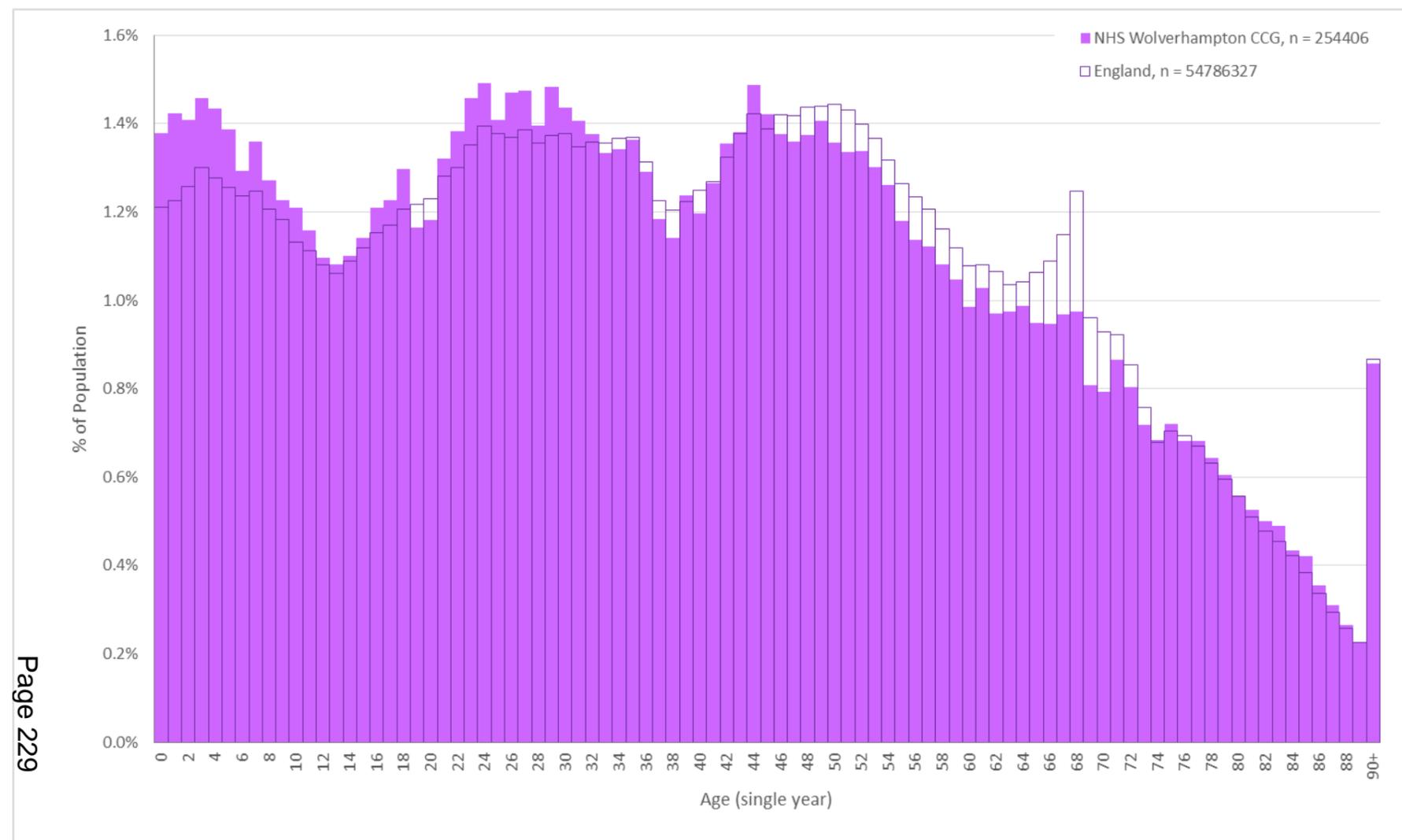
Ethnicity	England		NHS Wolverhampton CCG	
	n	%	n	%
White	45281142	85.42%	169682	68.02%
Asian British	4143403	7.82%	44960	18.02%
Black British	1846614	3.48%	17309	6.94%
Mixed	1192879	2.25%	12784	5.12%
Other	548418	1.03%	4735	1.90%
Total	53012456	100.00%	249470	100.00%

Table 2: The disability profiles of England and NHS Wolverhampton CCG's area based Census (all usual residents)

Disability	England		NHS Wo	
	n	%	n	%
Day-to-day activities not limited	43659870	82.36%	196226	
Day-to-day activities limited a little	4947192	9.33%	25381	
Day-to-day activities limited a lot	4405394	8.31%	23919	9.74%
Total	53012456	100.00%	245526	100.00%

Language profile of the CCG based on 2011 Census:





All information is based on the last census in 2011 but provides a clear picture of the diverse community that Wolverhampton CCG serves.

Population Projections estimate the city’s population will be 273,300 by 2037, an 8.9% rise from their baseline 2012 figure of 251,000. The balance of the population will change: an increase in the number of children, but fewer working-age people, and elderly. Slightly increasing birth rates, and inflow of migration greater than outflow, are important aspects of population growth, but decreasing mortality rates and longer life expectancies point to a steadily aging population overall. Services need to be planned to meet future need.

Overview of CCG health inequalities

A focus on reducing health inequalities

Unacceptable gaps in health exist across Wolverhampton. A baby born today in Bilston can expect to live seven years less than somebody born in Tettenhall. Improving the health of the entire city and reducing health inequalities is very important. The NHS has a key role to play in both treating people when they are ill or injured, and keeping people healthy. In partnership the CCG work with the Public Health team, who are within the City of Wolverhampton Council and together they work hard to promote healthy lifestyles and commission services that help people to make healthier lifestyle choices.

In order for Wolverhampton CCG to tackle the biggest health challenges in the city, three priorities have been identified which are:

1. Dementia – The CCG aim to increase the numbers of dementia patients who are able to stay at home for longer, keeping them out of hospital.
2. Diabetes – The CCG aim to reduce the number of avoidable admissions to A&E.
3. Urgent Care – The CCG want to increase the number of people with the condition who are able to manage their conditions themselves – at home.

Wolverhampton CCG believe by improving outcomes for people in these areas, we will have the best chance at improving the city’s health overall and reducing the health inequalities that remain.

“No decision about you, without you”

When the NHS changes were announced by the government in 2010, a key commitment was made to patients in Wolverhampton. This was that the local NHS would make decisions that were informed by the views of local people. This means the NHS has to get much better at listening to patients' views and using these to influence the decisions it makes. The CCG have a comprehensive engagement framework that enables us to talk and listen to local patient and community groups. We value the time people take to tell us their views and we use the information we gather to help us:

- determine the health needs and wishes of local people;
- decide how we spend our money – including what we need to start and stop doing;
- monitor the quality of the services we commission;
- investigate concerns that people have raised through using services;
- ensure there are a range of ways patients can get involved;

Statement of commitment from the CCG

The CCG believes that equality and diversity should include addressing health inequalities as well as being embedded into all commissioning activity. Equality and diversity are central to commissioning plans, where everyone has the opportunity to fulfill their full potential. The CCG also believes that equality is about creating a fairer society and diversity is about recognising and valuing difference in its broadest sense.

46 GP practices in the city are members of the CCG and this provides the CCG with the opportunity to work with our patients to improve services and the overall health of the city. The CCG's GP practice membership will ensure the needs and priorities of our population are clearly identified and addressed by delivering the right care in the right place, at the right time by the right people.

“Right care, right place, right time within our financial envelope”

CCG Approach to equality

Wolverhampton CCG has committed to have due regard to the Workforce Race Equality Standard (WRES) and use it as a force for driving change, both as an employer and as a commissioner of services.

The CCG will demonstrate its due regard using a combination of activities. Due regard means that the CCG has given consideration to issues of equality and discrimination in any decision that may be affected by them. This is a valuable requirement that is seen as an integral and important part of the mechanisms for ensuring the fulfillment of the aims of anti-discrimination legislation set out in the Equality Act 2010.

Finally, through its contracts with its providers, the CCG will seek assurance that there is evidenced compliance to Equality Act 2010 legislation. This is mainly achieved by Service Condition Section 13 of the NHS Standard Contracts, which sets out the requirements according to organisation type. Using Clinical Quality Review Meetings (CQRM) for larger organisations, the provider submits appropriate and relevant evidence that ensures assurance for the CCG. All providers are expected to demonstrate they understand their service users, workforce and race profile and have self-assessed against the WRES standards, the CCG will wish to see how the providers intend to implement the standard and what the impact will be on any key disproportionate representations of their service users and workforce.

Overarching activities of the CCG

Operating Plan

NHS Wolverhampton CCG 2015-17 operating plan represents the **second and third year** of delivering the Five Year Strategic Plan for Wolverhampton. The intent and strategic direction remains the same, though there are many new elements that shape the local landscape and the national picture:

- Approval of our Better Care Fund plans
- The Dalton Review
- The Five Year Forward View
- The 2014/15 Operating Plan was produced prior to agreement of the Five Year Strategic Plan

This plan demonstrates the CCG understands the borough it serves and identifies changes required to ensure their statement of commitment is delivered.

Comment [KD(A&GC1): Update

Governing Body

The CCG aims to commission the highest quality, evidence-based care on behalf of its patients by investing in skills available locally and otherwise to design new and improved care pathways. The mission of the CCG is:

“We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality sustainable services for all our population.”

Quality and Safety Committee

The Quality and Safety Committee (QSC) is established in accordance with paragraph 6.9.5(c) of NHS Wolverhampton Clinical Commissioning Group's constitution, standing orders and scheme of delegation. The QSC is accountable to the governing body and its remit is to provide the governing body with assurance on the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them. The QSC has specific duties that includes to monitor the group's delivery of the public sector equality duty (constitution 5.1.2(b)).

Equality Impact Assessments (EIAs)

Delivering on equality and embracing diversity is only possible if the impact of services, policies, functions and decisions on the community and staff is analysed. Under the Public Sector Equality Duty of the Equality Act 2010, public services are required to analyse the impact on equality when exercising its functions. The equality analysis is important in order to consider the effect on different groups when decisions are made and identify practical steps to tackle any negative impact. The analysis helps public services to pay due regard to the need to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it
- Foster good relations between persons who share a relevant characteristic and those who do not share it

An EIA should be carried out from the earliest stages of consideration by the CCG to make any changes. It enables managers to address fundamental questions in considering and understanding how a proposal for healthcare changes and can help them to meet all customer requirements. It specifically seeks to address the following issues:

- Is there any direct discrimination?
- Is there any potential for indirect discrimination?
- What engagement has been carried out and who with?
- What was the outcome of any engagement and how has this informed the decisions made?
- Is any group disproportionately affected?
- What are the potential adverse impacts?
- What actions will be taken to mitigate any adverse impact?

This process has been embedded within the CCG's policy, practice and procedures from the scoping stage of commissioning. It has been and will be embedded in our work throughout 2015-17, so the CCG can scrutinise key changes in healthcare for any adverse impacts on local protected groups (both patients and staff). The CCG understands that EIAs support them to consider protected groups in all of its planning and decision making processes, as required by the Equality Act 2010. The CCG undertake more detailed work to promote the use of EIAs for commissioned services, supported by relevant Health Impact Assessments and Health Equity Audits.

Equality Strategy and Equality Objectives

Equality and Diversity is central to commissioning plans, where everyone has the opportunity to fulfill their potential. The CCG strongly believes Equality is about creating a fairer society and Diversity is about recognising and valuing difference in its broadest sense. This covers the relationships with service users, staff, and with other stakeholders. It builds upon the strong foundation for equality, diversity and human rights in the constitution and governance arrangements, it is key to how the CCG make decisions and how a contribution to strategic planning with partners is made. It sets out how the CCG will ensure equality considerations and valuing difference so that it becomes a systematic part of thinking, tone and approach. The CCG's approach to equality and diversity will directly influence the relationships and transactions with individuals, groups and local communities; the way in which the CCG collects, analyses and interprets information and evidence; the collaborative arrangements with provider organisations; and finally the discipline adopted to reflect and consider if the CCG truly understand the consequences of their actions from the different perspectives of the community. This will apply particularly to those who are disadvantaged, vulnerable because of social determinants or ill-health. The current Equality objectives which inform the CCG's strategic direction can be found on page 3 of this document.

Procurement

The CCG procures services from a range of providers. Contracts vary from small one-off purchases to large works or service contracts. Whilst procuring services, the CCG ensure fair opportunity, competition and value for money. The form of procurement used varies depending on the nature of the product or service being procured but can include Any Qualified Provider (AQP) competitive and non-competitive tendering. The CCG follow public procurement regulations and guidelines when determining the form of procurement and approach. The regulations mean the CCG cannot favour providers simply because they are already in contract with the CCG, an NHS organisation, located in the area, or employing local people. The CCG operate procurements in a fair and transparent way in accordance with the Principles and Rules of Co-operation and Competition published by the Department of Health. In line with the requirements set out in the Statutory Guidance for CCGs on managing conflicts of interest in CCGs published in July 2016 by NHS England, the CCG maintain a register of procurement decisions taken, which includes:

- the details of the decision;
- who was involved in making the decision;
- a summary of how any conflicts of interest in relation to the decision have been managed;

This enables the CCG to demonstrate that it is acting fairly and transparently and in the best interest of patients across Wolverhampton

Equality Delivery System 2 (EDS2) Evidence Portfolio

1. Better health outcomes

The NHS should achieve improvements in patient health, patient safety and public health for all, based on comprehensive evidence of needs and results

1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities

How does the CCG design/procure/commission services which are appropriate to its local population? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Wolverhampton CCG aim to provide more personalised care, closer to people's homes. To achieve this, the CCG has set out an ambitious five year strategy to modernise care and look at different ways to deliver services for less. It may take time to bring about this change.</p> <p>The CCG's Commissioning Intentions (CI) demonstrates how the CCG will commission, procure, design and deliver services to meet the health needs of the population it serves. It shapes the strategic direction for 2017/18 and going forward The 'You said we did' demonstrates how the CCG involve and listen to the community - https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did</p> <p>This report highlights the engagement findings and recommendations during an engagement exercise completed during June 2017, on the CCG's proposals to develop, inform and guide the Wolverhampton Clinical Commissioning Group (WCCG) CI 2018/19. Work in 2017/18 will inform the financial year 2018/19. Results of the findings from the engagement results will be made available to the CCG Programme Boards. The Boards may suggest recommendations which may be reviewed by the CCG Governing Body later on in the year. The WCCG Governing Body should then confirm how the evidence gathered will influence the WCCG CI for 2018/19 based on the recommendations from the programme boards.</p> <p>The objectives are:</p> <ul style="list-style-type: none"> To promote (along with other communications plans) the WCCG as an effective custodian of the local NHS that makes decisions in the best interests of local people. Inform commissioning decisions using the engagement cycle and CCG Communications and Participation Strategy, to ensure they are focussed on the needs of service users and communities Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health To define and provide a range of communications and participation products and methods to help people to: <ul style="list-style-type: none"> learn about proposals in detail to help them form an opinion, and know how they can feedback, to share their opinion with us. 	<p>By ensuring that a joined up approach is used in the commissioning of services the CCG ensures that services do meet the needs of the local population. The CCGs use a robust Equality Analysis process to ensure that service design, commissioning and redesign take account of the needs of the population.</p> <p>To ensure the views of the population it serves is taken into account the CCG undertake very comprehensive engagement initiatives. Because of how the engagement is carried out specific views are taken into account and provide focus for key actions.</p> <p>By adopting a more integrated approach it is aimed to prevent people having unnecessary stays in hospital.</p> <p>The CCG are working with all providers to strengthen the service user and carers' voice across service re-design and delivery including evaluation of initiatives across the life span to develop self-efficacy and quality of life.</p>

The setting of CIs is an annual activity that seeks to ensure that commissioners have a clear oversight for delivering their on-going vision for improving local health outcomes, and to let providers know of the contractual changes that will be implemented in the forthcoming year.

CIs for Wolverhampton CCG have been clearly aligned to the following:

- Operating Plan
- Five year forward view
- Primary Care Strategy
- Primary and Community element of the Better Care Fund
- Link to the evidence as set out in the newly refreshed Joint Strategic Needs Assessment (JSNA) for Wolverhampton.

A thorough communications and participation plan was put together and monitored by the Commissioning Intentions Group to inform clinicians and staff within our organisations, partner organisations, patient/community groups and the public about the engagement exercise and how to get involved to share with us their views.

The Commissioning Dept were asked to provide key themes for discussion with the stakeholders.

Communications and Participation approach

A variety of engagement methods were used to share information about the CCG CI and encourage people to share their feedback. Below details each method:

2.1 Scheduled CCG meetings

Date/time	Meeting
06 October 2016	Planning
03 November 2016	Planning
17 January 2017	Planning
06 April 2017	Planning
25 July 2017	Planning
07 September 2017	Planning

Public events

Date/time	Venue	Present
Wednesday 14 June, 9am – 3.30pm	Asda, Molineux Way, Jack Hayward Way, WV1 4DE	public and interested stakeholders
Thursday 15 June, 9am – 3.30pm	Morrisons, Black Country Route, Bilston, WV14 0DZ	public and interested stakeholders
Friday 16 June, morning	Sainsbury's Superstore, Rookery Street, Wednesfield, WV11 1UP	public and interested stakeholders
Friday 16 June, afternoon	Co-op, Low Hill. WV10 9UN	public and interested stakeholders

Direct messages (electronic and paper based)

Type	Date	Reach
Advertise events – emails, press release, web, social media	May/June 2017	To patient partners, PPG Chairs, stakeholders and Citizens Forum, public

<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>Commissioning decisions and activity are informed by patient and public insight, experience and involvement in order to reduce health inequality and to drive improvement.</p> <p>The CCG's <i>Communications and Engagement strategy</i> is available to all staff and is used to inform commissioning work. For primary care specifically, public and patient insight is sought and used through the work of an operational group to support both the work of the <i>Joint Commissioning Committee</i> and to support the CCG's broader role in supporting quality improvement in Primary Care. This work is underpinned by patient feedback (range of sources i.e. surveys, expert patients, PPGs, complaints, compliments, engagement events) that is used to drive improvement. The CCG's approach is based on proactive engagement on a routine basis rather than as an afterthought. At present, further work needs to be done to link this work to health inequalities and this will continue as the CCG moves towards delegated commissioning.</p> <p>a) The Governing Body receive a report on patient insight activity each meeting and all reports include details of patient and public involvement. Specific reports relating to individual pieces of work are presented as and when they take place. b) Patient and Public insight has been used to develop the Primary Care Strategy and is reported through formal processes including the <i>Joint Assurance and Engagement Group</i> and <i>PPG Chairs meetings, Patient Partners forums</i> and <i>quality review work</i>. The CCG are seeking to move to greater involvement for patients in our operational work through the development of a <i>Patient Reviewers programme</i> who will support our work monitoring quality. c) The CCG works closely with Public Health to develop an overall understanding of population needs and health inequalities via the JSNA. This includes evaluation of patient and public insight but not necessarily in a structured way. d) Specific work has taken place to understand access to Primary Care through a structured survey. This formed part of the wider engagement work on the Primary Care Strategy which focusses heavily on population need i.e. health information, feedback from the community and practice understanding of need resulting in care closer to home, in the right place at the right time. e) The CCG works closely with Primary Care to develop mechanisms to gather patient feedback. In particular, the CCG supports the collection of data through the Friends and Family Test and is working closely with New Models of Primary Care delivery to ensure patient needs are at the heart of services. The CCG supports the development and effective operation of Patient and Participation Groups across Primary Care and has encouraged their involvement in the development of new services. Further work will be undertaken to understand and evaluate how effectively this is operating. https://wolverhamptonccg.nhs.uk/publications/corporate-policies-1/493-communications-and-engagement-strategy-1</p> <p>The CCG has put in place a range of contract monitoring requirements to ensure that services are delivered on its behalf in a way that genuinely meets the needs of diverse communities. These contract requirements are set out in sections 1.2 and 2.1. By doing so the CCG ensures that local accountability is maintained and that patients can access services in an equitable manner.</p>	<p>Commissioners understand their organisation's strategic approach and therefore how and why the use of patient and public insight, experience and involvement reduces health inequality and drives improvement.</p> <p>Commissioners seek and gather patient and public insight and experience data in order to inform their commissioning decisions, activity and evaluation.</p> <p>Commissioners use patient and public insight, experience and involvement to identify and fully understand all health inequalities and inequities.</p> <p>Commissioners use patient and public insight, experience and involvement to inform the development of possible solutions, decisions and activity, in order to reduce health inequality and drive improvement.</p>
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>The CCG's Commissioning Committee (CC) was established by the Governing Body, who supports them to discharge their respective responsibilities when commissioning services, according to NHS Wolverhampton Clinical Commissioning group constitution paragraph 6.4.1/6.4.2. https://wolverhamptonccg.nhs.uk/images/docs/Constitution_with_Appendices.pdf - Appendix H5</p> <p>This also includes terms of reference for the various committees.</p> <p>The CC is accountable to the governing body and its remit is to provide the governing body, Director of Strategy and Solutions and Executive Nurse with support in meeting the duties and responsibilities of the group as a commissioner of healthcare services, specifically:</p> <ul style="list-style-type: none"> • acting consistently with the promotion of a comprehensive health service and the mandate issued for each financial year by the Secretary of State to the NHS Commissioning Board, for which the CC will develop a Commissioning Policy (constitution 5.1.2(a)); • securing continuous improvement in the quality of services (constitution 5.2.4); • coordinating the work of the group as appropriate with the NHS Commissioning Board, other clinical commissioning groups, local providers of services, local authorities, patients and their carers, the voluntary sector and others to develop robust commissioning plans (Prime Financial Policies 14.1); 	<p>A consistent way to deliver commissioning duties by developing and delivering annual work programmes giving appropriate focus to the following:</p> <ul style="list-style-type: none"> • develop the <i>commissioning strategy, commissioning plans</i> and <i>annual commissioning intentions</i>, (https://wolverhamptonccg.nhs.uk/about-us/the-governing-body/board-papers/2014-1/november-1/1000-k-agenda-item-10c-gb-report-commissioning-intentions-register-2015-16-11-november-2014-1/file) • anticipating and adapting as required for national and international policy, the group's safeguarding and other statutory responsibilities, local and national requirements and patient expectations; • oversee the annual contracting processes and any other programmes of healthcare service procurement; • review of commissioning policies; • develop service specifications for the commissioning of healthcare services; • consider service and system reviews and develop

				<p>appropriate strategies across the health and social care economy to address any identified issues;</p> <ul style="list-style-type: none"> • review progress against commissioning strategies and plans to ensure achievement of objectives within agreed timescales; • make recommendations as necessary to the governing body on the remedial actions to be taken with regard to key risks and issues associated with the commissioning portfolio;
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>The CCG's Equality and Diversity Strategy 2013 – 2017, is inclusive of the equality objectives. The strategy sets out the CCG's commitment, vision and approach to integrating equality and meeting all legal requirements.</p> <p>https://wolverhamptonccg.nhs.uk/images/docs/Wolverhampton-CCG-Equality-Strategy-11_10_20131.pdf</p> <p>The CCG has now published new Equality Objectives for the period 2018-2021, these help set the direction for the next three years. Updates will be published on progress made against them on the CCG's website.</p> <p>https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2016</p>	<p>Targeted action to improve outcomes for patients and maintain a supported diverse workforce.</p>
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>Equality Analysis is an integral part of the commissioning process from the earliest point. Public services are required to analyse the impact on equality when exercising its functions. The equality analysis is important in order to consider the effect on different groups when decisions are made and identify practical steps to tackle any negative impact.</p> <p>The analysis helps public services to pay due regard to the need to:</p> <ul style="list-style-type: none"> • Eliminate discrimination, harassment and victimisation • Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it • Foster good relations between persons who share a relevant characteristic and those who do not share it <p>Equality triggers have been embedded into the project process from the scoping stage.</p> <p>The strategic process inclusive of equality is well documented and shared with all relevant staff.</p> <p>An operational process map is being documented for approval, to ensure clarity by all.</p> <p>There has been refresher training for relevant staff and a coaching approach was used in an effort to develop an understanding of;</p> <ul style="list-style-type: none"> • Why Equality Impact and Risk Analysis are important • Better understanding • Responsibilities 	<p>Equality and Inclusion is an integral and embedded part of the Equality Analysis and all staff including staff at senior Management levels knows what they should be doing when commissioning services and discharging its duty.</p> <p>It provides assurances to the CCG that this process/procedure supports meeting their legal and moral obligations as outlined in the Equality Act 2010.</p>
<p>Age Disability Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>The CCG has articulated the local need for children and young people in their commissioning plan. Although this does not specifically state Special Educational Needs and/or Disabilities (SEND), commissioning children and young people's services in a more effective and efficient way will have a positive impact on children and young people with SEND.</p> <p>The JSNA is now final to further aid evidence of SEND need.</p> <p>Based on this information, a number of services are commissioned and routinely reviewed in conjunction with families.</p> <p>Service redesign of some services is planned to ensure that all services continue to meet the needs of the local changing SEND population so that any potential gaps can be identified.</p>	<p>The CCG understand the local SEND population and services are commissioned appropriately to ensure needs are met. As a result outcomes improve for this group and Due Regard is given to the needs of this group of patients across services.</p>

<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>The CCG commissions Mental Health Services in line with statutory guidance, constitutional requirements, national policy and good practice guidance.</p> <p>The CCG have a range of stakeholder engagement forums and a number of governance processes that define our commissioning intentions and plans.</p> <p>These are articulated in the CCG operational plan and the Mental Health Strategy</p> <p>The CCG have achieved the following re-commissioning and transformation :</p> <ul style="list-style-type: none"> • Urgent MENTAL HEALTH care pathway • Children & Adolescent Mental Health Services (CAMHS) care pathways • Improving Access to Psychological Theory (IAPT) re-design • Learning Disability Community Services • Diagnostic Care pathways for Attention Deficit Hyperactivity Disorder (ADHD) and Autism 	<p>Recognised by National Health Service England (NHSE) as an outstanding CCG.</p> <p>Lead CCG for Mental Health Work Stream of the Black Country & West Birmingham (BCWB) Sustainability Transformation Plan (STP).</p> <p>By ensuring parity of esteem the CCG ensures that high quality services are delivered and meet the needs of a range of patients equitably.</p>
	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>Wolverhampton Clinical Commissioning Group have commissioned a new social prescribing pilot project in partnership with Wolverhampton Voluntary Sector Council. Social prescribing is a way of linking patients in primary care with sources of support within the community.</p> <p>It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.</p> <p>WV Social Prescribing Link Workers do?</p> <ul style="list-style-type: none"> • Accept referrals from GPs and other professionals within the GP practice • Build relationships with a range of health workers and voluntary and community sector providers; • Support people to connect with alternative sources of social and emotional support within their locality • Work with health teams to identify common issues that can be supported by the voluntary and community sector • Provide a holistic and integrated approach to support vulnerable individuals to improve their health and wellbeing <p>This service can support:</p> <ul style="list-style-type: none"> • Patients with long term conditions that could benefit from individualised support • Patients who are lonely • Patients who show mild symptoms of anxiety and/or depression • Circumstances where a medical solution or intervention is unlikely to be successful or satisfactory. • Patients who frequently access NHS services for non medical reasons • Who this service is unable to support: • Patients under the age of 18 • Patients for whom a medical intervention is required 	<p>The service has ensured that patients have access to additional support that helps provide a route to ensure all patients needs are met not just those medically treatable. With the current pressure to local authority and voluntary sector budgets the need for additional support is increased. In addition it assists GPs in navigating the complex and changing landscape of support which might otherwise limit their ability to address patient's non-medical needs.</p> <p>At the end of the pilot the CCG will review how the outcomes have been met, the benefit to patients and GPs and consider the options for further funding.</p>

1.2 Individual people's health needs are assessed and met in appropriate and effective ways

How does the CCG ensure individual health needs are met effectively? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The Joint Strategic Needs Analysis (JSNA) supports the CCG to understand the make-up, health needs and health inequalities of the population it serves. This work stream within Wolverhampton develops two kinds of JSNA Products – JSNA Overview Report and Topic specific JSNAs.</p> <p>The topic specific JSNAs aim to establish the current and future health and social care needs of the local community for that topic. It provides an overview of services currently in place to meet those needs and helps to identify the gaps and actions which partners may need to take to improve the outcomes for that particular topic.</p> <p>An important part of the JSNA process in Wolverhampton is to identify and prioritise topics which are of utmost importance to stakeholders as well as the public to develop the topic-specific JSNAs.</p> <p>We would like to invite you to complete this survey to help us understand which topics are important to you.</p> <p>http://www.wolverhampton.gov.uk/jsna</p>	The JSNA provides the CCG with baseline data that allows it to review the population profile and take due regard to health inequalities in its decision making.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>You said we did - Demonstrates what the CCG have done following engagement or consultation work. Listening and acting upon the feedback that patients and the public have taken time and effort to share is very important to the CCG.</p> <p>Wolverhampton CCG want to show how the CCG's decision-making has been enhanced by talking and listening to local people.</p> <p>https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did - Also linked to outcome 1.1</p>	By publishing this document the CCG demonstrates that it is taking account of feedback and how it has been used in the decision making. As a result those engaged with can feel more confident that their opinions are listened to and influence decision making.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Commissioning decisions and activity are informed by patient and public insight, experience and involvement in order to reduce health inequality and to drive improvement.</p> <p>The CCG Monitors Secondary Care Providers in line with national contract obligations and their work to gather and use patient insight and this is regularly discussed through Quality Review Meetings and reported to the Governing Body via Quality and Safety Committee. Patient engagement in secondary care settings i.e. acute and mental health is improving and where possible joint working between the CCG and providers is encouraged. Significant issues are escalated as appropriate, but more work is required to explicitly link to health inequalities.</p> <p>The CCG applies the following contractual requirements around E and D to ensure that the needs of individual patients are met appropriately.</p> <p>1. Equality and Diversity Compliance:</p> <p>a) Demonstrate full compliance with Equality and Human Rights Legislation in line with the EIHR protocol. (Detail set out in requirements 1, 2, 4 and 6 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).</p> <ol style="list-style-type: none"> i. Equality Act 2010 ii. Public Sector Equality Duty (PSED), including the duty to publish information in relation to the equality profiles of service users and the workforce. iii. Evidence of Equality Analysis and Due Regard processes. iv. Action plans and progress in addressing issues identified. <p>b) Demonstrate compliance with NHS Contractual requirements (requirements 3, 5, and 7 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).</p> <ol style="list-style-type: none"> i. Equality Delivery System2 (EDS2) ii. Workforce Race Equality Standard (WRES) iii. Workforce Disability Equality Standard (WDES) <p>Action plans and an update on progress in addressing issues identified.</p>	<p>The contract requirements ensure that a diverse range of patients can access services. For example providers have to give proactive assurance of the physical accessibility of their service and that they have arrangement for interpreting and translation in place. In addition the CCG requires providers to include in their report details of the profile of patients who are accessing services. By reviewing this year on year trends can be identified and key priorities reviewed.</p> <p>Commissioners require Provider Organisations to agree, understand and promote a strategic approach to using patient and public insight, experience and involvement to reduce health inequality and to drive improvement.</p> <p>Commissioners require Provider Organisations to use patient and public insight, experience and involvement to inform decisions, actions and evaluation throughout the Provider Organisation in order to reduce health inequality and to drive improvement.</p> <p>Commissioners require Provider Organisations to continually improve how they use patient and public insight, experience and involvement to reduce health inequality and to drive improvement.</p> <p>As a result the CCG can be confident that all patients including those from vulnerable groups are able to access services and should any issues arise, these will be identified</p>

			<p>These contractual requirements ensure that providers are required to evidence to the CCG how they are meeting their legal duty and are delivering the best possible outcomes for all patients. In particular the provider must satisfy the CCG that vulnerable group's needs are met and that access to services is equitable.</p> <p>Further work is required to link health inequalities specifically to Clinical Quality Review Meetings (CQRMS), and the contracting mechanism.</p> <p>https://wolverhamptonccg.nhs.uk/images/docs/Constitution_with_Appendices.pdf - Quality and Safety Committee Appendix H3</p>	so that they can be addressed.
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>Patient Choice supports patients to choose where they have their NHS treatment. The NHS is offering more and more options to enable patients to make choices that best suit their circumstances, giving greater control of their care and hopefully better results.</p> <p>View what choices are currently available to NHS patients in the NHS Choice Framework on GOV.UK. Here information can also be found about when a patient can't choose, for example, if there is a need for emergency care or a member of the armed forces.</p> <p>https://wolverhamptonccg.nhs.uk/your-health-services/patient-choice</p>	Increased patient involvement and increased choice supports the CCG in delivering the best quality person centred care
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>The Learning Disability Assessment and Treatment Service - Pond Lane - is a hospital for adults with learning disabilities who are registered with a Wolverhampton GP and who need to go into hospital because of a mental health problem or a behaviour that is labelled as challenging. People are supported with their mental health problems by specially trained team of staff – including nurses, psychiatrists, occupational therapists and psychologists. People stay at Pond Lane for a short time, and go home as soon as they are well enough.</p> <p>Things need to change because the Pond Lane site is isolated from the Trust's and other services for people with learning disabilities. This raises environmental, clinical and staffing concerns which have an impact on the delivery of the service to this very vulnerable group. The CCG in partnership with Black Country Partnership Foundation Trust (BCPFT) feel that a clinically safer and more viable service could be provided at BCPFT's other Learning Disability Inpatient services in Dudley, Walsall and Sandwell. All of these services are less isolated and provide a full Assessment and Treatment Service. They are all accessible by public transport.</p> <p>https://wolverhamptonccg.nhs.uk/images/NHS_Arden_8pp_Document_web.pdf https://wolverhamptonccg.nhs.uk/images/easy_read_consultation_lo_res_v5a.pages.pdf</p> <p>Pond Lane linked to 1.3</p>	<p>Clinical safety will be improved through the provision of more robust clinical cover arrangements, particularly at night and at weekends and by nature of being on a larger site.</p> <p>Single-sex accommodation will be able to be delivered as Black Country Plans with the Trust seek to have inpatient provision concentrated on only three sites.</p> <p>Clinical effectiveness will be improved through delivering inpatient services over few sites, with more expertise focused onto three wards.</p> <p>Patient experience will be improved due to the delivery of a safer, more clinically effective model of care.</p> <p>Enhanced assurances around safeguarding.</p> <p>Enhanced compliance with:</p> <ul style="list-style-type: none"> • Winterbourne Concordat 2010 • The National Plan - Building the Right Support 2015 • Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition Service model for commissioners of health and social care services 2015 • NICE Guideline: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges • NICE Learning disabilities: challenging behaviour Quality standard • NICE Guideline: Mental health problems in people with learning disabilities: prevention, assessment and management 2016 • Equality Act 2010

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Wolverhampton WCCG commissions (buys) Musculoskeletal (MSK) services on behalf of the population of Wolverhampton. MSK services diagnose, treat and care for conditions or injuries that affect muscles, tendons, ligaments, bones, joints and associated tissues for example arthritis, back pain, and osteoporosis. Such services can include treatment by a physiotherapist, rheumatologist or orthopaedic care. The service commenced in April 2017 and performance is good; waiting times are between 4-6 weeks and patient feedback has been positive.</p> <p>https://wolverhamptonccg.nhs.uk/images/docs/MSK_consultation_evaluation_report_FINAL.pdf</p>	<p>Provide a more streamlined, efficient, high quality service for patients, in a local community setting.</p> <p>Provide a value for money service.</p> <p>Patients managed within one integrated service with access to appropriate specialists/diagnostics and interventions</p> <p>Patients will receive education and advice on self-management where appropriate;</p> <ul style="list-style-type: none"> • Services closer to home, in the community, reducing the need to travel • Reduced visits to secondary care • Quicker access to diagnostics and treatments • Holistic approach/MDT approach to care management/treatment plans • Streamlined patient journey with easy access back into the service once discharged • Need for GP referral into different specialties' reduced resulting in a speedier patient journey • Health economy – greater community provision and increased education/awareness • Future providers/staff – new opportunities, improved ways of working.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Communications and Engagement Strategy for the CCG, sets out the strategic vision. It builds on the legacy of strong communications and engagement which already exists and outlines the ambitions for patients, members and other stakeholders to work in partnership with the CCG to deliver improved health outcomes for the population of the CCG.</p> <p>Wolverhampton CCG is a diverse city with many residents who face complex and challenging health needs. The CCG would like to ensure all residents have a voice in local health services. The CCG have already made excellent links to many patients and community groups across the city and are very much committed to seeking the views of those groups who may not have been heard in the past. Page 10 of the document clearly identifies equality as a key driver for engagement.</p> <p>https://wolverhamptonccg.nhs.uk/publications/corporate-policies-1/493-communications-and-engagement-strategy-1/file</p>	<p>The CCG has worked to ensure that it provides the opportunity to comment and shape services across the CCG's population base.</p>
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The Interpreting Services provide an interpreting service to be used by GP practices and Dentists within Wolverhampton CCG.</p> <p>Linked to 2.1 and 2.2</p>	<p>Procure a high quality service that meets the needs and requirements of Wolverhampton.</p> <p>Improved access and experience.</p>
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Children and young people with SEND are identified through the Education, Health and Care (EHC) Process and their health needs assessed and monitored via this process http://wolvesiass.org/wp-content/uploads/2016/02/Education-Care-Health-Plans-New-Editon.pdf</p> <p>The Designated Medical Officer (DMO) is a Medical Director, whom works at the acute trust and is therefore able to communicate well with providers. Part of the DMO role is to co-ordinate the health advice for the EHC plans from both the acute trust and the CAMHS trust and to ensure advice is returned in a timely manner. The EHC plans will also specify other health needs which are not related to a child or young person's Special Educational Need.</p>	<p>Children and young people with SEND are assessed in a timely way to meet their needs.</p>

Comment [KD(A&GC2): Update

			<p>The CCG has formal oversight of all EHC plans requiring health input and therefore is involved in the moderation and review of these. Any issues in relation to the effectiveness of services are raised with relevant managers of services.</p> <p>Regular attendance at the EHC funding panels where wider demands are recognised and addressed enables the CCG to see whether health needs are assessed and met in appropriate and effective ways particularly when taking the needs of the post 16 cohort into account.</p> <p>A specific focus group to review the Children's Continuing Care process will be developed.</p>	
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion or belief Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 8 Article 14</p>	<p>Mental Health - The intermediate care team deliver the National Framework for NHS Continuing Health Care (CHC). This is an end to end service, including a single point of referral, assessments, reviews and commissioning of care to meet identified needs. We collect the equality data as part of the assessment process. Patients and, if they wish their families/carers, are fully involved in the process and are given choices as to how the care is delivered; including the option of a personal health budget to support their needs.</p> <p>We have a Care Home Framework within the city; which is a quality based NHS Contract that care homes could apply to join. Opportunities to join this will be provided on at least an annual basis via an AQP procurement exercise.</p>	<p>High quality services are delivered offering the best possible outcome for all patients including diverse and vulnerable groups. Outcomes include:</p> <ul style="list-style-type: none"> • CCG Recognised by NHSE as an area of good practice. • Monthly completion of quality dashboards and monitoring. • Quarterly quality/contract review meetings.
Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 14</p>	<p>Seamless care for patients – A new Strategy, will explain how primary care will change and be delivered over the next few years. It will describe how more services will be delivered locally, meaning more opportunities for GPs and specialist nurses offering specialist care in the community; as well as increasing job satisfaction it will help to attract the necessary health care staff to Wolverhampton that will be needed to provide this service. It will also mean patients will gain more support in their own community and homes with less hospital visits.</p> <p>https://wolverhamptonccg.nhs.uk/news/blogs/221-seamless-care-for-patients-thanks-to-new-strategy</p>	<p>Patients can access care effectively and will not be required to travel long distances or spend time as inpatients unnecessarily.</p>
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 14</p>	<p>Urgent and Emergency Care Services - In summary, the plans describe how urgent and emergency care services will be brought together into a new purpose-built centre, based at New Cross Hospital which will be open all day, every day. This was successfully completed and opened in November 2015. The new Urgent and Emergency Care Centre building accommodates a number of services, including the new Emergency Department which was the first element of the urgent emergency care services.</p> <p>The second element of the plans was the development of an Urgent Care Centre. The Walk in Centre at Showell Park and the GP Out of Hours Service came together to form the Urgent Care Centre based in the new Urgent and Emergency Centre on the first floor above the Emergency Department in April 2016. This means that any patients who self-present to the Emergency Department will have the opportunity to speak to a nurse to determine if their care can be managed more appropriately in the Urgent Care Centre.</p> <p>https://wolverhamptonccg.nhs.uk/your-health-services/improving-urgent-care</p> <p>https://wolverhamptonccg.nhs.uk/news/193-improving-urgent-care</p>	<p>Enhanced urgent care services improve outcomes for patients, reducing waiting times and where care can be effectively provided elsewhere they can be triaged effectively.</p>
<p>Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation</p>	<p>Objective 1 Objective 2 Objective 3 Objective 4</p>	<p>Article 2 Article 3 Article 5 Article 14</p>	<p>The Children in Care Council (CiCC)</p> <ol style="list-style-type: none"> 1. Statutory health assessments for all of our Looked After Children (LAC) should gather their views and feelings. Each assessment is quality assured against a national screening tool that requires the voice of the child to be captured. 2. Joint CCG and local authority quality assurance visits to placements where an issue has been identified. This would involve audit of documentation and wherever possible direct liaison with the child. 3. LAC training delivered by the Named Nurse for LAC (RWT) includes the importance of obtaining the voice of the child. 	<p>The CCG gains assurance that this group of patient's needs are met.</p>

			<p>4. The Children in Care Council (CiCC) is a group of Looked after Children and Young People who help to shape the care system. The group is made up of young people aged 11 to 18 years old who meet at least once a month.</p> <p>5. All reports that are presented to the Corporate Parenting Board are sent to the CiCC beforehand for their information and comments, ensuring they are aware of any issues that may impact or affect them in any way. Please see www.wolverhamptonlac.co.uk for further information.</p> <p>6. Internal and external case files audits for commissioned services.</p> <p>7. Mind of My Own (MOMO) is a multi-platform app that modernises the processes and systems used to involve children and young people in their care and protection. Please see http://www.mindofmyown.org.uk/ for further information.</p> <p>Currently this is used by social workers but it is hoped that in the near future this app may be available for children to use during statutory health assessments.</p>	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>A pathway for obtaining health advice for young people aged 19-25 who have SEND is currently being developed with funding identified for GP advice along with a training session to ensure the advice provided is appropriate and meets the needs of the SEND agenda.</p> <p>An associated Business Case will also be developed for CCG consideration as to how this can be addressed if appropriate.</p> <p>A paper is currently being developed seeking commitment to assurance that we currently commission the breadth of health services identified in EHCPs of young people 19-25 years.</p>	High quality appropriate dedicated services are available for this group.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Mental Health – The CCG work jointly with our LA colleagues to ensure that if a person no longer meets eligibility for CHC the transfer of responsibility is undertaken in a structured way; following the correct processes.</p> <p>The CCG have also introduced a transition programme for young people with complex care needs who may be eligible once they reach 18 for adult CHC.</p> <p>We commissioned Changing Young Lives to co-produce improved pathways for young people moving into adult services.</p>	Patients experience a structured transfer and are not left with a care gap or left waiting for information.

1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse

How does the CCG ensure patient safety is a priority and ensures patients are free from mistakes/mistreatment/abuse? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Adult Safeguarding – The CCG believes that living a life that is free from harm and abuse is a fundamental right of every person. It acknowledges its statutory responsibility to promote the welfare of children and young people, and to protect adults from abuse and risk of harm.</p> <p>The CCG aims to commission services that promotes and protects individual human rights and effectively safeguard against abuse, neglect, discrimination or poor treatment. The CCG recognises that safeguarding adults and children is a shared responsibility and ensures appropriate arrangements are in place to co-operate with the local authority in the operation of the safeguarding boards. The CCG recognises and supports the need for robust and proportionate information sharing arrangements between health professionals and partner agencies to ensure the safety and wellbeing of children, young people and adults and in the interests of public safety.</p> <p>The CCG is currently developing a joint children and adults commissioning policy. https://wolverhamptonccg.nhs.uk/your-health-services/safeguarding https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/562-adult-safeguarding-policy-1/file</p>	By ensuring effective and robust safeguarding processes are in place the CCG ensures that relevant patients are protected and kept safe.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Children’s Safeguarding – The CCG believes that living a life that is free from harm and abuse is a fundamental right of every person. It acknowledges its statutory responsibility to promote the welfare of children and young people and to protect adults from abuse and risk of harm.</p> <p>The CCG aims to commission services that promotes and protects individual human rights and effectively safeguard against abuse, neglect, discrimination or poor treatment. The CCG recognises that safeguarding adults and children is a shared responsibility and ensures appropriate arrangements are in place to co-operate with the local authority in the operation of the safeguarding boards. The CCG recognises and supports the need for robust and proportionate information sharing arrangements between health professionals and partner agencies to ensure the safety and wellbeing of children, young people and adults and in the interests of public safety.</p> <p>https://wolverhamptonccg.nhs.uk/your-health-services/safeguarding https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/562-adult-safeguarding-policy-1/file</p>	By ensuring effective and robust safeguarding processes are in place the CCG ensures that relevant patients are protected and kept safe.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Clinical Quality Review Meeting (CQRM) – The CCG is the host commissioner of services delivered by various providers. As far as possible the CQRM will be used by commissioners for clinical quality discussions with provider representatives in an attempt to minimise replication and burden to the provider as there can be multiple commissioners.</p> <p>Representation will be required from both commissioning organisations and the contracted provider with a responsibility for reviewing the overall quality and performance of the commissioned service(s) to ensure patient care is delivered safely and focused on providing a positive experience for patients.</p>	Quality of service assurance. Compliance with required standards, constitutions and legislation.
			Pond Lane linked to 1.2 & 1.3	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Healthwatch are a member of the Health SEND work streams and invited to all meetings. Healthwatch have also arranged meetings with the Children’s Commissioner and relevant service leads concerns have been raised.</p> <p>Quality Assurance visits are carried out.</p> <p>All providers are expected to clearly set out their Complaints management process and have Whistleblowing and Safeguarding procedures in place.</p>	

All providers are expected to follow safe recruitment processes.

1.5 Screening, vaccination and other health promotion services reach and benefit all local communities

How does the CCG work in partnership to support health promotion in its local communities? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
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Not completed by CCGs as this is a Public Health function

2. Improved patient access and experience

The NHS should improve accessibility and information, delivering the right services that are targeted, useful and useable in order to improve patient experience

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

How does the CCG ensure all people can access healthcare services where no one is discriminated against and denied access on unreasonable grounds? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The CCG relies upon those organisations who provide services on its behalf to deliver services in line with the agreed specification and the principles of equitable access. To ensure these services are delivered in such a way. The CCG places a number of contractual requirements on the providers to ensure it can check – these are included below:</p> <ul style="list-style-type: none"> c) Demonstrate full compliance with Equality and Human Rights Legislation in line with the EIHR protocol. <i>(Detail set out in requirements 1, 2, 4 and 6 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).</i> <ul style="list-style-type: none"> v. Equality Act 2010 vi. Public Sector Equality Duty (PSED), including the duty to publish information in relation to the equality profiles of service users and the workforce. vii. <u>Evidence of Equality Analysis and Due Regard processes.</u> viii. Action plans and progress in addressing issues identified. d) Demonstrate compliance with NHS Contractual requirements <i>(requirements 3, 5, and 7 of the Equality, Inclusion and Human Rights Recommendations for Providers Contracts 2017 – 19).</i> <ul style="list-style-type: none"> iv. Equality Delivery System2 (EDS2) v. Workforce Race Equality Standard (WRES) vi. Workforce Disability Equality Standard (WDES) <p>Action plans and <u>an update on progress</u> in addressing issues identified.</p> <p>These contractual requirements ensure that providers are required to evidence to the CCG how they are meeting their legal duty and are delivering the best possible outcomes for all patients. In particular the provider must satisfy the CCG that vulnerable group’s needs are met and that access to services is equitable.</p> <p>In addition the CCG will review provider’s complaints reports, lessons learned and any complaints made by patients to the CCG. By doing so the CCG ensures that it is aware of any issues and that remedial action is taken. On occasion there will be an equality related issues within a reported Serious Incident or Never event, in such a case the remedial action agreed in response will have due regard to that issue.</p>	<p>By ensuring through robust monitoring and complaints analysis the CCG can be assured that patients are able to access services and that an individual’s needs are taken into account.</p>
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The Quality Nurse Advisors role is to provide assurance to the CCG that the care delivered in Care Homes is safe, high quality, effective and responsive to the needs of the individual. The Quality Nurse Advisors assess care delivery by carrying out quality monitoring visits and analysing data received from care homes on the national safety thermometer and the monthly quality indicator submissions.</p> <p>The CCG developed best practice guidelines that were based on need for example; poor record keeping and pressure injuries. The CCG has won an award for a tool to risk assesses and audit pressure injury.</p>	<p>The CCG is assured that care home resident’s needs are met and that services are effective and appropriate. Where issues do arise these are addressed robustly and lessons learned developed.</p>

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	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The Interpreting Services linked to 1.2</p> <p>High quality interpreting services are key to ensuring that patients can access services effectively. The CCG has put in place a contract that ensures that interpreters are available when required for GP and Dental appointments. The provider is required to ensure that such interpreters are fully qualified to the required standard and subject to DBS checks and other requirements.</p> <p>Where organisations provide services on behalf of the CCG they are also required under their contract to have interpreting and translation services in place to meet the needs of patients when required.</p>	Access to such services ensures due regard to the accessible information standard and ensures that barriers in accessing NHS services are removed.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Accessible Information Standard (AIS)</p> <p>The CCG has fully committed to following the principles of the NHS Accessible Information Standard. It also monitors the compliance of those organisations that provide services on its behalf. Through the Quality Schedule and through complaints / feedback the CCG proactively works to ensure access for all patients to services, working with GPs and providers.</p> <p>Within the schedule for each contract the CCG includes a range of requirements including around the AIS.</p> <p>These requirements ensure that services provided on the CCG's behalf are accessible and that each provider is meeting their legal duties and the requirements of holding an NHS contract.</p>	<p>The AIS is key to ensuring that all patients can access services especially those who have additional communication needs.</p> <p>The CCG's implementation of the AIS has ensured that communications it makes are accessible to all patients and through its contract monitoring process it is assured that both Primary Care and Commissioned services also have fully implemented the AIS.</p> <p>By starting with primary care services, the CCG ensures that when a patient is referred onto other services their communication needs are known and can be met.</p> <p>The contract requirements ensure that a diverse range of patients can access services. For example providers have to give proactive assurance of the physical accessibility of their service and that they have arrangement for interpreting and translation in place. In addition the CCG requires providers to include in their report details of the profile of patients who are accessing services. By reviewing this year on year trends can be identified and key priorities reviewed.</p>
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The SEND Local Offer provides information in a single place for children and young people with special educational needs (SEND) and their parents or carers http://www.wolverhampton.gov.uk/send/health</p> <p>Parents/carers are able to comment on the Local Offer in a 'You Said, We Did' format with the responses published to ensure that the site is continuously improving.</p> <p>Parents were proactively engaged in the initial designing of health pages for the Local Offer and ensuring that it is useful, useable and meets their needs.</p> <p>They continue to be involved when issues are raised via the Local Offer to comment on the responses to ensure that they are parent friendly.</p> <p>Routine Contract Review meetings to address any issues.</p> <p>Parents are actively involved in the Health Work-stream and as a result are able to discuss with commissioners and service leads any issues that have been reported to them regarding the services commissioned by the CCG.</p>	<p>Wolverhampton's work on the health component of the Local Offer has received national recognition in the Contact A Family good practice guide for parent participation.</p> <p>Families should be able to navigate the site so that all information in relation to SEND is accessible, up to date, comprehensive and transparent.</p>

Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	Mental Health - Discharge to Assess Programme has been developed to improve patient transfers when they no longer require acute care but are unable to return to their usual residence without support or require a period of care within a bed based provision (intermediate Care). This is a collaborative programme of work with the CCG, Local Authority and acute trust that will ensure a system wide approach to the changes required.	This minimises delayed transfers of care and individuals no longer requiring acute care will receive a period of assessment and support in the most appropriate setting to maximise their potential and minimise their long term care needs.
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2.2 People are informed and supported to be as involved as they wish to be in decisions about their care

How does the CCG ensure that people are at the centre of the decisions about their care? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>End of Life Care – “Helping residents live well until they die, and die well where they choose”</p> <p>The aim of this strategy is to detail Wolverhampton’s integrated approach to the design and delivery of a person centered, integrated, end to end, End of Life care service. The CCG believes this strategy will deliver a flexible, responsive, quality service to those approaching the end of their lives. It will provide reassurance that services will be wrapped around the patient at this difficult time and will facilitate person centered care encompassing the following elements:</p> <ul style="list-style-type: none"> • Early identification of the dying person to ensure patients are receiving appropriate care • Advance care planning to facilitate the persons needs and wishes • Coordinated care to ensure people don’t fall through gaps • Optimum symptom control based on clinical need • Choice to support preferred place of care and death • Workforce fit for purpose <p>Future planning will see the beginnings of conversations with different ethnic groups.</p> <p>https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/1496-wolverhampton-integrated-end-of-life-care-strategy/file</p> <p>https://wolverhamptonccg.nhs.uk/news/288-health-and-social-care-set-to-work-together-to-deliver-improved-end-of-life-care-for-wolverhampton-patients</p> <p>https://wolverhamptonccg.nhs.uk/images/end_of_life_newsletter_patients_pub2.pdf</p> <p>Patients satisfaction survey - www.ncpes.co.uk</p>	Integrated approach to a person centered, end to end and End of Life care service.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Cancer Strategy 5 Year Plan – There are 6 priorities;</p> <ol style="list-style-type: none"> 1. Prevention and Public Health 2. Earlier diagnosis 3. Patient experience 4. Living with and beyond cancer 5. Delivering a high quality service 6. Overall commissioning and provision and accountability <p>https://wolverhamptonccg.nhs.uk/publications/quality-and-safety-policy-1/1496-wolverhampton-integrated-end-of-life-care-strategy/file</p>	

			Patient and Public Partnership (PPG) – linked to 2.1	
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>SEND - A key feature of the Education & Health Care process is that families should be at the centre of decisions made about their child's care.</p> <p>The extent to which families wish to exercise choice and control around their child's health needs varies and the CCG is currently considering its offer around personal health budgets.</p> <p>The Young People's Forum has been involved in working with other peers to engage with the market to ensure more personalised packages of care.</p> <p>Young people have also been involved in the interviewing of new members of staff as part of a children's Panel.</p>	<p>Families will feel part of the decisions regarding their children and empowered to voice their views.</p> <p>Families will take control of the services and support required.</p> <p>That professionals put the child/young person and their family at the centre of any decisions made.</p> <p>All agencies, including the CCG have a good insight into the feelings of children and their families.</p>
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Mental Health - All individuals are encouraged whenever possible to be involved in the decision making as to where and how their care is delivered. This ensures that where a patient has capacity, they can be involved in their care choices. A key aspect of this is ensuring patients make informed decisions, to do this every effort is made to explain the position appropriately to the patient with due regard to their communication needs.</p>	<p>We provide a choice of provision when ever possible.</p> <p>We ensure that for individuals who have family living out of area that they can choose a care home within their area, once we have established it delivers safe care.</p> <p>We offer personal health budgets for all CHC eligible individuals living in the community and are currently working with Arden & Gem CSU to expand our PHB offer.</p>

2.3 People report positive experiences of the NHS

How does the CCG engage and involve people to listen to their views of the NHS? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>Locality Patient Participation Groups (LPPGs)</p> <p>The purpose of our three LPPGs is to support the overall aims of constituent Patient Participation Groups (PPGs). The groups will work with PPGs and their members to develop best practice for their PPG locally. The group will provide a forum for exchange of information and collaborative working on issues of concern.</p> <p>Priority issues will be taken forward to the Patient and Public Partnership by the locality representatives.</p> <p>All practices will be encouraged to develop PPGs and support will be available from the communications and engagement team, with actions including marketing to support recruitment, sharing information with the broader patient base via social media, etc. Patients will be able to use their experiences to develop and improve their local practice. They will be able to follow the DES format.</p> <p>Members will be encouraged to get involved in the wider Patient and Public Partnership.</p> <p>The PPGs, like Associates will be included in key communication messages. Practice-level feedback of experiences can be shared at the Patient and Public Partnership or in direct meetings with the PPG Chairs. All feedback and information will be collated, reviewed and included in the Joint Engagement Assurance Group (JEAG) reports to the Governing Body. This engagement will enable our PPGs to influence commissioning decisions.</p> <p>The JEAG sits at the top of our Participation Framework. Its mission is to ensure that the CCG is an accountable care organisation that delivers meaningful participation in commissioning.</p> <p>The JEAG will bring together communications and engagement leads from key partners in order to assess and review the communications and engagement activities taking place. It will ensure that the patient voice is heard in all sectors of the CCG and also report on the systematic adoption of the Engagement Cycle within the CCG's commissioning activities.</p>	<p>LPPGs provide an opportunity for patient feedback to shape service design.</p>

			<p>Patient Participation Group (PPG) – ensures that the CCG listen to and engage with patients in the City, providing some assurance that the patient voice is included in all the work of the CCG and the patient viewpoint can be expressed at the Governing Body meetings. In order to do this we have an engagement framework to reach as many patient groups as possible. There are quarterly forums for PPG Chairs to meet and network - this is a good way for issues to be heard, not only about GP surgeries but other services too.</p> <p>Usually the practice manager starts the PPG by recruiting a <u>variety of patients</u> and holding a meeting to decide what direction the patients wish to take the group. A patient is usually elected chair and patients decide the agenda and eventually have ownership of the group.</p> <p>It is important for patients, carers and public to be able to express their views on the health services available to them; even good quality services can be improved upon. These PPGs give vulnerable patients another voice – they can complete the PPG survey or contact the Chair directly and the issue is taken up by the group with the practice management or passed on to the relevant people.</p> <p>https://wolverhamptonccg.nhs.uk/news/blogs/190-blogs2</p>	Effective engagement with patients is key to ensuring that services genuinely meet the needs of all patients. The CCG makes effective use of the PPG network to ensure patients have a voice on decisions.
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.</p> <p>https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/</p> <p>http://content.digital.nhs.uk/workforce</p>	Patient feedback obtained and used for service improvements.
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 14	<p>The CCG has a mechanism for engagement with children and young people with SEND and their families via the SEND Partnership Board where there are parents and young people present to contribute to the shaping and designing of local SEND related policies, strategies and developments.</p> <p>The parents were actively engaged with health services to co-produce the services pages on the Local Offer and continue to be involved with the responses provided to any queries raised by parents regarding the health services and ensuring that any updates are parent friendly.</p> <p>There are parents participating in the Health work-stream and actively involved in contributing specifically to the shaping of health services to meet the needs of the local population regarding SEND.</p> <p>A Young Persons SEND Board will also be developed to provide challenge where appropriate.</p> <p>There are good links with Parent Carers Forum and Changing Young Lives with regular attendance at meetings.</p> <p>Young people and their families have also been involved in developing transition plans for people with complex health needs and identified providers who were able to deliver services required jointly with the CCG.</p>	Numbers of compliments/complaints received.
			The Children in Care Council (CiCC) – linked to 1.3	
			Communications and Engagement Strategy – Linked to 1.1	

2.4 People's complaints about services are handled respectfully and efficiently

How does the CCG handle and monitor complaints ensuring action is taken? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/ achieved?)	Impact
Age Disability Race Religion or belief Sex Sexual Orientation	Objective 1 Objective 2 Objective 3 Objective 4	Article 2 Article 3 Article 5 Article 8 Article 9 Article 10 Article 14	<p>The CCG has a Complaints Policy. This policy outlines the process by which complaints will be handled by the clinical commissioning group (CCG) when raised by a user of the service or their representative, or a member of the community who comes into contact with the service by other means or CCG employees. The CCG places high priority upon the handling of complaints and the organisation recognises that suggestions, constructive criticisms and complaints can be valuable aids to improving services and informing service redesign. Feedback from service users and their relatives is welcomed in line with our Public & Patient Engagement Strategy.</p> <p>The policy also has implications for providers of services to the CCG and they also have a duty to have a complaints policy structured in line with national policy.</p> <p>This policy applies to all complaints received by and made against the CCG.</p> <p>Also a Serious Incident policy. The purpose of this policy is to outline the CCG's governance arrangements for the performance management of serious incidents requiring investigation (SI's) and ensure that patient safety and other reportable incidents are appropriately managed within the CCG's commissioned services in order to address the concerns of patients and promote public confidence. The CCG will ensure incidents are investigated properly, that action is taken to improve clinical quality and that lessons are learnt in order to minimise the risk of similar incidents occurring in the future.</p> <p>https://wolverhamptonccg.nhs.uk/contact-us/how-to-complain</p>	<p>Clear understanding of how to complain and who is accountable.</p> <p>Patient complaints are investigated thoroughly and the CCG ensures that it works with providers to ensure that any lessons learned are put into practice.</p>

3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

How does the CCG demonstrate its commitment to equal pay for equal work and how is this monitored and evaluated? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 10 Article 14	<p>The CCG is committed to being as representative as possible across relevant protected characteristics in relation to the population it serves.</p> <p>The CCG is committed to ensuring that equal pay for work of equal value is maintained through the effective use of the NHS Agenda for Change (AfC) pay scale and inclusive recruitment, retention and selection procedures. This is shown in the CCG's Commitment Statement on Equal Pay.</p> <p>All of the CCG's internal workforce policies have been developed, and continue to be updated, in line with current legislative requirements including the Equality Act 2010. These policies cover the recruitment, selection and appointment process as well as all aspects of working for the CCG.</p> <p>The CCG carries out regular reviews of the workforce demographics though in view of the CCG's size this data cannot be published without risking identifying an individual.</p> <p>All new or amended job descriptions are evaluated in accordance with Agenda for Change evaluation and job matching processes. This is provided by Arden & GEM CSU to ensure independent objectivity and consistency of application of process. Results of job matching and evaluation are available to staff and their representatives on request.</p> <p>http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay</p>	<p>The approach taken gives staff assurance that the CCG is committed and working to deliver this aim. Monitored systems and processes in place for fair recruitment.</p>
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 4 Objective 5 Objective 6 Objective 7	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	<p>Demonstration of commitment to equal pay;</p> <ul style="list-style-type: none"> • Equal Pay Audit • NHS Agenda for Change Terms and Conditions • Starting salary statement • CCG Annual Equality Report 	<p>CCG demonstrates its commitment to equal pay and that this is monitored and evaluated.</p>

3.3 Training and development opportunities are taken up and positively evaluated by all staff

How does the CCG support the development and training needs of its staff? Please give examples

How does the CCG monitor the effectiveness of training through feedback from staff? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 14	<p>The CCG is strongly committed to ensuring that such opportunities are taken up and that all staff feel their development is being supported.</p> <p>The results of the CCG's annual staff survey provide a measure of that success. By supporting its staff the CCG increases staff wellbeing and maintains confidence – helping staff retention.</p> <p>The CCG support the development and training needs of staff, and monitors the effectiveness of this using various processes;</p> <ul style="list-style-type: none"> • Equality Analysis Training • Mandatory training on Equality and Diversity • Learning & Development Strategy • Team & Organisation development events • Leadership programmes 	Fair and equitable access to training is provided. By supporting its staff the CCG increases staff wellbeing and maintains confidence – helping staff retention.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	Staff survey data is monitored and maintained by the CCG. Retrospective information on Statutory & Mandatory training is held by Arden & GEM CSU on ESR.	CCG gains assurance on the equitability of training takeup.

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

What systems and processes are in place to ensure that CCG staff are not exposed to abuse/harassment/bullying /violence at work? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 4 Objective 5 Objective 6 Objective 7	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	<p>The CCG has in place a Zero Tolerance Scheme – Excluded Patients this is in place to ensure that where patients are abusive to staff, this can be managed and staff are protected. The service will be available to patients who have been removed from a General Practice list due to violent, aggressive or behavioural problems and are resident within the boundary of Wolverhampton CCG.</p>	Staff are protected from harassment by patients and their families.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion	Objective 4 Objective 5 Objective 6 Objective 7	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9	<p>The CCG have a suite of policies to ensure staff are protected and supported;</p> <ul style="list-style-type: none"> • Employee relations data • Harassment & Bullying policy • Staff Forums • Staff Surveys • Whistleblowing policy 	By setting out the required standards the CCG ensures staff are aware of their rights and responsibilities and should anyone have a concern they have a clear route to raise it.

Sex Sexual Orientation		Article 10 Article 14		
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	A new Bullying and Harassment Policy was implemented in April 2016. Relevant cases are monitored by the CCG's HR Business Partner along with any action taken.	Staff are clear on their rights and responsibilities and the relevant route to raise concerns.

3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

How does the CCG facilitate a work-life balance and ensure flexible working options are available for all staff? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	As part of its commitment to its staff and offering genuine work life balance the CCG has adopted the following policies: <ul style="list-style-type: none"> • Flexible Working Policy • Carers leave; maternity & paternity; adoption policies <p>By supporting staff to be flexible the CCG ensures roles are open to those with caring responsibilities or disabilities and ensures that reasonable adjustments can be accommodated</p>	The approach taken helps the CCG in delivering a positive achieving culture.

3.6 Staff report positive experiences of their membership of the workforce

How does the CCG engage with its employees and use their feedback constructively and positively to improve morale and experience? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex	Objective 3 Objective 4	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG engage with employees to gain their feedback by; <ul style="list-style-type: none"> • Staff survey • Exit interviews • Turnover data 	CCG gains assurance that staff are feeling supported.

Sexual Orientation				
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 4 Objective 5 Objective 6 Objective 7	Article 2 Article 3 Article 4 Article 5 Article 7 Article 8 Article 9 Article 10 Article 14	The CCG conducts an annual staff survey, the outcome of the staff survey is presented to Staff Forum and an action plan is put together. Staff Forum is held bi-monthly where representatives from each department come together to discuss any topics related to staff. This forum is also used to approve any changes or new HR policies. Charity raising and health and wellbeing initiatives are also discussed at this forum. Any constructive feedback from departments is also discussed at staff forum. Anonymous comments box in CCG facilities for staff to share any concerns anonymously.	CCG gains assurance that staff are feeling supported.

4 Inclusive leadership

NHS organisations should ensure that equality is everyone's business with everyone taking an active role

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

How has the CCGs senior management and governing body promoted equality throughout the organisation and the local health economy? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	<p>The CCG leadership are strongly committed to promoting Equality within the organisation and within the wider health economy. Taking an active role in the joint working across the black country the CCG's leadership works to ensure health inequalities are identified and addressed.</p> <p>Leadership of the CCG have committed to understand and promote their organisation's strategic approach to using patient and public insight, experience and involvement to reduce health inequality and to drive improvement.</p> <p>The CCG demonstrate evidence by;</p> <p>a) Comprehensive Communications and Participation Strategy details our approach in this area with the focus on how patient and public insight will drive quality. Future work will build on this to improve linkages to health inequalities</p> <p>Section1 Section 3 Section 4 Section 6 Section 7</p> <p>b) The CCG's operational arrangements detail that there will be a report on patient and public involvement to each meeting of the Governing Body. In addition, all reports to Governing Body and Committees include details of Patient and Public Insight activity and patient representatives sit on the Quality and Safety, Commissioning and Primary Care Commissioning committees. Communications & Engagement representatives attend Programme Boards and Senior Management Team meetings to ensure patient and public insight is considered throughout the project cycle and at senior levels. Key messages from patient and public insight are disseminated to all staff via staff meetings. The Arden & GEM CSU Communications and Engagement lead is embedded in the Operations team and meets with the directorate management team weekly to provide updates on patient and public involvement. Regular operational meetings also take place with Governing Body Lay member, Associate Director of Operations, Chair and Communications & Engagement team.</p>	<p>Leaders understand the strategic approach and therefore how and why the use of patient and public insight, experience and involvement reduces health inequality and drives improvement.</p> <p>Leaders are actively promoting the strategic approach and ensuring it is understood throughout the organisation.</p> <p>The organisation has a documented, strategic approach describing how patient and public insight, experience and involvement is used to reduce health inequality and to drive improvement.</p>
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	<p>Leaders ensure patient and public insight, experience and involvement informs decisions, actions and evaluation throughout the organisation in order to reduce health inequality and to drive improvement.</p> <p>a) Patient and Public insight has been used to develop the CCG's Commissioning Intentions for the year, the Primary Care Strategy as well as a number of procurement exercises (details attached) and is reported through our formal processes including the Joint Assurance and Engagement Group. The CCG are seeking to move to greater involvement for patients in its operational work through the development of a Patient Reviewers programme who will support the CCG's work monitoring quality.</p> <p>b) The CCG works closely with Public Health to develop an overall understanding of population needs and health inequalities via the Joint Strategic Needs Analysis (JSNA), including sharing details of its development with the Governing Body. This includes evaluation of Patient and public insight but not necessarily in a structured way.</p>	<p>Leaders ensure patient and public insight experience and involvement informs the development of possible solutions, decisions made and actions taken throughout the organisation in order to reduce health inequality and to drive improvement.</p> <p>Leaders ensure patient and public insight, experience and involvement is used to identify and fully understand all health inequalities and inequities.</p> <p>Leaders ensure patient and public insight, experience and involvement informs evaluation of decisions and actions</p>

			c) Specific work has taken place to understand access to Primary Care through a structured survey. This formed part of the wider engagement work on the Primary Care Strategy. Work on Commissioning Intentions was subject to a 'You Said - We Did' report at the conclusion of the exercise. https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did	including the impact of these decisions and actions on health inequality and improvement. Leaders ensure all learning gained through using patient and public insight, experience and involvement to reduce health inequality and drive improvement is shared throughout the organisation.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective3 Objective 4	Article 2 Article 3 Article 8 Article 14	The Senior Management and Governing Body demonstrate their commitment to promoting equality throughout the organisation and the local health economy by ensuring that the potential equality implications of issues under consideration are addressed throughout decision making processes. In particular, the Governing Body has demonstrated its commitment during the year by increasing its understanding of its legal duties to engage with the whole community when making decisions that lead to a procurement of services. A dedicated development session with legal advice was held where the importance of engaging with all sectors of the community was re-confirmed.	Equality issues/implications and potential equality implications of issues under consideration are addressed throughout decision making processes.

4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed

What processes are in place to demonstrate that the CCGs decision making committees have considered equality relating impacts? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	The CCG's Constitution clearly states in discharging its functions the group will meet the Public Sector Equality Duty and how this will be achieved. (Page 6/7 – 5.1.2) https://wolverhamptonccg.nhs.uk/images/docs/Constitution_with_Appendices.pdf	The CCG demonstrates its commitment to Equality from the top down.
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	The CCG's Programme Management Office has processes in place to ensure equality impact assessments take place throughout the project lifecycle. Additionally, decisions to disinvest in services require further consideration of the equality implications of any decisions. All reports to committees and the Governing Body include a section requiring report writers to set out the equality implications of their reports.	The CCG can be assured and is able to routinely demonstrate that every decision it makes is subject to robust equality analysis to which due regard is shown.

4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

How does the CCG ensure managers proactively engage with their staff to value diversity and so creating an inclusive working environment? Please give examples

Protected characteristics	Equality objective	Human Rights	Evidence (What has actually been done/achieved?)	Impact
Age Disability Gender Re-assignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion Sex Sexual Orientation	Objective 3 Objective 4	Article 2 Article 3 Article 8 Article 14	<p>In addition to the policies and procedures set out in section 3, the CCG has gained support from Arden & GEM CSU EIHR team to run training sessions for all staff.</p> <p>Fairness at work and good job performance goes hand in hand. Tackling discrimination helps to attract, motivate and retain staff and enhances an organisation's reputation as an employer. Eliminating discrimination helps everyone to have an equal opportunity to work in an environment of mutual respect and dignity.</p> <p>Working together as a team is a fundamental element to any organisation; it is evident that staff at the CCG want to feel more comfortable and confident when they have something to say. The feedback also suggests the need to be listened to, especially those who would normally be quiet in discussion matters.</p> <p>The CCG will continue to engage with staff through the annual staff survey and review the responses to ensure that all can work in an inclusive working environment.</p> <p>By providing training and support the CCG gains assurance that managers and staff are supported to work in culturally competent ways, eliminating discrimination and ensuring patients and staff benefit.</p> <p>Linked to 3.6</p>	By providing training and support the CCG gains assurance that managers and staff are supported to work in culturally competent ways, eliminating discrimination and ensuring patients and staff benefit.

Equality Objectives 2018-2021

Wolverhampton CCG has developed the following objectives for launch on the 1st of April 2018 with a three year timeframe. These objectives will form part of the CCG's strategic direction around equality, supporting action plans are being developed and updates will be published during the timeframe of the objectives on the CCG's website.

- 1. The CCG to work towards a comprehensive understanding of the barriers to accessing services experienced by patients. To work to reduce the barriers identified with partner organisations and stakeholders.**
- 2. The organisation will ensure that due regard is given to the needs of the CCG's population during service change, including vulnerable groups, through effective engagement aligned with the profile of the population affected by particular changes.**
- 3. The organisation will use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive, supportive values and competencies across the workforce.**
- 4. The CCG's leadership will, as system leaders, continue to champion improved outcomes for vulnerable groups and tackle health inequalities across Wolverhampton and the Black Country.**

Objective 1: has been developed to support and identify the work the CCG undertakes to enhance access to services for all patients, particularly those from vulnerable groups. This objective requires joint working between the CCG, relevant provider organisations and GP practices. It also requires on-going engagement with patient groups to ensure barriers are identified and resolved. Success will be measured through evidence of service change / enhancements that have addressed health inequalities.

Objective 2: recognises that the NHS is currently in a period of substantial change and that the impact of such changes is felt particularly by vulnerable groups. The CCG will use the findings of completed equality analysis to inform service change and ensure that it works with partner organisations to improve outcomes for vulnerable groups.

Objective 3: This objective has been designed to build on the CCG's internal focused organisational development and will evidence success through the CCG's relevant action plans, achieved goals and annual EDS2 progress against goal 3 of EDS2.

Objective 4: This objective is linked to the CCG's actions as system leader, involvement in the STP for the black country and actions of the leadership. Evidence of success will include STP activity and evidence from goal 4 of EDS2.

Updates against these objectives can be found on the CCG's Equality page and in these annual equality reports.



Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group

Technology Centre

Wolverhampton Science Park

Glaisher Drive

Wolverhampton

WV10 9RU

Email: wolccg.wccg@nhs.net

Telephone: 01902 44487

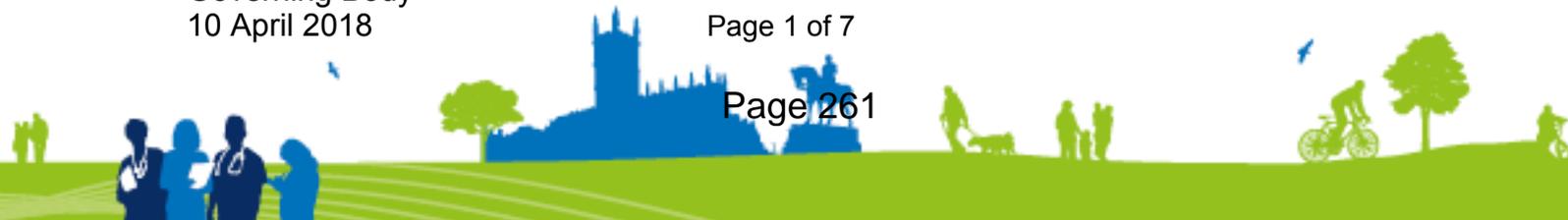
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WOLVERHAMPTON CCG

Governing Body
10 April 2018

Agenda item 15

TITLE OF REPORT:	Equality Objectives
AUTHOR(s) OF REPORT:	David King, EIHR Manager
MANAGEMENT LEAD:	Sally Roberts
PURPOSE OF REPORT:	Report presents the Equality Objectives for the CCG for 2018 - 21. Proposed objectives have been considered by SMT and approved by QSC prior to publication.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	<ul style="list-style-type: none"> • The CCGs is required to agree and publish new Equality Objectives before 1 April 2018 – which it has done. • As a result of the change to the statutory timeline for publication of information during 2017 the CCG published its annual equality information before 30 March 2018 rather than the previous annual timeline, which was October. • The current equality objectives were extended to bring the CCG in line with the new timeline of 30 March. (This was agreed following a report to GB in October 2017)
RECOMMENDATION:	GB are asked to: <ul style="list-style-type: none"> • Note the contents of the report and progress made • Note for information the new objectives set for the CCG.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	Equality, Inclusion and Human Rights (EIHR) are key to the three strategic aims of the CCG in delivering quality services to patients
1. Improving the quality and	<u>Ensure on-going safety and performance in the system</u>



<p>safety of the services we commission</p>	<p>Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions.</p>
<p>2. Reducing Health Inequalities in Wolverhampton</p>	<p><u>Improve and develop primary care in Wolverhampton</u> Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this.</p> <p><u>Deliver new models of care that support care closer to home and improve management of Long Term Conditions</u> Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings.</p>
<p>3. System effectiveness delivered within our financial envelope</p>	<p><u>Proactively drive our contribution to the Black Country STP</u> Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint.</p> <p><u>Greater integration of health and social care services across Wolverhampton</u> Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.'</p> <p><u>Continue to meet our Statutory Duties and responsibilities</u> 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.</p> <p><u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.</p>



1. Equality Objectives

1.1 Introduction

The report provides the Equality Objectives agreed at QSC for review. These are to be agreed and published before 30 March 2018. This provides an example of how the EIHR team is ensuring that the CCG remains compliant with the requirements of the Public Sector Equality Duty (PSED).

- 1.2 During a meeting with the Corporate Operations Manager, it was recommended that the equality objectives be presented to SMT for approval and to seek guidance on how the SMT would like the views of key stakeholders captured.

2. Background

Public bodies are required to prepare and publish one or more equality objectives as part of their duties under the Public sector Equality Duty (PSED). The CCG previously set objectives in 2013 with a four-year timeline and these, having been extended until March 2018, will then be complete.

The primary purpose of equality objectives is to focus organisations on the outcomes to be achieved through advancing equality, rather than the written documents and processes to evidence legal compliance (NHSE). The new objectives will build on the progress already made and set the CCG's direction of travel for the next four years. An accompanying action plan will support further success.

3. Previous CCG equality objectives (2013 – March 2018)

3.1 The CCG had nine Equality Objectives:

1. To ensure that leadership and governance arrangements persist in offering high level assurance of equality
2. Equality approaches are effectively included in key mechanisms of commissioning (such as business case development, procurement, contracting)
3. Equality Analysis becomes part of our organisational processes so that projects, policies, strategies, business cases, specifications and contracts have all been developed in consideration of equality, diversity and human rights issues
4. To apply goals one and two of the Equality Delivery System to an average of three patient pathways for each year of the strategy, and to demonstrate year on year improvements for goals three and four (staff and leadership)
5. To regularly review and update the strategic action plan and equality objectives (on at least an annual basis) to ensure that it is providing appropriate targets for development and improvement



6. To ensure all CCG staff receive basic training to ensure awareness of Equality Act 2010 responsibilities and the NHS Constitution, and that specific training on Equality Analysis and the Equality Delivery System is targeted to all staff who are involved in these processes
7. To ensure that Equality and Diversity forms an ongoing part of our leadership and organisational development programmes
8. To ensure that Equality and Diversity approaches are fully included in our engagement of people who use services and in our work with strategic partners and other stakeholders
9. Improve accessibility of information and communication for people from statutorily 'protected groups' and other disadvantaged

3.2 The intention of these objectives was to identify key areas of activity required for a new organisation and to ensure the best possible outcomes for patients. Updates have previously been published and much progress has been made towards these.

3.3 Four years later the CCG finds itself in a very different position to that in 2013 and needs to develop new objectives based on the key priorities.

4. New equality objectives (three-year timeline)

4.1 Four new equality objectives are in place, which are SMART and link to the CCG's priorities, the outcomes of the Equality Delivery System 2 (EDS2), the previous equality objectives, commissioning intentions and wider priorities within the NHS system.

1. The CCG to work towards a comprehensive understanding of the barriers to accessing services experienced by patients. To work to reduce the barriers identified with partner organisations and stakeholders.
2. The organisation will ensure that due regard is given to the needs of the CCG's population during service change, including vulnerable groups, through effective engagement aligned with the profile of the population affected by particular changes.
3. The organisation will use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive, supportive values and competencies across the workforce.
4. The CCG's leadership will, as system leaders, continue to champion improved outcomes for vulnerable groups and tackle health inequalities across Wolverhampton and the Black Country.

Adoption of these Equality Objectives will ensure that the CCG remains compliant with its legal duties and ensure that the CCG continues to work to reduce health



inequalities, improve outcomes for patients including vulnerable groups and maintain and develop a diverse supported workforce.

- 4.2** The CCG will provide updates to Quality Safety Committee and Governing Body on objectives' progress which will allow the publication of annual updates on the CCG website.

5. Next steps

- 5.1** It is recommended that the CCG consider seeking the views of key stakeholders and lay representatives on the proposed objectives before finalising them. By doing so the CCG gains external validation of the chosen objectives.

Action	Task	Date
Agree Equality Objectives	Present to SMT and QSC	
Seek feedback from CCG staff	Draft Equality Objectives to be included in Staff newsletter with opportunity to respond via email	
Seek feedback from Chairs Patient Participation Group	Present at next meeting	
Seek endorsement from Quality & Safety Committee (QSC)	Equality Objectives will be presented to QSC for comments	March 2018
Publish Objectives on CCG Website once approved	Material to be sent to comms team	Before 30 March 2018
Equality Objectives presented to Governing Body	Present a report to Governing Body	10 th April

- 5.2** GB is asked to note the objectives, next steps and make further suggestions if necessary.

6. CLINICAL VIEW

- 6.1** None for this report.

7. PATIENT AND PUBLIC VIEW

- 7.2** None for this report.



8. KEY RISKS AND MITIGATIONS

- 8.2 Publication of up to date, SMART Equality Objectives is a key aspect of compliance with the legal requirements of the PSED.

9. IMPACT ASSESSMENT

Financial and Resource Implications

- 9.2 None for this report.

Quality and Safety Implications

- 9.3 The implications on Quality and Safety are intrinsic to the report.

Equality Implications

- 9.4 Equality implications are intrinsic to the report.

Legal and Policy Implications

- 9.5 Equality Objectives are part of the PSED requirement which is a statutory duty of the Equality Act 2010. Compliance with the PSED is a key requirement on the CCG legally and to provide NHS England with Assurance.

Other Implications

- 9.6 None

Name: David King

Job Title: EIHR Manager

Date:

RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

Governing Body
10 April 2018

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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)	N/A	



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**MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 9th JANUARY 2018,
COMMENCING AT 10.30AM, IN THE MAIN CCG MEETING ROOM, WOLVERHAMPTON
SCIENCE PARK.**

PRESENT:	Dr R Rajcholan	-	WCCG Board Member (Chair)
	Sue McKie	-	Public Health / Lay Member
	Peter Price	-	Independent Member
	Marlene Lambeth	-	Patient Representative
	Maxine Danks	-	Interim Deputy Director of Nursing
	Sukhdip Parvez	-	Quality & Patient Safety Manager
	Liz Hull	-	Administrative Officer
APOLOGIES:	Jim Oatridge	-	Lay Member
	Dr Julian Parkes	-	Deputy Chair for Quality & Safety
	Kerry Walters	-	Public Health
	Alicia Price	-	Patient Representative
	Steven Forsyth	-	Interim Deputy Director of Nursing

1. APOLOGIES & INTRODUCTIONS

Apologies were noted by members.

RESOLVED: That the above is noted.

2. DECLARATIONS OF INTEREST

Sue Mckie was present at the meeting as a Lay Member for Patient and Public Involvement but also as a Public Health employee.

RESOLVED: That the above is noted.

3. MINUTES & ACTIONS OF THE LAST MEETING

3.1 Minutes of the 12th December 2017

The minutes of the meeting held on the 12th December 2017 were approved as an accurate record with the following exceptions:

- Page five, Item 5.2 – The sentence in relation to a number of inappropriate referrals by GPs should read referrals by GPs to EAU and A&E.

RESOLVED: That the above is noted.



3.2 Action Log from meeting held on the 12th December October 2017

The Action Log was reviewed and updated. Discussions took place as follows:

- December Action Log
 - 5.1 – Breakdown of maternity activity by area, on a monthly basis. Sukhdip Parvez confirmed that this is an ongoing activity and is being monitored by RWT.
 - 5.1 – RWT have not got enough resources to review data with regards to establishing if there is a link between perinatal deaths and the increase in capacity. However, the Trust has confirmed they do not think a link exists. Agreed to close.
 - 5.1 – RWT to provide a breakdown on Serious Incidents prior to June 2017. Agreed to close.
 - 5.1 – It was confirmed that there is nothing of significance to report in relation to the new Admission Model. Agreed to close.
 - 5.3 – Sukhdip Parvez to forward the email, relating to the non-urology catheterised patients, received from Matt Reid on 13th December 2017, to Dr Rajcholan. Agreed to close.

- November Action Log
 - 5.1 – It was confirmed that a formal letter has been sent to BCPFT Board Members and a response is awaited.
 - 5.4 – Agreed to close.

- October Action Log
 - 5.8 – Maxine Danks gave assurance that a brief summary on Fast Track would be produced and included in the GP News Bulletin by the next Committee meeting. Agreed to close.
 - 6.1 – Agreed to close.

RESOLVED: That the above is noted.

4. **MATTERS ARISING**

None discussed.

RESOLVED: That the above is noted.

5. **ASSURANCE REPORTS**

5.1 Quality Report

Sukhdip Parvez provided the Committee with an update and the following key points were noted:

Key Issues / Areas of Concern:

- Urgent Care Provider
 - Vocare has reported additional pressure in the system, which is being managed. The increase in activity has not led to any significant incidents.



- The CQC are planning an additional visit, which will be unannounced.
- The NHSE Quality and Surveillance Group have agreed to stand down the NHSE Quality Surveillance Group each month. However, the Improvement Board will still continue, with the next meeting taking place on 15th January 2018.
- **Maternity Performance Issues**
 - Key performance indicators are a growing concern which is impacting on the quality and safety of patients. This has been escalated to NHSI, NHSE, LMS and Maternity STP. The provider has also capped the maternity activity for the Trust.
 - 9 Serious Incidents.
 - The elective route for 'C' section has gone down to 11% and for emergency 'C' sections have increased to 17%. The Trust has confirmed that there is no correlation
 - The Midwife to birth ratio is 1-30, compared to 1-29 nationally.
 - Vacancy – 0.3% - amber risk
 - No neonatal deaths reported.
 - Sickness has reduced to 4.8% but still remains above the Trust target of 3.25%.
 - A reduction of bookings has been recorded – October 522, November 500.
- **Non-Emergency Patient Transport Service Issues**
 - The provider has failed to meet reporting requirements and the current performance has not been at the levels expected. This has led to an adverse impact on the quality element of the service.
 - Two incidents took place recently and the provider was asked to report them on STEIS as serious incidents. One incident has been downgraded. The second incident, in which the patient sustained an arm fracture, has been escalated to NHSE.
- **Mortality**
 - The Trust remains as red on the SHMI.
 - An Action Plan is in place and the Trust has commissioned independent coding, diagnostic, palliative and case note reviews.
 - The Trust advises that the SHMI does not relate to quality of care, but the number of admissions. Changes in the patient case mix and palliative patient code are also impacting on the SHMI.
- **Never Events**
 - In 2016/17 there were a total of 5. In 2017/18 ytd, a total of 6. The Chair of the CCG has written to the Chair of RWT about this and a Deep Dive is being completed. RWT Trust Board is also well sighted on this.
 - A themed report will be provided at CQRM in February.
 - The events mainly relate to human error.
 - Lessons are being learnt but there is still room for improvement.

Royal Wolverhampton NHS Trust: The following key points were noted:

- Serious Incidents (excluding pressure injury incidents) – 14 incidents were reported by RWT, which is a reduction from the 18 reported for November 2017.



- Slips Trip and Patient Fall SI's – 5 incidents were reported, which have all been discussed at the provider weekly scrutiny meeting. A Deep Dive exercise is being carried out.

Black Country Partnership Foundation Trust Serious Incidents: There were no serious incidents reported for this reporting period. However, a pressure injury serious incident still remains open on STEIS. The CCG has formally raised this with the provider and requested an updated Root Cause Analysis. If a response is not received within 2 weeks, this will be escalated to NHSE.

Children's Safeguarding: It was confirmed that Rachel Stone has commenced in the role of Deputy Designated Nurse.

Flu Outbreak RWT: It was reported that 6-7 clinical areas have been affected. Daily meetings are taking place within the Trust, who have reported that 46 cases are confirmed and 42 cases are pending outcome.

RESOLVED: The Committee noted the assurance update provided.

5.2 Primary Care Report

Liz Corrigan presented the Committee with an overview of activity in Primary Care, and assurances around mitigation along with any actions taken as necessary. The following key points were noted:

- Influenza Vaccination – The flu vaccine uptakes for Wolverhampton, up to December, show an average uptake across all adults. Figures in relation to children were unavailable at the time of writing the report. A summary of vaccine uptake was noted as:
 - 65 and over – 66.8%
 - Under 65 (at risk only) – 43%
 - All pregnant women – 41.7%
 - All aged 2 – 37.3%
 - All aged 3 – 34.8%
- It was confirmed that pregnant ladies should be offered the vaccine at the 20 week scan. However, for various reasons, some ladies receive it earlier.
- Friends & Family Test – An update was provided for October 2017 figures:
 - Practices with no submission - increased to 21%
 - Practices with suppressed data has remained the same – 9%
 - Practices with no data available – increased to 25%
 - In comparison, regionally and nationally, no submissions are at 34.1% and 35% and suppressed data is at 14.1% and 11.2% respectively
 - It was noted that where Practices had zero responses, they did not think they were required to feedback.
 - Lessons learnt, from qualitative data, are being reviewed



- Quality Matters – The most common theme identified by category for 2017 is Information Governance breaches, due to patients being given incorrect blood forms. A high number of incidents took place at 1 Practice. Discussions have taken place with the Practice Manager and the CCG Locality Manager and any future breaches will require completion of a significant event report.
- Complaints
 - No complaints or compliments relating to Primary Care have been noted for the CCG.
 - There are 9 active complaints that have been forwarded from NHS England. They mainly relate to processes, some relate to clinical incidents and one relates to training. As a result, Dementia training has been recommended.
- Serious Incidents – no incidents currently under investigation.
- NICE / Clinical Audit – The latest guidelines are under review and up to date information will be presented at the next meeting. Assurance was given that the guidelines will be applied in line with the peer review system for GPs.
- CQC Inspections & Ratings – There have been no inspections in Wolverhampton in November. Two practices currently have a require improvement rating and are being monitored by the Primary Care and Contracting Team, with input from the Quality Team.
- Workforce – The Workforce Implementation Plan has been revised in line with new milestones and action points from STP and national drivers. This includes:
 - Workforce succession planning
 - Medical workforce attraction and retention
 - Nursing workforce attraction and retention
 - Newer roles within Primary Care
 - Development of non-clinical workforce
 - Assurance was given that priority is being given to the development of the Workforce Strategy.

RESOLVED: That the above is noted.

5.3 Information Governance Quarterly Report

Peter McKenzie provided the Committee with an overview of performance in relation to the CSU Information Governance (IG) activity for the IG Toolkit. The Committee was advised of the following:

- The IG Team has now reached its full complement of staff.
- Training sessions have taken place to promote Governance awareness and changes to Data Protection Law
- Staff have also been asked to complete mandatory training through ESR
- Once staff training is complete, a piece of work will be undertaken Once staff training done, will be working with teams to make sure the asset database is up to date. On track to reach compliance with the toolkit.



Dr Rajcholan explained that GP's undertaken training that is separate to the CCG and forms part of CQC requirements.

RESOLVED: That the above is noted.

5.4 FOI Report

Peter McKenzie informed the Committee that the CCG has responded to all of the FOI requests received within 20 working days.

RESOLVED: That the above is noted.

5.5 Board Assurance Framework

No report available.

RESOLVED: That the above is noted.

5.6 Equality & Diversity Quarterly

Deferred.

RESOLVED: That the above is noted.

5.7 Health & Safety Performance Report Quarterly

In view of the fact that Steven Forsyth was not present, and the lateness for the report, it was agreed that Committee members could read the report separately and email any comments to Sukhdip Parvez.

RESOLVED: That the above is noted.

5.8 Quality Assurance in CHC Quarterly Report

Maxine Danks presented the Committee with the quarterly assurance report for CHC. It was noted that:

- The Individual Care Team (ICT) continues to receive a significant number of referrals for consideration against the criteria for NHS funded care.
- In Q2 2017/18 the number of referrals that were not assessed within 28 days was 5, the majority of which were due to circumstances outside of the Team's control.
- The number of appeals to be heard at a Local Appeal Panel is currently 13.
- No appeals have been overturned at a local level for over 9 months
- Fast track numbers continue to be a problem. Despite raising the profile of Fast Track Tools, it is increasingly evident that a significant proportion of the Fast Track Tools completed within Wolverhampton are inappropriate. The CCG is a significant outlier



when considered against comparator CCGs. This has been identified by NHSE as an area which the CCG are required to address.

- Personal Health Budget (PHB) requests remain static, despite the continued efforts of the Team. There appears to be a reluctance to consider any changes in the way in which care is provided. The benefits are not viewed favourably due to the additional responsibilities for families. Individuals are being encouraged to consider a 'notional budget' or a 'third party budget' as this provides an opportunity to have more control and input to the patient's care without the financial responsibility.
- Stepdown – there have been considerable delays recorded, due to a lack of timely therapy intervention. This has been addressed, through a specified contract with Wolverhampton City Council who has provided dedicated support since 1st June 2017, and is having a positive impact on patient outcomes.
- Costs for Stepdown are averaging at £37, 800 per month at the end of Month 8. For some of this time period, Probert Court had not been receiving step down patients and a recharge is due. The end of year forecast is £454,452, which should demonstrate an under spend of £300, 000.
- The CCG have achieved requirements in relation to the Quality Premium.
- The Ombudsman – in the last 12 months the CCG has received one fine of £250 for late records.
- Complex Care Cases – due to staff sickness absence there were some capacity issues within the Team which resulted in some cases not being reviewed as frequently as usual. A plan is in place to ensure that all cases are reviewed as soon as possible.
- For this Financial Year there have been a number of extremely complex cases which are costly. Currently, for Month 8 the CHC budget is forecast to over spend by £88,000. However, this is offset by the £96,000 underspend on the FNC budget.

RESOLVED: That the above is noted.

6. RISK REVIEW

6.1 Quality & Safety Risk Register Update

Phil Strickland gave the Committee an overview of the current position:

- Extreme
 - 466 – Out of Hours Provider: inaccurate reporting of performance data.
 - Vocare has addressed the issues relating to inaccurate data being reported. Any recent errors are simple human errors as opposed to formal data collection / reporting mechanisms.
 - Significant progress has also been made in addressing the areas of poor quality identified by the CQC and CCG.
 - NSHE Quality and Surveillance Group have reduced the level of scrutiny. However, the CCG maintains a level of scrutiny through data monitoring, fortnightly teleconferences, monthly Contract Review meetings, CQRM, Improvement Board and oversight at the Governing Body.
 - The CQC are planning to revisit Vocare in February 2018.
 - A report will be submitted to Governing Body in February 2018 detailing progress.



- High
 - 492 – Maternity Capacity and Demand
 - The number of bookings in November 2017 had gone down from 522 to 500
 - The number of deliveries has increased from 442 to 448
 - Midwife sickness rates have improved
 - Midwife vacancy rate has reduced to 0.3%
 - 2 Serious Incidents were reported for Maternity services in November 2017 and in total there have been 8 reported since June 2017.
 - Key Performance Indicators on the Maternity dashboard are a growing concern, which is impacting on Quality and Safety. This has been escalated to NHSI, NHSE, LSE and Maternity STP. The provider has also capped the Maternity activity for the Trust.
 - 312 – Mass Casualty Planning
 - On call staff, including directors, have undertaken refresher training on Mass casualty planning – The CCG are awaiting a handbook from the Regional EPRR Lead.
 - 489 – Inappropriate arrangements for a Named Midwife – RWT
 - No changes since July 2017. The Head of Safeguarding is in discussion with the Head of Midwifery on how this can be progressed.
 - 493 – PTS poor performance
 - A Contract Performance Notice has been served for all of the KPI's that are underperforming and WMAS are working to a Remedial Action Plan.
- Moderate
 - 502 – Looked After Children CAMHS
 - The CAMHS Transformational Plan will address service delivery.
 - The Children's Commissioner and Designated Nurse for LAC have agreed KPI's to be included in 2017/18 contracts, with exceptions reported to CQRM.
- Low
 - Safe working practices – no update provided.

RESOLVED: That the above is noted.

7. ITEMS FOR CONSIDERATION

7.1 Policies for Consideration

None.

RESOLVED: That the above is noted.

8. FEEDBACK FROM ASSOCIATED FORUMS

8.1 CCG Governing Body Minutes

No issues were raised.



8.2 Health & Wellbeing Board Minutes

No minutes to review.

8.3 Draft Quality Surveillance Group Minutes

No issues were raised.

8.4 Commissioning Committee Minutes

No minutes to review.

8.5 Primary Care Operational Group Minutes

No issues were raised.

8.6 Clinical Mortality Oversight Group Minutes

No minutes to review.

8.7 NICE Group Minutes

No issues were raised.

RESOLVED: That the above is noted.

9. ITEMS FOR ESCALATION / FEEDBACK TO CCG GOVERNING BODY

None.

10. ANY OTHER BUSINESS

None.

Date of Next Meeting:

Tuesday 13th February 2018 at 10.30am to 12.30pm in the CCG Main Meeting Room



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**MINUTES OF THE QUALITY & SAFETY COMMITTEE HELD ON 13th FEBRUARY
2018 10.30 AM - CCG MAIN MEETING ROOM, WOLVERHAMPTON SCIENCE PARK**

PRESENT:

Dr R Rajcholan	WCCG Board Member (Chair)
Peter Price	Independent Member
Marlene Lambeth	Patient Representative
Molly Henriques-Dillon	Quality Nurse Team Leader
Sally Roberts	Chief Nurse
Alicia Price	Patient Rep
Liz Hull	Administrative Officer
Hemant Patel	Medicines Optimisation
Salma Reehana	Chair of CCG Governing Body (Part)

APOLOGIES:

Jim Oatridge	Lay Member
Sukhdip Parvez	Quality & Patient Safety Manager
Liz Corrigan	PC Quality Assurance Co-ordinator

QSC001 APOLOGIES & INTRODUCTIONS

Apologies were noted by members.

RESOLVED: That the above is noted.

QSC002 DECLARATIONS OF INTEREST

Alicia Price informed members of the Committee that she is working as a Receptionist at Showell Park Health Centre.

RESOLVED: That the above is noted.

QSC003 MINUTES & ACTIONS OF THE LAST MEETING

Minutes of the 9th January 2018

The minutes of the meeting held on the 9th January 2018 were approved as a true and accurate record.

RESOLVED: That the above is noted.

Action Log from meeting held on the 9th January 2018

The Action Log was reviewed and updated.

RESOLVED: That the above is noted.



QSC004 MATTERS ARISING

None discussed.

RESOLVED: That the above is noted.

QSC005 ASSURANCE REPORTS

QSC006 Quality Report

Molly Henriques-Dillon provided the Committee with an update and the following key points were noted:

Key Issues / Areas of Concern:

- Urgent Care Provider

An unannounced visit to Vocare by WCCG took place on 29th January 2018, which identified the following serious concerns:

- Unsafe staffing levels
- Escalation process
- No clinical ownership of the service
- No clinical oversight
- No triage function
- Lack of information provided to patients at Reception
- Waiting times

The provider has been asked to provide clarity and assurance, to the CCG, for a number of priority actions and a report will be submitted to the CCG Governing Body, proposing that Vocare are given 10 days to make improvements.

Concerns were expressed by members of the Committee in relation to sustainability issues and the lack of pro-activeness.

It was noted that preparatory work is being undertaken, as a precautionary measure, to consider the option of a step in provider.

RESOLUTION: The Committee are not satisfied with the quality aspect of the Vocare contract and will refer back through the A&E Delivery Board following the Governing Body Meeting.

- Maternity Performance Issues

The provider has capped the maternity activity for the Trust and there is a slight improvement on the Maternity Dashboard. Monthly discussion is taking place, for assurance, at CQRM's.

RESOLUTION: An action was agreed to include information about capped birth rates the report going forward.



- RWT Serious Incident Categories

Peter Price queried whether there is any learning from the incidents that are reported.

RESOLUTION: An action was agreed to include context, correlate data and for the CCG and RWT to look at reviews together.

In November 2017 the CCG formally raised an SBAR with the provider, due to an increase in the prevalence in the number of diagnostic and treatment delay serious incidents reported by the Emergency Department at RWT. The following changes have been made to address issues:

- Radiology reporting – a new inbox with a flagging system to review urgent and suspicious findings.
- Senior review – A senior review process has been agreed following RCEM guidelines and it will be audited on a monthly basis.
- Locum doctors – A revised induction pack has been created and will be sent electronically to locum doctors before a shift.
- Discharge safety – A new check list has been introduced to Emergency Department documentation.
- Fast track referral process – A revised process has been established for fast track referral with Cancer Services and communicated to all staff.
- ECG review – It has been agreed that all ECGs must be reviewed by a senior clinician.
- Triage process – A review has taken place. All nurses have been advised, that as well as following the Manchester Triage model, urine output must also be considered and clinicians alerted when any patients do not pass urine.
- RCA's – Measures have been put in place to ensure information is shared better.

RESOLVED: That the above is noted.

11.05 am - Dr Reehana left the Committee

RESOLVED: The Committee noted the assurance update provided.

QSC007 Primary Care Report

As Liz Corrigan was not present, it was agreed that any comments should be sent to her.

Infection Prevention - Peter Price expressed concern in relation to the 3 month follow up period for infection prevention audits.

RESOLUTION: An action was agreed for Liz Corrigan to provide further assurance in the next report.



Friends and Family Test – A discussion took place about the practices that fail to submit.

RESOLUTION: An action was agreed to undertaken correlation and triangulation to establish if the practices that are not reporting, are performing badly in specific areas.

QSC008 Safeguarding Adults, Children & LAC Quarterly Report

Lorraine Millard presented the Committee with a report to provide assurances that the designated professionals continue to maintain an oversight of the quality and safety matters of safeguarding and looked after children, and are working collaboratively with partner agencies to address issues as they are identified. The following key points were noted:

Electronic NHS England Self-Assessment Tool (SAT) Pilot – The CCG Safeguarding Team has completed the SAT, which is used to provide assurance to NHS England. It contains 9 standards and is divided into Safeguarding Adults and Children, Safeguarding Adults, Safeguarding Children and Looked After Children (LAC). The Designated LAC Nurse attended a review meeting with NHS England and the self-assessment completed by the CCG was recognised as being a really good piece of work.

Training – A rolling programme of safeguarding training is in place for GP’s and the CCG.

Domestic Homicide Review (DHR) – DHR 07 is still in progress and the final report is awaited.

Safeguarding Adult Reviews (SAR) – There are 2 new Learning Reviews in progress and an Author / Chair is being sought for a pending SAR. A final report is in the process of being completed by the Task and Finish Group for the Learning Review on JF.

Serious Case Reviews (SCR) – Publication of the final report for Child G was published on 5th January 2018. Lessons learnt will be embedded in training. Recommendations for relevant agencies have been accepted by the Wolverhampton Safeguarding Children Board and implementation of those recommendations is being monitored.

Table Top Reviews – Continue to take place for children who do not meet the threshold for a SCR. The Head of Safeguarding for Wolverhampton City Council is developing a strategy to ensure the workforce is equipped to respond appropriately.

CQC – An action plan has been developed to address recommendations made by the CQC following a review of health services relating to safeguarding children and LAC in Wolverhampton.

Child Protection – Information Sharing (CP-IS) – The CP-IS project is helping health and social care staff to share information securely to improve the protection of society’s most vulnerable children. IT systems will be linked across health and social care so that information can be shared securely. Wolverhampton City Council are planning to integrate CP-IS into their new system, to go live in April 2018. The Designated Nurse is attending meetings for the CCG.



New Posts – Recruitment underway for the Deputy Designated Adult Safeguarding Lead. The Deputy Designated Nurse for Safeguarding Children has commenced in post.

NHSE Funded Safeguarding Project – The CCG has been successful in a bid for £15,000 to fund a project working in collaboration with the Refugee and Migrant Centre and the Wolverhampton Domestic Violence Forum.

GP Domestic Violence Training and Support Project – This has been funded by the Safer Wolverhampton Partnership from the VAWG.

RESOLUTION: The Committee welcomed the report and acknowledged its contents. An action was agreed to undertake an analysis of data, to ensure a fully comprehensive report.

QSC009 Quality Assurance in Care homes Quarterly Report

A report was presented to the Committee, by Molly Henriques-Dillon, to provide the Committee with an assurance report and update on progress made from the Safer Provision And Care Excellence (SAFE) programme.

Serious Incidents – 11 were reported on STEIS compared to 17 for the last quarter. Although pressure injury and falls remain as the top reason for SI's, an improvement is noted.

Safeguarding Concerns / MASH referrals – 11 were raised with the Quality Team in Q2, which indicates an improvement against 19 made in Q1. All of these were related to neglect and acts of omission. The Care Homes are implementing Quality Improvement Action Plans with support from the CCG.

Care homes in suspension for Q3 sees a reduction from 4 to 2. Both homes provide residential care, which continue to be managed by the Local Authority Large Scale Strategy, supported by the QNA Team. Care homes commissioned by the CCG for step down / up are continually monitored for sustained improvement.

Hospital admissions have increased from 71 to 80 for Q3, with chest infections being the main cause. The Quality Team are working with secondary and Primary Care colleagues to develop a training programme for early recognition of deteriorating patients to support admission avoidance.

Participation in NHS Safety Thermometer remains suspended.

Collaborative working with the Local Authority has been extended to include the adoption of quality improvement models and methodologies. The suite of Best Practice Guidelines review is on schedule to re-launch during Q4.

SPACE – 18 care homes continue to remain fully engaged in the programme. Quality Improvement training is ongoing, due to staff and manager turnover. Targeted themed training has been delivered to care homes with increased incidents of UTIs, falls and pressure injuries. The SPACE Awards event was hosted in December to celebrate achievements and commitment so far.

RESOLUTION: The Committee noted the contents of the assurance report.



QSC010 Medicines Optimisation Quarterly Report

Hemant Patel provided an assurance report to update the Committee in relation to the Medicines Optimisation Work Programme. It was noted that:

- Safety alerts received in September, October and November 2017, were referred too and no issues were raised.
- Snapshot antibiotic audit – a two week snapshot audit was undertaken, of all antibiotic prescribing, in four higher prescribing practices and one average prescribing practice. Individual practice results were fed back to the relevant prescribers with a more details analysis to identify patterns to follow over the course of the coming months.
- Myocardial infarction audit – Up to 10 patients per practice were identified who were discharged from RWT post MI (July 2016 – June 2017) and reviewed medication to check if ACE Inhibitor and/or beta blocker had been titrated within 6 weeks as per NICE guidance. Individual audit reports were produced for each practice and practices agreed action plans based on the results.
- Patient Contacts – The team had a total of 208 face to face or telephone patient contacts from October to December 2017.
- Multiple prescribing of anticoagulants and anti-platelet medicines – A medication review was undertaken for 256 patients who were co-prescribed an anticoagulant and an anti-platelet. This was to ensure that intended/appropriate co-prescription treatment periods were not being exceeded unintentionally for individual patients. Medication was stopped or changed and a potential admission avoided for 54 patients.
- Polypharmacy – 20 or more medicines – The ePACT2 beta site has made it possible to compare practices with respect to the number of patients prescribed 20 or more medicines, based on a single month's prescribing of medicines. A search tool has been developed to enable individual patients to be identified in each practice so that medication can be reviewed.
- Prescribing Incentive Scheme (PIS) 2017 – 2018 – This has been offered to GP practices to review and, if appropriate revise current prescribing practices.
- Reporting requirements from RWT – The Trust continue to ensure that all hospital FP10 prescriptions issued by the provider are used to support generic prescribing or brand prescribing where appropriate and not used to by-pass the formulary. Assurance has been provided that medicines are being prescribed in line with national and local commissioning policies.
- Mental Health Trust
 - Shared Care Agreement – Black Country Partnership continue to work to ensure that patients on shared care drugs have an agreement in place and there is a process and training to be embedded for the use of ESCAs.
 - Generic Prescribing / formulary compliance – assurance provided.

RESOLUTION: The Committee received, discussed and noted the report.



QSC011 Equality & Diversity Quarterly

Sally Roberts requested that this item is deferred to the Committee in March, due to the recent change over of staff.

RESOLVED: That the above is noted by the Committee.

QSC012 Quality & Risk Action Plan

The Committee agreed to defer this item to the Committee in March.

RESOLVED: That the above is noted.

QSC013 **RISK REVIEW**

Quality & Safety Risk Register Update

Phil Strickland summarised the current position as follows:

- Extreme Risks

406		
Out of Hours Provider - Inaccurate reporting of performance data		16

- High Risks

492		
Maternity Capacity and Demand		12

312		
Mass Casualty Planning		9

489		
Inappropriate arrangements for a Named Midwife at RWT		9

493		
PTS Poor Performance		12

507		
Public Health - decommissioning Base 25's counselling services		9

RESOLUTION: The Committee noted the update provided and the following actions were agreed:

- 507 – EQIA to be completed
- 489 – Sally Roberts to liaise with Lorraine Millard
- Sally Roberts to review the Risk Register with Phil Strickland

QSC014 **ITEMS FOR CONSIDERATION**

QSC015 Policies for Consideration

None.



RESOLVED: That the above is noted.

QSC016 Terms of Reference Review

The Committee agreed that this item should be deferred to the meeting in March.

RESOLUTION: Sally Roberts to review the Terms of Reference and submit a revised draft to the Committee in March.

QSC017 FEEDBACK FROM ASSOCIATED FORUMS

QSC018 CCG Governing Body Minutes

No minutes to review.

QSC019 Health & Wellbeing Board Minutes

No issues were raised.

QSC020 Draft Quality Surveillance Group Minutes

No issues were raised.

QSC021 Commissioning Committee Minutes

No issues were raised.

QSC022 Primary Care Operational Group Minutes

A query was raised with regards to Dr Bagary's practices. An action was agreed for Sally Roberts to look into this.

QSC023 Clinical Mortality Oversight Group Minutes

No minutes to review.

QSC024 NICE Group Minutes

No minutes to review.

RESOLVED: That the above is noted.

QSC025 ITEMS FOR ESCALATION / FEEDBACK TO CCG GOVERNING BODY

None.

QSC026 ANY OTHER BUSINESS

Main Quality Report – Sally Roberts advised the Committee that she would be reviewing the main Quality Report with a view to making some changes.



Deputy Chief Nurse – Sally Roberts informed members of the Committee that Yvonne Higgins starting will commence in post in May.

RESOLVED: That the above is noted.

Date of Next Meeting:

Tuesday 13th March 2018 at 10.30am to 12.30pm in the CCG Main Meeting Room



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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

**Minutes of the meeting held on 30th January 2018
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
Mr P McKenzie	Corporate Operations Manager

In attendance

Mrs H Pidoux	Administrative Team Manager
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1. Apologies

Apologies were submitted by Mr Marshall and Mr Hartland.

2. Declarations of Interest

FP.227 There were no declarations of interest.

3. Minutes of the last meetings held on 28th November 2018

FP.228 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.229 Item 1184 (FP.225) – Risk Report – on agenda – action closed.

5. Matters Arising from the minutes of the meeting held on 28th November 2017

FP.230 There were no matters arising to discuss from the last meeting.

6. Performance Report

FP.231 Mr Bahia highlighted the key points of the Executive Summary relating to Month 8 performance. It was noted that performance has worsened; however, this was expected due to the time of year and winter pressures. The following was considered;

- RTT – the impact of cancelling elective activity is not yet clear, however, it is anticipated that this will be minimal as the majority of elective activity is undertaken at Cannock Hospital.

There are concerns regarding the level of performance and whether the Trust will be able to deliver the recovery trajectory by the end of March. Performance was slightly in front of trajectory but is expected to slip in December and January. It may be necessary to consider a revised trajectory. It was noted that as RWT have not cancelled elective activity this could impact on performance levels.

The number of referrals for diagnostic tests has increased; the reason for this is unknown. In particular fast track breast cancer referrals had risen significantly. It was suggested that further analysis was required to identify whether these were being made by particular practices.

Mrs Sawrey reported that in the T&O speciality day cases are going through whilst inpatients are waiting longer.

Discussions are required with RWT regarding plans for long term recovery.

- A&E Urgent Care Performance – Performance was the worst in year and the quarter 3 target of 90% was missed. There has been an increase in attendances and ambulance conveyances year on year. The main issues are bed availability, patient flow and ambulance batching. RAPs and exception reports are in place to support performance improvements.

It was highlighted that RWT are performing well in comparison to other local Trusts. Discussion took place that this is a national issue and it was suggest that national and Black Country data be included in the report if possible to give a fuller view of the situation.

The situation of beds not being available leading to breaches in A&E was discussed and it was felt that this was not a measurement A&E performance rather that the situation elsewhere in the hospital was impacting on A&E.

RWT had reported that they are likely to miss the STF target for Quarter 3, which had been revised to delivering the level of performance as the same time last year or 90%.

- 62 day cancer waits – There had been a drop in performance and this is below the recovery trajectory. The main breaches are due to tertiary referrals and capacity issues which are out of the control of the provider. RWT are joining the cancer performance calls with the CCG, NHSE and NHSI. NHSI are investigating the tertiary referral issues across the STP. Funding is in place for the cancer specialist to be re-employed to continue with the Tranche 2 review of all pathways.

There is sustained pressure from NHSE on the CCG to improve performance with the Executive Team giving fortnightly feedback.

- Delayed Transfers of Care (DToC) – RWT had achieved both the in month threshold (excluding Social Care) reporting 1.66% for November and the combined threshold. Following new guidance a health economy wide plan including Social Care had been developed. This includes the Director of Adult Social Services signing of all DToCs and a DToC Directory containing the details of all key individuals.

Early indications are that the December Performance is 1.11% which is the best performance in year.

- E-Referral – ASI rates – currently ahead of trajectory plan and exception report in place to achieve 4% by April 2018. Staff shortages in specific specialities are affecting performance particularly in Ophthalmology, Paediatrics, Urology and Orthopaedics.

It is part of the CQUIN for paper switch off to be implemented by October 2018. November performance is ahead of local trusts but behind national performance. It was noted that currently only 9 systems across the country have achieved paper switch off. RWT is reporting that they will hit the target date of 1st October 2018 for switch off.

- MRSA – A further breach has been indicated for December. A Root Cause Analysis is underway.
- Ambulance handover breaches – Handover breaches, waiting more than 30 minutes, are the highest in year. There has been a 5.1% increase in ambulance conveyances. In December there were 122 breaches and sanctions are in place for each breach.
- Delayed Transfers of Care (DToC) – Black Country Partnership Foundation Trust (BCPFT) had seen a significant increase in

November (10.50%) and had breached the 7.5% threshold, relating to Wolverhampton performance only. The main issue is patients on Older Adults Ward waiting for specialist nursing home beds. A multi-agency working group had been established to address delays.

Following the December Clinical Quality Review Meeting (CQRM) the Trust had shared additional information regarding delays detailing timelines and actions taken.

- IAPT – performance is being maintained ahead of targets. A drop had been seen in access rates however performance remains close to trajectory. Plans are in place to address access issues.

A query was raised about a Never Event which had been reported for a Wolverhampton patient at the Nuffield Hospital during December 2017. It was thought that this had been downgraded as it had been found to be a data recording error; however this would be checked and clarified in the next report.

Resolved: The Committee noted

- the content of the report
- clarification on possible Never Event to be included in the next report.

7. Contract and Procurement Report

FP.232 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

The Trust has been asked to add more narrative generally for future presentations to the Contract Review Meeting, with specific focus on explanation for variances. A meeting is to be held to agree how to maximise this part of agenda at CRM and how to report focusing on the areas that give best intelligence.

There are currently no Contract Performance Notices issued to RWT.

The exception reporting process had embedded and significant improvement had been made in the information received. The key issues reviewed at the CRM meeting include the reasons for variance, actions to correct and the trajectory. The CCG is able to take more assurance from the documentation.

As discussed at previous Committee meetings issues continue with the Sepsis counting and coding change. The CCG's and Trust's perspectives differ in relation to this. The CCG had shared with the Trust, as part of a formal challenge, an analysis of the impact completed by the CSU. The Trust had responded that it disagrees with the methodology used; however, their own methodology had not been

shared with the CCG. Guidance is awaited from NHS Improvement (NHSI). A counter response is being prepared back to the Trust due to the proximity of year end and the lack of guidance.

It was queried what would happen if an agreement cannot be reached. Clarification was given that this is a national issue. The current position is that NHSI are instructing Trusts not to pay while NHSE are informing CCGs that payment should be pursued. A steer is required from NHSI.

The total fine value for all breaches in period was noted at £29,677.

A meeting is due to be held on 8th February to finalise the contract agreement for 2018/19. There is an outstanding issue relating to non-recurrent support for cost reduction. The CCG's view is that this should sit outside the quantum.

Black Country Partnership Foundation Trust

There is an over performance issue on Adults/Older Adults inpatient beds. The level is financially unsustainable for the Trust. A letter had been received by the Director of Strategy and Transformation escalating this issue. A meeting is to be arranged to discuss. The CCG will need to consider how to move forward with this contract.

Urgent Care Centre (UCC)

At the Vocare Improvement Board meeting held in January it had been acknowledged that some progress against performance had been made and the CCG was satisfied with the responses received. However, this week had seen a further deterioration. An unannounced visit had been conducted by the CCG which had raised major concerns regarding the safety of the service. In particular around the ability to triage appropriately especially paediatrics.

Mr Hastings reported that a meeting with Vocare had been held that morning where the CCG had stated that there was no assurance that there is sufficient capacity to deliver the service specification. The provider had been asked to consider this and provide the CCG with recommendations. He noted that there were a number of actions still outstanding from the Improvement Board meeting held in August which is indicative of how the service is run. There are clinical staffing issues and the CCG has requested to see training records for all staff.

Mr Middlemiss confirmed that the Vocare Improvement Board will continue to meet as an oversight board to give increased scrutiny. It was noted that a CQC inspection in way of a planned visit is due in February.

WMAS – Non-Emergency Patient Transport (NEPT)

In December WMAS raised concerns with this contract and performance is under scrutiny. An Executive level meeting had been held and the provider had indicated it may wish to serve notice on the contract. It was highlighted that the previous provider served notice early. Work is ongoing with the provider to review the current contract, concerns and how to make the KPI's and reporting reasonable for all parties so that there can be focus on improving the quality of the service provided. The CCG will balance being supportive to the provider whilst managing the contract effectively.

National Contract Variation

Mr Middlemiss informed the Committee that a national variation had been issued by NHSE with an expectation that it would be signed and implemented by 1st February 2018. A summary of the key headlines had been shared with the papers. It is perceived that the impact of the changes will be relatively minimal and is it not anticipated that there would be problems in signing off the variation with providers.

Resolved – The Committee noted the contents of the report and actions being taken.

8. Finance Report

FP. 233 Mrs Sawrey introduced the report relating to month 9, December.

The following key points were highlighted and discussed;

- Acute portfolio (other than RWT) – further Business Intelligence resource is being brought in to allow further analysis of data and to review issues when flagged.

There is an increased level of activity going through Dudley Group of Hospitals (DGoH) for Vascular and non-electives; however there is no reduction in activity being seen at RWT or other providers.

Further work is needed relating to QIPP and reviewing pathways following challenge from Internal Auditors.

- WMAS – there is a high conveyance rate in Wolverhampton compared with the rest of the Black Country and the reason for this needs to be understood.
- Mental Health – there is an unusually high utilisation of inpatient beds at BCPFT and Dudley and Walsall Partnership Mental Health Trust. Spend is also increasing on the high cost PICU placements.

- Prescribing – currently reported as over spending partly due to an increase in volumes.
- Continuing Health Care – the number of clients is reducing; however, the cost of packages is increasing. Although this is being managed in year it will impact on the Long Term Financial Model as it will become a recurrent cost pressure.

The Committee was informed that it had been anticipated that the financial plan for 18/19 would be shared at this meeting, however, guidance had not been received and this will be brought to the February meeting.

Mr Gallagher reported that in the 2 year finance plan 2017/18 submission the CCG had identified a requirement for 2.9% QIPP (£11m). Recent guidance from the local NHSE Team is that the CCG need to identify 3.5% (£14m).

A Project Initiation Document (PID) had been submitted to NHSE for each QIPP plan as requested.

It was clarified that QIPP schemes included in contract offers would be developed and agreed to ensure the 2018/19 offer complied with part of the 2 year contract. Consideration was given to the option of moving to risk gain share agreements for future contracts.

Resolved: The Committee noted the contents of the report and the areas of concern

9. Risk Report

FP.234 Mr McKenzie presented the latest risks relevant to corporate organisational and Committee level risks relevant to this meeting. These were discussed as follows;

Corporate - Organisational Risks:

- ID CR03 (NHS Constitutional Targets) the level of risk was challenged as to whether this reflected if the target will be missed or whether there are mitigation plans and actions in place to address. It was agreed to review the wording and level of risk.
- ID CR07 (Failure to meet overall financial targets) was discussed in relation to whether this related to an overall risk or an in year risk. It was agreed to consider if this should be two separate risks.

Committee Level Risk

Two new risks were noted

- FP11 (Winter Pressures – A&E performance)
- FP12 (Winter Pressures – Financial Impact).

FP05 (Over-performance of Acute Contract) – suggested that the risk level should be reviewed as although measures are in place to manage the over performance this continues due to pressure on the system.

It was noted that the Corporate Risk CR07 (Failure to meet overall financial targets) is influenced by Committee Level Risks FP01 to FP12. It was suggested that the rating for the Corporate Risk should be mirrored in the Committee level risks.

A suggestion was made that it would be useful to have the latest update and key mitigations next to the residual risk.

Mr McKenzie stated that there is a need to review risk reporting and management and a new approach is being undertaken following challenge from an Internal Audit Review of the current process. He reported that the Black Country Audit Chairs meeting had discussed best practice around risk management and how to share this. This will be used in the development work on the risk reporting templates. The continued use of the Datix system as a tool to record and manage risk is under consideration as it is difficult to interrogate this information.

Resolved: The Committee

- noted the current level of risk
- requested that the risk scoring matrix be circulated

10. Any other Business

FP.235 The Committee thanked and gave best wishes to Mr Bahia as he was taking up a secondment outside the organisation.

11. Date and time of next meeting

FP.235 Tuesday 27th February 2018 at 3.15pm

Signed:

Dated:

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

**Minutes of the meeting held on 27th February 2018
Science Park, Wolverhampton**

Present:

Mr L Trigg	Independent Committee Member (Chair)
Mr T Gallagher	Chief Finance Officer
Mr M Hastings	Director of Operations
Mr S Marshall	Director of Strategy and Transformation
Dr M Asghar	Governing Body GP, Deputy Finance and Performance Lead (part meeting)

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr V Middlemiss	Head of Contracting and Procurement
Mr P McKenzie	Corporate Operations Manager

In attendance

Mrs H Pidoux	Administrative Team Manager
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1. Apologies

Apologies were submitted by Dr Bush and Mr Hartland.

2. Declarations of Interest

FP.236 There were no declarations of interest.

3. Minutes of the last meetings held on 30th January 2018

FP.237 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.238 Item 117 (FP.220) RAS - Mr Middlemiss reported that since this issue had been raised a CCG/Trust workshop had been held and discussions had taken place regarding electronic referrals and two way communication between primary and secondary care. This is challenging within mental health and there is a move towards paperless communication including a generic email address for referrals. This will form part of the Data Quality Improvement Plan rather than as part of the RAS at this stage - action closed.

Item 118 (FP.118) - Never Event - Mr Hastings gave an update on this incident that had been treated as a Never Event. The CCG's Patient Quality Manger had reported that this event had taken place in December when a surgeon had injected the wrong foot before a surgical procedure. This was soon identified and subsequently the correct foot was injected and the planned surgery continued. The surgery was uneventful and the patient made a full recovery post-surgery. A conversation had been held with Nuffield's Director about this incident and initially it was reported as human error, however a full Root Cause Analysis is being undertaken and this is expected to be submitted to the CCG before 12th March. No harm came to the patient and duty of candour was applied by the Trust on the same day. Following the incident, the CCG had carried out a quality visit to Nuffield, this went well and there were no immediate or serious concerns related to their surgical safety procedures and processes – action closed

Item 119 (FP.119) - Risk Report - Matrix to be circulated - this had been done following the last meeting - action closed

5. Matters Arising from the minutes of the meeting held on 30th January 2018

FP.239 There were no matters arising to discuss from the last meeting.

6. Finance Report

FP. 240 Mrs Sawrey introduced the report relating to month 10, January 2018

The following key points were highlighted and discussed;

- In Month 10 breakeven has been assumed
- Financial metrics are being met and the CCG is on target to meet duties.
- Reporting achieving QIPP target, however, shortfall is being supported by reserves and other underspends.
- The recurrent overspend had increased to £1.173m forecast outturn (FOT) which is currently offset by non-recurrent underspends and the use of reserves. This has very serious implications for 2018/19 onwards.
- There is a considerable level of flexibility within Delegated Primary Care, of approximately £1m.
- CCG continues to bring forward plans and commit recurrent spend although the impact will now be minimal. Any unused budget can be used non-recurrently to support the financial position, if required, as the budget is ring fenced on a recurrent basis.

- RWT is giving concern as the Month 9 activity is indicating a potential FOT of approximately £1.6m as a result of lower than expected activity in December (even after phased plan). The CCG is maintaining a higher FOT in anticipation of activity levels recovering in the last quarter of 17/18.
- Mental Health Complex cases are continuing to over perform. Assurances have been given by the Mental Health Commissioner that the spend will reduce and fall back in line with budget as cases are reviewed and costs reduced. This is now unlikely to occur thus increasing the pressure on budgets. There is a risk in financial planning of around £1m.

It was noted that this month's reporting was the last time the FOT can be changed.

Resolved: The Committee noted the contents of the report and the areas of concern

7. Performance Report

FP.241 Mr Hastings highlighted the key points of the Executive Summary relating to Month 9 performance. The following was considered;

- RTT - had missed trajectory again. This is due mainly to the areas previously reported; ENT, General Surgery, Ophthalmology, Oral Surgery, Plastic Surgery, Trauma and Orthopaedics and Urology. This indicator is amber rated on NHSE reports. It was noted that this is a small co-hort of patients, waiting lists are constantly being reviewed and there are no over 52 week waits.
- A&E - Performance in January was worse than December. One of the issues is inconsistency in performance. Ambulance conveyances have increased across the area. RWT remains top performing A&E in the Black Country.
- Cancer 62 day waits - a decrease in performance has been seen. This is an area of focus for NHSE and a meeting had been held between the CCG's Chief Officer and NHSE's Alison Tonge, Director of Commissioning Operations – West Midlands.

RWT had been asked to rewrite the Recovery Action Plan with the overriding message that this needs to be more clinical than operational and needs to be tightened. The lines in the Plan need to be quantified. The revision was expected shortly.

Since the last report the Patient Tracking List Meeting had been revamped and is now chaired by Gwen Nuttall, RWT's Chief Operations Officer. The meeting is more proactive and it

is mandatory that administrative and diagnostic teams are in attendance. This had commenced on 25th February and Mr Hastings is due to review.

- DTOC - continues on target with a downward trajectory.
- E-referrals ASI rates - performance is at 16.65% which is the lowest for 18 months. It was noted that this is a long way from the target of 4%, however, actions being undertaken are impacting and more are planned including putting more capacity into clinics. The Trust continues to report paper switch off is on target for October.

Resolved: The Committee noted the contents of the report.

8. Contract and Procurement Report

FP.242 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

Diagnostics, 62 day cancer wait - RWT had submitted a further bid to NHS Improvement (NHSI) for £70k to fund additional capacity for Cancer Diagnostics. The CCG had requested further details including how planning to spend the money. An invoice had been received, however, it was noted that this money had been received in the draft allocation and not the final one. It was agreed that this position would be checked.

Dr Asghar joined the meeting

Performance Sanctions - Sanctions for Month 8 had been agreed at just under £38k. There had been a notable increase in Ambulance handover breaches compared to the previous month.

Sepsis Counting and Coding Change - supplementary guidance had been issued by NHSI the Providers regulator. This is explicit and the CSU are to run this to establish the implications of the value of following this model. It was confirmed that this is a non-recurrent adjustment for 17/18.

2018/19 Contract Review Process - following the meeting held on 26th February it was reported that the CCG is close to agreement with RWT. The main area of risk is the Staffordshire CCG part of the contract. The CCG is currently awaiting confirmation from Staffordshire of their position. As host commissioner Wolverhampton CCG has a duty to notify NHSE of the position. There should be no further impact on Wolverhampton CCG, however, it is trying to facilitate agreement but there is a material difference.

The variation to the contract is due to be signed by 23rd March. RWT, however, may not signed if have not reached agreement with Staffordshire. It

was felt that, although Staffordshire have a substantial amount of the contract, RWT need to draw a distinction between the two.

Black Country Partnership Foundation Trust

Meetings are on-going to agree contracts for 2018/19. No concerns were raised.

Nuffield

A re-based plan is being worked on and meetings are ongoing to agree contracts for 2018/19.

Urgent Care Centre

A further recovery plan is in place and unannounced visits are being undertaken. This remains high on the CCG's Risk Register. The Improvement Board continues to meet.

WMAS – Non-Emergency Patient Transport (NEPT)

Following concerns raised by WMAS, in relation to KPIs and reporting requirements, a proposal had been received containing potential changes. This appears to be more amenable to all parties. A meeting had been held and it appears that this is likely to be supported by Dudley and Wolverhampton CCG's with some caveats. It was noted that agreement would reduce the risk of the contract ending early.

Resolved – The Committee

- noted the contents of the report
- actions being taken
- allocation of additional money to fund additional capacity for Cancer Diagnostics.

9. Finance Plan and Budget for 2018/19

FP.243 Mr Gallagher gave an overview of the latest plans for 2018/19 and the risks contained in the final position. The key elements considered were;

- In February NHSE had issued revised planning guidance for 2018/19
- In order to submit a balanced, assured plan for 2018/19 the CCG had included a QIPP programme of £14m 3.5% of its allocation. This is an extremely stretching target, however, unidentified QIPP has been closed to a gap of just over £2m.
- The total allocation for Programme costs is £360,601m. This includes the adjustments to the notified budget which have been made. The Running costs allocation is £5,515m, this cannot be exceeded.

- Planning guidance also sets out additional specific activity growth percentages which the CCG had modelled and funded from the additional growth allocations of £2,978m
 - Non elective and Ambulance growth to be 2.3% above FOT at Month 6 after QIPP
 - Growth in A&E to be 1.1% above FOT at Month 6 after QIPP
 - Elective growth to be 3.6% above FOT at Month 6 after QIPP
 - Outpatient growth to be 4.9% above Month 6 FOT after QIPP
 - GP referrals to be 0.8% growth above Month 6 FOT after QIPP

The above assumptions will consume approximately £1.8m of the additional growth monies. The implications have been modelled and form the basis of all contract offers to providers.

For planning purposes the Long Term Financial Model (LTFM) has incorporated the 2017/19 National Tariff published in December 2016 which includes the efficiency and inflation assumptions as follows;

- Tariff inflation 2.1%
- Tariff efficiency 2%
- HRG4+ incorporated into tariff
- Marginal Rate Emergency Tariff remains unchanged at 70%/30%
- Current Market Forces Factor, MFF remains in place
- STP growth assumptions to be used

Medium Term Financial Planning 2017/18 to 2020/21, the CCG is reporting it will meet the in year control total targets,

There is a positive drawdown in 2018/19 and the model includes only drawing down that approved.

Mr Trigg queried that beyond 2018/19 QIPP savings are not identified. Mrs Sawrey confirmed that as allocations for 2019/20 and 2020/21 are not confirmed assumptions have to be made as to what the QIPP target will be.

It was noted that in 2018/19 the target for identified QIPP is £14m. Through the assurance process with NHSE positive progress has been noted. Following challenge the unidentified gap in QIPP has been closed.

The high level of QIPP associated to prescribing was queried. Clarification was given that the prescribing leads had met to agree a consistent approach across the Black Country. Although it was acknowledged that the figures were challenging the schemes and areas identified meant that the targets were not unrealistic.

A key risk is over performance in the acute contract. The contingency reserve can be used to manage some pressures, however it is difficult to mitigate against this.

Risks and mitigations;

- The CCG is green on all metrics.
- The CCG has identified risks included within the 2018/19 budgets which total £3.5m. The key risks are as follows;
- £2.0m related to potential level of overspend in the Acute Sector. This is an estimate as the main Acute contract with RWT had not been finalised although it is close to agreement. £2m associated with over performance within the Acute contracts.
- £500k associated with Prescribing and the volatility within this budget particularly around NCSO.
- £1.0m in relation to the uncertainty around FTA's (Financial Transfer agreements) and the future of TCP for LD services.
- The CCG has identified mitigations for risks as detailed below.
- £2.0m - as in 2017/18 the CCG will utilise all off the Contingency reserve to offset overspends if they arise.
- £1.5m of the 1% reserve £200k - utilisation of SOP flexibilities.
- As a consequence of the risks and mitigations the CCG starts 2018/19 with nil net risk (noted this is draft at the stage).

Mr Gallagher asked the Committee to support the paper, with the caveats that minor amendments are required to the QIPP information and a more formal update on contract negotiations, with a view to recommending to the Governing Body to sign off the budgets.

Resolve - The Committee,

- Noted the contents of the report
- Noted the level of financial risk associated with the proposed 2018/19 budgets
- Recommends to the Governing Body that it signs off the budget, noting the inherent risk and supporting the CCG's Executive Team to pursue avenues to close the QIPP gap and therefore reduce financial risk.

10. Risk Report

FP.244 Mr McKenzie presented the latest risks relevant to corporate organisational and Committee level risks relevant to this meeting.

Changes to Corporate Risks

CR18 - this had been split into financial risks present in year and long term financial risks. It was discussed that this was high as it was rated before planning guidance had been received and should now be reviewed.

Committee level risks;

FP01 - Tier 4 Obesity Services - the level of risk had reduced as the impact on the overall financial position had been covered and is not expected to worsen.

Mr Gallagher suggested that a risk should be added relating to TCP in terms of ongoing plans. The level and scoring was considered. It was felt that the financial risk was high and should be added to the Committee risk register. It was discussed that there was risk around linking TCP to performance and quality as well. It was agreed to liaise with Sally Roberts, Chief Nurse, Director of Quality whether a Corporate Risk should also be registered to enable discussion at Governing Body.

It was also agreed, due to the additional NHSE scrutiny, to add Cancer 62 day waits to the Committee Level Risk Register.

Resolved: The Committee;

- Noted the changes to the Corporate and Committee Level Risk Registers
- Requested that a risk related to TCP on going plans to be added to Committee Level Risk Register
- Adding Corporate Risk relating to TCP performance and quality to be raised with Chief Nurse, Director of Quality
- 62 Cancer 62 Day waits to be added to Committee Level Risk Register.

10. Any other Business

FP.245 There were no items to discuss under any other business.

11. Date and time of next meeting

FP.246 Tuesday 27th March 2018 at 3.15pm

Signed:

Dated:

**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE**

Minutes of the Primary Care Commissioning Committee Meeting (Public)
Held on Tuesday 5th December 2017, Commencing at 2.00 pm in the in PC108, Creative
Industries Building, Wolverhampton Science Park

MEMBERS ~

Wolverhampton CCG ~

		Present
Sue McKie	Chair	Yes
Dr David Bush	Locality Chair / GP	Yes
Dr Manjit Kainth	Locality Chair / GP	No
Dr Salma Reehana	Clinical Chair of the Governing Body	Yes
Steven Marshall	Director of Strategy & Transformation	No
Les Trigg	Lay Member (Vice Chair)	Yes

NHS England ~

Bal Dhami	Contract Manager	Yes
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Independent Patient Representatives ~

Sarah Gaytten	Independent Patient Representative	No
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Non-Voting Observers ~

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

In attendance ~

Mike Hastings	Associate Director of Operations (WCCG)	Yes
Dr Helen Hibbs	Chief Officer (WCCG)	No
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	No
Sarah Southall	Head of Primary Care (WCCG)	Yes
Liz Corrigan	Primary Care Quality Manager Assurance Coordinator	Yes
Jane Worton	Primary Care Liaison Manager	Yes
Laura Russell	Primary Care PMO Administrator (WCCG – minutes)	Yes

Welcomes and Introductions

WPCC153 Ms McKie welcomed attendees to the meeting and introductions took place.

Apologies for absence

WPCC154 Apologies were submitted on behalf of Dr Helen Hibbs, Steven Marshall, Sarah Gaytten, Gill Shelley and Jeff Blankley.

Declarations of Interest

WPCC155 Dr Bush and Dr Reehana declared that, as GPs they have a standing interest in all items related to primary care.

Ms McKie declared she works two days a week with Public Health at the Wolverhampton Local Authority.

As these declarations did not constitute a conflict of interest, all participants 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 5th December 2017.

WPCC156 **RESOLVED:**

That the minutes of the previous meeting held on the 7th November 2017 were approved as an accurate record.

Matters Arising from the minutes

WPCC157 There were no matters arising from the minutes.

RESOLUTION: That the above is noted.

Committee Action Points

WPCC158 **Minute Number PCC302a - Premises Charges (Rent Reimbursement)**
Mr Hastings noted the CCG have been informed the cost directives will be made available in January 2018. Action to remain open.

Minute Number WPCC117 - Provision of Services post Dr Mudigonda Retirement from a Partnership to single handed contract - Business Case

A report expected in September 2018 from Ms Shelley regarding the progress made to secure a partner onto the contract. Mrs Southall advised the Committee that the Practice have confirmed their intention to align within

Primary Care Home 1 (PCH1), however they will not be taking part in the hub working until the end of the year.

RESOLVED: That the above is noted.

Primary Care Quality Report

WPCC159 Ms Corrigan presented the quality report to the Committee which provides an overview of activity in primary Care. The following was highlighted to the Committee:

- The infection prevention standards and scores have improved since the new infection prevention audit was first introduced, Practices are becoming more aware of the new requirements. The Primary Care Liaison for infection prevention continues to provide support to a Practice who had a red rating in August 2017.
- The results for Friends and Family data slightly dipped for the month at 81% compared to the previous month at 82% (percentage recommended). The Friends and Family Test data is monitored at the Primary Care Operational Management Group and via NHS England Primary Care Dashboard. An options paper around increasing uptake and analysis of qualitative data was presented to the Primary Care Operational Management Group on the 24th October 2017. A Task and Finish Group has been set up and is due to meet for the first time to discuss methods of increasing engagement, uptake and promoting Friends and Family across the Practices.
- The Quality Matters data was shared with the Committee, the themes have been reviewed and work is being undertaken with the Information Governance Team, more detail will be provided within the next report.
- There are no complaints or compliments relating to Primary Care noted for the CCG. The reporting for complaints has changed and the CCG will now receive a copy of the complaints sent to NHS England, which previously the CCG did not receive. The historic complaints for the previous year and those for quarter 1 are now available. It was agreed this report would be provided at the next meeting.
- The assurance framework around NICE guidance is currently being reviewed and will be applied in line with peer review system for GPs.
- The risk register will now be addressed via the full risk report within the private committee.
- The workforce plan continues in line with the Primary Care Strategy, STP and national drivers. An STP wide workforce action plan has been submitted to NHS England. A video on promoting primary care in the City has been completed within the month and is currently being edited once finalised this will be made available on the CCG Internet site. It was suggested by the Committee this needed to be shared quite widely. The Trainee Nurse Associates have taken part at a London conference to discuss and share their experiences in primary care, this has been well received.

RESOLUTION: Ms Corrigan to provide the NHS England's Complaints report to the next meeting.

Governing Body Report/Primary Care Milestone Programme Review Board Update

WPCC160 Mrs Southall informed the Committee the report presented had been shared with the Governing Body at the November meeting, which was based on the activity during the month of October 2017. The following points were highlighted to the Committee:

- An overview of work being undertaken within each Task and Finish Group has been provided and the programme is largely running in accordance with anticipated timescales. There were however 3 exception reports received at the October Primary Care Milestone Review Board meeting. The Board reviewed and agreed the exception reports, which were in relation to following;
 - Practices as Providers - review of back office functions
 - General Practice as Commissioners - Enhanced Services at scale
 - Primary Care Contract Management - Risk/gain share agreement
- The implementation plan for the General Practice Five Year Forward View continues to make good progress. There are currently 39 live projects with a further 3 due to commence however the CCG are just awaiting national guidance. A stakeholder event took place in October pertaining to Care Navigation where 6 pathways have been short listed for inclusion in the first roll out of care navigation. A training event has been organised for January with the launch of the first phase for care navigation in February 2018.
- The Primary Care Milestone Programme Review Board has in place a series of risk logs and an escalation log. There are currently no red risks raised to the Governing Body, however the following risks were discussed by the Board;
 - Workforce Task and Finish Group: Depletion of workforce numbers in primary care (score 12) anticipated reduction in score in quarter 3.
 - Workforce Task and Finish Group: Financial implications associated with roles in primary care (score 12) anticipated reduction in score in quarter 3.
 - Estates Task and Finish Group: The impact of new leases with NHS Property Services not yet being signed (score 12) anticipated reduction in score in quarter 3.

Ms Cresswell advised in relation to patient engagement the message needs to be consistent and made clear to patients for example with care navigation. Mrs Southall highlighted that in relation to care navigation presentations have been made at both September and November PPG Chairs meetings. There will also be resources going out to practices to display within practices and a comms plan

is being developed. A discussion took place around how to manage patient's expectations in relation to services and their GP practices.

Dr Reehana asked in terms of Sound Doctor which was referenced under the IMT Task and Finish Group update, when the first set of data would be made available. Mrs Southall/Mr Hastings agreed to check with the Provider and report back.

RESOLUTION: Mrs Southall and Mr Hastings to check with the provider of Sound Doctor to see when the first set of data will be made available.

Primary Care Operational Management Group Update

WPCC161 Mr Hastings informed the Committee of the discussions which took place at the Primary Care Operational Management Group Meeting on the 21st November 2017 and highlighted the following points:

- The Clinical Reference Group notes were shared and discussions took place regarding a proposed QOF+ type scheme for risk stratification, which has since been discussed at the last members meeting.
- IT migration has highlighted some issues with Docman 10 document management system when practices are undergoing a merge, these issues are being reviewed.
- New leases from NHS Property Services are currently going through legal checks.
- CQC provided an update on the practices they have visited and those that are planned. All the outcomes are published on the CQC website.
- Following a review of Team W Events for clinical staff a number of changes are to be introduced including changing the timings of the meeting and plan to publish the meetings online for web access.

RESOLVED: That the above is noted.

Any Other Business

WPCC162 Winter Scheme for Practices

Mrs Southall asked for this to be placed on the next agenda, for a full update to be provided to the Committee. Ms Russell to add to agenda.

RESOLUTION: To add Winter Schemes update onto the next agenda.

Date, Time and Venue of the Next Meeting

WPCC163 **CANCELLED- Tuesday 2nd January 2018 at 2.00pm in the Stephenson Room, Wolverhampton Science Park**

Next Meeting - Tuesday 6th February 2018 at 2.00pm in the Stephenson Room, Wolverhampton Science Park, Technology Centre, WV10 9RU

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**WOLVERHAMPTON CLINICAL COMMISSIONING
GROUP COMMISSIONING COMMITTEE**

Minutes of the Commissioning Committee Meeting held on Thursday 25th January 2018 commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~

Present

Dr M Kainth (Chair)	Lead for Commissioning & Contracting	Yes
Dr Gulati	Deputy Lead for Commissioning & Contracting	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	No
Sarah Smith	Interim Head of Commissioning - WCC	Yes

In Attendance ~

Liz Hull	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Peter McKenzie	Corporate Operations Manager	Yes
Mark Williams	Wolverhampton City Council	Yes
Juliet Grainger	Wolverhampton City Council	Yes
Sandra Smith	Development Manager - WCCG	Yes (part)

Apologies for absence

Apologies were submitted on Tony Gallagher.

Declarations of Interest

CCM654 None.

RESOLVED: That the above is noted.

Minutes

CCM655 The minutes of the last Committee meeting, which took place on 23rd November 2017 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM656 None.

RESOLVED: That the above is noted.

Committee Action Points

CCM657 (CCM619) Direct Access Diagnosis Spirometry Business Case: Vic Middlemiss to provide an update at the next Committee meeting.

RESOLVED: That the above is noted.

(CCM638) Primary Care Counselling Service – Options Paper: Included as an agenda item.

RESOLVED: That the above is noted and action closed.

(CCM645) Vocare Improvement Board Improvement Plan – Tabled at the meeting.

RESOLVED: That the above is noted and action closed,

(CCM647) Review of Risks – Risk Management Process: Peter McKenzie to send Cyril Randles a copy of the Risk Management Process.

RESOLVED: That the above is noted.

(CCM652) Sue McKie, Patient & Public Involvement Lay Member – Introductory meetings to be arrange between Sue McKie and the Patient Representatives for Commissioning Committee.

RESOLUTION: That the above is noted and an action agreed for Liz Hull to organise the introductory meetings.

Social Prescribing Service Commissioning Intentions

CCM658 Sandra Smith presented the Committee with a proposal to continue the Social Prescribing Service for a further 12 months, from April 2018 to March 2019.

The Social Prescribing Pilot, currently in place, was implemented to improve:

- The quality of life of patients through education and low level support
- Patient satisfaction and experience
- The emotional health and wellbeing of patients
- Isolation
- Promote personalisation, self-care and independence
- Working relationships with other agencies in order to maximise the options available to patients
- Unnecessary hospital admissions and A&E attendances
- Demand on Primary Care by increasing patients independence and wellbeing

The Committee was advised that even though positive feedback has been received from patients and GPs, an extension of the contract would allow a more meaningful evaluation to take place.

A discussion took place about the Local Authority undertaking a similar trial, however, assurance was given by Sarah Smith that it is of a much smaller scale and any findings would be shared to ensure they were incorporated into the CCG's project.

It was confirmed that referrals are made in Primary Care by the GP who is required to complete a form on EMIS. It was clarified that this should reduce subsequent visits to the GP.

RESOLVED: That the above is noted and the Committee approved the recommendation to continue the Social Prescribing Service for a further 12 months, from April 2018 to March 2019

Review of Risks

CCM659 Peter McKenzie presented the Committee with a summary of the Commissioning Committee Risk Profile. An update was provided for each risk and the current situation noted as follows:

Corporate Organisational Risks:

CR10 High – The overall rating remains the same
CR14 High – The rating has reduced from Extreme

Committee Level Risks:

CC04 Very High – The rating has increased from High. However, there is an expectation that the risk should reduce once the Local Authority have confirmed the Community Equipment service will continue to be delivered.

CC08 Very High – A new risk has been added to the Committee's Risk Profile, regarding RITs Capacity, as a result of Winter pressures.

CC02 High – No update

CC03 High – No update

CC05 Moderate – The rating has reduced from High and recommended for closure.

RESOLVED: That the above is noted and the Committee approved the recommendation for risk CC05 to be closed.

Contracting Update Report

CCM660 Vic Middlemiss provided the Committee with a monthly overview of key contractual issues and areas of concern including actions proposed or being taken to address issues. Highlights of the report presented include the following:

Royal Wolverhampton NHS Trust

Main Issues with Activity:

- The overall acute activity position, across all commissioners, is over-performing by £921k which is a significant rise from the reported position of £56k in Month 5.
- Staffordshire CCGs (combined) are over performing by £855k. Outpatient activity is the largest contributor to this
- Non Elective Activity is the largest over performing Point of Delivery
- Cardiology is the largest over performing speciality
- Obstetrics and Urology are both above plan
- A&E has over performed at Month 7 by £543k, equal to 2,081 activities
- The CCG is forecasting an outturn of £1.75m and although the report states that RWT is forecasting a £3.093m year-end over-performance, it was confirmed that their position is now more closely aligned to the £1.75m

Contract Performance:

- RTT Incomplete – There has been a small improvement in performance and the Trust continue to focus on reducing the backlog.
- Diagnostics – Performance has deteriorated in November and the Trust is developing a Business Case for an extra £70k, to increase capacity, which will support the Cancer 62 day target.

- A&E (4 hour target) – The Trust has achieved above 90% throughout the financial year. However, performance for November 2017 dropped to 87.43%. The drop in performance relates to the increased number of A&E attendances in November, 319 more than November 2016.
- Cancer 62 Day Target – RWT predicted, correctly, non-achievement in 31 Day Sub Surgery, 62 Day Screening and 62 Day Wait for First Treatment for November 2017. Mitigating actions are in place and weekly escalation meetings continue.

Performance Sanctions:

- Month 5 (August) - £22, 350
- Month 6 (September) - £26, 000
- Month 7 (October) - £29, 677

Vocare Improvement Board – A summary from the meeting on 15th January 2018 was circulated and it was confirmed that improvements are being evidenced. Clinical Governance is in place and triaging is being undertaken in a more collaborative and constructive way.

Sepsis Counting and Coding Charge:

- An analysis of the impact has been completed by the CSU and this has been shared with the Trust as part of a formal challenge.
- A response has been sent back stating that the Trust disagrees with the CSU methodology, but they have not provided their own methodology.
- It is understood that NHS Improvement is due to issue guidance to providers on this issue.
- There is an outstanding letter from the CCG to the Trust. If guidance is not received by the end of January, this letter will be sent.

Black Country Partnership Foundation Trust (BCPFT)

Fines / Sanctions:

- A sanction has been issued of £250 for a late STEIS report in November.

Service Development Improvement Plan (SDIP):

- The SDIP requires review for 2018/19

Data Quality Improvement Plan (DQIP):

- Significant improvement is being made with e-discharge and rolling this out Trust wide.
- Issues still exist in relation to IAPT data

Finance – Over Performance:

- An over performance issue exists with regards to Adults / Older Adults inpatient beds

- The Trust has requested additional non-recurrent funding available to elevate the financial pressure on the Trust. However, it was noted that the CCG is not in a position to meet this request.

WMAS Non-Emergency Patient Transport (NEPT)

- Following concerns raised about operational pressures, in December, Dr Helen Hibbs met with Mark Docherty at WMAS.
- The outcome of the meeting was that a review of the current contract, concerns, KPI's / reporting should take place to ensure there is a focus on improving the quality of service provided for the patients that use NEPTs.
- It was noted that the provider has indicated that they may want to terminate the contract early because of the pressures and financial loss experienced.
- A meeting is due to take place on 26th January 2018, where the provider will be given the option to put a remedial action plan in place.

RESOLUTION: The Committee noted the update provided and an action was agreed for Peter McKenzie to update the Commissioning Committee Risk Profile, to incorporate the risks associated with this contract.

National Contract Variation – Summary of Key Points

The Committee were referred to the National Contract Variation Summary of Key Points, which was attached to the Contracting Update as an appendix. It was noted that:

- The deadline for sign off is 1st February 2018
- No direct financial impact exists
- The main issue of significance for the CCG is GP referrals. All referrals must be 'e' referrals by October 2018. It is anticipated that there will be some challenges in relation to meeting this deadline. Vic Middlemiss will be discussing how this will fit in with the IT Strategy, with Mike Hastings.
- Wolverhampton CCG is one of the highest performing CCGs in the region for 'e' referrals.

2 pm – Jeff Love joined the Committee

RESOLVED: That the above is noted.

Procurement Update Report

CCM661 Vic Middlemiss provided the Committee with the quarterly update of the CCG's procurement activity and associated projects.

The Community Eye Service: This service is a repeat of the Any Qualified Provider (AQP) procurement which was conducted in 2014. The schemes, included within the contract, have been reviewed by the CCG to ensure specifications reflect national guidelines. The contract was awarded to the Heart of West Midlands Primary Eyecare Ltd, which is the same provider that held the contract previously.

Thrive in Work – Individual Placement and Support Service: A procurement process was undertaken, led by Arden and GEM Commissioning Support Unit to select appropriate specialist providers. The contract was awarded to 3 providers across 4 lots. As the programme grant is provided by NHS England, the programme was required to identify a host CCG to receive the grant and provide a conduit of services in order to run it. Wolverhampton CCG was selected as the host by West Midlands Combined Authority (WMCA).

Pipeline Projects: A number of projects are currently being scoped and are therefore potential procurements for 2018/19.

CSU Procurement Highlight Report: The report identifies that 3.25 units have been used YTD, which leaves 2.25 surplus. The Committee was asked to note that the Thrive to Work project was funded separately and therefore used zero units. The surplus can be carried over into 2018/19.

Terms of Reference Audit: An audit has been undertaken by PwC which will be submitted to the Audit Committee in February.

Primary Care Basket Services: Juliet Grainger informed the Committee that Public Health contracts with GPs are coming to an end in March 2018. A discussion took place about a joined up process at some point in the future. However, it was noted that this would include the contractual element. Juliet advised that, from a Local Authority point of view, action would need to be taken very soon, to avoid a lapsed contract.

RESOLVED: That the above is noted.

Any Other Business

CCM662 Transforming Public Health Services: Juliet Grainger mentioned that the Public consultation for Transforming Public Health Services ends on 19th February 2018. A consultation booklet was circulated to the Committee and a request made to share the information as much as possible.

RESOLVED: That the above is noted.

Date, Time and Venue of Next Meeting

CCM663 Thursday 22nd February 2018 at 1pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

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**WOLVERHAMPTON CLINICAL COMMISSIONING
GROUP COMMISSIONING COMMITTEE**

Minutes of the Commissioning Committee Meeting held on Thursday 22nd February 2018
commencing at 1.00 pm in the Main CCG Meeting Room, Wolverhampton Science Park

MEMBERS ~

Clinical ~

Present

Dr M Kainth (Chair)	Lead for Commissioning & Contracting	Yes
Dr Gulati	Deputy Lead for Commissioning & Contracting	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	No
Sally Roberts	Chief Nurse & Director of Quality	Yes
Sarah Smith	Head of Commissioning - WCC	No

In Attendance ~

Liz Hull	Administrative Officer	Yes
Lesley Sawrey	Deputy Chief Finance Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Peter McKenzie	Corporate Operations Manager	No
Juliet Grainger	Wolverhampton City Council	Yes

Apologies for absence

Apologies were submitted on behalf of Sarah Smith, Tony Gallagher and Peter McKenzie.

Declarations of Interest

CCM664 None.

RESOLVED: That the above is noted.

Minutes

CCM665 The minutes of the last Committee meeting, which took place on 25th January 2018 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM666 None.

RESOLVED: That the above is noted.

Committee Action Points

CCM667 (CCM619) Direct Access Diagnosis Spirometry Business Case – Outstanding.

(CCM647) Review of Risks – It was confirmed that Cyril Randles has been sent a copy of the Risk Management Process (RMP). Action Closed.

(CCM652) Sue McKie – It was confirmed that introductory meetings with patient reps will be arranged by the Communications and Engagement Team, to take place in April. Action Closed.

(CCM660) NEPTS Contract – Risk profile is still to be updated.

RESOLVED: That the above is noted.

Review of Risks

CCM668 Risk CC02 & CC03 – Steven Marshall apologised for an oversight and advised the Committee that the risks are the same but expressed differently.

RESOLUTION: An action was agreed for Steven Marshall to liaise with Andrea Smith and Karen Evans to rectify this.

Risk CC04 – It was confirmed that a decision should be made by 31st March with regards to procurement of the Community Equipment service.

Risk CC08 – Steven Marshall advised that the score of 20, for this risk, may be incorrect.

RESOLUTION: An action was agreed for Steven Marshall to request a review

of the risk to ascertain the correct score.

Risk CC009 – Vic Middlemiss informed the Committee that proposals are currently being considered in relation to KPI's.

RESOLVED: That the above is noted.

Contracting Update Report

CCM669 Vic Middlemiss provided the Committee with a monthly overview of key contractual issues and areas of concern including actions proposed or being taken to address issues. Highlights of the report include the following:

Royal Wolverhampton NHS Trust

Contract Performance (Key Performance Indicators / Quality):

- Referral To Treatment – Below trajectory for December, largely due to the impacts of Winter.
- Cancer Two Week Wait (Breast Symptoms) – A 20% increase is reported in the number of referrals. Figures have been compared with neighbouring trusts who have confirmed that they have not experienced a similar increase. Currently awaiting further information to establish what caused the spike.
- Ambulance Handovers – The Trust reported an unprecedented increase in ambulances during December.
- Performance Sanctions – Sanctions agreed for Month 8 are just under £38k. Month 9 was the highest month year to date - £84k, which was mainly due to ambulance handover fines.

Other Contractual Issues:

- Contract Review Process – A formal offer has been presented to the Trust. The value is similar to that of when the contract was signed. The planning guidance released by NHS England, requires all CCGs to complete contract variations by 23rd March and it is envisaged that an offer will be finalised on 26th February 2018.

Black Country Partnership Foundation Trust (BCPFT)

Service Development Improvement Plan (SDIP):

- A meeting has been arranged to review the SDIP for 2018/19 and the service specifications within the contract.
- A workshop took place as part of developing the Primary/Secondary care interface. Positive feedback was received and another one is anticipated to take place in the next few months.

Urgent Care / Ambulance / Patient Transport

Urgent Care Centre:

- A scheduled CQC inspection took place on 6th February and the interim feedback is that overall the visit was positive and improvements have been noted in a number of areas. Assurance was given, that the CCG will put a plan in place which will be monitored regularly.

RESOLVED: The Committee noted the contents of the update provided.

Anti-Coag Specification

CCM670 Deferred.

RESOLVED: That the above is noted.

Any Other Business

CCM671 None.

RESOLVED: That the above is noted.

Date, Time and Venue of Next Meeting

CCM672 Thursday 29th March 2018 at 1pm in the CCG Main Meeting Room

RESOLVED: That the above is noted.

**Wolverhampton Clinical Commissioning Group
Audit and Governance Committee**

Minutes of the meeting held on 14 November 2017 commencing at 11.00am
In Brunel Room, Science Park, Wolverhampton

Attendees:

Members:

Mr P Price	Chairman
Mr D Cullis	Independent Lay Member
Mr L Trigg	Independent Lay Member

In Regular Attendance:

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 J McLarnon	Manager, External Audit, Grant Thornton
Mr S Grayson	Local Security Management Specialist, CW Audit

Apologies for attendance:

AGC/17/81 Apologies for absence were submitted by Dr Hibbs, Mr Oatridge and Mr Stocks.

Declarations of Interest

AGC/17/82 Ms Watson asked to declare for information that her Dr Julian Parkes who was currently a member of the Wolverhampton Clinical Commissioning Group Governing Body was her GP.

There were no other declarations of interest declared.

Minutes of the last meeting held on 18 July 2017

AGC/17/83 The minutes of the last meeting were agreed as a correct record.

Matters arising (not on resolution log)

AGC/17/84 It was raised that at the last Audit and Governance Meeting that the committee had discussed the implications of the recruitment of the patient lay member as the previous holder of the post had retired. Mr McKenzie advised that this item had been covered under risk and that

this position had now been recruited to.

Resolution Log

- AGC/17/85 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 – the report had been circulated to the committee prior to the meeting. Mr Cullis asked if there was any potential for QIPP regarding this audit as the Nuffield had paid a fine. Mr Gallagher advised that he would speak to the Head of Contracting and Procurement outside of this meeting regarding any QIPP opportunities and that he would bring back an update at the next meeting.
 - Item 96 (AGC/17/68) - IT summary to be circulated to Mr Price and Mr Gallagher - This had been circulated and the item was closed
 - Item 97 (AGC/17/69) – Update on actions in Internal Audit Charter – Ms Watson to clarify if this had been circulated and to be brought forward to the next meeting updating the charter.

Internal Audit Progress Report

AGC/17/86 Ms Watson gave a summary on the below items which were all progress against the 2017/18 Internal Audit Plan:

- Corporate Governance – Primary Care Co-commissioning
- Conflicts of Interest
- Risk Management
- Finance
- Better Care Fund
- Arrangements with the CSU
- AIPP
- Information Governance
- Audit follow-up

Mr Cullis asked if there were any follow up on recommendations and what the CCG's position on at implementing the actions. Mr Cullis also asked if Management were being made aware of these actions. Mr Price advised that he had met with Mr Gallagher about the possibility of introducing a tracker to monitor actions and to incorporate this in the internal audit work. It was asked that this was brought back to the next meeting to discuss and that clarification was received by the Committee as to who would be picking up the implementation of relevant actions.

Ms Watson had met with Mr Hastings – Director of Operations and with Mr McKenzie to discuss progress made in implementing the agreed actions in the internal audit report on risk management. There had been significant progress since last year and a status was given in the report of all the high risk areas. Risk had now been transferred to the Operations team and Mr Hastings and Mr McKenzie were looking at ensuring that

teams and individual committees were taking ownership of their respective risks and being challenged when this was not the case. Ms Watson informed the Audit and Governance Committee that the Board Assurance Framework (BAF) was being taken to the Private Governing Body Meeting today and that Internal Audit had been attending all CCG Committee meetings to observe discussions around risk.

Appendix B gave a business insight into ongoing work by the internal audit team.

RESOLUTION: The Committee:

- Noted and received assurance from the report.
- Ms Watson to meet with Mr Gallagher to discuss.
- An update on follow up to any recommendations to actions to be brought to the next meeting.

Risk Register Reporting/Board Assurance Framework

AGC/17/87

Mr McKenzie gave an update on Risk and the BAF. Risk had now been moved under the remit of the Operations Team. A key piece of work that had been undertaken was the realignment of the Governing Body assurance framework from NHSE to the CCG's strategic aims.

Ongoing work continued on the new Governing Body assurance framework and was supported by the strategic risk register. The hope was that the CCG will work towards using a dashboard to present information. Mr McKenzie is working with teams individually to identify risks. The onus was on teams to take ownership of their individual risks and that they would be challenged if they were not completed. Mr McKenzie also advised that there were ongoing discussions for other staff to support this work.

The Datix system which is currently used by the CCG may not be adequate to deal the new process and so there was a potential to look at other systems.

Mr Price felt that the BAF should drive the Governing Body Agendas. Mr McKenzie advised that the BAF will be discussed as part of the Governing Body Agenda today.

Risk profiles were still being worked on and although good progress was ongoing, there was still a lot to be done to bring it up to level.

RESOLUTION: The Committee:

- Noted the report.
- That the risks from each committee meeting are brought back to the next meeting.
- That a report on the observations by Ms Watson and internal audit at committee meetings be brought back to the next meeting.

Ms Watson left the meeting.

External Audit Update

AGC/17/88 Mr McLarnon introduced himself as a Manager for the External Audit Team. Work had commenced but a report had been circulated as part of the committee papers to show key timelines and key outputs that had been identified. It was proposed that a report on the Audit Plan was brought to the February 2018 committee and an Audit Findings Report would be presented at the May 2018 committee.

RESOLUTION: The Committee:

- Noted the report.

Audit Fieldwork and Audit Committee Dates 2017/18

AGC/17/89 This was discussed under AGC/17/88

Annual Governance Statement

AGC/17/90 Mr McKenzie gave an update and reminder of the content of the annual governance statement.

Highlights included:

- Risk - the CCG were in a place to show how they had responded and embedded a new process.
- How the CCG dealt with the previous Chair's conflict of interest as a GP contracted by RWT under the Vertical Integration process. The new GB GP Dr Julian Parkes is employed by RWT. The potential conflict is mitigated by the CCG's proactive processes.
- How the CCG is working more closely with other CCGs around STP and that the statutory body is working towards getting the statutory duties right.
- That as a CCG we understand the statutory duties and are ensuring that we are compliant.
-

RESOLUTION: The Committee:

- Noted the report.

Update from the Black Country Joint Commissioning Governance Forum (BCJCGF)

AGC/17/91 Mr McKenzie presented a paper to ask the Committee to note the establishment of a Joint Governance Forum made up of Audit Committee members across the four CCGs in the Black Country.

The Terms of Reference (TOR) had been amended and circulated. Mr McKenzie advised that Mr Oatridge chaired the forum.

The committee then discussed issues around the work done by the

forum.

Mr Trigg asked if the committee would be receiving reports from the forum. Mr McKenzie advised that the Audit and Governance Committee would continue to be the CCGs statutory audit service and the forum would provide support for this.

Mr Cullis asked how feedback would be received. Mr Price thought that it would be useful to have an agenda item to feedback to and from the Audit and Governance Committee and the Black Country Joint Commissioning Governance Forum.

RESOLUTION: The Committee:

- Noted the report.
- Support the establishment of the Joint Governance Forum in line with its agreed TOR.
- An agenda item regarding feedback to and from the Audit and Governance Meeting and the Black Country Joint Governance Forum to be added to the agenda.

Losses and Compensation Payments – Quarter 2 2017/18

AGC/17/92 Mr Gallagher presented this report and advised the Committee that there was 1 loss of £296.07 during quarter 2 of 2017/2018 relating to the expiry of gift cards purchased by the CCG for employee Christmas gifts/long service awards. There were no special payments during the same quarter.

RESOLUTION: The Committee:

- Noted the report

Suspension, Waiver and Breaches of SO/PFPS

AGC/17/93 Mr Gallagher noted the below in quarter 2 of 2017/18:

- During quarter 2 of 2017/18 there were 22 invoices in breach of PFPs (2.70% of all invoices paid);
- 5 waivers were raised during quarter 2;
- 22 non-healthcare invoices were paid without a purchase order being raised during quarters 1 & 2.

Mr Trigg asked if there were any concerns or issues to be noted to which Mr Gallagher advised that there wasn't.

Mr Price raised that the contract for Mills and Reeves did not seem to have been through a procurement process as its renewal date seemed to be soon and Mr Gallagher was asked to look into the CCG either renewing this or going out to a procurement exercise. Mr Cullis added that he would like to know how the contract renewals were being

monitored.

The committee thanked Mr Gallagher and his team on the level of work and detail that was made available in their reports.

RESOLUTION: The Committee:

- Noted the report
- Mr Gallagher to look into the number of contracts that are up for renewals and report back to the committee including the current contract with Mills and Reeves.

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

AGC/17/93 The Committee noted that as at 30 September 2017 there were:

- No sales invoice greater than 10k and over 6 months old.
- 13 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.

Local Counter Fraud Specialist Progress Report

AGC/17/94 Mr Mohan presented the Local Counter Fraud Specialist Progress Report for information.

RESOLUTION: The Committee:

- Received the report for information.

Local Security Management Update

AGC/17/95 Mr Grayson presented the Local Security Management Update for information.

Mr Price asked how if staff received any feedback from LSM findings such as through the staff newsletter. Mr Grayson informed the committee that he had attended a staff meeting but would liaise with Mr McKenzie about how to relay information back to staff.

RESOLUTION: The Committee:

- Noted the above.
- Mr Grayson to liaise with Mr McKenzie around LSM updates to staff.

Any Other Business

AGC/17/96 Mr McKenzie gave an overview on General Data Protection Regulation (GDPR) and advised that he would bring a full report back to the Committee in February 2018.

Highlighted were the below:

- Mr McKenzie had been appointed as the Data Protection Officer for WCCG
- WCCG manages information governance supported by the Commissioning Support Unit
- An IG CSU member of staff is on site one day a week
- The CCG are compliant with the IG Toolkit
- The requirements for GDPR are less new for the NHS as we are already working to the standards
- Mr McKenzie regularly meets with the IG support
- Commissioners are responsible for their compliance
- GPs are responsible for their own compliance and are supported by NHSE

RESOLUTION: The Committee:

- Noted the above
- A full report on GDPR to be brought back to the meeting in February 2018.

The committee discussed the rolling agenda for future meetings and it was asked that any amendments or suggestions were forwarded to Miss Patel.

RESOLUTION: The Committee:

- Miss Patel to circulate future dates document and rolling agenda item document.
- Committee members to review and send back any comments to Miss Patel. This will then be circulated at the next meeting with the agreed amendments.

Date and time of next meeting

AGC/17/97 Tuesday 20 February 2017 at 11am in the Armstrong room at Wolverhampton Science Park

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Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 15th February 2018

Members:

Prof. Nick Harding – Chairman, Sandwell & West Birmingham CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Helen Hibbs – Accountable Officer, Wolverhampton CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Dr Anand Rischie – Chairman, Walsall CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief
Finance Officer Walsall and Wolverhampton CCG's
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Angela Poulton - Programme Director – Joint Commissioning Committee
Mike Abel – Lay Member, Walsall CCG
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG

In Attendance:

Charlotte Harris – Note Taker, NHS England
Laura Broster – Director of Communications and Public Insight
Dr Ruth Tapparo – GP/Board Member, Dudley CCG
Paula Furnival, Director of Adult Social Care, Walsall MBC
Claire Parker – Chief Officer – Quality, SRO TCP

Apologies:

Dr David Hegarty – Chairman, Dudley CCG
Peter Price – Lay Member, Wolverhampton CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. INTRODUCTION

- 1.1 Nick Harding welcomed members.
- 1.2 Apologies as noted above
- 1.3 All Declaration of Interest forms have been submitted. Nick Harding asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. None were given.
- 1.4 The minutes of the meeting held on the 10th January were agreed as an accurate record of the meeting with the following exceptions:
 - Paul Maubach requested that his reference to the establishment of a Chief Executives sponsor group to deliver the NHS element of the STP agenda be added to section 3.1.3
 - Action in relation to clarifying the West Birmingham position to be added on page 6, section 3.1.6

- 1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.
- 1.6 Regarding action 068, Angela Poulton provided the group with an updated draft of the Joint Governance Group Terms of Reference to remove West Birmingham from the remit.
- 1.7 Regarding action 070, Angela Poulton confirmed she had sent the revised working to the governance leads. Matt Hartland stated that he had not seen the revised wording in relation to 1.2.6c.

Action: Angela Poulton to send the revised wording in relation to 1.2.6c to the Chief Financial Officers.

- 1.8 Regarding action 071, the Accountable Officers have met but have not fully covered the appointment process to STP Clinical Lead roles. There will be a clearer idea after the meeting scheduled on 19th February. Nick Harding is undertaking identifying what is needed to make the Clinical Leadership Group work so the case for resources can be made.
- 1.9 Regarding action 072, Angela Poulton reported that discussion at the Joint Governance Group had identified a reluctance to move to a single Risk Register template. Julie Jasper added that the Governance Subgroup had been tasked with reviewing the risk registers for all four CCGs to review commonalities and strategies and to report back to a future meeting.
- 1.10 Regarding action 075, Matt Hartland tabled a proposal for the due diligence for review and comment. The proposal sets out a desktop exercise to be undertaken by each CCG, driven by Chief Financial Officers (CFOs). It will develop the STP modelling undertaken, building on the current planning round and Sustainability and Transformation Partnership (STP) plan but also take account of other potential occurrences such as the opening of the Midland Metropolitan Hospital based on the knowledge of projected activity flows. It is proposed that on completion of phase one there will be a discussion with providers. No timeline agreed but the work could not be finalised until after the 18/19 contracts are agreed. James Green suggested the proposal be discussed with CFOs for further joint development. Paul Maubach suggested that the exercise needs to inform the risk sharing process that organisations might be party to in the future. There was discussion regarding the benefits of signing up to a system control total and the importance of being clear that the benefits outweigh the risks. Members agreed the approach was good practice but greater provider openness is essential. James Green stated that for the exercise to be meaningful, action was required at Chief Executive level to achieve greater openness by providers before phase 2 of the work. Helen Hibbs emphasised the importance of greater openness and transparency in becoming an Integrated Care System (ICS).
- 1.11 Regarding action 077, Angela Poulton stated that a performance information had not been made available and that Simon Collings had indicated that the situation was changing. Simon Collings to provide an update at the next meeting.
- 1.12 Regarding action 078, the final bid document needs to be submitted by 9th March. The pre-final draft is due to be finished and circulated to CFOs by close of play on 16th February.

2. CORE BUSINESS – DECISIONS REQUIRED

2.1 Black Country Transforming Care Partnership (TCP) Community Model

- 2.1.1 Helen Hibbs discussed assurance concerns raised in the letter from the Director of Commissioning Operations (DCO) team regarding Black Country delivery of the TCP programme. Helen Hibbs stated that whilst the Black Country STP is going to miss its trajectory, it has been made clear that patients will only be discharged from the hospital if it is clinically safe to do so. There are some delayed transfers of care about which greater understanding is needed. NHSE need assurance that the new community is being commissioned creating increased urgency for the four CCGs to agree to and implement the proposed future model.
- 2.1.2 Claire Parker explained that TCP is seeking to reduce beds and increase community services in each place i.e. intensive and forensic support across the Black Country. Transition funding has been made available and the provider needs to be authorised to proceed to implementation. The business case, including the clinical model and financial implications, have been produced by the TCP Operations Group involving the provider. The model will be implemented on a pilot basis for 12 months, and further discussions are required regarding the potential for a longer contract in the future. Claire confirmed that Laura Broster had been involved in developing the engagement plan, and parallel engagement will need to be undertaken. By not doing this there are implications on the patients and the trajectory. Helen Hibbs stated that whilst there are some risks in proceeding to implement the new community model, there are greater risks by not going ahead. This Committee and the four CCG Governing Bodies need to agree the model and authorise its implementation with urgency.
- 2.1.3 Paul Maubach acknowledged that in the context of bed reductions and suggested that the only change in the existing and future community model lies in Tier 3 - Intensive Community Support and Forensic Community Support. Helen Hibbs confirmed this, emphasising the importance of ensuring there is a community forensic psychiatrist across the patch going forward but also the necessary upskilling of existing staff in the community teams to establish a safe and resilient service. Paul Maubach initiated a discussion about providers, Helen Hibbs confirming that the Black Country Partnership Foundation Trust (BCPFT) is currently the only provider in the Black Country who can provide this. National TCP delivery requirements will not allow the delay a full procurement at this stage would require, hence the proposal to proceed to implementation via a contract variation for 12 months.
- 2.1.4 Claire Parker confirmed that the business case excludes West Birmingham. Paul Maubach noted that the level of investment by CCG differs and implementation of the model would have differential impacts on each CCG. Helen Hibbs explained that the business case is based upon current funding abilities, and shared that Wolverhampton have already implemented the model resulting in lower spending on beds so there is the potential for reduced costs in the longer term. Going forward the provider needs to be held accountable for delivery of work and greater understanding of the financial implications for each CCG as the service is established. Matt Hartland shared that the CFO's are meeting on 16th February to discuss financial aspects of the model.

- 2.1.5 Laura Broster confirmed the engagement plan to be proportionate and that it allows for co-production and future influence. However, Laura raised that she felt there is a risk of legal challenge owing to the proposed changes involving reductions in the number of inpatient beds with reference made to the commitment made in Dudley with the Local Authority in relation to Ridge Hill. Helen Hibbs shared the process undertaken in Wolverhampton and that as patients and carers wanted the new model there were no problems. Claire Parker confirmed that Sarah Norman, Executive Sponsor for the Black Country TCP, is reasonably comfortable that the plan is proportionate and no issues are anticipated where empty beds are closing.
- 2.1.6 Dr Anand Rischie shared that many Learning Disabilities patients are looked after in the community by GPs and the proposed clinical model does not describe how community team will work with primary care. All four place based teams are different and the model will need to allow for this. Helen Hibbs confirmed that this can be added to the model description.
- Action: Claire Parker to ensure the clinical model includes details about how the Community Learning Disability Team will work with primary care.**
- 2.1.7 Helen Hibbs emphasised the focus for the TCP programme is getting patients out of the secure hospitals and moving them into community settings. Paul Maubach agreed that this is the right thing to do for patients but raised concerns about ensuring the changes do not lead to placements outside the system. Helen Hibbs explained that this model with BCPPT is about assessment and treatment beds but agreed the need for commissioning focus and ensuring the provider is held to account for delivery and continues to work co-productively through the pilot year. Nick Harding noted that this is a national requirement and if the change is better for patients it will be supported.
- 2.1.8 Nick Harding referred member to the acute problem relating to delivering the trajectory and delayed discharge for which Alison Tonge is seeking assurance. Helen Hibbs shared that whilst commitment continues to achieving the trajectory set by NHSE it was potentially not achievable at the outset owing to the impact of St Margaret's on the population base as well as other factors including step down from Specialised Commissioning and new patients requiring admission as well as some readmissions. However, there are still some unnecessary delays occurring.
- 2.1.9 Paul Maubach suggested that TCP programme performance reports should be reported to the JCC every month which was agreed. Nick Harding asked how the STP assurance and Andy Williams shared that this was the function of the TCP team working with the providers. Anand Rischie asked for clarification regarding whether the new model will be commissioned jointly or by each CCG. Helen Hibbs confirmed that the TCP Board take a joint lead role and that individual CCG in governance terms is acting independently but are commissioning one model across the four geographical areas that best fits with local arrangements.
- 2.1.10 Claire Parker referred member to the TCP programme relates to learning difficulties and autism, and that commissioning for autism has yet to commence. Paul Maubach asked whether there were clinical interventions for autism, Helen Hibbs explaining that whilst it is unusual there are some patients without a learning disability diagnosis that have severe autism and behavioural difficulties, requiring behavioural management interventions funded by health.

- 2.1.11 Angela Poulton asked whether the difficulty in getting activity levels impacting upon the ability to identifying staffing levels and related costs referred to in page 4 of the clinical model paper presents a risk. Claire Parker noted some are being addressed by the transition funding for recruiting and retaining staff and confirmed that the main risk remains the Funding Transfer Agreements.
- 2.1.12 Nick Harding noted concerns regarding resources and whether more would be needed. Helen Hibbs stated that there is enough resource as long as we are working in the right way. Angela Poulton confirmed that the business case had been shared with Commissioning Directors/Chief Officers. The JCC approved the business case subject to the agreed changes to the clinical model (refer to 2.1.6 above). It was agreed that a briefing paper setting out the recommendations would be provided by Claire Parker for presentation to all four CCG's Governing Bodies in March.

Action: Claire Parker to supply a briefing of recommendations, including the clinical model, around the TCP Community Model to presented to all Governing Bodies.

2.2 Integrated Care System (ICS) Development Programme

- 2.2.1 Helen Hibbs referred members to the papers sent out and stated that the language had now changed from Accountable Care Systems (ACS) to Integrated Care Systems, with the ambition that systems will be integrated by 2020. This fits in with the Five Year Forward View as the STP is about working in an integrated way. The DCO team have created a development programme across the West Midlands to support this transition with support from the national team.
- 2.2.2 The STP is early on the journey, and there needs to be evidence of clear financial stability and open accounting with the providers to become an ICS. It is more about the journey than the destination. It is voluntary but all other STP's are participating in it. There is also a national commissioning capability programme which the STP has been asked to take part in. Helen Hibbs does not have the full details of this but believes it is an NHS funded programme that is looking at how commissioners can become more strategic commissioners going forward. Referring to the paper entitled "What good looks like", this sets out the core capabilities required to be an ICS.
- 2.2.3 The programme is designed to support the STP in becoming an ICS. To be an ICS, the population footprint needs to be over one million. Helen Hibbs believes the model of the programme works well with the place based work already occurring. The vision is for GP practices to come together in groupings on 30,000-50,000 patients, which a lot of areas are already doing. The next layer is the integrated place based layer which fits well with the MCP model and what is being done in Wolverhampton and Walsall. The ICS is the overarching system for providers linked and working together and the strategic commissioning layer. Helen Hibbs shared her view that the system should continue on the journey to becoming an ICS.
- 2.2.4 Andy Williams suggested that at the system leadership session on 19th February it would be useful to use the "What good looks like" checklist as part of the agenda and have a discussion about where the system currently is. Helen Hibbs confirmed that ICS is included on the agenda for the JCC Executive Day on the 16th February. Andy Williams described the programme to become an ICS to be an integrating process that is a means by which the end can be achieved.

- 2.2.5 Helen Hibbs confirmed that the first part of the process is a self-assessment on readiness at a workshop scheduled in March, the results of which will inform any additional support that NHSE will provide.
- 2.2.6 Paul Maubach noted that the population requirements have doubled from the ACS plans to the ICS plans, and that the Black Country still have over one million population should West Birmingham not be included. Paul Maubach stated the issue of West Birmingham needs to be resolved to understand the development into an ICS. Andy Williams informed that there is a West Birmingham Commissioning Committee that will be nested in other systems as it is not over one million in population. It will need to rest in another ICS, but there is a question as to which one. Helen Hibbs suggested there could eventually be a bigger layer above the ICS and that the ICS number could fluctuate. Andy Williams noted that it is not about the destination but the journey of working on relationships. Ruth Taparro questioned whether the change from accountable to integrated in itself would deliver greater success in system working. Helen Hibbs responded by stating that there needs to be more clarity on the workstreams and their work in addition to how we are working collaboratively. This will enable there to be focus on both the place and the system as a whole.
- 2.2.7 There was a discussion regarding the benefits of having a single control total system, the benefits being identified as increased freedoms and less regulation and the consensus view that needs to be certainty that the benefits outweigh the risks being picked up by the CFOs as discussed earlier in the meeting.

2.3 Governance Update

- 2.3.1 Andy Williams stated that the STP has three distinct accountabilities and to date the system has attempted to deliver all three in one process. There is the agenda to have place-based partnerships that make sense to primary and social care and there needs to be a way to deliver this. There is the NHS agenda requiring STP partners with a health focus to be working collaboratively, and managing upwards to secure delegated resources. The third accountability is the need to work at a greater scale to deliver whole system change with a focus on the wider determinants of health involving working with the West Midlands Combined Health Authority.
- 2.3.2 To progress, different governance arrangements are needed. Members were referred to the paper which suggests the appointment to three posts: an Independent Chair, a Programme Director, and an NHS Lead/SRO. The independent Chair was described as a key role that would be an ambassador for the organisation and would hold the partners to account. To ensure independence there is an argument that a person not in the NHS should be appointed, and the post holder needs to possess a specific set of qualities and gravitas to be effective. The STP needs more robust infrastructure, with current resources being provided largely by one CCG in addition to their substantive roles. The recommendation is to have a full-time Programme Director, a joint appointment resourced by all CCGs to reflect an essentially 'commissioner' contribution. The NHS Lead suggested acts as a co-ordinator for the system as a whole, either a part time or full time role when other systems are considered. For independence, the suggestion is that this role is full-time. Andy Williams is consulting on these proposed successor arrangements including meetings with Chief Executives and Councils, and sought the view of the committee.

All the discussions will be correlated for decisions to be made at the March STP meeting.

- 2.3.3 Helen Hibbs stated that in her view the CCGs should hold the Programme Director role as work the post holder will deliver is currently the remit of CCGs, and only CCG's have the capacity and capability to manage the work programmes. Paul Maubach agreed that work should sit with the CCG's as most of the issues to review are NHS issues. The structure supporting that resource would need to be equally accountable to all four CCG's, essentially sitting above CCGs. The issues relating to what the PMO structure looks needs sorting, and ICS self-assessment should help with this as it needs to be aligned to the future ICS. Paul Maubach confirmed he agreed the principle but felt the structure supporting the role should be reviewed after the ICS workshop.
- 2.3.4 There was discussion about the number of days per week required for the independent Chair and that the number of days finally agreed was dependent upon whether the incumbent would be required as a coordinating figurehead or an executive Chair. Paul Maubach suggested the SRO could be a part time role and part of their current job. Nick Harding advised that other STP leaders who are SRO's have found that it has become a full time role. Paul Maubach suggested that there could be benefit from feedback from other SRO's and how it worked for them. Andy Williams said the amount of work will determine how much emphasis is put on each of the roles.
- 2.3.5 Paula Furnival stated that the appointment of an independent Chair was both important and symbolic, and supported a non-NHS appointment which she felt would be received positively by all Local Authorities. The STP areas that have positive narratives around their partnership working have non-NHS chairs. It needs to be very clear about the areas that are joined, such as the place-based health and care and referred to existing governance mechanisms that can progress the wider determinants accountability. Paula Furnival felt that the proposed governance arrangement presents an opportunity to reset some of the negativity and work more jointly. Andy Williams agreed that this structure offers potential for some success rather than the current negativity, and the system needs to demonstrate where it matches 'what good looks like'. Nick Harding noted it would be good for local authorities to see that health and social care are working collaboratively across the system. Paula Furnival confirmed the pre-briefing had been done with the chief executives. The measure of success is moving on from the discussions on governance and leadership structure, and to actually proceeding to put it in place.
- 2.3.6 Nick Harding noted that the next version needed to include work time commitments required for all positions and not just the independent chair. Andy Williams will feed the comments from this committee into the revised proposal, and the role of the independent Chair needs further discussion.
- 2.3.7 Nick Harding stated that to be a fully developed ICS the voice of primary care has to be 'at the top table' and whilst acknowledging the challenges in achieving this he felt it would help to show that GPs are being included early on. Andy Williams requested feedback and support from the Chairs on who to invite from Primary Care to have this conversation, indicating that the meeting needs to take place in the next 2-3 weeks.
- 2.3.8 It was noted that financial implications need further consideration and agreed that the revised governance proposal to be brought back to the March JCC meeting

Actions:

- **CCG Chairs to supply a list of potential attendees to Andy Williams for a meeting with Primary Care representatives to discuss the suggested STP governance structure in the next few days.**
- **Andy Williams to present the revised costed STP governance structure at the March JCC meeting.**

2.4 GP Forward View Workforce Plan

- 2.4.1 Paul Maubach presented the latest iteration of the GPFV workforce plan which he was confident would achieve NHSE assurance. The target increase in GPs to more than 800 set out in the plan was considered extremely challenging. A formula for recruiting additional GP's has been developed including retaining GPs and international recruitment but financial support is needed to do this. Work is underway to submit an application to participate in the national programme for international recruitment. Andy Williams stated that he was unsure whether CCGs could underwrite the costs for any GPs recruited overseas as CCGs cannot provide employment. Paul Maubach agreed that commissioners should not underwrite finding jobs for GPs recruited but could determine an appropriate phrase to include in the proposal that reflects CCG commitment to finding appropriate employers.
- 2.4.2 There was discussion about the agenda being how to create new models of care to alleviate the current pressure on GPs and the need to develop a primary care workforce agenda, properly resourced. The JCC agreed the GPFV workforce plan.
- 2.4.3 Mr Maubach led the discussion on the paper presented setting out a proposal for the Black Country to undertake primary care workforce planning going forward. There was a discussion about there being neither the capacity nor the capability to develop plans within current arrangements and there the need to resource properly. Andy Williams acknowledged the immense work involved to develop credible plans and asked whether CCGs could work differently to free up the necessary resources without adding to costs. Helen Hibbs stated that CCGs do not have the funding to recruit to new posts and supported this suggestion. It was agreed that the activities currently undertaken by primary care commissioning staff needs to be identified with a view to considering which to stop to potentially create the necessary resource to fulfil primary care workforce planning in the future.

Actions:

- **Paul Maubach to meet with Primary Care teams leads to agree the phrase to include in the international recruitment proposal that reflects CCGs commitment to find appropriate employers**
- **Paul Maubach to lead the work to assess current work undertaken by CCG primary care staff and identify how to create capacity for primary care workforce planning.**

2.5 JCC Executive Development Session

- 2.5.1 Angela Poulton referred members to the agenda. The purpose of the session was to update Executives on the collaborative work underway, understand the ICS vision

and journey and suggest ways to better collaborate moving forward. The agenda was agreed.

2.6 STP Funding for Self-care and Personalisation

2.6.1 Laura Broster referred members to the paper, and explained that Dudley CCG has been an intensive support for empowering people and communities for the last 12 months. NHSE would like this to continue on a Black Country scale and escalate it to be a national demonstrator site for personalised care. STP support is required. There are some targets and trajectories that are happening already around the Black Country for personal health budgets and best practice. These can be used to justify an income stream that could come from an agreed Memorandum of Understanding (MOU).

2.6.2 The JCC supported the proposal and it was agreed that a completed MOU would be brought back to the March JCC meeting, and it was noted that this would then require STP sign off. It was agreed that AOs would confirm a lead officer for their CCG with responsibilities for personalised care to work with Laura Broster.

Actions:

- **AOs to confirm named leads for the personalised care demonstrator site initiative in the next few days**
- **Laura Broster to present the personalised care demonstrator site MOU for approval at the March JCC**

3. CORE BUSINESS – FOR INFORMATION

3.1 Clinical Leadership Group Update

3.1.1 Prof Nick Harding reported that the Clinical Leadership Group (CLG) meeting on the 25th January was a success and that he sensed real momentum behind the Group despite the tensions existing between the work to be done and resources available to do it. Much work is being undertaken on cardiovascular disease, with the team reviewing what actions will make the real difference. There is a respiratory group led by Helen Ward that will report into the CLG in the future. There was discussion regarding the work programme and whether frailty should be added. It was noted that clinical leads will need to be appointed. There are two West Midland reviews occurring; stroke and end of life care. Updates were provided regarding the Local Maternity Strategy and how it will be implemented. There were questions raised over whether other groups should be added such as frailty and some clinical leads need to be appointed. Dr Ruth Tapparo suggested it would be good to learn from other clinical leads in other areas.

3.1.2 Dr Anand Rischie, Chair – Walsall CCG, added that there had been a good discussion on urgent care performance. The biggest challenge for urgent care will be working across the network as a whole. Paul Maubach suggested there should be some work on air quality for the respiratory group as this is a big issue for the Black Country.

3.2 Feedback from Governing Bodies

- 3.2.1 Angela Poulton informed all recommendations had been sent to the governing bodies except for the section on 1.2.6c, where if a decision is required quickly, one CCG could make it. At the last JCC meeting, it was agreed that it should be that all four CCG's are party to the decision making. One of the lay members had suggested a phone call to the chief officer to ensure that there was a robust response if a quick decision is needed. Each CCG is still responsible for making sure their duties are fulfilled. Previously, the governing bodies, other than Wolverhampton, had met to have the discussion. Helen Hibbs confirmed that it was a way of focussing everyone on a matter when a decision is needed quickly.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

- 4.1 No update reports provided.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

- 5.1 Nick Harding referred members to the opportunity to include subacromial decompression, a shoulder operation, as a procedure of limited clinical value (POLCV). Anand Rischie stated that the procedure is ineffective if it is done at the wrong time and that there are triaging measures in place at Walsall now to ensure recommendations for surgery are appropriate. Issues in Walsall arose from private providers recommending surgery too soon. Mike Abel noted the feedback from Walsall CCG would be good. Nick Harding said it is a way of saving money as the procedure can be done at the wrong time resulting in no effect.
- 5.2 Angela Poulton advised that Paul Tulley has suggested this, and has identified that £1.8m was spent last year in the Black Country on the procedure. Shropshire CCG have already reviewed and established this as a POLCV. Angela Poulton asked the JCC to support the policy to be developed for the Black Country, pointing out that Sandwell and West Birmingham currently work with Birmingham and Solihull to develop such policies. Joint policy development was agreed, and the final POLCV to be presented at a future JCC meeting.
- 5.3 Dr Anand Rischie suggested reviews need to be done on clinical coders as he felt there may be double coding, and this could be done collaboratively. Helen Hibbs advised they had had several in depth clinical coding reviews and Royal Wolverhampton Trust, and there had been no evidence of inaccuracies. Matt Hartland confirmed that providers are also audited independently.

Action: Angela Poulton to confirm POLCV for subacromial decompression to be developed for the Black Country to commissioning leads, and to present to policy at a future meeting.

6. DATE OF NEXT MEETING – *please note time of meeting*

Thursday 22nd March, 13:30-15:30, Room 1, Jubilee House, Bloxwich Lane, Walsall, WS2 7JL

JCC Action Log