

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 10 July 2018 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

A G E N D A

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Extraordinary Governing Body Meeting held on Tuesday 22 May 2018
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~

Dr S Reehana

Chair

Clinical

Dr D Bush
Dr R Gulati
Dr M Kainth
Dr J Parkes

Board Member
Board Member
Board Member
Board Member

Management

Mr T Gallagher
Mr M Hastings
Mr S Marshall
Ms S Roberts

Chief Finance Officer – Walsall/Wolverhampton
Director of Operations
Director of Strategy and Transformation
Chief Nurse Director of Quality

Lay Members/Consultant

Ms S McKie
Mr J Oatridge
Mr P Price
Mr L Trigg

Lay Member
Lay Member
Lay Member
Lay Member

In Attendance

Ms K Garbutt
Mr M Hartland

Mr P McKenzie
Ms M Tongue

Administrative Officer
Chief Finance Officer – Dudley CCG (Strategic Financial
Adviser)
Corporate Operations Manager
Head of Financial Resources

Apologies for absence

Apologies were received from Mr D Watts, Ms S Gill and Ms H Ryan

Declarations of Interest

WCCG.2138 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.2139 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 8 May 2018 be approved as a correct record.

Matters arising from the Minutes

WCCG.2140 There were no matters arising.

RESOLVED: That the above is noted.

Sign off the accounts and annual report

WCCG.2141 Mr T Gallagher stated that an Audit and Governance Committee had taken place this morning and they have recommended the final accounts be approved.

Mr T Gallagher drew the Governing Body's attention to the Annual Report and Accounts –

Statement as to disclosure to auditors

“Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

So far as the member is aware, that there is no relevant audit information of which the Clinical Commissioning Group's external auditor is unaware; and,

That the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.”

Mr Gallagher pointed out that the Executive team has been asked separately regarding the final accounts and there are no items in the final accounts that require additional disclosure.

Mr S Marshall raised a question relating to the table on page 57 of the report around the areas of audit and level of assurance recorded as “medium risk”. Mr Gallagher confirmed this had been discussed at the Audit and Governance Committee and would be the subject of a separate discussion with internal audit to inform the final assurance level.

Dr D Bush referred to bullet point 4 on page 13 of the report and asked for clarity regarding this point. Mr Gallagher stated that the Primary Care underspend had arisen partly as a consequence of the receipt of approximately £800k from NHS England in relation to the working balances transfer following the decision to formally approve the CCG’s delegates status largely a consequence of some income received from NHS working balances. We have underspent in Primary Care and Community Services. Dr Hibbs assured Dr Bush that funding in respect of General Medical Services (GMS) was fully ring fenced.

Mr P Price confirmed on behalf of the Audit and Governance Committee we are happy to recommend the accounts.

Dr Hibbs thanked the finance team for the hard work which has been carried out and pointed out that the Auditors were very complimentary about the team.

Mr J Oatridge pointed out that the statement Mr Gallagher read out the wording could be improved in the future. Mr Gallagher confirmed this could be reviewed ensuring it is more meaningful.

RESOLVED: That the Governing Body agreed with the statement which was read out. That the Governing Body approved the Annual Report and Accounts.

Committee Annual Reports

WCCG.2142

Mr P McKenzie stated this report introduces the annual reports of the Governing Body Committees that demonstrate how each of them has met their terms of reference as set out in the CCG’s Constitution.

He pointed out that an annual report for the Remuneration Committee will be prepared for their meeting in June as they meet on an ad hoc basis. The Primary Care Committee produces an annual report for NHS England.

RESOLVED: That the Governing Body accepted the report presented by its Committees as a record of their continued delivery of their terms of reference.

RESOLVED: That the above is noted.

Public Health Vision and Annual Report

WCCG.2143 RESOLVED: That the documents are noted.

Any Other Business

WCCG.2144 RESOLVED: That the above is noted.

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

WCCG.2145

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2146 The Board noted that the next meeting was due to be held on **Tuesday 10 July 2018** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 1.35 pm

Chair.....

Date

WOLVERHAMPTON CCG
GOVERNING BODY
10 JULY 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"> • Developments continue in primary care in the Wolverhampton place and across the wider Black Country STP.
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 Place based Alliance update

- 2.1.1 Progress is being made on the Wolverhampton Place Based Alliance. Primary and Secondary care clinicians have met and formed Task and Finish groups to progress the redesign of end to end pathways for End of Life (EoL), Paediatrics, care of the frail elderly and Mental health. The Mental Health planning includes access to all services for all ages and strengthening community support and ties between secondary care clinicians and GPs. In addition, the Governance workstream are finalising the terms of reference for the Group and an implementation plan is being provided.

2.2 Sustainability and Transformation Plan (STP) / Integrated Care System Development

- 2.2.1 The Black Country STP is currently refreshing its programme of work and the senior leaders are taking part in development work to ensure that the STP will be in a position to evolve to become an integrated system in due course. A lot of focus is being put on the development of a clinical strategy that will be prioritised and will enable the STP work to be clinically lead.

2.3 IMT Developments

- 2.3.1 The IT Refresh Programme of work is continuing with the upgrading of the IT infrastructure, the Network upgrade project has just completed and the replacement of old PC's will continue for the rest of this year. We here are a number of collaborative projects taking place at the moment working across the Black Country STP to support the sharing of maternity records of expectant mothers to allow them to be able to allow have their information available at any hospital that they visited in the black country.

2.4 Update of Black Country Local Maternity Systems (LMS)

- 2.4.1 NHSE has confirmed that the LMS will receive £320k to implement a number of projects proposals to support the improvement in service transformation, support some of our most vulnerable women; in order to tackle health inequality and improve the outcomes for women and their babies.
- 2.4.2 The Strategic Board met on 4 June and it was agreed that a LMS model for implementation would be developed by September 2018 which each Provider Trust would be asked to sign up to, in order to ensure that Key Lines of Enquiry trajectories set by NHS England are achieved by the relevant deadlines.
- 2.4.3 Each workstream is working on progressing the trajectories, as well as ensuring that they achieve three tangible differences to maternity services over the next 12 months.

- 2.4.4 The LMS presented to NHS England at the Maternity Plans Review on 8 June 2018 having submitted substantial documentation. The verbal feedback has been positive but written feedback is awaited.
- 2.4.5 The LMS is progressing a PMO approach and in the process of being implemented. Risk Registers have been developed for each workstream. Governance arrangements are in place via exception reports submitted to the Operational and Delivery Programme Board which then feeds into the Strategic LMS Board.
- 2.5 Transforming Care Programme (TCP)
 - 2.5.1 Collaborative working continues across the STP to drive the Transforming Care Programme. The programme is transforming care for both adults and children with learning disability and/or autism. Current pathways are being redesigned with an overall aim of improving health and care services to enable more people to live in the community, with the right support, and close to home.
- 2.6 Business Intelligence Work
 - 2.6.1 It is imperative that the commissioning of Local and strategic health and social care services is underpinned by system wide business intelligence systems. The CCG, Public Health, Local Authority and RWT have set up a Joint Intelligence Unit (JIU) to ensure that joint commissioning is intelligence driven. The JIU will bring together the skills of analysts and commissioners to interrogate integrated data systems, adhering to the appropriate governance agreements.
- 2.7 Primary Care Update
 - 2.7.1 Dementia Friendly Practices - Launched in May 2018 during Dementia Action Week in Partnership with the Dementia Action Alliance and Alzheimer's Society. This initiative is one of a series of pledges the CCG has made, this has been well received by practices many are liaising to confirm how they are achieving level 1.
 - 2.7.2. Integrated Care Alliance - Clinicians and managers from organisations across the city met recently to discuss how care pathways can be improved to achieve greater co-ordination and care planning for patients of all ages.
 - 2.7.3 Improving Access in General Practice - More appointments have been made available to patients since April during evenings and weekends. Practices are working together to offer same day appointments, utilisation is being closely monitored and where possible patients are being offered appointments in different locations in order to offer patients more choice and also reduce waiting times.
 - 2.7.4 STP - Black Country CCGs are working in Partnership with trusts and Health Education England to recruit more doctors to work in general practice, hospital settings or leadership roles. Offers for clinical fellowships are due to be made in July 2018.
 - 2.7.5 Practices Introduce Two-way Texting - Almost all Wolverhampton practices have introduced a new facility to enable patients to receive and respond using text facilities. This enables

patients to communicate with their practice at their own convenience without the need to call the practice. Text reminders and information sharing / gathering is working well.

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:	27 June 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	27/06/18



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WOLVERHAMPTON CCG

GOVERNING BODY
10 JULY 2018

Agenda item 7

TITLE OF REPORT:	Governance Arrangements for Primary Care
AUTHOR(s) OF REPORT:	Peter McKenzie – Corporate Operations Manager
MANAGEMENT LEAD:	Corporate Operations Manager
PURPOSE OF REPORT:	To ask the Governing Body to agree to clarify the governance arrangements for Primary Care strategic management and development by delegating responsibility for monitoring the implementation and development of the Primary Care strategy to the Primary Care Commissioning Committee
ACTION REQUIRED:	<input checked="" type="checkbox"/> Decision <input type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	<ul style="list-style-type: none"> • Currently the governance arrangements for Primary Care give the Governing Body responsibility for development of the overall Primary Care strategy and this Committee responsibility for exercising the delegated powers in respect of Primary Medical services contracts from NHS England • These arrangements were established to ensure that there were robust lines of accountability as the CCG developed its Primary Care agenda through full delegation but have increasingly led to duplication of work as involvement in Primary Care has matured. • It is proposed that, to clarify these arrangements, this committee is given delegated authority to develop and monitor the implementation of, the CCG’s Primary Care Strategy.
RECOMMENDATION:	<p>That the Governing Body agree:</p> <ul style="list-style-type: none"> • To amend the Terms of Reference of the Primary Care Commissioning Committee to give it responsibility for managing the implementation and development of the Primary Care Strategy • To include the revised terms of reference in an application to vary the CCG’s Constitution
LINK TO BOARD ASSURANCE FRAMEWORK	



AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	<u>Ensure on-going safety and performance in the system</u> The Committee will continue to use quality monitoring information to support its decision making role.
2. Reducing Health Inequalities in Wolverhampton	<u>Improve and develop primary care in Wolverhampton</u> The Committee will be empowered to continue to play an active role in the development of Primary Care across Wolverhampton both strategically and operationally.
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Committee will continue to exercise the powers delegated to the CCG by NHS England. Its membership will continue to reflect the requirements of statutory guidance for managing conflicts of interest in relation to Primary Care Commissioning.

1. BACKGROUND AND CURRENT SITUATION

- 1.1. The CCG has had delegated responsibility from NHS England for managing Primary Medical Services contracts since January 2016. This responsibility was exercised initially through a Joint Commissioning Committee and, since 2017, through the Primary Care Commissioning Committee (PCCCC).
- 1.2. The CCG has a Primary Care Strategy, approved by the Governing Body in March 2016. The implementation of this strategy is managed on a programme basis, progress with which is reported to the Governing Body which retains responsibility for managing and developing the strategy.
- 1.3. These arrangements have provided a clear distinction between the strategic and operational decision making associated with Primary Care and have worked well as the CCG has developed its approach to delivering the delegated powers from NHS England. However, as work has progressed with the implementation of the Primary Care Strategy, it has become clear that continuing with these arrangements may lead to duplication and confusion about governance arrangements.

2. PRIMARY CARE COMMISSIONING COMMITTEE – ROLE AND FUNCTION

- 2.1. The PCCC and its predecessor Joint Commissioning Committee were established by the CCG in response to NHS England’s national move towards Co-commissioning of Primary Care with CCGs. NHS England has delegated a number of functions in relation to the commissioning of Primary Medical services to the CCG which, in order to meet requirements around the management of conflicts of interest, must be exercised by the Primary Committee.

- 2.2. The functions exercised by the committee on behalf of NHS England are set out in its Terms of Reference include:
- Management of GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
 - Implementing Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
 - Designing local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
 - Decision making on whether to establish new GP practices in an area;
 - Approving practice mergers; and
 - Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

The committee also maintains an overview of the CCG’s coordinating activities in relation to the delegated functions. This includes monitoring the CCG’s integrated approach to contract and quality management. The CCG has not formally delegated any CCG responsibilities to the Committee.

- 2.3. The terms of reference for the committee set out that it will be accountable to the Governing Body for conducting its business in line with the CCG’s Primary Care strategy. In order to meet this requirement, the committee has received regular updates on the implementation of the strategy once they have been considered by the Governing Body. Whilst this has supported the committee in maintaining an understanding and overview of the strategy, the information considered can sometimes be out of date and the committee does not have an opportunity to influence the work on the strategy.
- 2.4. Since the CCG became fully delegated in April 2017, the committee and the CCG’s management team have worked to ensure that the CCG has been able to effectively deliver its delegated responsibilities. The focus on the operational decision making at the committee has supported this process however, as the committee and CCG have matured into these responsibilities, it is worth considering whether there would be benefits of it taking a more strategic approach.

3. PRIMARY CARE STRATEGY – SUPPORT ARRANGEMENTS

- 3.1. The arrangements for monitoring and managing the delivery of the Primary Care strategy have evolved over the two years since it was written. Initially, to drive the significant level of change a Primary Care Strategy ‘committee’ was established to monitor the achievement of the outcomes in the strategy, which have been operationalised through a series of task and finish groups. As the work of the task and finish groups has progressed, the management of the programme of work has been flexed to review progress through a milestone review board, which reports into the Governing Body.

3.2. The direct reporting line into the Governing Body has been particularly helpful in the initial stages of the implementation of the primary care strategy. The Governing Body was involved in establishing the programme structure and agreeing milestones. However, as the work moves towards 'business as usual' the limited time available at Governing Body meetings means that it is not always possible to hold a detailed discussion and address any issues. As part of the move to business as usual, delegating some of the responsibility for oversight of the strategy to the PCCC, which could build time for discussion into its agenda, would bring this programme into line with the other committees across the CCG. The committee would be responsible for providing the Governing Body with assurance that progress with the strategy and the other work associated with the development of Primary Care was progressing in line with agreed targets, escalating issues to the Governing Body as appropriate.

4. PROPOSED NEW ARRANGEMENTS AND NEXT STEPS

4.1. It is proposed that the PCCC's Terms of Reference are revised so that responsibility for managing and developing the Primary Care Strategy are delegated to it on behalf of the Governing Body. It is important to note that the Governing Body would retain overall ownership of the strategy and responsibility for signing it off whilst this committee would be responsible for providing assurance that delivery was on track and managing any work to refresh or revise the strategy.

4.2. In addition to bringing the governance arrangements for Primary Care into line with the CCG's other committees, this approach has a number of other significant potential benefits as follows:-

- **Greater focus on Primary Care Strategic Development** – Currently the reporting lines for the Primary Care Strategy mean that there is the potential for work to be either duplicated or not discussed in appropriate detail. Having a single line for detailed discussion that can link the strategic and operational agenda will enhance the assurance provided to the Governing Body that strategic outcomes will be delivered.
- **Risk Management** – Following the introduction of the CCG's new risk management arrangements the PCCC has maintained an overview of the risks under its purview. Up until now this has involved the management of risks associated with the CCG's delegated powers and GP contracts. Risks associated with the implementation of the Primary Care strategy are managed through the programme management arrangements and escalated directly to the Governing Body if appropriate. In practice, there is some crossover between risks in these areas and allowing this committee to act as the prime escalation point for risks associated with primary care will help to ensure that those risks are managed effectively.
- **Conflict of Interest Management** – In line with NHS England guidance on the management of conflicts of interest, the PCCC has non-voting clinical attendees and a lay and Executive majority. This ensures that potential conflicts of interest in relation to GP contracts are managed effectively, however these conflicts of interest also exist in relation to the strategic development of Primary Care.



Bringing the detailed work on the strategy to this committee, rather than the Governing Body will help to manage these potential conflicts.

- 4.3. The figures in Appendix 1 illustrate the current and proposed arrangements for functional responsibilities of Primary Care Strategy delivery and development and delegated commissioning. The diagrams also recognise some of the CCG's commissioning in Primary Care settings (particularly in relation to new services) will continue to be delivered through the Commissioning committee. Appendix 2 is a revised version of the committee's terms of reference, reflecting the additional responsibilities and a change of name to 'Primary Care Committee'.

5. CLINICAL VIEW

- 5.1. Not Applicable.

6. PATIENT AND PUBLIC VIEW

- 6.1. Not applicable.

7. KEY RISKS AND MITIGATIONS

- 7.1. There are no specific risks associated with this report. As highlighted above, the proposed arrangements will help to support the management of risks associated with Primary Care.

8. IMPACT ASSESSMENT

Financial and Resource Implications

- 8.1. There are no financial implications arising from this report.

Quality and Safety Implications

- 8.2. There are no Quality and Safety implications arising from this report. The committee will continue to maintain its overview of quality management in Primary Care to support delivery of its delegated powers from NHS England.

Equality Implications

- 8.3. There are no equality implications arising from this report.

Legal and Policy Implications

8.4. The proposed changes to the Committee's Terms of Reference will result in an application to vary the CCG's constitution.

Other Implications

8.5. There are no other implications associated with this report.

Name Peter McKenzie
Job Title Corporate Operations Manager
Date: June 2018

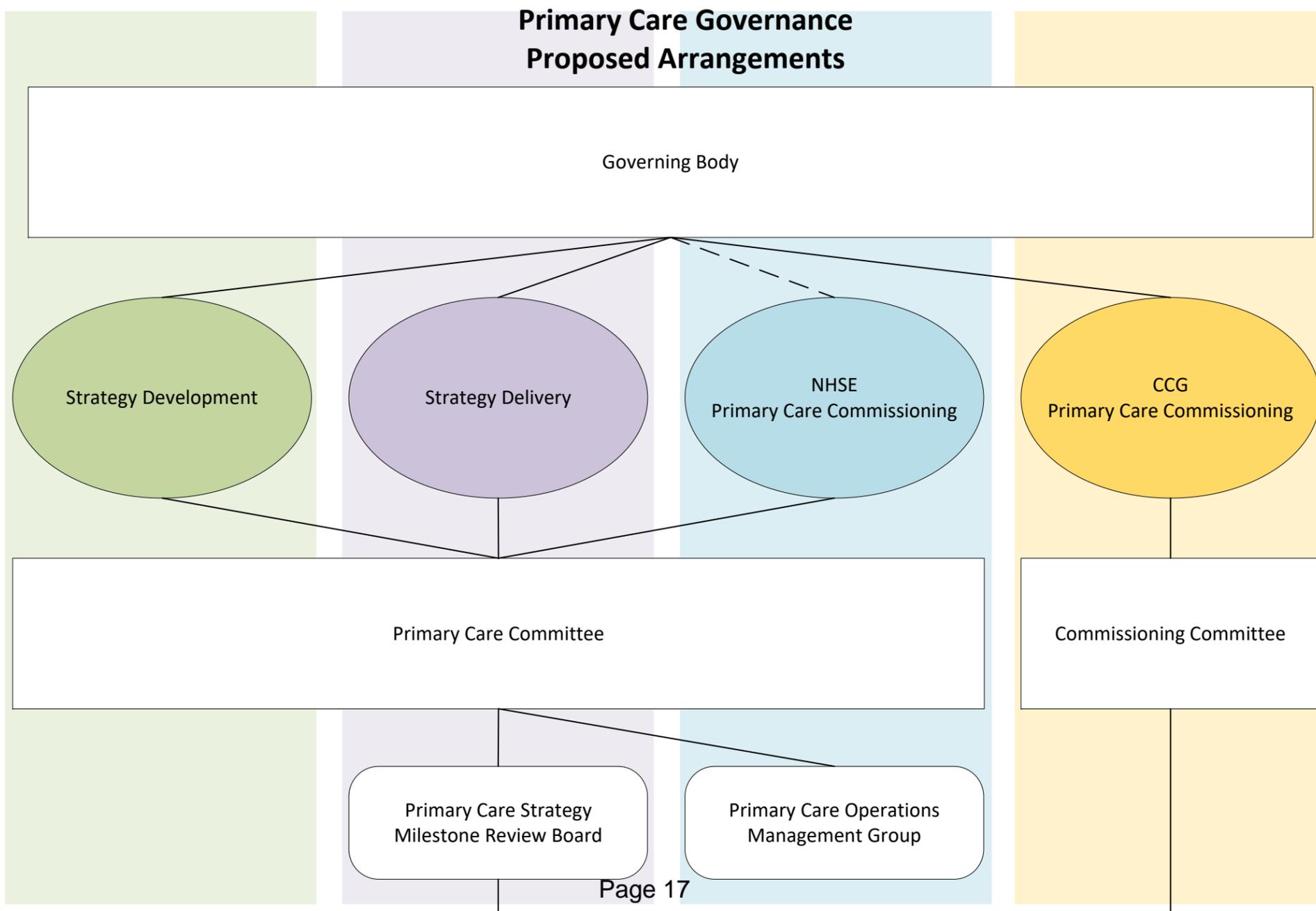
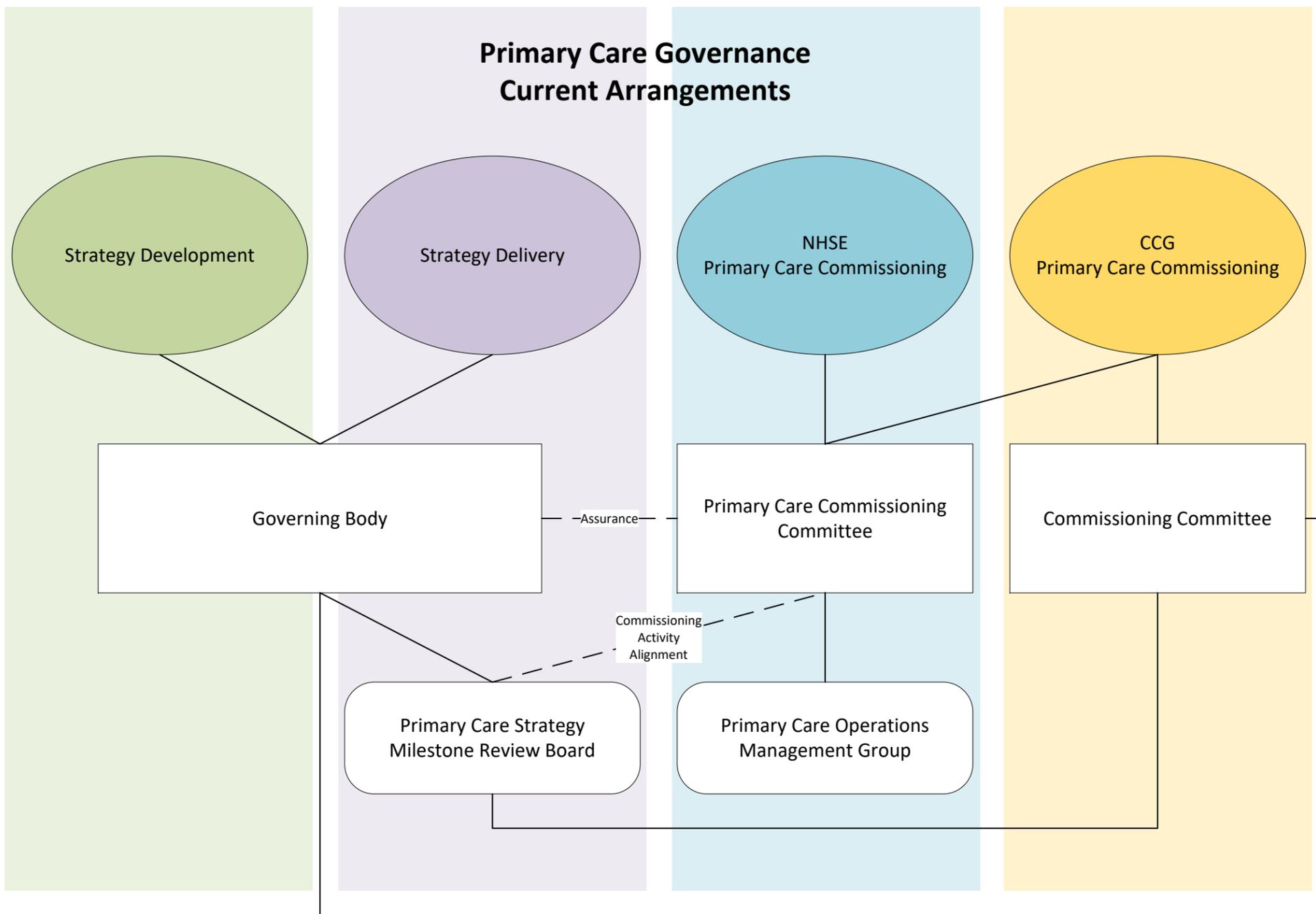
ATTACHED:

Appendix 1 – Proposed Functional responsibilities
Appendix 2 – Proposed Revised Terms of Reference.

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	Report Author	26/06/18
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)	P McKenzie	28/06/18



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NHS Wolverhampton Clinical Commissioning Group Constitution Appendix H6

The Primary Care ~~Commissioning~~ Committee Terms of Reference

1. Introduction

1.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 1 to these Terms of Reference to Wolverhampton CCG.

1.3 The CCG has established the Wolverhampton CCG Primary Care ~~Commissioning~~ Committee ("the Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of these delegated powers for commissioning primary medical services for the people of Wolverhampton.

1.4 ~~1.3~~ The committee will also support Wolverhampton CCG's Governing Body in developing and delivering the CCG's overall Primary Care Strategy. The committee will be responsible for monitoring delivery of the outcomes in the strategy, escalating matters of concern or importance and making recommendations to the Governing Body for action as appropriate.

2. Statutory Framework

2.1 NHS England has delegated authority to the CCG to exercise the

NHS Wolverhampton Clinical Commissioning Group
Primary Care Commissioning Committee Terms of Reference Version [23]

1

commissioning functions set out in Schedule 1 in accordance with Section 13Z of The National Health Service Act 2006 (as amended) (“NHS Act”).

- 2.2 Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.
- 2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
- a) Management of conflicts of interest (section 14O);
 - b) Duty to promote the NHS Constitution (section 14P);
 - c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
 - d) Duty as to improvement in quality of services (section 14R);
 - e) Duty in relation to quality of primary medical services (section 14S);
 - f) Duties as to reducing inequalities (section 14T);
 - g) Duty to promote the involvement of each patient (section 14U);
 - h) Duty as to patient choice (section 14V);
 - i) Duty as to promoting integration (section 14Z1);
 - j) Public involvement and consultation (section 14Z2).
- 2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions set out below:-
- Duty to have regard to impact on services in certain areas (section 13O);
 - Duty as respects variation in provision of health services (section 13P).
- 2.5 The Committee is established as a committee of the Governing Body of the CCG in accordance with Schedule 1A of the NHS Act.
- 2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Wolverhampton, under delegated authority from NHS England.

3.2 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.3 The primary role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

3.4 The Committee will also be responsible for managing the delivery and development of the CCG's Primary Care Strategy on behalf of the Governing Body. It will also maintaining an overview of the CCG's other activities in relation to the delegated functions related to Primary Care and ensuring that they are aligned with the CCG's Primary Care strategy. These activities include:-

- Planning for sustainable primary medical care services in Wolverhampton;
- Reviewing primary medical care services in Wolverhampton with the aim of further improving the care provided to patients
- Co-ordinating the approach to the commissioning of primary care services generally;
- Managing the budget for commissioning of primary medical care

services in Wolverhampton.

- 3.5 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Wolverhampton CCG, which will sit alongside the delegation and terms of reference.

The Committee will be responsible for ensuring that risks identified through the CCG's risk management arrangements and allocated to the committee due to its relevance to its responsibilities are effectively managed through regular consideration of the committee's risk profile. The committee will assure the Audit and Governance Committee and the Governing Body that these risks are being managed, escalating and de-escalating risks as it considers necessary.

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4. Geographical coverage

- 4.1 The Committee will comprise the Wolverhampton CCG (The CCG). It will undertake the function of jointly commissioning primary medical services for Wolverhampton.

5. Membership

- 5.1 The Membership of the Committee shall consist of:-
- The Deputy Chair of the CCG's Governing Body
 - The CCG Governing Body Lay Member for Finance and Performance
 - Two Executive Members of the CCG's Governing Body (currently the Director of Strategy and Transformation and the Executive Director of Nursing and Quality)
 - The Three GPs elected to the CCG Governing Body as Locality Leads (Non-Voting)
 - Two Patient Representatives
- 5.2 The Chair of the Committee shall be the Deputy Chair of the CCG's Governing Body
- 5.3 The Vice Chair of the Committee shall be the CCG Governing Body Lay Member for Finance and Performance.
- 5.4 Any member of the committee may nominate a substitute to attend a meeting on their behalf, provided that they notify the Chair 24 hours before the meeting.

6. Invited Attendees

- 6.1 Both a representative of Healthwatch Wolverhampton and a representative of the Wolverhampton Health and Wellbeing Board (who must represent Wolverhampton City Council on the Board) shall be invited to attend meetings of the Committee as a non-voting observer.
- 6.2 The observers shall be invited to provide assurance that the provisions for managing conflicts of interest are being correctly applied and shall be entitled to attend private sessions of the Committee.

~~6.46.3~~ The Committee may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

7. Meetings and Voting

- 7.1 The Committee will operate in line with the CCG's Standing Orders and Policy for Declaring and Managing Interests. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place unless a shorter time period for circulation of papers is necessary due to a meeting being re-scheduled at short notice.
- 7.3 Decisions of the Committee should be reached by consensus where possible. Where this is not possible, a vote will be taken with a simple majority of the votes cast being required to reach a decision with the Chair having a second and casting vote in the event of a tie.
N.B. In line with national statutory guidance, the GP representatives on the Committee shall not be entitled to vote.
- 7.3 Meetings of the Committee shall be held in public, unless the Committee resolves to exclude the public from either the whole or part of the proceedings whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
- 7.4 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and

provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.5 Members of the Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the committee in which event these shall be observed.

8. Quorum

8.1 Meetings of the Committee shall be quorate when over 50% of its members, including the Chair or Vice Chair and at least one Executive Governing Body member is present and overall make up of those present is such that there is a majority of non-clinical members.

9. Frequency of Meetings

9.1 The Committee shall agree a regular programme of meetings each year. In addition, the Chair may call additional meetings if they are required in line with the provisions for notice of meetings set out above.

10. Secretary

10.1 A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Committee's business and for drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

10.2 The Secretary will circulate the minutes and action notes of the committee with 3 working days of the meeting to all members and present the minutes and action notes to NHS West Midlands and the governing body of the CCG.

10.3 The Secretary will also provide an executive summary report which will be presented to NHS West Midlands and the governing body of the CCG each month for information.

11. Accountability of the Committee

11.1 The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG's responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

11.2 For the avoidance of doubt, the CCG's Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.

11.3 The Committee is accountable to the governing body to ensure that it is effectively discharging its functions.

12. Procurement of Agreed Services

12.1 The procurement arrangements will be set out in the delegation agreement (Schedule 1 and 2 to this Terms of Reference between NHS Wolverhampton CCG and NHS England).

13. Decisions

13.1 The Committee will make decisions within the bounds of its remit set out in paragraph 3 above. The decisions of the Committee shall be binding on NHS England and NHS Wolverhampton CCG and will be published by both parties.

14. Review of Terms of Reference

14.1 These terms of reference will be formally reviewed by the Committee in April of each year, following the year in which the committee is created and any recommendations for changes will be made to the Governing Body.

SCHEDULE 1 – DELEGATED FUNCTIONS

The functions delegated to NHS Wolverhampton CCG by NHS England under section 13Z of the National Health Service Act 2006 are as follows:-

- Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:
 - Decisions in relation to Enhanced Services;
 - Decisions in relation to Local Incentive Schemes (including the design of such schemes);
 - Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
 - Decisions about 'discretionary' payments;
 - Decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
- The approval of practice mergers;
- Planning primary medical care services in the Area, including carrying out needs assessments;
- Undertaking reviews of primary medical care services in the Area;
- Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
- Management of the Delegated Funds in the Area;
- Premises Costs Directions Functions;
- Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
- Such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Further detail on the exercise of these functions is detailed in the Delegation agreement between NHS England and NHS Wolverhampton CCG.

WOLVERHAMPTON CCG

Public Governing Body
10th July 2018

Agenda item 8a

TITLE OF REPORT:	The Wolverhampton Place Strategy and the Integrated Care Alliance
AUTHOR(s) OF REPORT:	Steven Marshall
MANAGEMENT LEAD:	Steven Marshall
PURPOSE OF REPORT:	To recap on the development of the Wolverhampton Place Strategy and the Integrated Care Alliance and to endorse and adopt formally the 'Place' strategy of Wolverhampton
ACTION REQUIRED:	<input checked="" type="checkbox"/> Decision <input type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	<ul style="list-style-type: none"> • Substantial development work has taken place over the last two years with regard to the Strategy for the local Wolverhampton plan (Place) and the report summarised and advises of these developments and future next steps • For the sake of clarity, the Governing Board is asked to formally endorse the adoption of the strategy and agree the next steps and way forward
RECOMMENDATION:	To endorse and adopt the strategy and implementation plan for the Wolverhampton place and ICA
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Care will be delivered closer to home with greater integration between all providing stakeholders in the Wolverhampton health economy
2. Reducing Health Inequalities in Wolverhampton	The realisation of the strategy will ensure there is no unwarranted variation of equity of service in Wolverhampton



<p>3. System effectiveness delivered within our financial envelope</p>	<p>The strategy is designed to ensure that the CCG remains within financial balance while ensuring improvements in quality and effectiveness of services in Wolverhampton</p>
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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. The CCG has been on a path of continuous and iterative development of its strategy for the Wolverhampton place and the Integrated Care alliance for the last two years. With national guidelines finally becoming regarding the direction of travel of the NHS Commissioning landscape, Governing Body approval is now sought for the endorsement of the strategy and agreement towards the next steps

2. NEXT HEADING

- 2.1. Attached is a paper and associated appendices which outlines the journey for strategy development, planning and implementation

3. CLINICAL VIEW

- 3.1. Clinicians have been intimately involved in the development of the Wolverhampton place approach and the Integrated Care Alliance

4. PATIENT AND PUBLIC VIEW

- 4.1. The direction of travel largely reflects what has been feedback from multiple patient engagement forums. However, additional engagement will be built into the programme to April 2019

5. KEY RISKS AND MITIGATIONS

- 5.1. Risks are identified in the apper

6. IMPACT ASSESSMENT

Financial and Resource Implications

- 6.1. The Finance team have developed the contracting models framework

Quality and Safety Implications

6.2. As each pathway is addressed then Q&S will form part of the pathway re-design

Equality Implications

6.3. Each service change will be accompanied by appropriate QIA and EQIA consideration

Legal and Policy Implications

6.4. None

Other Implications

6.5. None

Name Steven Marshall
Job Title Director of Strategy and Transformation
Date: 28/06/18

ATTACHED:

The Wolverhampton Place_GB_Final_26_06_18
Appendix 1a GP groupings and list size
Appendix 1B Wolverhampton place strategy V 1 final_09_03_18
Appendix 2 Prospectus 24 08 17 final (003) (2)
Appendix 3 Wolves contract proposal_20180531_Risk_Gain_Share_V05
Appendix 4 v3split of budgets 2018.06.04
Appendix 5 High level Timeline
Appendix 6 Gantt development for Wolverhampton Place

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The Wolverhampton 'Place'

1. Background

Over the last 24 months, Wolverhampton CCG has pursued a collaborative solution to develop a place based alliance in which the equality of all the Provider partners is paramount. We have been cognisant that clinical leadership is central to success and that primary care working alongside secondary care and social care breaking down traditional barriers will be essential as we move forward. It is a partnership model in which clinicians are pro-active, engaged members in addressing the burgeoning challenge of increasing multiple long term co-morbidities, an ageing population, and increasing personalisation and self -help. All research evidence suggest that the core of evolving and instituting successfully new models of care has, as a core requirement, positive and trustful working relationships

To implement new models of care, the CCG acknowledges that there must be a shifting of the resource to increase investment in Primary Care, something which has fallen consistently over the last few years as a proportion of NHS spend. In addition there needs to be a much stronger relationship between GP Primary Care and Community Services along with additional investment in Community Services.

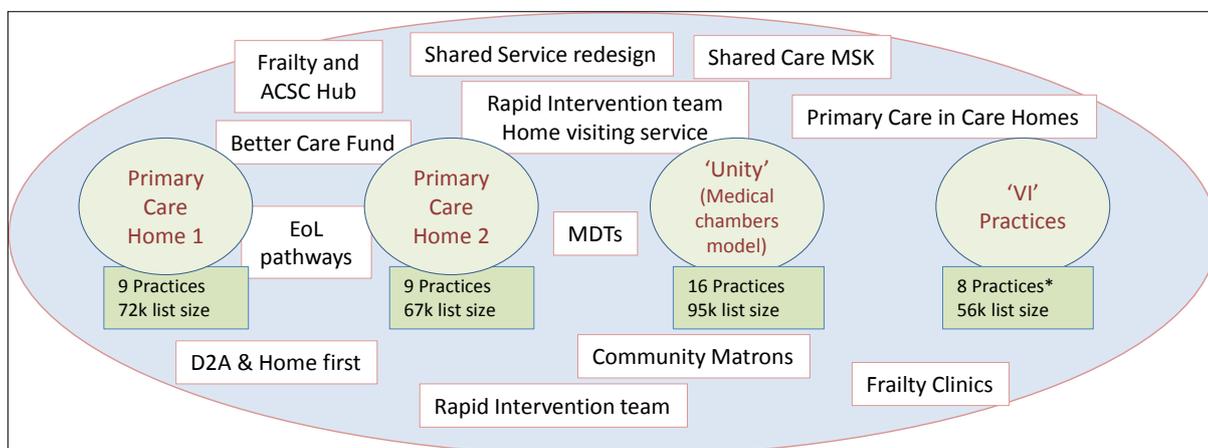
2. The Strategy

The Strategy has a number of imperatives:

- 2.1. An agreed, collaborative shift in patient care to ensuring that those patients who can be cared for in a non-hospital setting, are
- 2.2. 'Bend' the demand curve for acute activity ensuring more pro-active primary and community focus with the accompanying financial resources to support this
- 2.3. Institute positive, aligned and collaborative working relationships with and between all Providers (Primary, Acute, Community, MH and LA) in the Wolverhampton health economy
- 2.4. Ensure the alignment of all GP Practices into collaborative groupings, (recognising that there is a mixed model in Wolverhampton of PCH, Medical Chambers and VI)
- 2.5. Ensure that Multi-Disciplinary teams are grouped around clusters of GP practices to ensure the delivery of pro-active community care
- 2.6. Discard the perversely incentivised Acute PbR contract
- 2.7. Agree a collaborative new contract solution with the Acute/Community provider and a virtual contract (compact) between stakeholders with improved allocative efficiency to respond to changing health challenges, while ensuring that the Acute provider remains financially viable
- 2.8. Ensure that the LA are part of the solution
- 2.9. Craft the right solution as emerging thinking and regulatory directions of travel emerge (rather than adopting an 'a priori' hard dogmatic approach)
- 2.10. Appropriate public consultation and engagement

3. From Strategy to Plan

3.1. All practices are clustered into groupings. This is summarised below and additional detail is provided in appendix 1.



3.2. A key output of the preparatory work was an agreed 'Propectus' signed by Dr. H Hibbs and Mr. D Loughton on behalf of the CCG and RWT respectively. This had already been agreed and approved by the CCG Governing Body. This is attached as appendix 2.

3.3. A new model has been developed to move from the current PbR method of contracting to a mixed model of contracting. This is made up of a number of components:

Fixed Cost (i.e. block): This is predominantly non-elective activities

Risk/Gainshare: This is predominantly for elective activity

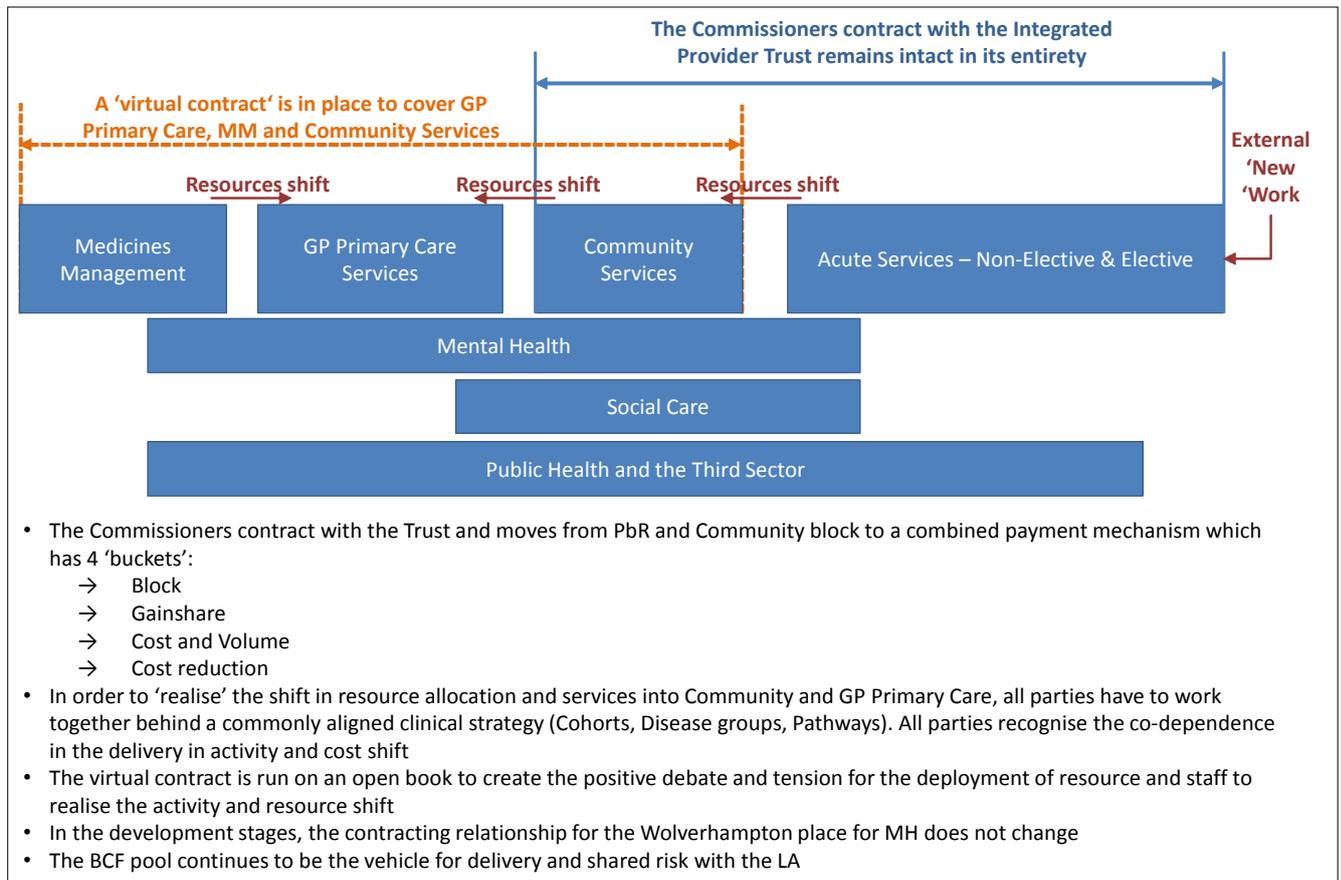
Cost & Volume: This covers a number of areas incl. A&E

Cost Reduction: This is predominantly Medicines

(Exploratory discussions are ongoing with the Trust currently). Further details are laid out in appendix 3. It is anticipated that a full F&P and Governing Body approval will be sought for the new contracting arrangements

Areas	18/19 Plan Activity Annual	Plan Price Annual	% of contract
Segment 1 - Risk/Gainshare	366,009	£60,342,915	37%
Segment 2 - Cost Reduction	3,094	£9,045,150	6%
Segment 3 - Fixed Cost	31,529	£52,243,808	32%
Segment 4 - Fixed income	-	£7,373,630	5%
Segment 5 - Cost and Volume	606,868	£34,412,215	21%
Totals		£163,417,718	100%

3.4. Work has been ongoing to develop and articulate the new model for the new system model of care (the Wolverhampton place). This has been presented on several occasions to the Governing Body, is summarised below and the full presentation is laid out in appendix 3



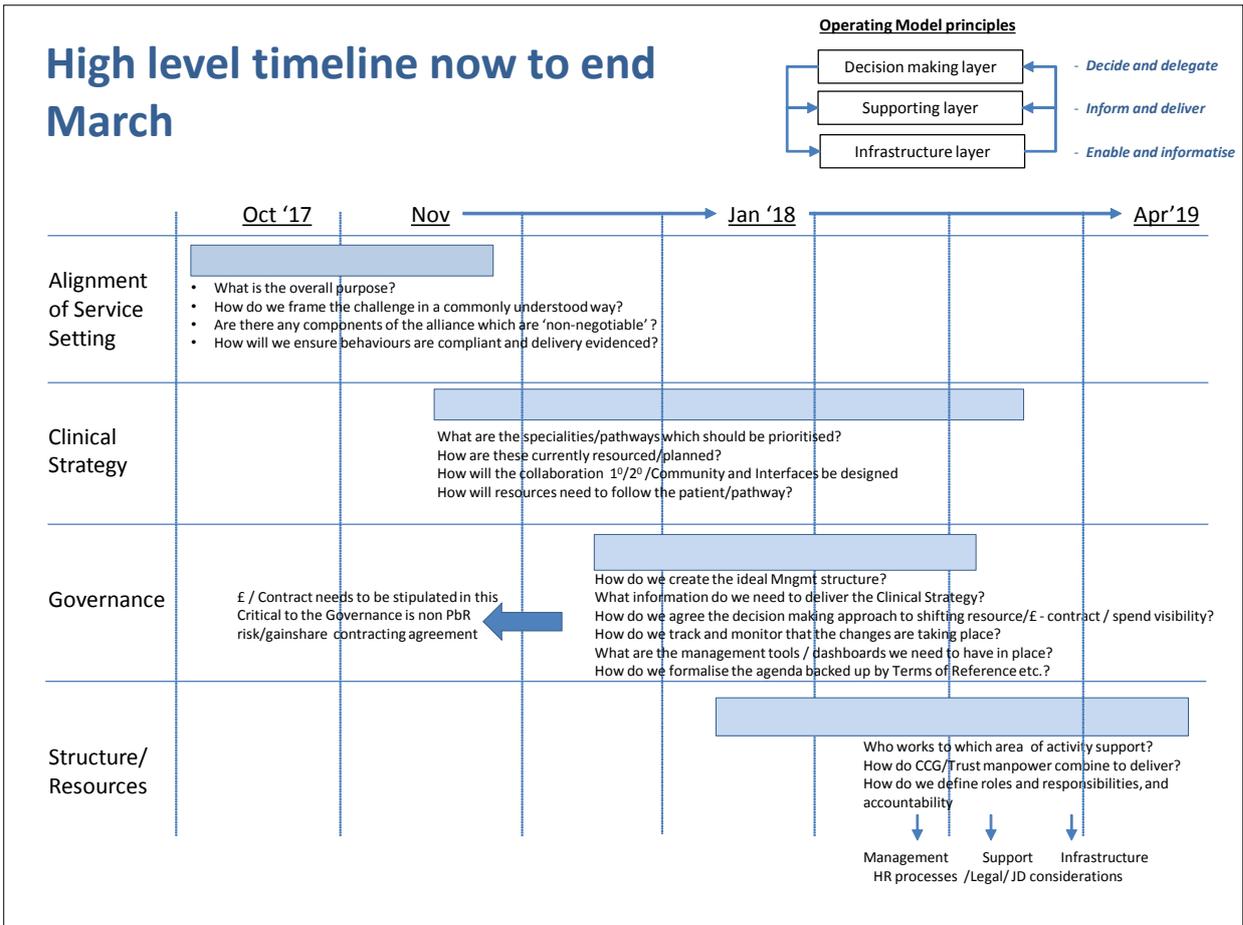
Attached, as appendix 4, is the financial overview of the agreed areas in scope of the 'virtual contract'.

A key consideration in the development of the Wolverhampton place is ensuring that clinical strategy and alignment is at the heart of the new models and that GPs are equal decision makers in the allocation and application of resources. Substantial development time has been invested in the alignment of the GP groupings, the agreement of the clinical areas to focus on and the development is now moving into how the decision making of virtual contract areas of responsibility will play out.

It needs to be recognised that the Local Authorities and the Mental Health Provider are also equal partners in the way forward.

Next steps necessarily move onto how the resources in the CCG are deployed under the new models of care/system and how we can make the best use of informatics to support decision making and prioritisation

The overall schematic approach and headline timetable for the development is laid out below



The full side is attached as appendix 5

4. From Plan to Implementation

- 4.1. A detailed implementation plan has been drawn up to deliver the outline schedule. This includes:
 - 4.1.1. The initial set of clinical pathways for patient cohorts has been determined and Task and finish groups have commenced work
 - 4.1.2. Timings for the final contractual approach to be in place (overall main contract and the virtual contract)
 - 4.1.3. Dedicated resource has been set aside in the CCG to support and lead the different areas of work
 - 4.1.4. The planned completion date is April 2019 but it is likely that the cohort/identification and clinical development work will continue beyond this
 - 4.1.5. Overall governance and how/where this will fit in a 'system' has yet to be determined but what is clear is that the integrity of current statutory bodies will not be compromised nor their governance responsibilities of that statutory body
 - 4.1.6. Attached as appendix 6 is the detailed GANNT chart for development

5. Public and Patient engagement

The Wolverhampton place strategy builds on all of the Commissioning Cycle engagement and the 'You said we did' feedback which has consistently stated that patients want greater care closer to home and stronger relationships with Primary Care.

Nevertheless, a full engagement approach will be developed for discussions with PPGs and members of the public (The Healthwatch AGM on 04/07/18 is the first step in this). The Governing Body will be sighted fully on the engagement plan as it is firmed up over the next 6 weeks

6. Risks

There are a number of risks of not moving forward as well as a number of risks associated with moving forward.

- 6.1. There is a degree of uncertainty with regard to the evolution of strategic commissioning in the Black Country Not endorsing and officially adopting the strategy in sight of full governance could lead to a shift /complete change in the collaborative approach that has been adopted in Wolverhampton – ostensibly to deliver a similar result but based on a forced, rather than a collaborative decision
- 6.2. The programme fails to progress to the required timescales through non engagement of the Acute provider in either the clinical strategy development or the transparency of spend across the agreed cohorts
- 6.3. Disentangling and providing transparency across the 'longitudinal spend' lens proves to be too difficult and the role of the management team becomes dissipated and engagement in the new model of care drops away
- 6.4. Not all of the GP groupings buy into the new model of care solution and there is not full participation in the way forward
- 6.5. Disruption to staff could lead to a lack of focus on delivering the CCGs core agenda and its staying in financial balance

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Wolverhampton CCG

List Size(s) updated quarterly based on NHSE Updates (last updated May 2018 [April 2018 data])

June18/V9.7 SS

Clinical system	Locality	M Code	Practice	Actual List Size QTR 4
PCH 1 Wolverhampton Total			Health (Group Lead Dr G Pickavance)	
E	NE	M92016	M92016 - TUDOR MEDICAL CENTRE	17,270
E	NE	M92629	M92629 - DRS KHARWADKAR & MAJI	3,579
E	NE	M92019	M92019 - KEATS GROVE SURGERY	6,400
E	SE	M92030	M92030 - CHURCH STREET SURGERY	5,272
E	SE	M92649	M92649 - DR MUDIGONDA	3,794
E	SE	M92630	M92630 - EAST PARK MEDICAL PRACTICE	5,354
E	SE	M92012	M92012 - DUNCAN STREET PRIMARY CARE PARTNERSHIP	9,744
E	SW	M92029	M92029 - NEWBRIDGE SURGERY	4,809
E	SW	M92607	M92607 - WHITMORE REANS MEDICAL PRACTICE	14,031
Total				70,253
PCH2 Wolverhampton Care Collaborative (Group Lead Dr P Mundlur)				
E	SE	M92612	M92612 - GROVE MEDICAL CENTRE (Health and Beyond - inc Grove, Caerleon (PMS) and All Saints & Rose Villas)	13,145
E	SE	M92647	M92647 - BRADLEY MEDICAL CENTRE	2,985
E	SE	M92003	M92003 - DR SURYANI	1,716
E	SE	M92654	M92654 - BRADLEY CLINIC PRACTICE (MGS)	7,660
E	NE	Y02736	Y02736 - SHOWELL PARK HEALTH CENTRE	4,882
E	NE	M92609	M92609 - ASHFIELD ROAD SURGERY	5,294
E	NE	M92039	M92039 - DR ST PIERRE-LIBBERTON	6,443
E	NE	M92009	M92009 - PRESTBURY MEDICAL PRACTICE	14,221
E	NE	M92013	M92013 - WODEN ROAD SURGERY	6,787
Total				63,133
Medical Chambers 1 (Group Lead Dr K Ahmed)				
T	SE	Y02757	Y02757 - BILSTON URBAN VILLAGE MEDICAL CENTRE	7,069
E	SE	M92015	M92015 - IH MEDICAL (DRS PAHWA)	2,354
E	SE	M92627	M92627 - DR SHARMA	3,204
E	SE	M92040	M92040 - MAYFIELD MEDICAL CENTRE	7,892
E	SE	M92024	M92024 - PARKFIELD MEDICAL CENTRE	13,689
E	SW	M92043	M92043 - PENN SURGERY	5,498
T	SW	Y02636	Y02636 - INTRA HEALTH LIMITED (PENNFIELDS)	4,873
	SW	M92640	M92640 - THE SURGERY - DR WHITEHOUSE	2,410
E	SW	M92010	M92010 - LOWER GREEN HC- TETTENHALL	12,134
E	SW	M92008	M92008 - CASTLECROFT MEDICAL PRACTICE	12,447
E	NE	M92022	M92022 - DR RAJCHOLAN	4,171
E	NE	M92041	M92041 - PROBERT ROAD SURGERY	4,621
E	NE	M92014	M92014 - FOWLER	1,991
E	NE	M92001	M92001 - POPLARS MEDICAL CENTRE	3,611
E	NE	M92004	M92004 - PRIMROSE LANE PRACTICE	3,040
T	NE	M92026	M92026 - DR BILAS - Ashmore Road	3,836
Total				92,840
Vertical Integration RWT				
E	SW	M92007	M92007 - LEA ROAD MEDICAL PRACTICE	6,681
E	NE	M92002	M92002 - ALFRED SQUIRE MEDICAL PRACTICE	8,331
E	SE	Y02735	Y02735 - ETTINGSHALL MEDICAL CENTRE	4,457
E	SW	M92042	M92042 - WEST PARK SURGERY - DRS SIDHU KOODARUTH	3,539
E	SW	M92044	M92044 - DRS DE ROSA & WILLIAMS	4,325
E	SW	M92011	M92011 - PENN MANOR MEDICAL PRACTICE	11,496
E	SW	M92006	M92006 - COALWAY ROAD MEDICAL PRACTICE	5,036
E	SW	M92028	M92028 - THORNLEY STREET MEDICAL CENTRE	10,212
Total				54,077

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The Wolverhampton Context (1)

- Wolverhampton is an area with ca. 250,000 residents living within the city boundary
- There is one Local Authority
- There is one Mental Health Trust which also serves other parts of the Black Country (BCPFT)
- There is one integrated Acute and Community services provider which also provides acute services to other areas of the Black Country and Staffordshire
- The Acute Trust also provides tier 2 specialised services
- There are currently 42 GP practices
- There is a long history of collaborative working across the city
- In 2012 Community Services, as part of the TCS programme, migrated from the PCT to the Acute Trust.
- Also as part of TCS, Mental Health & Learning Disability services migrated to Black country Foundation partnership trust - a specialist Mental Health provider.
- The PBR tariff for Acute services and Block arrangements for Community and Mental Health have provided a disincentive for the local health economy to move services closer to peoples' homes
- Over the years the 'connectivity' between GP Primary Care and Community Services has suffered as well as the connectivity between GPs and 2^o care consultants (leading to fragmentation of services and care pathways)
- Social Care which is integral to many health care pathways has also suffered from often working in isolation from health services.
- Primary Care has been historically under-invested in Wolverhampton

The Wolverhampton Context (2)

- Around 20% of all practices in Wolverhampton are either single/double handed and up to 16/17 there had been little history of practice collaboration
- Great strides have been made over the last two years with regard to collaborative working in primary care. Following some recent movements, all but two practices are aligned to collaborative GP groupings. These are:
 - Primary Care Home 1: 8 practices, 60k list size
 - Primary Care Home 2: 8 practices, 55k list size
 - Medical Chambers: 15 practices, 77k list size
 - VI (Vertically integrated) practices: 9 practices, 61k list size*
 - Unaligned: 2 practices, 23k list size
- Over the last 3-4 years good working relationships have been developed with the LA and the BCF has been a positive vehicle for community based delivery over the past three years

*1 practice leaving VI asap, list size 8k

The Wolverhampton Context (3)

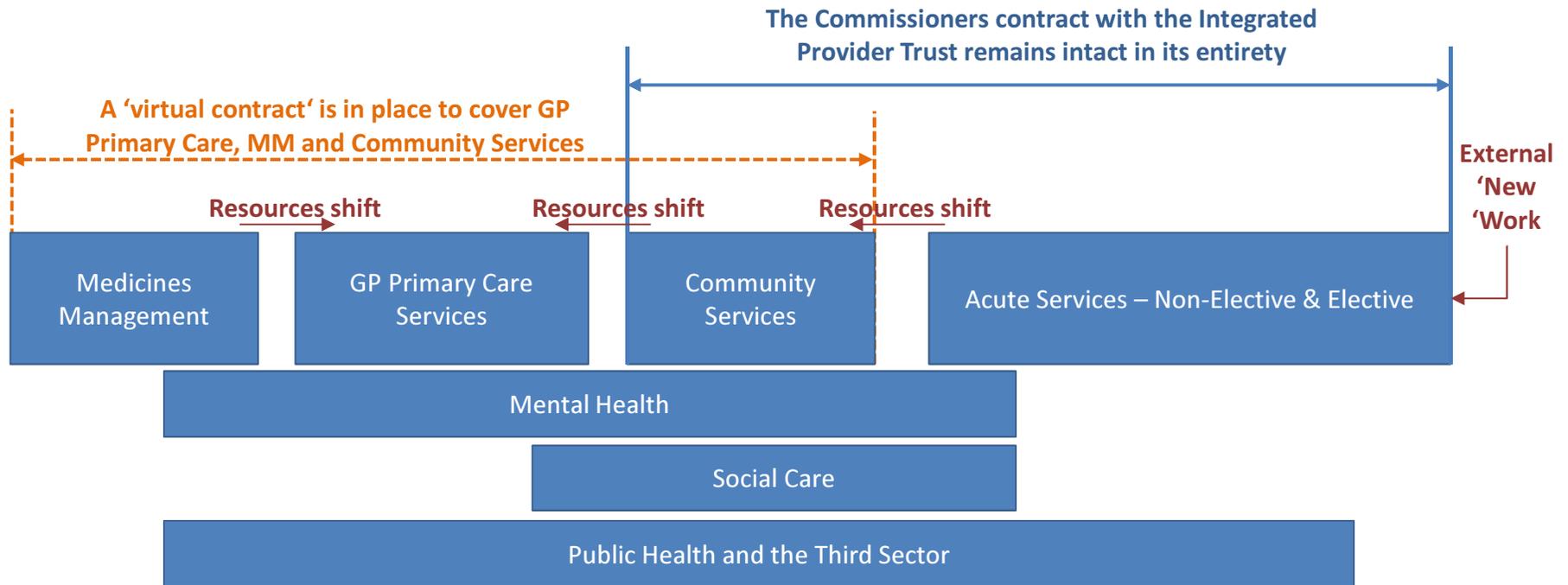
- The core patient centred strategy jointly signed up to by all organisations in Wolverhampton is to deliver care closer to home where appropriate and to invest in capacity and capability in Primary and Community care settings. This is informed not simply by national policy but also by Public commissioning engagement events held by the CCG over recent years.
- There is substantial and strong collaborative working programme already in place and the Better Care Fund over the past three years has been the vehicle for delivery for :
 - MDTs in community/primary settings
 - Joint Health and Social Care teams to support admission avoidance as well as facilitating supported post acute home living
 - Mental health planned and unplanned Care pathways
- The intent of our local programme of work is to create and ‘architect’ the environment where a collaborative solution is the answer – this means working with our GP practices and with provider colleagues and the local authority to co-design the local solution
- There is no appetite locally for adversarial relationships but rather for developing and working in a high trust environment
- We are clear this may mean difficult conversations are needed as we progress but this will only further cement a joint solution

The Wolverhampton Local Model – Integrated Care “Alliance”*

- The local model will deliver the agreed core strategy which must be realised in a financially constrained environment, in which all parties ‘buy into’ the common delivery and financial challenge
- The voice of the Wolverhampton citizen and patient will be central
- In order to deliver the core strategy there will need to be a different contracting and payment mechanism agreed with providers
- The model recognises that the Acute Trust is having ever increasing demands placed on it from neighbouring health economies (Staff, Telford & Shropshire, Walsall) as well as increasing activity from Spec Comms. Therefore the Trust needs room to expand and appropriate activity therefore has to shift to Primary and Community Care settings
- As activity shifts resource needs to shift
- The Transformation programme to the 'ICA' in Wolverhampton will allow all of these articulated pressures to be realised

*“Alliance” reflects the developmental stage of the collaboration

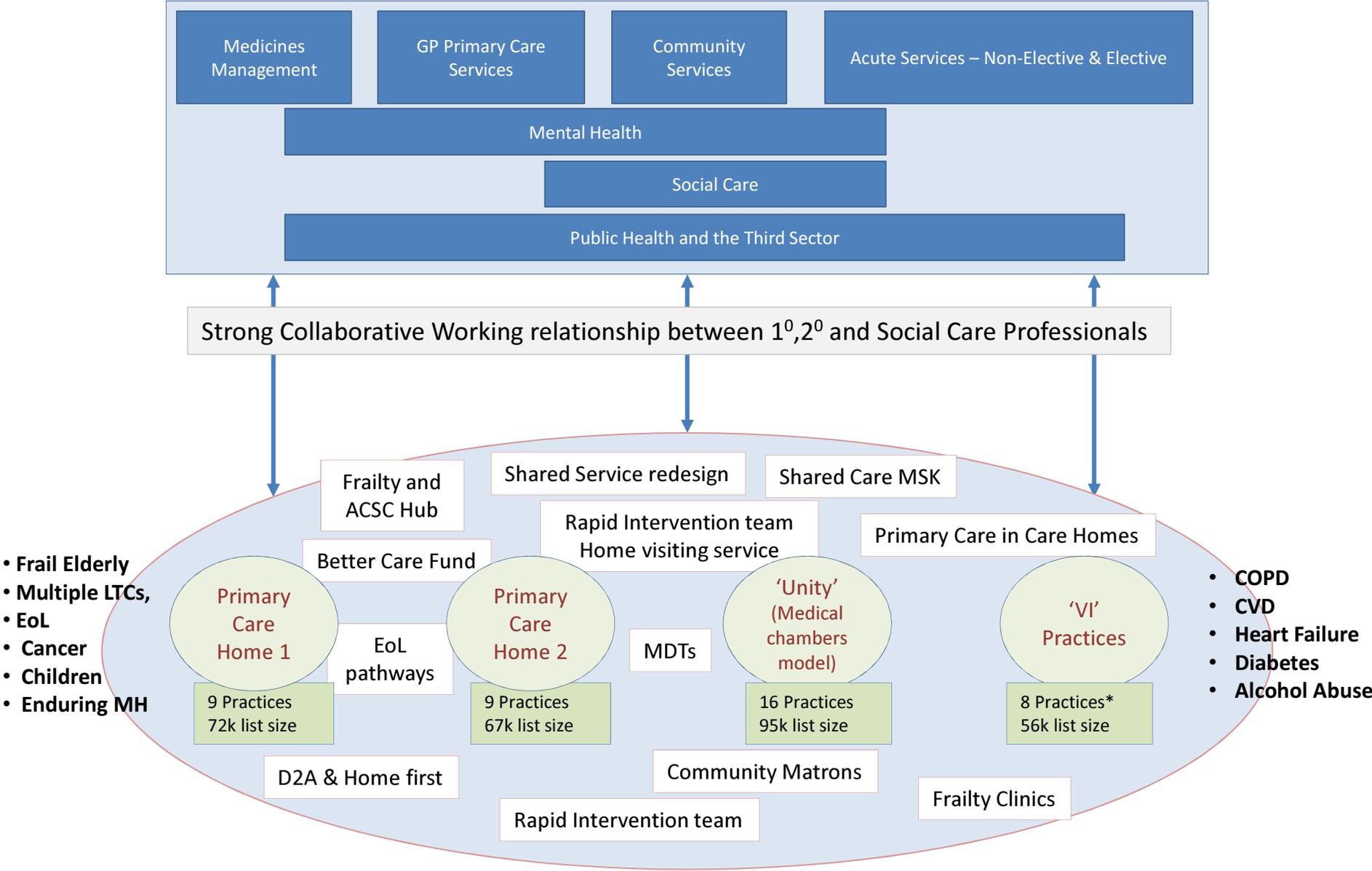
'ICA'– Wolverhampton Place – *Developmental phase*



- The Commissioners contract with the Trust and moves from PbR and Community block to a combined payment mechanism which has 4 'buckets':
 - Block
 - Gainshare
 - Cost and Volume
 - Cost reduction
- In order to 'realise' the shift in resource allocation and services into Community and GP Primary Care, all parties have to work together behind a commonly aligned clinical strategy (Cohorts, Disease groups, Pathways). All parties recognise the co-dependence in the delivery in activity and cost shift
- The virtual contract is run on an open book to create the positive debate and tension for the deployment of resource and staff to realise the activity and resource shift
- In the development stages, the contracting relationship for the Wolverhampton place for MH does not change
- The BCF pool continues to be the vehicle for delivery and shared risk with the LA

Wolverhampton Localities

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Principles of the Wolverhampton 'ICA'

- The Wolverhampton 'ICA' is not a 'procured' hard solution. It is a collaborative approach based on shared vision and clinical alignment
- On 10th May (2017), NHS leaders in Wolverhampton agreed to explore the further development of an accountable care approach. Key principles agreed were:
 - Our strategy must be **clinically led**. The clinical workforce must be deployed effectively across the health system, removing artificial distinctions between “primary” and “secondary” care 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 a **shared governance system** across the parties which will provide system leadership
 - We will provide a clear vision for our system that will be a joint public commitment, and hold ourselves **mutually accountable** for delivering this
 - The alliance partnership 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 funding flows as they do not always incentivise best practice

Leadership and Shared Governance principles

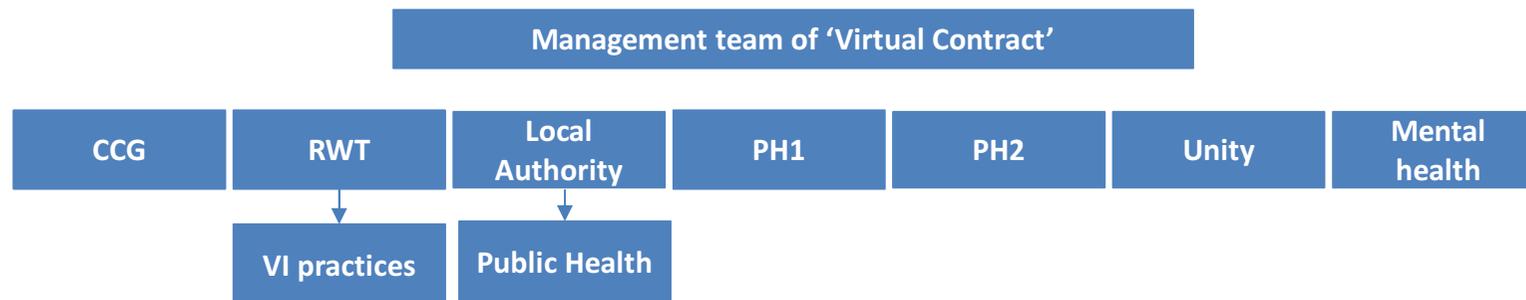
- Our 'ICA' will be clinically led and managerially supported
- The clinical strategy will be informed by clinicians from across primary and secondary care
- Clinicians will be involved in the governance **and** the formation, delivery and ongoing evolution of the clinical strategy
- **All** partners will be part of the cross organisational leadership team
- A management team will be responsible for enacting the vision and plans agreed at system level and for ensuring the open and transparent operation of the virtual contract mechanism
- Patients and public will be involved from the earliest stage

Governance of the Wolverhampton 'ICA'

Building from the broader principles, new governance arrangements that support new ways of working together will be established:

1. Work collegiately to develop coherent plans for the Wolverhampton health and care system
2. Work by consensus. No-one can be over-ruled on any matter. However, once a decision has been made we will all support it
3. Be transparent and open with regard to the challenges we face and have an open book approach to finance, contracting and performance
4. Take no unilateral actions that potentially result in a cost or workload shift to other organisations, without prior review and agreement in the Alliance Leadership Team
5. Commit necessary resources and support to the accountable care alliance, including participation in the Alliance Leadership Team and supporting groups

To support our alliance approach we will formally agree a set of 'joint working principles and behaviours' that we hold ourselves mutually accountable to uphold. We will also develop a dispute resolution process to help us maintain a consistent approach to these principles and behaviours



Financial Management Principles

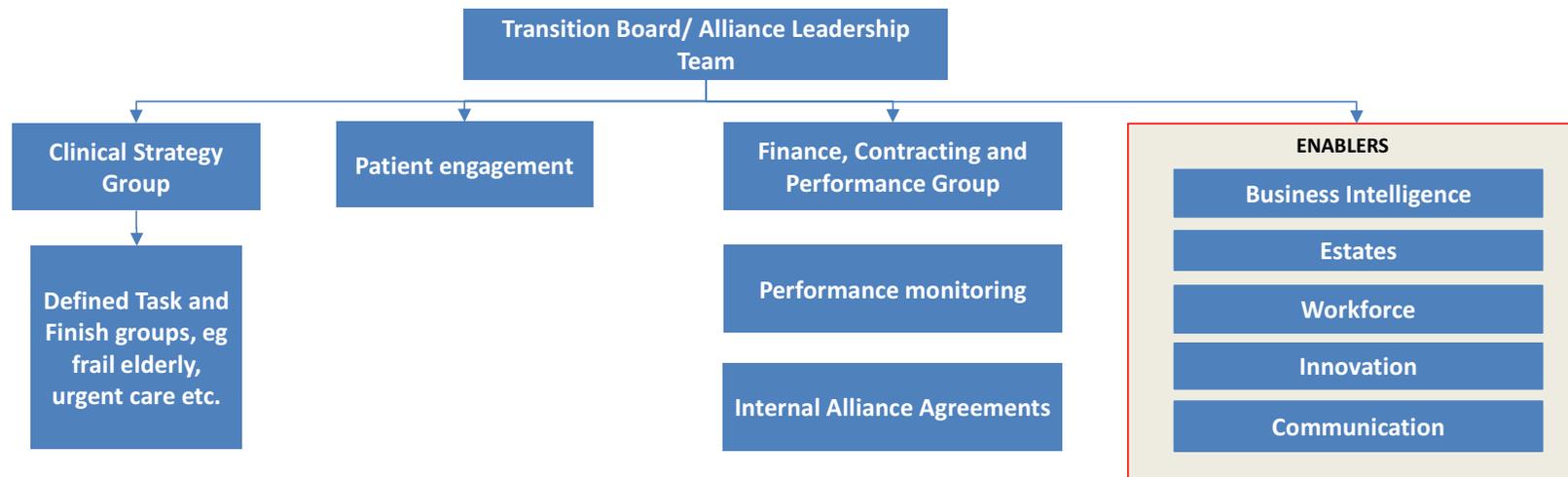
- Strong financial controls will be put in place
- New contracting methodology will be explored as part of a shadow running year 18/19 and fully enacted FY 2019/20
- Organisations will work together on cost savings plans to ensure a financially sustainable system (CIP and QIPP alignment)
- No work will move from Acute to Primary and Community care without appropriate resource
- Organisations, whilst needing to ensure their own financial controls, will also look to ensure joint working enables financial balance across the system **and** we will not work to the detriment of each other

Health Promotion, Prevention and Outcomes

- The system will agree a series of outcome measure at individual, practice group and population level.
- All national require outcomes will be worked to as part of this programme, in addition to the locally agreed outcomes
- Constitutional standards will be upheld
- Where possible health care will be preventative rather than purely reactive and interventional
- Population data and risk stratification will be used to aid clinical delivery and outcomes
- Open culture of data sharing

Transition

- A transition programme structure will be put in place which will address the some of the key enablers to the solution
 - Estates strategy
 - IMT strategy
 - Joint health and social care records
 - Business intelligence



Transition Schedule and Key milestones

Decision making layer - *Decide and delegate*

Supporting layer - *Inform and deliver*

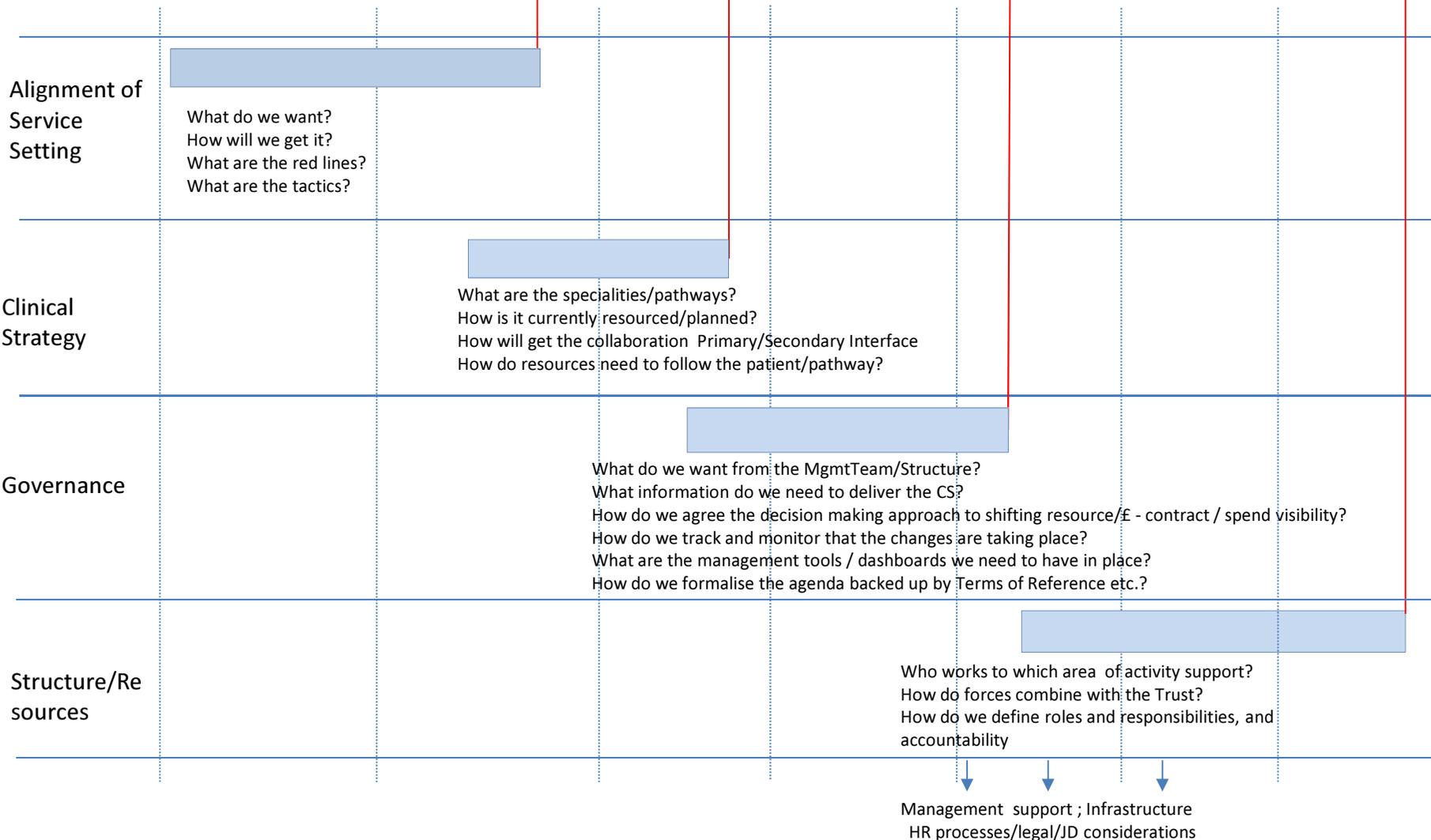
Infrastructure layer - *Enable and 'informatise'*

Milestone 1

Milestone 2

Milestone 3

Milestone 4



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Prospectus for an Accountable Care Alliance in Wolverhampton

August 2017

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This report was prepared by EY. In carrying out its work and preparing this report, EY has worked solely on the instructions of Royal Wolverhampton NHS Trust and NHS Wolverhampton CCG and for the purposes of Royal Wolverhampton NHS Trust and NHS Wolverhampton CCG. Our report may not have considered issues relevant to any third parties. Any use such third parties may choose to make of our report is entirely at their own risk and we shall have no responsibility whatsoever in relation to any such use.

Introduction

We are committed to working together to transform services and improve the health and well-being of the population of Wolverhampton. In the context of rising demand and financial pressures, we believe that change to the NHS is not only desirable but necessary.

On 10th May, lead clinicians from both primary and secondary care and senior managers met and committed to the following principles to pursue a Wolverhampton approach to accountable care:

- 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 a **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

Our proposals for an Accountable Care Alliance are set out in this Prospectus. They are, by necessity, high-level, and much more work will be needed throughout this year to develop our plans further. An outline programme plan is included in this document. The Accountable Care Alliance will bring together the main providers of health and social care in Wolverhampton. We anticipate that members will include:

- NHS Wolverhampton CCG
- Royal Wolverhampton NHS Trust, including the “Vertical Integration” primary care practices whose GMS/ PMS agreements have been sub-contracted to the Trust
- the Primary Care groupings, including Primary Care Home One, Primary Care Home Two, Primary Care Home Three and Unity
- Wolverhampton Local Authority as a commissioner and provider of care, with a particular focus on social care and public health
- Black Country Partnership NHS Foundation Trust which is the mental health service provider in the area. It is expected that this organisation will be integrated with Birmingham Community Healthcare NHS Foundation Trust and Dudley and Walsall Mental Health Partnership Trust in October

The associate members of the Alliance would include the West Midlands Ambulance Service NHS Foundation Trust and commissioners of specialised services.

An Accountable Care Alliance provides a mechanism for us to work together to deliver integrated care that serves our population more effectively. Importantly our proposal includes not only the main commissioners and large providers of services but also will enable our GP practices in their groupings to be a central part of the alliance as we move forward. We believe that true transformation requires a new relationship between all clinicians whether in primary or secondary care alongside the need to overcome organisational sovereignty. This approach will enable us to focus on 'doing the right thing' for the patients and residents of Wolverhampton which in turn will drive high quality, sustainable health and social care services for the future .

The proposal aligns with the direction of the Black Country Sustainability and Transformation Plan that proposes the development of place-based strategies to serve the different communities within the STP footprint.

The proposals represent a statement of our thinking at this point in time and will require further development. We would like to engage with other organisations, with patients and with the broader community, with an intention to introduce the Alliance from April 2018 at a minimum in shadow form.

Signed



Helen Hibbs
NHS Wolverhampton CCG

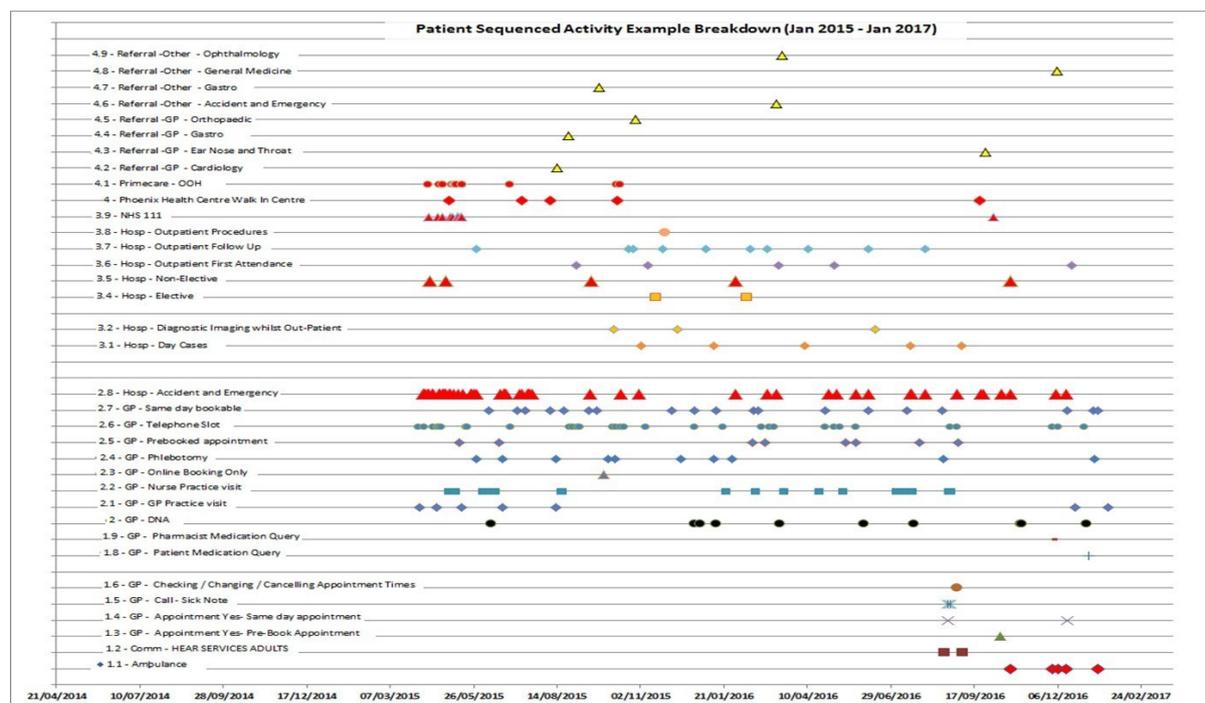


David Loughton
Royal Wolverhampton NHS Trust

Chapter One: The Case for Change

In Wolverhampton we face the challenges of a significant increase in demand for primary and acute care seen over recent years. However, we have not always managed this demand effectively with multiple points of contacts and handoffs in the patient journey. The following illustration sets out the combined interventions for a single patient over a period of time and this example could be replicated many times over:

Figure 1: Breakdown of a single patient's care interventions over a two year period



The episodes represent a failure on multiple levels, including:

- poor experience for patient and family
- patient telling the story on many occasions
- multiple attendances to GP practice
- multiple attendances to hospital
- NHS being reactive in its response
- The cost to the NHS was in excess of £35k over a two year period (just hospital activity subject to national tariff); it does not include the cost of primary care, community health care, social care or drugs

The challenge of managing increased numbers of patients with long-term conditions can only be met through a new model of care with primary and secondary care clinicians and carers working together more effectively to support patients with evidenced based information and interventions where appropriate. As the Chief Executive of NHS England, Simon Stevens, has commented:

“We need to tear up the design flaw in the 1948 NHS model where family doctors were organised entirely separately from hospital specialists and where patients with chronic health conditions are increasingly passed from pillar to post between different parts of health and social services”

We have recognised for some time that our model of care must also adapt from the reactive model that was fit for purpose when infectious diseases were one of the primary health problems to a much more preventative and proactive approach which will be able to meet the increasing needs of a population increasingly living longer with a burden of long term conditions:

- The Office of National Statistics (ONS) estimates that the population of Wolverhampton will grow by 6% from 253,000 in 2014 to 268,000 in 2024. There will be a particularly significant growth in the number of older people. The population aged over 65 in Wolverhampton will increase from 42,000 in 2014 to 47,000 in 2024, an increase of 12%
- As people age, they are more likely to develop long-term conditions. Obesity is an important predictor of long-term conditions a high number of people in the local area are obese. Published public health data¹ reports that 28.5% of the population of Wolverhampton are obese, against a national average of 23%. The Wolverhampton Cabinet Member for Public Health described the situation as “a ticking time bomb²”

The NHS and local authorities will not have the resources to meet this likely increased demand without radical and ambitious transformation. The Black Country Sustainability and Transformation Plan estimates the financial shortfall across the Black Country to be £512m by 2020-21. Local authorities in the area are anticipating a combined shortfall for social care of £188m in the same period.

Why accountable care?

Accountable care is not an end in itself. Instead it is an approach that is designed to alter fundamentally the experience of individual patients, the outcomes for whole populations and to make more effective the use of scarce resources across the health and care community.

Our vision for accountable care encompasses the following:

- A system of community based, integrated services founded on multi-disciplinary working among health and care professionals
- Joined up strategy and delivery across agencies, ensuring improvements in health and wellbeing and the marshalling of wider community resources in this aim
- Sustainable providers that share a common framework of outcomes, objectives and incentives, and hold themselves mutually accountable for their delivery

¹ Public Health profiles for Cannock Chase and Wolverhampton, dated June 2015

² Wolverhampton Express and Star, 21st September 2015

Chapter Two: Our Clinical Model

Introduction

The development of the ACA will unlock new mechanisms for collaboration at a clinical level in a way that has previously not been possible. The ACA will allow us to challenge professional and organisational boundaries and to develop different clinical solutions to meet the needs of the population of Wolverhampton.

Our approach to developing a new clinical model will include the;

- development of a targeted approach to meet the specific needs of the population of Wolverhampton
- development of standardised care models which deliver evidence based interventions across Wolverhampton
- development of locality approaches, delivering integrated care in North East, South East and South West Wolverhampton
- definition of clear benefits cases which would be used to assess and evaluate the impact of the changes and provide an evidence base to support ongoing decision making

This work will build on existing Wolverhampton strategy publications, including the Wolverhampton CCG Primary Health Care Strategy 2016-2020 and the Wolverhampton Health and Care Economy Better Care Fund Plan narrative 2017-2020.

Locality proposition

The ACA proposes to work primarily through three localities; Wolverhampton North East, South East and South West. In developing these localities, we will continue to support the development of primary care at scale. Primary care clinicians in Wolverhampton have already grouped together in three primary care homes, one medical chambers model and one group of vertically integrated practices to work together to support their patients more effectively. As the primary care groupings continue to develop the ACA will be in a position to ensure that they will be well supported by excellent community health services, working closely with social care as well as enabling seamless transition to and from secondary care services and advice where this is required.

This model ensures the patient is at the centre of service provision. An emphasis will be placed on prevention, self-management, healthy lifestyles, early identification and intervention in those at risk of developing long term conditions. In the cohort of patients who require more services proactive case management, regular medication review and education will be available to provide navigation and support and ensure that people are helped to stay as active and fit as possible for as long as possible. This proposed way of working aligns closely with and builds on the current direction of community neighbourhood teams as set out in Wolverhampton's Better Care Fund plan.

Figure 2: Community Neighbourhood Teams as set out in the Wolverhampton Better Care Fund



Stratified Care Model

As well as addressing access to high quality health and care services, addressing lifestyle, environmental and other determinants of health is also vital to improving health and wellbeing. We recognise that we need to enhance our care model so that it focuses on health promotion and primary and secondary prevention to address the root causes of ill health. As an ACA we have a real opportunity to achieve this in a way that as previously not been possible. Ensuring that our care models are stratified will ensure that resource is targeted at those most in need whilst those with lower needs are empowered to self-manage where appropriate. This way of working will provide us with solutions that are sustainable, cost effective and offer the quality of care and support the population of Wolverhampton require.

A stratified care model at system level means designing a series of aligned interventions and services across the system to meet the specific needs of cohorts of individuals across a disease or clinical grouping.

The illustration below provides an example of a stratification for long term conditions. From this stratification the ACA will develop an understanding of;

- The cohort of patients at each level
- The current service model and the associated resources, funding and costs
- Comparative clinical outcomes for the population

Figure 3: Example of stratification of population for long term conditions

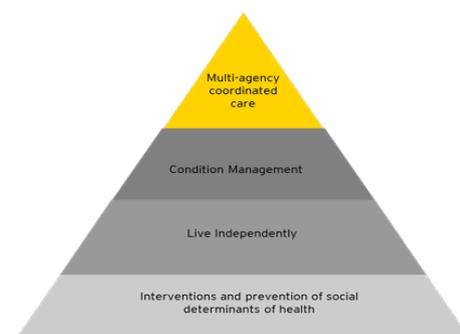
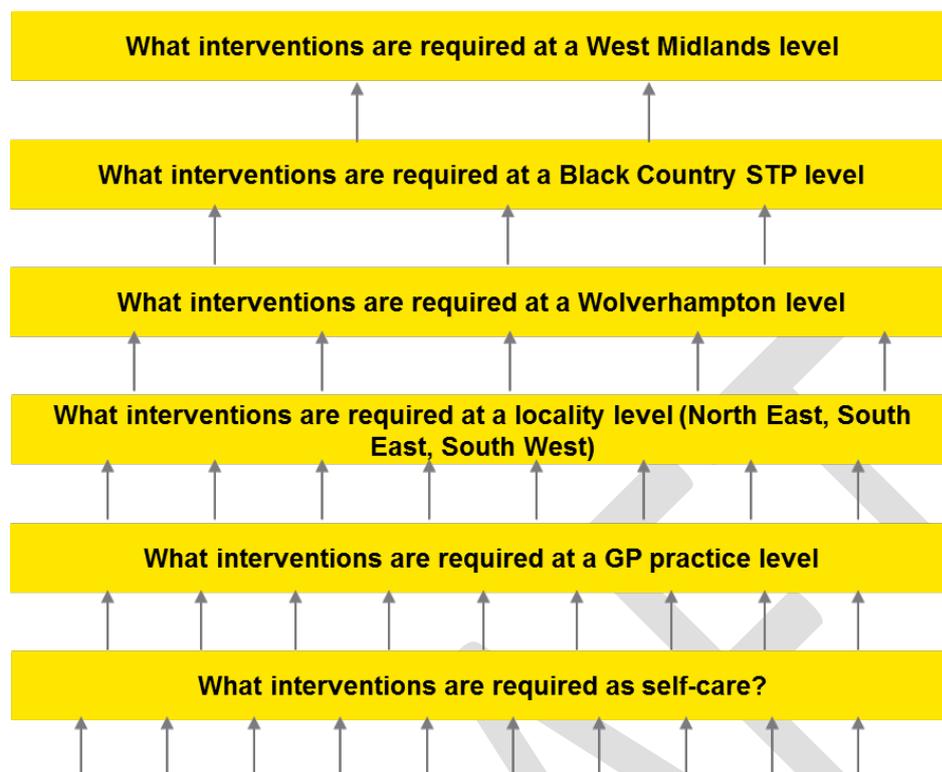


Figure 4: Providing services to address patient needs at different levels of population



In developing the stratified system response, clinical leaders from across Wolverhampton will work with patients, other service providers and key stakeholders to understand the needs of the population and improve the health and well-being of the population by radically redesigning services. We will deploy evidence from the Joint Strategic Needs Assessment and Better Care Better Value indicators to support this work.

Potential clinical groupings we might prioritise in redesigning the clinical model include:

- The Frail Elderly, which would include the treatment of dementia
- End of Life care, enabling patients to die with dignity in a place of their choice
- Patients with multiple long-term conditions (LTCs) including support for patients identified with LTCs adversely impacted by poor mental health and wellbeing
- City wide action plan on delivering Mental Health Five Year Forward view recommendations
- Vulnerable adults, including support with learning disabilities
- Children, recognising the need for effective interventions to promote life-long physical and mental wellbeing. Wolverhampton is a significant outlier for paediatric acute stays of three days or longer
- Continued progress on Public Health improvement priority programmes particularly Infant mortality and CAMHS services

Definition of benefits

We believe our approach will support the following benefits and will use these benefits as a means to assess progress.

Table 1: Proposed benefits of the clinical model

Area	Proposed metrics
Improved Health outcomes	<ul style="list-style-type: none"> Reduction in health inequalities Prevention of long term conditions Improved management of long term conditions with improved outcomes for patients Early identification and management of both children and adults with incipient and enduring mental health challenges including dementia Reduction in early deaths from cancer Improved maternal and infant health Increased healthy life expectancy
Improved Quality of Care	<ul style="list-style-type: none"> Reduction in A&E attendances Reduction in Non Elective Admissions Improved access to primary care, and increased satisfaction with primary care Patient satisfaction with the end-to-end care experience Staff perception at all levels that the quality of care in their area has got better over the previous twelve months
More Sustainable local health and care economy	<ul style="list-style-type: none"> Improved financial performance against projected shortfall Reduction in identified workforce shortages

Chapter Three: Leadership and Governance of the Accountable Care Alliance

Introduction

The aim of the ACA is to develop a coherent system of care for the population of Wolverhampton that delivers high quality outcomes. The ACA will hold itself to account for the delivery of those outcomes and will pool local capacity and capability to ensure the outcomes are delivered.

Status of the ACA

The ACA is a voluntary alliance between organisations which remain sovereign. Under ACA arrangements, existing contractual relationships remain in place, utilising current contracts until it is appropriate to move to new contractual forms being developed by NHS England. However, the ACA partners agree to work together and to common cause, allowing those existing contracts to be delivered and managed differently moving away from the perverse incentives of PBR and ensuring that funding and investment decisions can be made which move resource to where it is most required to deliver the most effective care. This agreement will be underpinned by an Alliance Agreement, based on the template and documentation set out by NHS England

Role of the ACA Leadership Team

An ACA Leadership Team will oversee the work of the Alliance. The Alliance Leadership Team will be made up of the leaders of the member organisations and sets the direction for the ACA. Our proposal is that the existing Transition Board in Wolverhampton will be amended to become the Alliance Leadership Team. Associate members of the ACA would be invited to attend meetings.

Formal evidence! (³ & ⁴) tells us that integrated care needs to be underpinned by the right behaviours- those that support collaboration and shared decision making. This is as true for leadership as it is for front line clinical teams. We therefore will devote time and energy to agree the way to which we want to work together as well as the things we jointly want to achieve.

The Alliance Leadership Team will work by the following principles:

1. Work collegiately to develop coherent plans for the Wolverhampton health and care system
2. Work by consensus. No-one can be over-ruled on any matter. However, once a decision has been made we will all support it
3. Be transparent and open with regard to the challenges we face and have an open book approach to finance, contracting and performance
4. Take no unilateral actions that could result in a cost or workload shift to other organisations, without prior review and agreement in the Alliance Leadership Team

³ Evans J, Daub S, J Goldhar et al, "Leading Integrated health and social care systems: perspectives from research and practice" in Healthcare Quarterly, 2016.

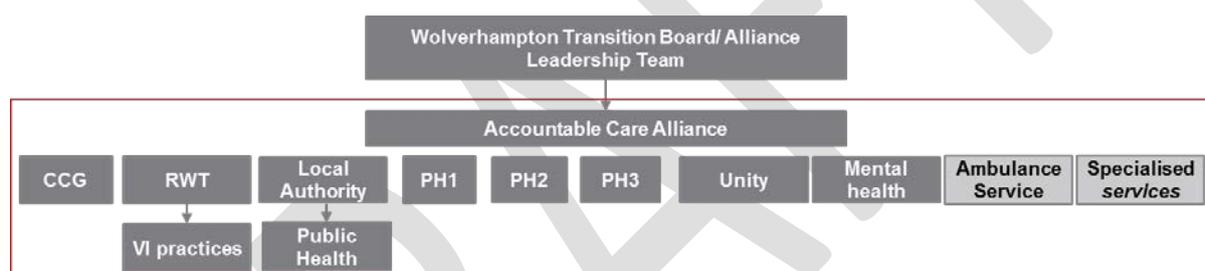
⁴ Glasby J, Dickinson H and R Miller. "Partnership working in England – where we are now and where we've come from" in International Journal of Integrated Care, 2011; 11

5. Commit necessary resources and support to the ACA, including participation in the Alliance Leadership Team and supporting groups

We recognise that collegiate working presents challenges and is not straightforward when difficult decisions need to be made. To support our alliance approach we will formally agree a set of 'joint working principles and behaviours' that we hold ourselves mutually accountable to uphold. We will also develop a dispute resolution process to help us maintain a consistent approach to these principles and behaviours. The precise form of resolution is still to be developed, but it is likely to involve Non-Executive Directors in a mediation role.

The proposed partners of the ACA are shown in figure 5 below. It is proposed that those providers and commissioners focused solely or mainly on the population of Wolverhampton are full members of the alliance. Other organisations that work across a larger footprint (such as the ambulance services and commissioners and providers of specialist services) would be associate members of the ACA.

Figure 5: Wolverhampton Transition Board and the member organisations



Developing local capacity for accountable care

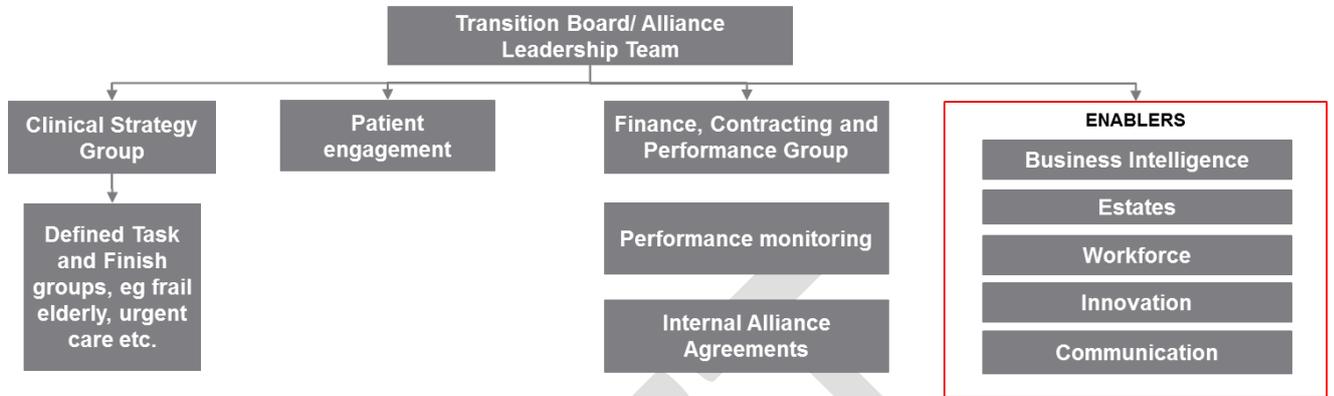
To deliver its agenda, the ACA will require a leadership and management capacity. This will be created by sharing resources across the participating members. We will bring the expertise of the local health and care economy to bear, including primary care clinicians who will have a pivotal role to play.

The following functions to support the work of the ACA are proposed (and set out in Figure 6):

- A Clinical Strategy Group brings together clinicians from different sectors and specialties including public health and mental health to set the strategic direction of the ACA. The Clinical Strategy Group would establish a combined design and delivery team, supported by task and finish groups, as required, to work through defined issues
- A patient representation function. Patient engagement is fundamental to the development of the ACA and its clinical proposals. Engagement is particularly important in the context of competition being replaced by collaboration between providers. 'Voice' as a key input in governance is important
- A separate Finance, Contracting and Performance Group would identify how the clinical strategy would be enabled, overseeing contracting with the Commissioner and between the provider organisations, and monitoring performance

- Separate defined groups would look at defined aspects of service delivery which support a developing clinical model. These might include business intelligence, estates, workforce, innovation and communication

Figure 6: Supporting structures for the ACA



The supporting infrastructure of the ACA will be delivered by staff from the member organisations. This may require some re-prioritisation of existing work programmes to generate sufficient capacity and the diverting away from lower value activities such as contract management. In the transition period some double running will be required.

Integration of the ACA into existing local governance

The ACA is well aligned to the Black Country STP as well as other local and national governance.

The Black Country STP proposes a series of place-based commissioning plans. The ACA will develop proposals for Wolverhampton, including Wolverhampton’s contribution to reducing the projected STP financial deficit. The ACA will contribute to the development of commissioning arrangements at the Black Country level, including mental health and specialist acute services.

In the alliance model Wolverhampton CCG will retain its statutory role as a commissioner but as part of the ACA it will work in an open and transparent way with the providers within the alliance (although the formalities of the commissioner: provider split will be observed where it is necessary and appropriate for that to occur).

Chapter Four: Financial arrangements to support the delivery of the clinical model

Introduction

A significant advantage of accountable care arrangements is that they enable different elements of the NHS to work together within a shared financial envelope and facing common incentives. The ACA will ensure that resources are focused on the most clinically and cost effective settings.

Under the current arrangements, acute providers may be financially destabilised if a significant proportion of their activity is transferred to primary and community care without a coordinated restructuring of hospital services, even when it is best for patients. Working within a single, unified funding and decision making framework encourages the transfer of activity to the most appropriate setting, avoiding expensive specialist care by intervening early and co-ordinating services across care boundaries.

This section sets out how we will use new financial mechanisms to support the delivery of the clinical model, creating the right incentives across the system

Funding accountable care

Our approach to funding will be underpinned by the development of a clear view of the 'Wolverhampton pound'. The ACA will oversee the use of our community's financial resources to get the very best value for every pound spent. The alliance will collectively review the commissioning allocation and service providers cost base in respect of commissioned services

While community services are already subject to a block contract, acute hospital activity is governed by PBR. This current mix of contract types is not optimal and does not incentivise the clinical model that we want to provide. The Alliance will use the flexibilities afforded to successful health economies by NHSE and NHSI and will actively consider a range of payment mechanisms for providers to incentivise integrated care. These include the wider use of block contracts and risk sharing for Non Elective activity.

GMS/ PMS services will remain as currently contracted unless GPs choose otherwise, although the aim is for new resources to be directed to primary care via 'enhanced service contracts' and other initiatives including:

- QOF+ Frameworks;
- The development of Practice Staff including Managers and Nurses;
- Practice resilience support;
- Supporting the deployment of resources to different primary care practice delivery models.
- The implementation of quality contracts, where applicable, to provide more equitable services that provide a higher standard of care and enable efficiencies to allow investment in primary and community care.

We will look to incentivise good practice through the finance and contracting system. Quality outcomes agreed by the Clinical Strategy Group will be incentivised through a quarterly payment (a revised CQIN).

While PbR will be suspended in favour of block contracting for some agreed services, we will continue to monitor activity for the purposes of quality and planning (and also for 'external trading' beyond the ACA population).

As services are transformed, we will understand the impact on activity and cost across the system and adjust contracts accordingly in the spirit of gain loss sharing. This will take account of how quickly costs can be released and staff redeployed as appropriate.

We will enable the delivery of our transformation priorities through a series of business cases; each of which will set out clearly the agreed:

- Proposed service change and benefit to patients
- Impact on activity by setting
- Impact on delivery costs by setting and provider
- Any stranded costs and/or semi-variable costs with a plan as to how to address
- Any pump-prime resources required
- Impact on current contracts
- ROI and payback period

Financial Governance

The alliance will collectively review the commissioning allocation and service provider cost base in respect of commissioned service. A Finance, Contracting and Performance Group will bring together ACA Directors (for example, Directors of Finance and Contracting). It will establish mechanisms to transfer resources between and within organisations to facilitate initiatives designed in the Clinical Strategy Group. It is proposed that a set of principles are agreed in advance to support a consistent approach and to avoid, where possible, disputes. These will be fully developed by the group but are likely to include agreements over:

- Calculation and recalibration of block contracts (for example, taking account of annual efficiency requirements including QIPP and CIP)
- Agreement of costs
- Agreement on the timing for the removal of semi-variable and stranded costs
- Agreement of funding for double running/pump priming alternative service models
- Data sharing to support financial transparency within the ACA
- How to work with 'open book accounting'
- How to work towards a single control total for Wolverhampton

Improving value for money for taxpayers

The ACA will focus on getting better value for every Wolverhampton pound. We expect to deliver improvements in value for money by:

- Shifting activity to clinically appropriate and lower cost settings
- Making better use of shared facilities, people and assets across the ACA
- Reducing costs associated with less value adding transactions
- Removing unnecessary health care costs through better upstream prevention

However, we also recognise that the ACA will require initial investment to get up and running. We will explore opportunities for additional funding with regulators and would be willing to explore matching this with local money if we are permitted to access CCG non-recurring money.

Chapter Five: Next Steps

Introduction

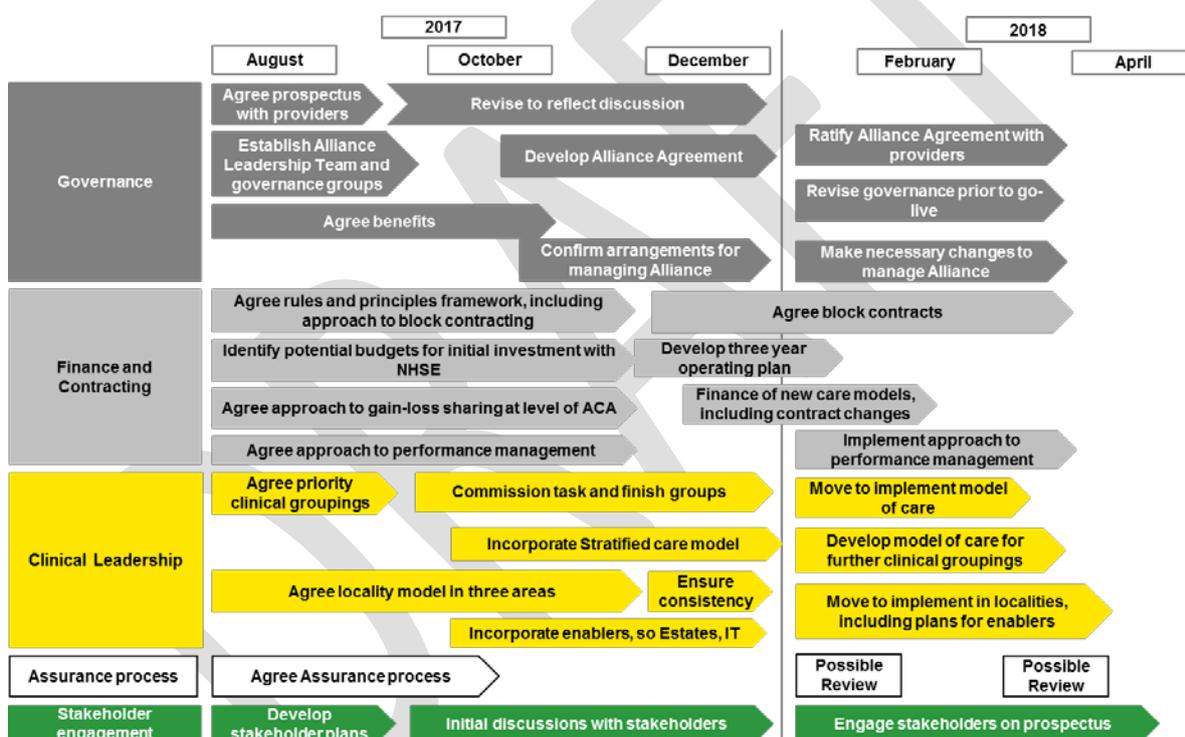
Our work programme is an ambitious one. Our challenge is not just to establish a new Accountable Care Alliance arrangement, but to link it to the ongoing delivery of a clear clinical model. Our intention is that the ACA should be in place from 1st April 2018.

We recognise that there is more work to do to turn this prospectus into a concrete plan for delivery. We aim to carry out this preparation work with significant involvement of the ACA stakeholders and through the implementation of a programme plan. We aim to establish the Alliance Leadership Team and its supporting groups by early autumn to steer subsequent progress.

Proposed implementation road-map

A high-level plan is set out below, setting out the main steps leading to implementation in April 2018. A full programme plan is available as a separate document.

Figure 7: High-level plan for implementation in April 2018



We will work through a number of issues to feed into the emerging Alliance Agreement. These would include the rules and principles framework and an approach to block contracting; potential budgets for initial investment with NHS England and an approach to gain-loss sharing at the level of the ACA. Our expectation is that the Alliance Agreement can be agreed before the end of 2017, with ratification through ‘governing bodies’ in early 2018.

We will also be working through how best to manage the Alliance. This prospectus sets out initial proposals for benefit indicators and these will be discussed further with local and national stakeholders. We will agree an approach to performance management using those indicators. We will establish what supporting infrastructure is required to manage the Alliance before the end of 2017, so that any changes can be made in the period leading to implementation.

Our clinical community will be developing proposals for integrated care in localities working with patients, social care, voluntary groups and the broader community. The three localities will be North East, South East and South West Wolverhampton. The model of care for the localities will be flexible and enable bottom-up implementation that takes account of local contexts.

As the locality proposals come together, we will consider how to develop an integrated clinical workforce in Wolverhampton, change buildings to deliver enhanced services in localities and exploit opportunities for digital transformation.

In parallel, the Clinical Strategy Group will prioritise clinical groupings where new models of care are required to support progress against the proposed ACA benefits. .

Task and Finish Groups will then define the new models of care for those clinical groups. Business cases will set out how resources should be moved to support the new pathways and what changes are required to contracts.

The ACA will produce or commission supporting analysis of the potential opportunities arising from an integrated clinical workforce, from changes to our combined estate (including the potential role of service hubs) and from digital transformation and service innovation. This analysis will feed into the development of costed locality proposals.

The Finance, Contracting and Performance Group will consider potential means to invest in service models, which will include the redeployment of existing resources alongside any additional funding which we are able to secure for transformation. We would expect to work through these issues in Autumn 2017, to inform the development of a three year operating plan for early 2018.

Engagement

Our proposals can only succeed if we take patients, clinicians, staff and the broader community on the journey. We understand that it will be essential to foster community support and even enthusiasm for our new way of working, and this will be important in explaining the consequences of a transfer of resource from acute to primary care.

The following table provides an initial stakeholder analysis. The leaders of the member organisations will agree a common approach to managing the stakeholders with individuals owning particular relationships.

Table 2: Main stakeholders

Group	Stakeholder	Potential issues
Commissioners	Other CCGs (esp Cannock Chase, Dudley CCG, Sandwell and West Birmingham CCG, South East Staffordshire and Seisdon Peninsula CCG, Walsall CCG)	Would continue to commission services from RWT but be outside the ACA – this may present consistency challenges as new models are introduced in Wolverhampton
	NHS England specialised commissioning	RWT is a significant provider of specialised services, which need to be integrated into new pathways
	Wolverhampton local authority	Commissioner of social care and of public health services will need to be engaged by the ACA
Regulators	NHS England	Would need to approve the ACA and the financial approach
	NHS Improvement	Would need to approve the ACA and the financial approach
Providers	Other acute trusts	Consider impact on patient flows of new Wolverhampton pathways
	Other mental health trusts in the West Midlands	Mental health trusts are working to create an integrated organisation. Service proposals should align with the emerging Wolverhampton service model
	Other community health providers in the West Midlands	Engaging with other community providers is opportunity to share best practice. There is a need for some alignment across the Black Country
Patients and the community	Healthwatch	Important to engage and invest in patient involvement in developing new service models
	Local groups	Patient input will be essential to shape proposals
Clinicians and staff	Clinicians	Important to secure buy-in to the concept and reality of the unified clinical workforce across Wolverhampton
	Staff groups	Staff will want to contribute and engage in new service models and to understand implications for them
	Trade Unions	Will want to be involved in earliest stages, considering the potential implications for staff
STP	STP Leadership	Need to align place-based commissioning proposals to the continuing development of the STP.

Assurance process

Our proposals for a virtual accountable care organisation need to be developed with our regulators

We would envisage that this prospectus forms the basis of a substantial discussion with NHS England about the proposal for an alliance agreement. Subject to their approval, we would then develop a more detailed proposal for December 2017.

We will agree an assurance process with them during which we would expect to work through the following questions:

- Will the service model produce net benefits?
- Are the provider and commissioner capable of managing the contract?
- Have the consequences for other providers been thought through?
- What are the risks associated with the ACA and what is the mitigation plan

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				IMPACT OF RWT PROPOSAL				IMPACT OF RWT PROPOSAL with CCG Adjustments				
18/19 Plan Activity Annual	Plan Price Annual	% of contract	RWT Proposed treatment	Additional Activity			Difference to plan (negative = CCG gain Positive = RWT gain)	Additional Activity			Difference to plan (negative = CCG gain Positive = RWT gain)	CCG Proposed treatment
				% of plan paid	MR	Total Payment		% of plan paid	MR	Total Payment		
				100%	70%			100%	50%			
Segment 1 - Risk/Gainshare	366,009	£60,342,915	37%	£60,342,915	£0	£60,342,915	£0	£60,342,915	£0	£60,342,915	£0	
Elective	2,999	£9,273,132		£9,273,132	£0	£9,273,132	£0	£9,273,132	£0	£9,273,132	£0	If below 95% "floor" then CCG only pay at 50% MR. CCG will pay for activity above plan at 50% MR
Elective XBD	509	£124,171		£124,171	£0	£124,171	£0	£124,171	£0	£124,171	£0	
Non Pbr Other	43,249	£3,224,169		£3,224,169	£0	£3,224,169	£0	£3,224,169	£0	£3,224,169	£0	
OP First	76,961	£11,801,483		£11,801,483	£0	£11,801,483	£0	£11,801,483	£0	£11,801,483	£0	
OP Follow-up	167,268	£11,615,277		£11,615,277	£0	£11,615,277	£0	£11,615,277	£0	£11,615,277	£0	
OP Procedures	52,558	£7,186,056		£7,186,056	£0	£7,186,056	£0	£7,186,056	£0	£7,186,056	£0	
PSD	22,465	£17,118,627		£17,118,627	£0	£17,118,627	£0	£17,118,627	£0	£17,118,627	£0	
				100%	0%			100%	0%			
Segment 2 - Cost Reduction	3,094	£9,045,150	6%	£9,045,150	£0	£9,045,150	£0	£9,045,150	£0	£9,045,150	£0	
Drugs & Devices	2,754	£6,005,920		£6,005,920	£0	£6,005,920	£0	£6,005,920	£0	£6,005,920	£0	Block contract - RWT takes all risk/ reward for costs above/ below plan in year 1
Stepdown	340	£402,781		£402,781	£0	£402,781	£0	£402,781	£0	£402,781	£0	
<i>Biosimilar drugs - 17/18 cost for model purpose</i>		£2,636,449		£2,636,449	£0	£2,636,449	£0	£2,636,449	£0	£2,636,449	£0	
				100%	0%			100%	0%			
Segment 3 - Fixed Cost	31,529	£52,243,808	32%	£52,243,808	£0	£52,243,808	£0	£52,243,808	£0	£52,243,808	£0	
Non Pbr Other	4,550	£1,763,478		£1,763,478	£0	£1,763,478	£0	£1,763,478	£0	£1,763,478	£0	Block contract including MRET and readmissions returns
Non-Elective	22,815	£49,484,074		£49,484,074	£0	£49,484,074	£0	£49,484,074	£0	£49,484,074	£0	
Non-Elective XBD	4,164	£996,256		£996,256	£0	£996,256	£0	£996,256	£0	£996,256	£0	
MRET		£519,000		£519,000	£0	£519,000	£0	£519,000	£0	£519,000	£0	
Readmissions		£850,224		£850,224	£0	£850,224	£0	£850,224	£0	£850,224	£0	
MRET		£519,000		£519,000	£0	£519,000	£0	£519,000	£0	£519,000	£0	
Readmissions		£850,224		£850,224	£0	£850,224	£0	£850,224	£0	£850,224	£0	
				90%	0%			90%	0%			
Segment 4 - fixed income	-	£7,373,630	5%	£6,994,411	£0	£6,994,411	£-379,219	£6,994,411	£0	£6,994,411	£-379,219	
Block	-	£3,581,445		£3,581,445	£0	£3,581,445	£0	£3,581,445	£0	£3,581,445	£0	Standard block contracts and CQUIN at a 90% floor
Acute CQUIN	-	£3,792,185		£3,412,967	£0	£3,412,967	£-379,219	£3,412,967	£0	£3,412,967	£-379,219	
				100%	0%			100%	0%			
Segment 5 - Cost and Volume	606,868	£34,412,215	21%	£34,412,215	£0	£34,412,215	£0	£34,412,215	£0	£34,412,215	£0	
A & E	85,000	£11,174,227		£11,174,227	£0	£11,174,227	£0	£11,174,227	£0	£11,174,227	£0	Normal Pbr Mechanism
Critical Care	1,834	£2,114,572		£2,114,572	£0	£2,114,572	£0	£2,114,572	£0	£2,114,572	£0	
Direct Access	509,268	£4,879,246		£4,879,246	£0	£4,879,246	£0	£4,879,246	£0	£4,879,246	£0	
Maternity Pathway	6,939	£6,254,152		£6,254,152	£0	£6,254,152	£0	£6,254,152	£0	£6,254,152	£0	
Births	3,701	£9,945,799		£9,945,799	£0	£9,945,799	£0	£9,945,799	£0	£9,945,799	£0	
Births XBD	126	£44,219		£44,219	£0	£44,219	£0	£44,219	£0	£44,219	£0	
Grand Total	1,007,500	£163,417,718	100%	£163,038,500	£0	£163,038,500	£-379,219	£163,038,500	£0	£163,038,500	£-379,219	
<i>Non Recurrent funding</i>	-	£1,107,000		£1,107,000	£0	£1,107,000	£0	£1,107,000	£0	£1,107,000	£0	
TOTAL ACUTE CONTRACT VALUE		£164,524,718		£164,145,500		£164,145,500	£-379,219	£164,145,500		£164,145,500	£-379,219	
				100%	0%			100.00%	60%			
Cap and collar												
Community	589,799	£32,582,214		£32,582,214	£0	£32,582,214	£0	£32,582,214	£0	£32,582,214	£0	Standard block contracts and CQUIN at a 90% floor
Community CQUIN		£814,554		£733,099	£0	£733,099	£-81,455	£733,099	£0	£733,099	£-81,455	
TOTAL COMMUNITY CONTRACT VALUE		£33,396,768		£33,315,313		£33,315,313	£-81,455	£33,315,313		£33,315,313	£-81,455	
TOTAL CONTRACT VALUE		£197,921,487		£197,460,813		£197,460,813	£-460,674	£197,460,813		£197,460,813	£-460,674	

Variance to Contract Value

-£460,674

-£460,674

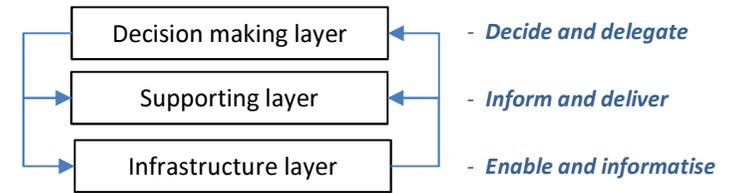
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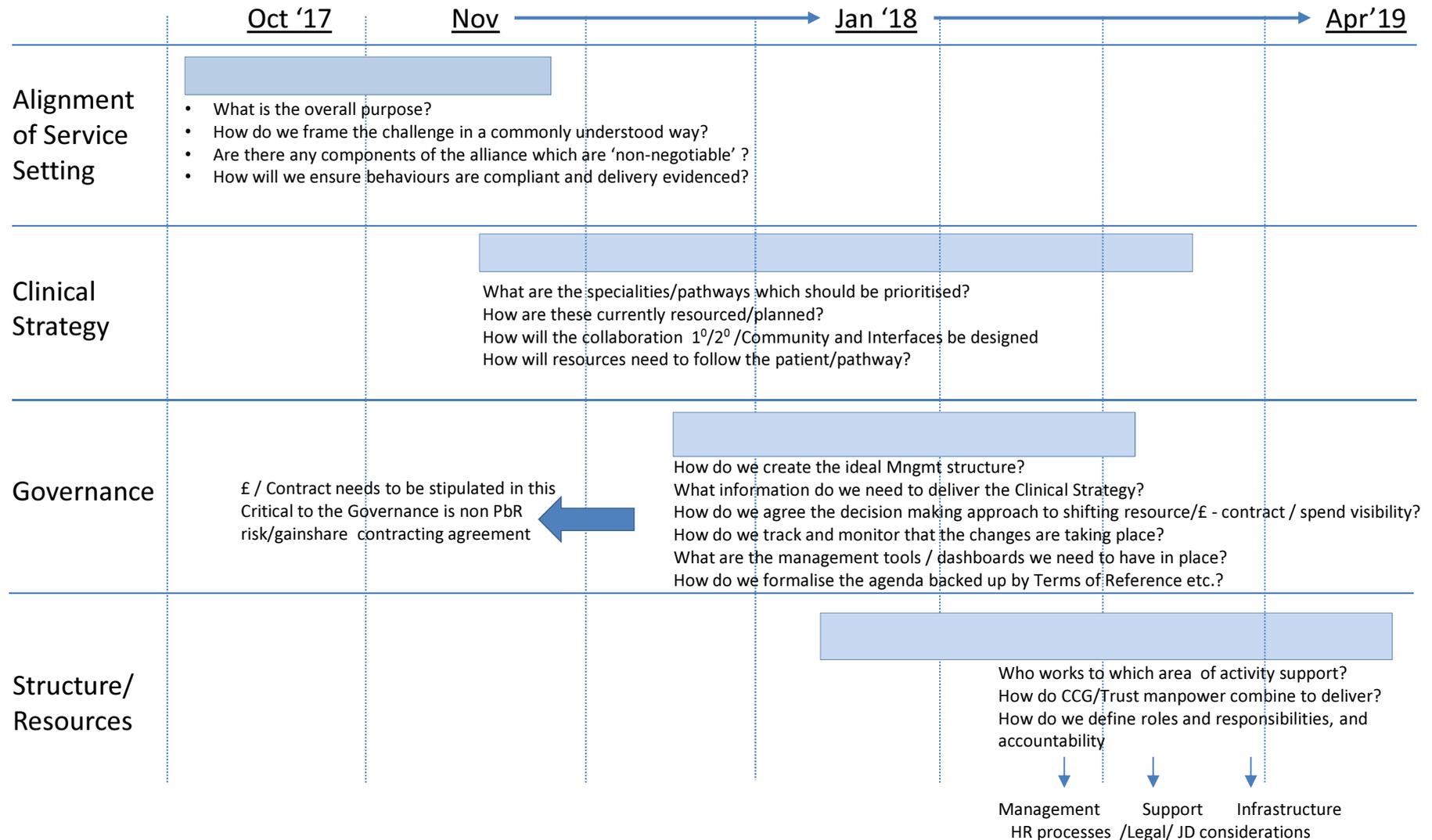
High level timeline now to end March

Operating Model principles

Appendix 5



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NHS WOLVERHAMPTON CCG
Governing Body
10th July 2018
Agenda item 9

TITLE OF REPORT:	An update regarding the Joint NHS Wolverhampton Clinical Commissioning Group and the City Of Wolverhampton Council Joint Mental Health Strategy 2018/19 – 2020/21.
AUTHOR(s) OF REPORT:	Sarah Fellows
MANAGEMENT LEAD:	Steven Marshall
PURPOSE OF REPORT:	<p>The purpose of this report is to provide an update for the NHS WOLVERHAMPTON CCG Governing Body regarding the Joint Mental Health Strategy 2018/19 – 2020/21.</p> <p>This follows previous verbal and written updates regarding the Mental Health Strategy development generally and specific pieces or programmes of work that describe the mental health transformation programme in line with the Five Year Forward View for Mental Health (2016) and the General Practice Forward View (2016).</p>
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain



<p>KEY POINTS:</p>	<ul style="list-style-type: none"> • The development of the Joint Mental Health Strategy 2018/19 – 2020/21 follows extensive and on-going transformation work on the part of CCG colleagues in terms of assessment of need, appraisal of current service models and re-design and re-commissioning of service models and models of care to achieve and compliance with the NHS England mandated requirements of the Five year Forward View for Mental Health (2016) and Future in Mind (2015) and the CCG Improvement and Assurance Framework (2017/18) • The Joint Mental Health Strategy 2018/19-2020/21 will deliver transformation to agreed local, regional and national priorities that include the ‘mental health improvement blue print’ of the Five Year Forward View for Mental Health and the CCG Improvement and Assurance Framework and key drivers in terms of the Wolverhampton Better Care Fund Programme, the Black Country and West Birmingham Sustainability and Transformation Plan (2016) and the West Midlands Combined Authority THRIVE Action Plan (2016). • A draft Joint Mental Health Strategy 2018/19 – 2020/21 has been developed by the CCG and this is currently out to consultation with partners across health and social care. A wider consultation process with stakeholders and service users and carers is planned – supported by the CCGs partners across health, social care and the voluntary and community sector and building on the CCGs commissioning intentions events. The wider consultation and engagement includes work
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with KIC FM and BCPFT on the 'Lamp, Lifeboat and Ladder' theme and also clinician to clinician engagement i.e. commissioners with GPs and Consultant Psychiatrists. A visualisation of this is attached as Appendix 2 following an engagement session at the Mental Health Stakeholder Forum

- The draft Mental Health Strategy 2018/19-2020/21 builds upon the deliverables of the Five Year Forward View for Mental Health, the Better Care Fund, the General Practice Forward View and our knowledge of local gaps and inequalities which have been identified as part of an extensive needs analysis, listening process and learning from pressure points and 'hot spots' in the system such as our approach to Out of Area Treatments, our need to improve transition from CAMHS to AMHS and from AMHS to Older Adult Mental Health Services, our ambition to deliver the aspirations of our WOLVERHAMPTON CRISIS CONCORDAT and our need to refocus the Care Programme Approach across the whole system.
- The CCGs aspirational Joint Mental Health Strategy 2018/19-2020/21 which aims to cohesively describe and articulate the vision, values and deliverables of our Mental Health Integrated Care System as a blueprint for transformation and change.
- The Draft Mental Health Strategy 2018/19-2020/21 describes a Mental Health Integrated Care System which will 'Be a lifeboat and a lamp and a ladder' (Rumi



	<p>- 1207-1273 AD). The CCG's partners BCPFT and Kic FM have agreed to work with service users and carers to explore this theme as part of the Strategy development.</p> <ul style="list-style-type: none"> • The re-launched Wolverhampton Mental Health Stakeholder Forum will deliver engagement and consultation across all stakeholders and will form a key part of the governance structure in terms of monitoring the delivery of the Joint Mental Health Strategy 2018/19-2020/21 Implementation Plan. • A revised draft Joint Mental Health Strategy 2018/19-2020/21 is included as Appendix 1 addressing comments from CWC. • A Financial Plan is under development – coordinated via the Joint Efficiency Review Group which is a BCPFT and CCG Forum. • An EIA, QIA and DPIA have been conducted and are with respective leads for comment.
<p>RECOMMENDATION:</p>	<ul style="list-style-type: none"> • It is recommended that the Governing Body approve next steps in terms of the Draft Joint Mental Health Strategy 2018/19-2020/2 development and implementation including the commissioning plan for the services in scope as part of the CCG's on-going transformation and development working with local partners such as GPs, Care Groups and the Vertical



	<p>Integration and Colleagues in Primary Care, the City of Wolverhampton Council (CWC), The Black Country Partnership NHS Foundation Trust (BCPFT) and the Voluntary Sector Council (VSC) as part of the Better Care Fund work programme, and partners across the Black Country and West Birmingham Sustainability and Transformation Partnership (BC&WB STP) involving collaborative commissioning approaches with NHS Dudley Clinical Commissioning Group, NHS Sandwell and West Birmingham Clinical Commissioning Group and NHS Walsall Clinical Commissioning Group.</p>
<p>LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:</p>	
<p>1. Improving the quality and safety of the services we commission</p>	<p>The draft Joint Mental Health Strategy 2018/19-2020/21 will ensure that the health needs of people with mental health difficulties will be met in a timely and holistic manner as per relevant NICE guidance and the Five Year Forward View for Mental Health ensuring accessible, responsive and cohesive care pathways across mental health promotion, early intervention and prevention, assessment and diagnosis to intervention and care, treatment and support, improving quality of life, adding years to life, improving clinical outcomes and ensuring and promoting self-efficacy and recovery.</p>
<p>2. Reducing Health Inequalities in Wolverhampton</p>	<p>The draft Joint Mental Health Strategy 2018/19-2020/21 will ensure that the health needs of people with mental health difficulties will be met in a timely and holistic manner as per relevant NICE guidance and the Five Year Forward View for Mental Health ensuring accessible, responsive and cohesive</p>



	<p>care pathways across mental health promotion, early intervention and prevention, assessment and diagnosis to intervention and care, treatment and support, improving quality of life, adding years to life, improving clinical outcomes and ensuring and promoting self-efficacy and recovery and , reducing variation in delivery and health inequalities.</p>
<p>3. System effectiveness delivered within our financial envelope</p>	<p>The draft Joint Mental Health Strategy 2018/19-2020/21 describes and articulates the vision, values and deliverables of our cohesive Mental Health Integrated Care System as a blueprint for transformation and change working within our financial envelope to:</p> <ul style="list-style-type: none"> • Eliminate duplication and gaps and ensure compliance with the 'mental health blue print' as outlined in Implementing the Five Year Forward View for Mental Health (2017) and the local needs and gap analysis that has informed development of the strategic plan • Provide for gaps in service from within in the current financial envelope and while meeting the Mental Health Investment Standard (MHIS) Better utilise the mental health budget across local and STP partners to ensure value for money • Grow and develop capacity and capability in our system as we do so allowing our health and social care economy to share and develop expertise, develop workforce training and recruitment plans and pool resources where possible to optimise impact / effect.

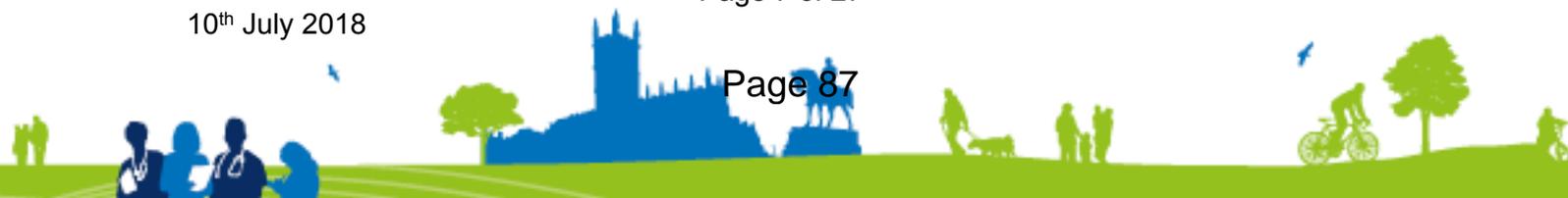
1. BACKGROUND AND CURRENT SITUATION



1.1. The NHS England mandated mental health transformation programme presents challenges but also great opportunities for NHS Wolverhampton Clinical Commissioning Group (the CCG) and partners to deliver transformational change with key improvements and benefits for our registered population/s as discussed at the BIC PROGRAMME BOARD in May 2018.

1.2. Building our strategy from the Five Year Forward View for Mental Health (2016) and Future in Mind (2015) the key five priorities for the Joint Commissioning Strategy are as follows:

- **Integration of mental and physical health - closing the mortality gap** - having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population (Future in Mind 2015). Five Year Forward View For Mental Health highlights that people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 % whereas providing dedicated mental health provision can improve outcomes, such as in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Pilot schemes show providing such support improves health and cuts costs by 25%.
- **Improving access to the quality and evidence base and improving access to and responsiveness of services, referral to treatment and waiting times - closing the treatment gap** - a UK epidemiological study suggests that less than



25% – 35% of individuals with a diagnosable mental health condition accessed appropriate help (Future in Mind 2015). In addition there is a strong link between parental (especially maternal) mental health and children’s mental health. Future in Mind highlights that according to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country and that almost three-quarters of this cost (72%) relates to the impact on the child / infant. £1.2 billion of the long-term cost is borne by the NHS (Future in Mind, 2015). There is a requirement for access to evidence based interventions across the **lifespan and that access to services in a NICE concordant evidence based care pathway is measured and reported along with measurement of outcomes.**

- **Improving Data Quality – closing the data quality gap** - there is a need for good, transparent, regular data and information that is collected in line with national requirements reporting recording new KPIs / measurements etc. including use of the APRIL 17 New MH SDS and the monitoring new access and waiting times and referral to treatment standards such as within IAPT, Early Intervention In Psychosis and Eating Disorders Services.
- **CCGs commitment to Mental Health Investment Standard - closing the parity of esteem / funding gap** (in addition to the Mental Health Investment Standard our commitment to parity of esteem includes submitting applications for NHS E Transformation funding and funding for New Models of Care that meet our local needs and needs on a BC&WB footprint).



- **Improving the Wider Determinants of Mental Health – closing the early intervention and prevention gap** The Five Year Forward View for Mental Health highlights that between 60–70 % of people with common mental health problems are in work, yet few employees have access to specialist occupational health services and that for people being supported by secondary mental health services, there is a 65 % employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression. People in marginalised groups are at greater risk, including people from BAME and LGBT+ groups, disabled people, care leavers, people who have had contact with the criminal justice system, amongst others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems. People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a Learning Disability and /or Autism are also at higher risk. As many as nine out of ten people in prison have a mental health, drug or alcohol problem. **These statistics emphasise the requirement for a focus upon the wider determinants of mental health and targetted mental health promotion across the lifespan and across universal services and primary secondary and tertiary care delivered as part of our local Prevention Concordat.**

1.8 The key deliverables are as follows:

- Mental Health Liaison / Core 24 – including dementia – Adult and Older Adult
- Adult - Community Recovery Service with rapid response dual diagnosis and personality disorder focus
- Older Adult Community Mental Health Team with rapid response and Nursing Home In-reach



- Criminal Justice Mental Health – DAPA and Court Diversion
- Mental Health Therapists embedded in Primary Care
- Crisis Resolution Home Treatment – fidelity with national guidelines
- Early Intervention in Psychosis 14-65 years fidelity with national guidelines
- Eating Disorders - fidelity with national guidelines
- IAPT with focus on BAMEs Older People Perinatal IAPT and LTCs
- Perinatal Mental Health
- Reduced OATS
- Improved care pathways for Section 117 MHA Aftercare Packages
- Supported Housing and Accommodation Care Pathway – with increased join up with general needs housing
- In-reach support into Nursing and Residential Care
- Focus upon personalisation and home based support including bespoke domiciliary care packages
- IPS
- Prevention Concordat
- Suicide Prevention Plan
- Crisis Concordat

2. Details of the Current Situation

- 2.1. A draft Joint Mental Health Strategy 2018/19 – 2020/21 has been developed by the CCG and this is currently out to consultation with partners across health and social care including the Clinical Directors and Executive and Senior Managers in BCPFT and commissioning Colleagues in the City of Wolverhampton Council. A revised strategy document is attached as Appendix 1. An EIA, QIA and DPIA have been prepared and are with respective leads for sign off.



- 2.2. BCPFT have developed a draft Equality and Diversity Strategy which is being used to address inequalities across the lifespan of mental health service provision and will be used as an addendum to the Mental Health Strategy to ensure focus upon improve care pathways for Black and Asian men and LGBT+ groups for example and to support targeted interventions across parts of our City affected by issues such as deprivation poverty unemployment poor housing and substance misuse.
- 2.3. Coproduction with all service users and carers and staff across our Mental Health Integrated Care System is a key and important focus of our vision and values. We will all work together to establish the self-efficacy and recovery of our system, remove the stigma associated with mental health and support each other to thrive and grow. This work is being supported by KIC FM and BCPFT AHP leads who are running engagement events together.
- 2.4. BCPFT have developed a revised draft CPA policy which will be used as an addendum to the Mental Health Strategy to support compliance with national guidance for out of hospital care packages within and outside the Care Programme Approach.
- 2.5. A summary of needs analysis information is described in Section 2 of the Draft Joint Mental Health Strategy. A detailed needs analysis is provided as Appendix 1 to the Draft Joint Mental Health Strategy.
- 2.6. Our WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public. For the purposes of delivery of a Mental Health Integrated Care System the implementation plan will be structured across the 14 Key Goals described below:



2.13 Our WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public. For the purposes of delivery of a Mental Health Integrated Care System the implementation plan will be structured across the **14 Key Goals** described below:

1. DEVELOP AN ALL AGE APPROACH ACROSS OUR SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS WHO REQUIRE TRANSITION TO ADULT MENTAL HEALTH SERVICES.

We will develop a commissioning plan / care pathway/s that align all initiatives within the MENTAL HEALTH STRATEGY IMPLEMENTATION PLAN with existing and future plans regarding CAMHS as described in the WOLVERHAMPTON CAMHS PLAN ensuring that there is safe sound support transition to Adult Services that are consistent, seamless, age appropriate and inclusive and support the needs of Children and Young People at transition and preparing for transition to ADULT SERVICES in line with good practice as outlined in NICE GUIDANCE the CPA, CONTINUING CARE and CONTINUING HEALTHCARE GUIDANCE.



LEAD MULTI-AGENCY FORUM/S – CAMHS TRANSFORMATION BOARD AND WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

2. DEVELOP AN ALL AGE APPROACH ACROSS OUR ADULT AND OLDER ADULT SERVICE MODEL THAT INCORPORATES AND ADDRESSES THE NEEDS OF PEOPLE OVER 65 YEARS WHO REQUIRE TRANSITION TO OR ACCESS / ENTRY TO OLDER ADULT MENTAL HEALTH SERVICES.

We will develop care pathway/s and services that align all initiatives within the implementation plan across Adult and Older Adults Mental Health Services so that services are consistent, seamless, age related and inclusive. Service re-design and delivery across the BETTER CARE FUND URGENT AND PLANNED AND DEMENTIA CARE PATHWAYS will be joined up and coterminous. Our refreshed Dementia Strategy will sit aside our Mental Health Strategy and will respond to relevant NICE GUIDANCE and CARE PATHWAYS and we will ensure older people and/ or people with dementia have equity of access to mental and physical health services and that care plans in both primary and secondary meet the requirements of the CPA for service users and carers.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

3. DEVELOP A LOCAL PREVENTION CONCORDAT

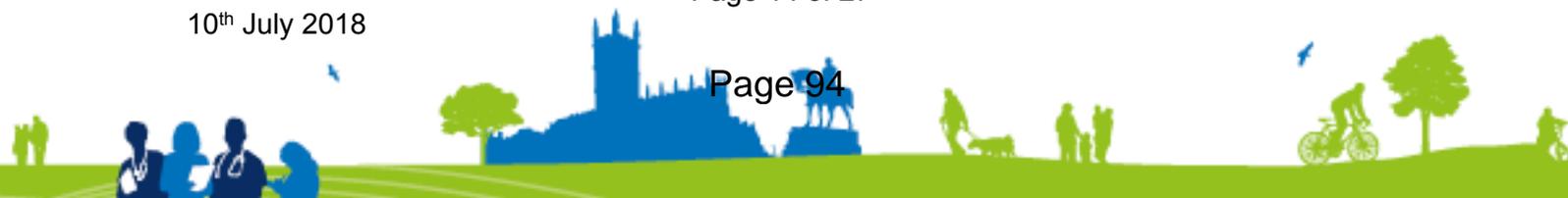
We will develop a local PREVENTION CONCORDAT with key stakeholders via the MENTAL HEALTH STAKEHOLDER FORUM. This will help us to deliver targeted mental health promotion and early intervention and prevention interventions cross our commissioned services, and to work with partners across universal primary secondary and tertiary care and partners and stakeholders in education, employment, leisure and housing and voluntary and community sector services, for example to focus initiatives upon the wider determinants of health and mental and physical health promotion. Our information revolution will provide signposting navigation advice and guidance and self-management self-care and peer support. This approach will include initiatives to address the broader determinants of mental ill-health including issues pertaining to:



- Parental mental health
- Mental Health Promotion
- Physical health and disability
- Leisure and physical activity
- Bullying
- Mental Health in the work place
- Self-harm
- Substance misuse
- Improved information and communication
- Targeted Interventions for carers
- Targeted interventions for at risk groups (BAME, LGBT+)
- Debt Advice
- Un-employment
- Educational attainment
- Ending stigma attached to mental health

In addressing those issues highlighted above the Resilience Plan will incorporate the Suicide Prevention Plan and will assess, map and scope the needs of the City's key vulnerable groups people affected by vulnerabilities related to and including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender



(LGBT+)

- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

4. MAINTAIN OUR WOLVERHAMPTON SUICIDE PREVENTION STRATEGY

We will maintain our local multi-agency Suicide Prevention Strategy with key stakeholders. This will be aligned with the WOLVERHAMPTON CRISIS CONCORDAT and will respond to local needs across each of the National Suicide Prevention Strategy areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

This will incorporate learning from the Preventing Suicide in England: One year on First Annual Report (2014), and local data regarding current trends and new messages from research, including the use of social media, learning regarding 7 day follow up, health and social care assessments, treatment and clinical interventions for people with depression and people at risk of self-harm, and specific vulnerabilities related to age, gender and ethnicity and the specific needs of the LGBT+ community and people who misuse substances.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON SUICIDE PREVENTION STAKEHOLDER FORUM

5. DEVELOP PRIMARY CARE MENTAL HEALTH

To ensure best practice in terms of early intervention and prevention, improving the physical health of people with mental health difficulties and improving care pathways into and out of

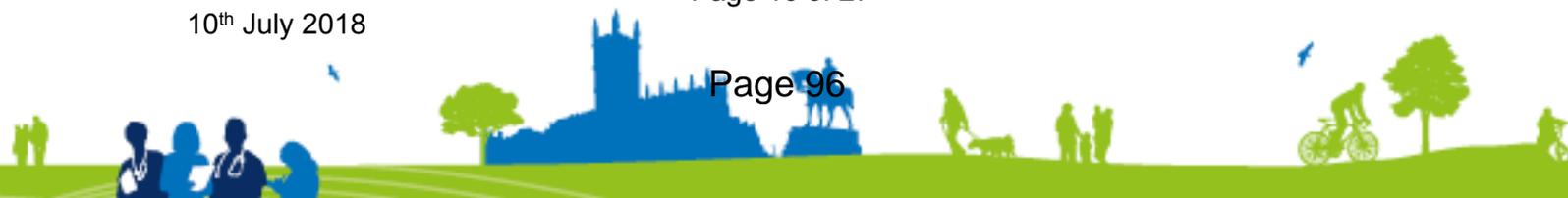


secondary services for people of all ages, we will commission mental health care pathways in primary care supported by primary care champions and workers in primary care facing and secondary services. This will include pathways of care for people with specialised mental health needs such as autism, attention deficit disorder, eating disorders, perinatal mental health, depression and personality disorder, dual diagnosis and the primary care support needs of people taking anti-psychotic medication. This will include review of all of our well-being and support services commissioned from community and voluntary sector organisations and third sector organisations to strengthen early intervention and prevention initiatives. This includes delivery of IAPT, LTC IAPT, increasing IPAT access for BAMES and PERINATAL IAPT and delivering SMI PHYSICAL HEALTH Checks and social prescribing pilot. This will also include delivery of e referrals and e discharge and advice and guidance across primary and secondary care.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM**

**6. DELIVER THE BETTER CARE FUND URGENT MENTAL HEALTH CARE
PATHWAY**

As part of our Better Care Fund development plans to implement the Integrated Mental Health Urgent Care Pathway we will review the current model. We will re-commission MENTAL HEALTH LIAISON ENHANCED CORE 24 and CRISIS RESOLUTION HOME TREATMENT fidelity with NHS E CORE. We will review the capacity and capability of the health and social care urgent mental health care pathways to increase the capacity and capability of the service to meet the needs of people of all ages outside normal working hours and respond to requests for assessment under the Mental Health Act. We will commission a service model and care pathway that provides an integrated collocated and aligned approach to mental health urgent care within a multi-disciplinary context, including access in an emergency to specialist medical and Consultant Psychiatry support that is consistent with Royal College guidelines and the Care Programme Approach. We will deliver our WOLVERHAMPTON CRISIS CONCORDAT DECLARATION AND ACTION



PLAN through this work stream.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM**

**7. DELIVER THE BETTER CARE FUND PLANNED MENTAL HEALTH CARE
PATHWAY**

We will re-commission and implement an integrated planned care pathway promoting independence, self-efficacy and recovery as part of our Better Care Fund plans. This will promote independence, facilitate recovery and allow service users to progress along the care pathway and prevent relapse and re-admission. The integrated pathway will also allow pooled and effective deployment of and efficient use of resources across the ‘whole system’ that responds to local need and demand management. This will facilitate step-down from in-patient, specialised and secure care, allow repatriation to local services from ‘out of area placements’ and consolidate commissioning approaches for people requiring continued support in supported housing, nursing and residential care and hospital placements into an aligned care pathway of continued support. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery, and will allow the re-allocation of resources from acute, specialised, ‘out of area’ placements to local community based services maintaining recovery and promoting independence, self-efficacy autonomy and recovery in the mid to long term. We will review our current commissioning model of the Complex Care Service and Well-Being Service. This will include reviewing the capacity and capability of the service to offer support and interventions of an assertive outreach model, the function of the personality disorder hub and the forensic team. This is to increase the capacity and capability of local services to support people with the highest levels of need, and provide step-down from secure care and specialised services locally and ‘out of area’ and reduce relapse and re-admission/s. The model will also be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning



support and interventions that are compliant with the national guidance regarding the Care Programme Approach.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM**

8. MAINTAIN OUR WOLVERHAMPTON CRISIS CONCORDAT

We will maintain our local multi-agency WOLVERHAMPTON CRISIS CONCORDAT ensuring connectivity with this initiative and the Suicide Prevention Strategy and the Better Care Fund Mental Health Urgent and Planned Care and Dementia Strategies and the WOLVERHAMPTON Local CAMHS Plan. We will ensure minimum 6 monthly reviews of the WOLVERHAMPTON CRISIS CONCORDAT DECLARATION and ACTION PLAN with all service user and carer groups.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM**

9. DELIVER SOME MORE SPECIALIST MENTAL HEALTH CARE PATHWAYS AND SERVICES ACROSS A BC&WB STP FOOTING

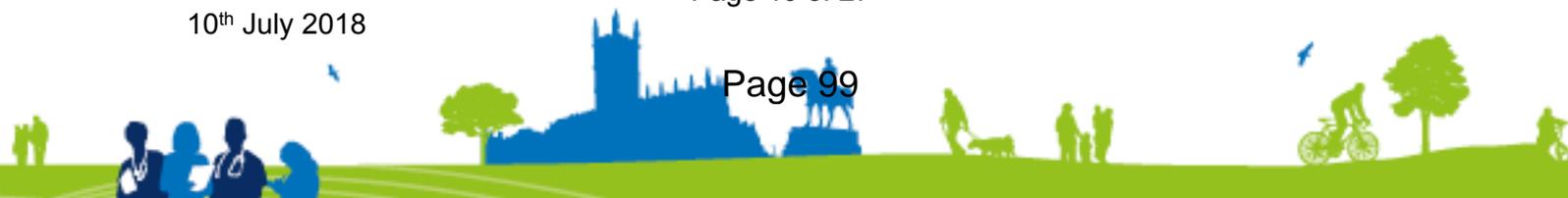
Collaborative commissioning as per the outputs of the BC&WB STP Mental Health Work Stream will ensure that the health needs of people with mental health difficulties will be met in a timely and holistic manner as per NICE guidance and from diagnosis to early intervention and care, treatment and support, improving quality of life. We will pool resources and expertise to deliver a critical mass of specialist services that are locally delivered and financially sustainable across our BC&WB footprint. We work with providers of health and social care services to commission and implement specialist care pathways for the following:

- Eating Disorders
- Early Intervention in Psychosis
- Personality Disorder
- Perinatal Mental Health



- Attention Deficit Disorder and Autism
- Psychiatric Intensive Care
- Street Triage
- Criminal Justice Mental Health (including Court Diversion and Liaison and the Forensic Liaison Scheme)
- Veteran Mental Health
- Alignment with the West Midlands Combined Authority THRIVE Action Plan

This will increase capacity and capability, providing specialist assessment and intervention within mainstream mental health services within the local system and facilitating effective liaison with specialist services commissioned by NHS England. This will include review of our current commissioning of all out of area mental health admissions to identify opportunities to maximise the resources available within local services as alternatives to out of area admissions and to identify 'preferred providers' for Female Psychiatric Intensive Care (PIC) in the short term, whilst liaising with local providers and commissioners regarding a medium to longer term solution. We will optimise the available capacity and capability within community recovery and promoting independence services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. We will realise cost efficiency savings by reducing the numbers of all types of out of area placements and reducing lengths of stay. We will work with local providers to develop capacity and capability of locally commissioned services to meet the needs of people who are discharged and / or transferred from secure and specialised services, so that we can optimise deployment of and efficient use of resources across the 'whole system' that is consistent with local need, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches sub –specialisms including hospital placements for rehabilitation. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery.



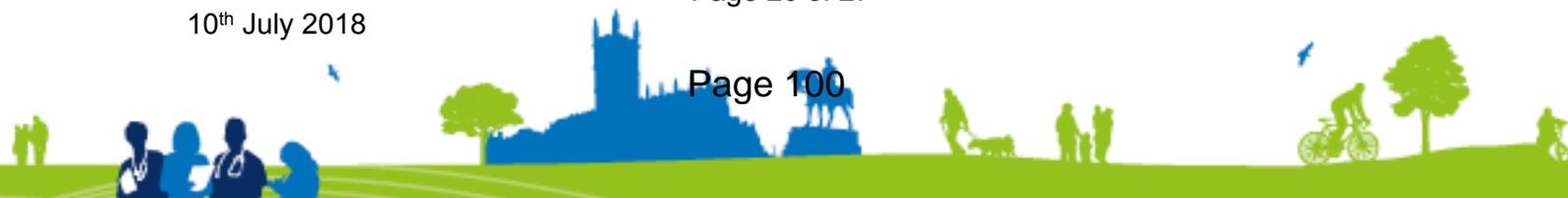
**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM**

10. DELIVER ROBUST CARE PATHWAYS ACROSS PRIMARY, SECONDARY AND TERTIARY CARE TO ENSURE THAT PEOPLE WITH A LEARNING DISABILITY / AND OR AUTISM AND CO-OCCURRING MENTAL HEALTH DIFFICULTIES CAN ACCESS APPROPRIATE AND SEAMLESS HELP, CARE, TREATMENT AND SUPPORT

In line with Transforming care: A National response to Winterbourne View Hospital (2012), Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015) we will develop robust care pathways across Learning Disability and Mental Health Services to support the specific needs of people with a learning disability / and or autism and co-occurring mental health difficulties to ensure equal access to assessment and diagnosis and post diagnosis care treatment and support and this will be delivered in line with the requirements of the Care Programme Approach (CPA) as appropriate / required.

11. DELIVER TARGETED INTERVENTIONS TO SUPPORT THE NEEDS OF MARGINALISED AND / OR SELDOM HEARD GROUPS INCLUDING SPECIFIC ACTIONS TO REDUCE THE NUMBERS OF BAME PEOPLE DETAINED UNDER THE MENTAL HEALTH ACT

In line with the Mental Health Five Year Forward View and the WOLVERHAMPTON CRISIS CONCORDAT we will include work across partners and with local community groups to provide a dedicated focus upon people who are marginalised, people who have particular vulnerabilities, and people who have difficulties accessing right care in the right place at the right time including people for example with Autism / and or ADHD, people with a Learning Disability, people with Dual Diagnosis and / or a Personality Disorder and people from BAME and LGBT+ groups and Veterans, refugees new arrivals and asylum seekers and Serving Members of Her Majesty's Armed Forces and their families for example to ensure improved access to and support and treatment from mental health services providing right care at the right time in the right place . This will include specific actions to substantially



reduce Mental Health Act detentions and also include targeted work to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM**

12. DELIVER A WORK FORCE PLAN & ALIGN ACROSS BC&WB STP FOOTING

We will develop a work force plan in line with Stepping Forward to 2020 and align with developments and initiatives across our STP to allow development of recruitment and retention and training, supervision and mentorship of all staff across our **Mental Health Integrated Care System** to develop capacity and capability to support and deliver new service models and facilitate delivery of local priorities and the priorities of the Five Year Forward View for Mental Health. As we do this we will develop and demonstrate sound processes to support and recruit staff with lived experience of mental difficulties and support the mental health and emotional well-being of all our staff.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM**

13. DELIVER A FINANCIAL PLAN & ALIGN ACROSS BC&WB STP FOOTING

We will develop a Mental Health Strategy Financial Plan and align with developments and initiatives across our STP to deliver financially sustainable services and deliver value for money whilst covering critical gaps and meeting the mental health investment standard. New or revised services and service specifications will be delivered within the financial envelope our commissioning authorities i.e. NHS W CCG and CWC. Resources – including key elements of our workforce - will be used to best effect with strong clinical and medical leadership evident at each part of the Mental Health Integrated Care System. This is in addition to any transformation funds applied for and received from NHS England for example including ‘Winter Pressures’ and A&E Delivery Board funding used to ‘pump prime’



change. Compliance with the Mental Health Investment Standard will be supported across all CCG commissioned activity. LGBT+

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM**

14. DELIVER A GOVERNANCE, COMMUNICATION AND ENGAGEMENT PLAN AND
ALIGN WITH WORK ACROSS AN BC&WB STP FOOTING

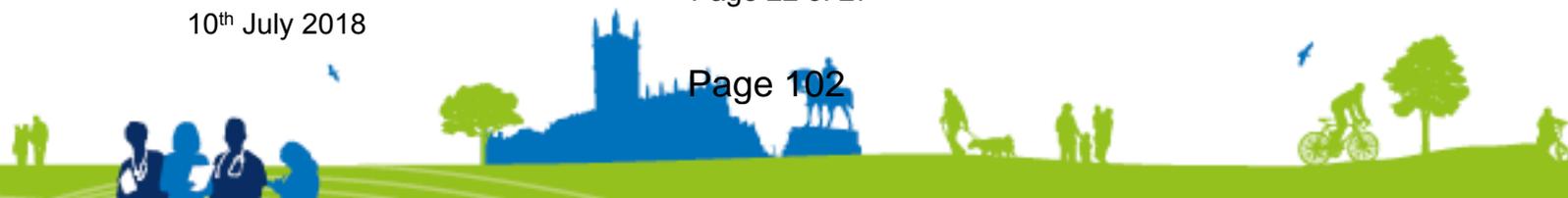
We will develop a governance, communication and engagement plan and align with developments and initiatives across our STP to ensure co-production with and continuing engagement with all relevant forums and service users and carers and the general public to support delivery of our strategy including the anti-stigma, mental health promotion and advice and guidance elements to achieve parity of esteem with physical health and improve our City's mental health.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH
STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM**

2. CLINICAL VIEW

3.1. The views of clinicians across primary, secondary and tertiary care have been utilised during the development of the Strategy, following workshop event held at Penn Hospital in February 2018. The draft strategy document has been shared with Clinical Directors in BCPFT and further workshops and clinical engagement events are planned. Multi-agency approaches to engagement and consultation across health and social care and are partners are planned.

4. PATIENT AND PUBLIC VIEW



- 4.1. The views of service users and carers and the general public have been sought and utilised during commissioning intentions events and during BC&WB STP stakeholder consultation and engagement processes. Further events will be delivered as part of a communications and engagement plan during the consultation process.

5. KEY RISKS AND MITIGATIONS

- 5.1. There are current risks that patients of all ages can experience delays in terms of waiting times and access standards and 'fall through gaps' due to insufficient connectivity, cohesion and co-ordination across mental health, universal, primary care secondary care and tertiary care services including social care and housing and employment services and that this leads to absent or sub optimal care of insufficient quality and efficacy leading to the requirement for longer periods of care with higher intensity of treatment and / or support.

- 5.2. There are current risks regarding delivery against the mental health improvement blue print and also some other gaps in service provision across our STP footprint such as Personality Disorder Services, Neurodevelopmental Services, Assertive Outreach Services (in Adult Community Mental Health Teams), and Dual Diagnosis (Substance Misuse and Mental Illness). Areas of cross over and duplication of some service models are also present and should be further explored. Medical staffing across some services requires some review to ensure an appropriate distribution of senior clinicians across the primary, secondary and tertiary care i.e. community and in-patient services to deliver fidelity with the evidence base and deliver admission avoidance for example.

- 5.3. There are some current clinical, financial and reputational risks therefore. Insufficient intervention at primary and secondary care level can lead to higher levels of secondary and tertiary care including out of area services. This approach is both clinically and financially inefficient with poor outcomes for patients and their carers - such as delays accessing services and longer recovery periods - and higher financial costs.



Commissioning to the evidence base across the mental health improvement blue print will better support areas of critical need with re-calibration and re-specification of some services including their financial profiles allowing opportunities for re-investment where there are gaps or QIPP (including those services to be commissioned on a BC&WB STP footprint).

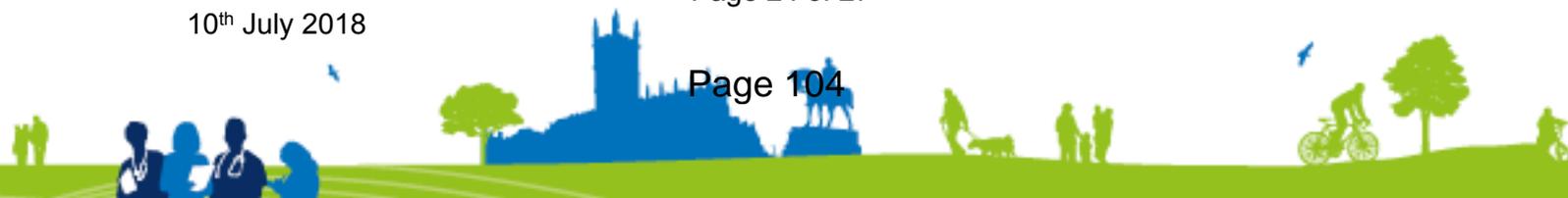
6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. The implementation plan will be delivered within the financial envelope of the CCG, CWC and where applicable the BC&WB STP Mental Health Plan. We will develop a Mental Health Strategy Financial Plan and align with developments and initiatives across our STP to deliver financially sustainable services and deliver value for money whilst covering critical gaps and meeting the mental health investment standard. New or revised services and service specifications will be delivered within the financial envelope our commissioning authorities i.e. NHS W CCG and CWC. Resources – including key elements of our workforce - will be used to best effect with strong clinical and medical leadership evident at each part of the Mental Health Integrated Care System. This is in addition to any transformation funds applied for and received from NHS England for example including ‘Winter Pressures’ and A&E Delivery Board funding used to ‘pump prime’ change. Compliance with the Mental Health Investment Standard will be supported across all CCG commissioned activity.

6.2. A draft Financial Plan is in development and will be coordinated via the Joint Efficiency Review Group with BCPFT.

Quality and Safety Implications



6.3. Commissioning a NICE compliant service model across our Mental Health Integrated Care System is part of risk mitigation processes for the CCG. A Quality Impact Assessment will be conducted.

Equality Implications

6.4. Commissioning a NICE compliant pathway across our Mental Health Integrated Care System will reduce health inequalities. An Equality Impact Assessment will be conducted.

Legal and Policy Implications

6.5. The CCG has statutory obligations to commission safe, effective services that deliver value for money in partnership with key stakeholders and in response to levels of need and service user and carer views. This is in keeping with the seven key principles of the NHS Constitution (2015) and operational and planning guidance as laid out in mandate to NHS England by the Department of Health. Policy implications have been described in earlier sections of this report.

Other Implications

6.5 The timeline for the presentation of the Draft Joint Mental Health Strategy 2018/19-2020/21 at City of Wolverhampton Council Committees is detailed below:

Mental Health Strategy:

Health and Well Being Board	11 July 2018
Health Scrutiny	20 September 2018
Health and Well Being Board (final sign-off)	17 October 2018

Cabinet Resource Panel (Final - DW to present)

06 November 2018

6.6 The Joint Efficiency Review Group has recommenced. This is the forum that will deliver the transformational change that pertains to the BCPFT commissioned and contracted services in line with the contract quantum / available finance. This forum will deliver all requirements utilising the DQIP and SDIP as contractual levers / frameworks.

Name Sarah Fellows
Job Title Mental Health Commissioner
Date: 11th June 2018

ATTACHED:

Appendix 1 Draft Joint Mental Health Strategy 2018/19-2020/21

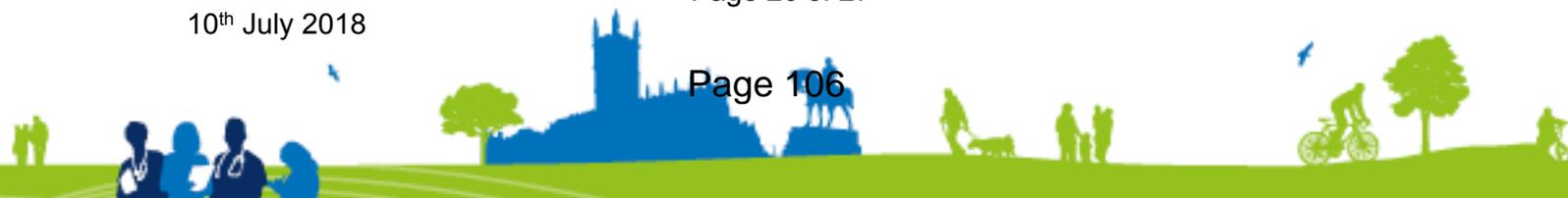
RELEVANT BACKGROUND PAPERS

(Including national/CCG policies and frameworks)

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		
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)		



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**MENTAL HEALTH
COMMISSIONING
STRATEGY
2018/19-2020/21**

CONTENTS

1. INTRODUCTION AND OVER VIEW
2. INFORMATION REGARDING PREVALENCE AND NEED
3. VISION AND VALUES
4. OUR MODEL OF CARE
5. KEY PRIORITIES
6. IMPLEMENTATION, NEXT STEPS AND 14 KEY GOALS
7. LIST OF APPENDICES

1. INTRODUCTION AND OVER VIEW

The **FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH (2016)** reminds us that mental health problems can affect people in all walks of life and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental Health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year which is roughly the cost of the entire NHS. We also know that mental health problems are widespread, at times disabling, but also often hidden. One in four adults will experience at least one diagnosable mental health difficulty in any one year. The following paragraph from the **FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH** summarises the current need to re-energise and improve mental health care to meet increased demand and improve outcomes:

‘For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths. But in recent years, the picture has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.’

Harnessing the change in public attitudes and the growing commitment to preventing and treating mental health difficulties and delivery of the FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH imperatives via commissioning and delivery of safe, sound and supportive mental health services and care pathways is a key strategic priority for our health and social care economy therefore. This is aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient and carer experience as outlined in our **Wolverhampton Health and Well-Being Board Strategy** and the **NHS Wolverhampton Clinical Commissioning Group Operational Plan**.

It is acknowledged that the role of local government has a major contribution to make to effective mental health and well-being. In the Local Government Association's (LGA) "Being mindful of mental health – the role of local government in mental health and being" (June 2017) it states that "Council services from social care to parks to open space to education to housing help to make up the fabric of mental health support for the people in our communities." (p.4) It aspires to the creation of "mentally healthy "places for people of all ages across their whole life-course.

These national and local contexts are aligned with a number of other key deliverables such as reducing health inequalities, reducing the impact of long term conditions upon quality of life and improving patient and carer experience as outlined in our Wolverhampton Joint Health and Well-Being Board Strategy and the NHS Wolverhampton Clinical Commissioning Group Operational Plan.

The NHS Wolverhampton Clinical Commissioning Group and the City of Wolverhampton Council and Mental Health Strategy 2018/19-2020/21 is a collaborative commissioning statement of intent wherein we outline our commissioning plans to develop our **Mental Health Integrated Care System** a mental health 'whole system' which will deliver improved outcomes for the people of our City in line with local needs and local and national priorities in line with the FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH deliverables. We will achieve this by working in partnership with key agencies, partners and stakeholders including our patients,

services users and their carers, our registered and resident populations, the Voluntary and Community Sector, NHS and Independent Sector Providers and our partners in the Black Country and West Birmingham Sustainability and Transformation Partnership (BC&WB STP) and the West Midlands Combined Authority (WMCA) for example. Our **WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM** will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public.

We will develop a **Mental Health Integrated Care System** building on the changes and developments of the Joint Mental Health Commissioning Strategy developed in 2014/15 and responding to key local and national priorities and deliverables and priorities including the **Better Care Fund**, the **Joint Dementia Strategy 2015-2017**, the **Wolverhampton Joint Autism Strategy 2016-2021** the **Wolverhampton CAMHS Transformation Plan 2017-20**, the **Black Country and West Birmingham Sustainability and Transformation Plan (2017)** and the **NHS England Mental Health Transformation Blue Print** out lined in **Future in Mind, Promoting, protecting and improving our children and young people’s mental health and wellbeing (2015)**, the **Five Year Forward View for Mental Health (2016)**, **Implementing the Five Year Forward View for Mental Health (2017)** and **Next Steps on the NHS Five Year Forward View (2017)**, the **General Practice Forward View (2016)**, **BETTER BIRTHS Improving outcomes of maternity services in England A Five Year Forward View for maternity care (2016)**, **Transforming care: A National response to Winterbourne View Hospital (2012)**, **Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015)**, the **NHS England CCG Guidance for Operational and Activity Plan 2018/19** the **CCG Improvement and Assessment Framework 2018/19**, **Stepping Forward to 2020/21: the Mental Health Workforce Plan for England (2017)**, the **Prevention concordat for better mental health (2017)**, **Surviving or Thriving? The state of the UK's mental health – the Mental Health Foundation (2017)** and **THRIVE WEST MIDLANDS an**

Action Plan to drive better mental health and wellbeing in the West Midlands (2016), and the LGA’s “Being mindful of mental health – the role of local government in mental health and being” (2017).

A link to the WOLVERHAMPTON CAMHS PLAN is provided below:

<https://wolverhamptonccg.nhs.uk/publications/miscellaneous/2286-camhs-plan-refresh-2017-final/file>

Some Key Important Points are highlighted in the table below

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Some Key Important Points
1. Our <u>Mental Health Integrated Care System</u> will promote a “mentally healthy Wolverhampton,” building resilience amongst the whole population starting in childhood and seeking to prevent mental distress. Our system will respond pro-actively and with compassion to the impact of mental health difficulties and mental illness on individuals, families, communities and our City as a whole delivering mental health promotion and local anti-stigma campaigns and initiatives that support self-help and self-management, peer support, autonomy, self-efficacy, personal growth and recovery across universal, primary, secondary and tertiary services.
2. Our <u>Mental Health Integrated Care System</u> will ensure that patients, service users and carers and the general public are engaged and involved in the design and delivery of services, care pathways and initiatives and that patients and

service users are pro-actively listened to and are supported to self-manage at every step of their journey, taking and maintaining autonomous ownership and co-production of their **personalised care plans** and that **carers are supported and enabled as equal partners** with health and social care professionals every step of the way.

3. Our **Mental Health Integrated Care System** will **connect mental and physical health initiatives care pathways and services** championing ‘no health without mental health’, placing a focus upon early intervention and prevention at every stage of the service user and carer care pathway, **improving physical health, increasing the life expectancy of people with mental health difficulties and their carers and improving the quality of life ‘adding life to years and years to life’ delivering mental and physical health promotion** at every stage of the care pathway and **making every contact count**. This will be especially evident via developments in Universal Services, Primary Care Services and also via **Primary and Secondary IPS** and **Mental Health First Aid Training** and **robust care pathways across mental and physical health**.

4. Our **Mental Health Integrated Care System** will work to **support and strengthen the Voluntary and Community Sector (VSC) involvement in the design and delivery of universal primary secondary and tertiary care** increasing the capacity to deliver peer and self-support initiatives that are connected and seamless with statutory health and social care, aiming to deliver a **mental health information revolution** that provides easily accessible advice and guidance about self-help, peer support, care pathways and services with targeted information for at risk groups.

5. Our **Mental Health Integrated Care System** will deliver an **evidenced based set of care pathways and services** that provide **connectivity across universal, primary, secondary and tertiary care** with seamless points of transition including from **CAMHS to AMHS and from AMHS to Older Adult Services** and with timely access and egress to services, care pathways and initiatives with personalised care which appropriately and robustly utilises the framework of the **Care Programme Approach (CPA)**.

6. Our **Mental Health Integrated Care System** will deliver Interventions to support the specific needs and vulnerabilities of key

groups including disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments and c/ or physical disabilities and / or LTCs for example). This will include focussed support to carers both in terms of access to and responsiveness of services but also by ensuring there are adequate and supportive 'carers care plans' especially for carers of people with high levels of need including people subject to Section 117 Mental Health Act 1983 and the **Care Programme Approach (CPA)**.

7. Our **Mental Health Integrated Care System** will work to **reduce the impact of known risk issues and inequalities upon mental health, delivering a focus upon the wider determinants of mental health, providing dedicated and targeted support that responds to the particular needs of** people who are economically inactive, un-employed people, people with housing needs and / or who are homeless, people with physical disabilities and / or a long term condition, people with a neurological condition such as Autism and / or ADHD (Attention Deficit Hyperactivity Disorder), people with enduring mental health difficulties such as depression and anxiety, psychosis and personality disorder, people who have a history of mental or physical trauma including sexual abuse and exploitation, bullying including work and school based bullying, domestic violence and veterans, people from Black and Minority Ethnic Groups (BAME), and / or LGBT+ (Lesbian Gay Bisexual Transgender Questioning Intersexual Asexual Groups), refugees, migrants and new arrivals, looked after children (LAC), women and their partners, children and families who have a mental health difficulty related to pregnancy and / or child birth, people who have a history of offending behaviour, Veterans and Serving Members of her Majesty's Armed Forces and their families and carers, and people with a dual diagnosis (alcohol and/ or substance misuse) supporting us all to **achieve self-efficacy, fulfil personal hopes, dreams, goals and aspirations and thrive**.

8. Our **Mental Health Integrated Care System** will deliver a 'Think Family' approach **responding pro-actively to the needs of poor parental and spousal mental health upon the mental health and developmental milestones of children**

and adolescents, partners and the whole family and within this context will deliver a focus upon perinatal mental health working with partners in Childrens and Maternity Services Universal and Primary Care Services Public Health Teams and Mental Health Secondary and Tertiary Services across our Sustainability and Transformation Partnership (STP) to deliver a perinatal mental health 'whole system' of care pathways and services that achieves the key outputs of the **Black Country and West Birmingham Local Maternity System (LMS)** including the aspirations of **Better Births Improving outcomes of maternity services in England A Five Year Forward View for maternity care (2016)** for our local system. This will include a focus upon **reducing maternal mental health related deaths including deaths related to alcohol and / or substance misuse and suicide**. This will also include a focus upon improved health and developmental outcomes for the child, sibling, partner and the whole family.

9. Our **Mental Health Integrated Care System** will deliver a set of **interoperational processes systems care pathways and services across primary secondary and tertiary care to ensure more pro-active and responsive approaches within primary care for people with mental health difficulties** – delivered by staff within NICE Guidance compliant services with mental health expertise in line with the **General Practice Forward View – blurring some boundaries across primary and secondary care for people with mental health difficulties and improving systems and processes for better shared care**. This will involve inclusion of mental health staff working in and embedded in primary care services and primary care and mental health multi-disciplinary team meetings in each GP practice and in every Primary Care Group including the Vertical Integration with the Royal Wolverhampton NHS Trust. There will be a particular focus upon improving access and responsiveness to evidence based care including physical health checks for people with SMI (Severe Mental Illness), improved care pathways for people with co-occurring mental health problems .and physical ill health including Long Term Conditions (LTCs) - such as Diabetes, Cancer, Cardio-Vascular Disease including Stroke and Heart Disease, Chronic Obstructive Pulmonary Disease, Neurological Disorders, Dementia, Physical Disability, Musculoskeletal Disorders and or

Acquired Brain Injury - shared care and improved information sharing, improved referral processes for mental health secondary care generally but including a focus on improved referral processes for primary care and social care staff and staff working in statutory and non-statutory services and looking at ways to support and improve self-referral and access support and advice for carers.

10. Our **Mental Health Integrated Care System** will support the mental health needs of all staff patients and service users and carers including friends and family members and informal carers by ensuring appropriate levels and types of support across the system and particularly at times of escalation and crisis helping us all to work together and support each other with professionalism and with accountability and in enabling, kind and compassionate ways.

Ten ways to look after your Mental Health (The Mental Health Foundation, 2017) are highlighted in the table below.

10 WAYS TO LOOK AFTER YOUR MENTAL HEALTH



Talk about your feelings



Keep active



Eat well



Take a break



Drink sensibly



Keep in touch



Do something you're good at



Accept who you are



Ask for help



Care for others



Mental Health Foundation

mentalhealth.org.uk

Across our Mental Health Integrated Care System we will operate as 'ONE SILO' – operating as 'ONE SILO' means that there will be pro-active seamless support for people of all ages delivered with a cohesive set of values based on our vision for our City

Our values will focus upon compassionate kind empathic responsive effective evidence based and empowering and enabling care, treatment and support that directs and enables individuals to achieve autonomy, self-efficacy growth and recovery and supports the achievement of optimum health to achieve wider personal aspirations hopes dreams and goals

Working as **ONE SILO** we will reduce the mortality gap, increase numbers of people in evidence based treatment, improve data collection and measurement to demonstrate improvement and exponential improvement and **integrate mental health care and physical health care and social care pathways systems and processes** achieving key deliverables of the mental health improvement blueprint. This is an important part of achieving mental health 'parity of esteem' which includes a focus on the performance management of CCGs regarding equity of access to evidence based care and treatment, equity of status in the measurement of mental health outcomes (including the April 2017 Mental Health Standard Data Set) and equity of funding both in terms of the CCG Mental Health Investment Standard but also with release of NHS England targeted investment funding (IAPT Expansion, Mental Health Liaison, Crisis and Urgent Care, Perinatal Mental Health and New Models of Care Vanguard).

Five Key Priorities of our Mental Health Commissioning Strategy 2018/19-2020/21 are therefore

Building our strategy from the Five Year Forward View for Mental Health (2016) and Future in Mind (2015) the **KEY FIVE PRIORITIES** are as follows:

- **Integration of mental and physical health - closing the mortality gap** - having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population (Future in Mind 2015). Five Year Forward View For Mental Health highlights that people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 % whereas providing dedicated mental health provision can improve outcomes, such as in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Pilot schemes show providing such support improves health and cuts costs by 25%.
- **Improving access to the quality and evidence base and improving access to and responsiveness of services, referral to treatment and waiting times - closing the treatment gap** - a UK epidemiological study suggests that less than 25% – 35% of individuals with a diagnosable mental health condition accessed appropriate help (Future in Mind 2015). In addition there is a strong link between parental (especially maternal) mental health and children’s mental health. Future in Mind highlights that according to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country and that almost three-quarters of this cost (72%) relates to the impact on the child / infant. £1.2 billion of the long-term cost is borne by the NHS (Future in Mind, 2015). **There is a requirement for access to evidence based interventions across the lifespan and that access to services in a NICE concordant evidence based care pathway is measured and reported along with measurement of outcomes.** (See Fig. 2 below).

- **Improving Data Quality – closing the data quality gap** - our system recognises that there is a need for good, transparent, regular data and information that is collected in line with national requirements reporting recording new KPIs / measurements etc. including use of the APRIL 17 New MH SDS and the monitoring new access and waiting times and referral to treatment standards such as within IAPT, Early Intervention In Psychosis and Eating Disorders Services. We will build on our achievements in promoting better, more joined-up data.
- **CCGs commitment to Mental Health Investment Standard - closing the parity of esteem / funding gap** (in addition to the Mental Health Investment Standard our commitment to parity of esteem includes submitting applications for NHS E Transformation funding and funding for New Models of Care that meet our local needs and needs on a BC&WB footprint).
- **Improving the Wider Determinants of Mental Health – closing the early intervention and prevention gap** - the Five Year Forward View for Mental Health highlights that between 60–70 % of people with common mental health problems are in work, yet few employees have access to specialist occupational health services and that for people being supported by secondary mental health services, there is a 65 % employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression. People in marginalised groups are at greater risk, including people from BAME and LGBT+

groups, disabled people, care leavers, people who have had contact with the criminal justice system, amongst others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems. People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a Learning Disability and /or Autism are also at higher risk. As many as nine out of ten people in prison have a mental health, drug or alcohol problem. **These statistics emphasise the requirement for a focus upon the wider determinants of mental health and targeted mental health promotion across the lifespan and across universal services and primary secondary and tertiary care delivered as part of our local Prevention Concordat.**

Early Intervention in Psychosis

If everyone who needed
Early Intervention in
Psychosis received a
service, each year the
NHS would save



£44 million

Source: National Institute for Health and Care Excellence, 2014. Costing statement: Psychosis and schizophrenia in adults: treatment and management

This Mental Health Commissioning Strategy 2018/19 – 2020/21 describes our plans therefore regarding delivery against the mental health improvement blue print to develop our **Mental Health Integrated Care System** and close gaps in service provision across our footprint working with partners across our STP to deliver evidence based services of critical mass and at scale and pace delivering value for money and avoiding unnecessary duplication of costs.

Areas of particular development include the IAPT Expansion (including Perinatal IAPT, IAPT for LTCs, and increasing access to IAPT for Older People and People from BAME Groups), Urgent Care Services, Planned Care Services, Perinatal Mental Health Services, Early Intervention in Psychosis Services, Personality Disorder Services, Neurodevelopmental Services, Assertive Outreach Services (in Adult Community Mental Health / Community Recovery Teams), and Dual Diagnosis Services (Alcohol and Substance Misuse and Mental Health Services). Medical staffing across some services requires some review to ensure an appropriate distribution of senior clinicians across the Primary, Secondary and Tertiary Care i.e. Community and In-patient services to deliver fidelity with the evidence base and deliver admission avoidance and right care in the right place and at the right time for example.

Wider approaches led by the Council will also contribute in this context: the development of the £3m “Wolves Into Work” programme supporting people with disabilities – including those with mental health needs – to return to employment; the use of a £10m “HeadStart” programme promoting the mental health of children and young people in the City; recognition of the City of Wolverhampton as a Dementia friendly city; suicide prevention; ongoing support to family carers; etc.

We will redesign care pathways across primary and secondary care mental health to ensure early intervention and prevention and prevent avoidable use of secondary and tertiary care including Out of Area Treatments (OATs) such acute overspill placements.

This approach is both clinically and financially inefficient with poor outcomes for patients and their carers - such as delays accessing services and longer recovery periods - and higher financial costs.

BC&WB STP level collaborative commissioning across the mental health improvement blue print where appropriate and required and some other areas of critical need will allow re-calibration and re-specification of some services including their financial profiles to ensure value for money and provide opportunities for reinvestment where there are gaps or service development requirements for example.

Improving the quality and responsiveness of key services with adherence to an agreed evidence base across a broader footprint is therefore a key ambition as is improving the clinical effectiveness of services whilst achieving value for money by driving down costs associated with sub-optimal delivery models. This includes a focus upon improving services associated with frequent relapse rates and re-admissions, lengths of stay and discharge delays and inefficient mental / physical health care pathways including those for people with long term conditions and /or people who self-harm for example (including high volume service users).

New or revised services and service specifications will be delivered within the financial envelope our commissioning authorities i.e. NHS W CCG and CWC. Resources – including key elements of our workforce - will be used to best effect with strong clinical and medical leadership evident at each part of the **Mental Health Integrated Care System**. This is in addition to any transformation funds applied for and received from NHS England for example including ‘Winter Pressures’ and A&E Delivery Board funding used to ‘pump prime’ change. Compliance with the Mental Health Investment Standard will be supported across all CCG commissioned activity. A **Financial Plan** will form part of the **Mental Health Strategy Implementation Plan**.

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH DELIVERABLES are outlined in the table below:

The Five Year Forward View For Mental Health Deliverables (NHS England - 2017)

Overall Goals for 2017-2019

Implementing the Mental Health Forward View (2017) sets out clear deliverables for putting the recommendations of the Independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/2021 in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this.

Deliverables for 2018/19 and 2019/2020 2020//2021

Each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs' auditors will be required to validate their 2018/19 year-end position on meeting the MHIS.

Ensure that an additional 49,000 children and young people receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people's mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs.

Make further progress towards delivering the 2020/21 waiting time standards for children and young people's eating disorder services of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases (in WOLVERHAMPTON this standard is also being applied to our Adult Eating Disorder Service).

Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds.

Continue to increase access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.
Continue to improve access to psychological therapies (IAPT) services with, maintaining the increase of 60,000 people accessing treatment achieved in 2017/18 and increase by a further 140,000 delivering a national access rate of 19% for people with common mental health conditions with support from Health Education England (HEE) who are commissioning of 1,000 replacement practitioners and a further 1,000 trainees to expand services. This will release 1,500 mental health therapists to work in primary care. Approximately two-thirds of the increase to psychological therapies should be in new integrated services focused on people with co-morbid long term physical health conditions and/or medically unexplained symptoms, delivered in primary care. Continue to ensure that all IAPT access, waiting time and recovery standards are met.
Continue to work towards the 2020/21 ambition of all acute hospitals having mental health crisis and liaison services that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals subject to hospitals being able to successfully recruit.
Ensure that 53% of patients requiring early intervention for psychosis receive NICE concordant care within two weeks.
Support delivery of STP-level plans to reduce all inappropriate adult 'acute overspill' out of area placements (OATs) by 2020/21, including increasing investment for Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21.
Review all patients who are placed out of area to ensure that have appropriate packages of care.
Deliver annual physical health checks and interventions, in line with guidance, to at least 280,000 people with a severe mental health illness (SMI).
Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and

home treatment teams and mental health liaison services in acute hospitals.
Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.
Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.
Provide a 25% increase nationally on 2017/18 baseline in access to Individual Placement and Support services (IPS).
Maintain the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care (in WOLVERHAMPTON as we are achieving this target we have a 'stretch target'. Have due regard to the NHS implementation guidance on dementia focusing on post-diagnostic care and support.
Support disabled people and people with complex health needs to benefit from a personal health budget, with expansion to over 20,000 people in 2017/18 and 40,000+ in 2018/19.
Continue to maintain focus on diagnosis and post-diagnostic support for people with dementia and their carers (key drivers to keeping in their own homes, preventing crises and avoiding unnecessary admission to hospital).
Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and

home treatment teams and mental health liaison services in acute hospitals.
Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
Eliminate out of area placements for non-specialist acute care by 2020/21.
Measurable improvement on all areas of Prime Minister’s challenge on dementia 2020, including: <ul style="list-style-type: none"> • maintain a diagnosis rate of at least two thirds • increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral • improve quality of post-diagnosis treatment and support for people with dementia and their carers
To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce).
Access and waiting time standards for mental health services embedded, including: 50% of people experiencing first episode of psychosis to access treatment within two weeks; and 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks.
Deliver the contribution to the mental health workforce expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people’s workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21.
Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicide rate by 2020/21.
Deliver liaison and diversion services to 83% of the population.
Ensure all commissioned activity is recorded and reported through the Mental Health Services Dataset.

2. INFORMATION REGARDING PREVALENCE AND NEED

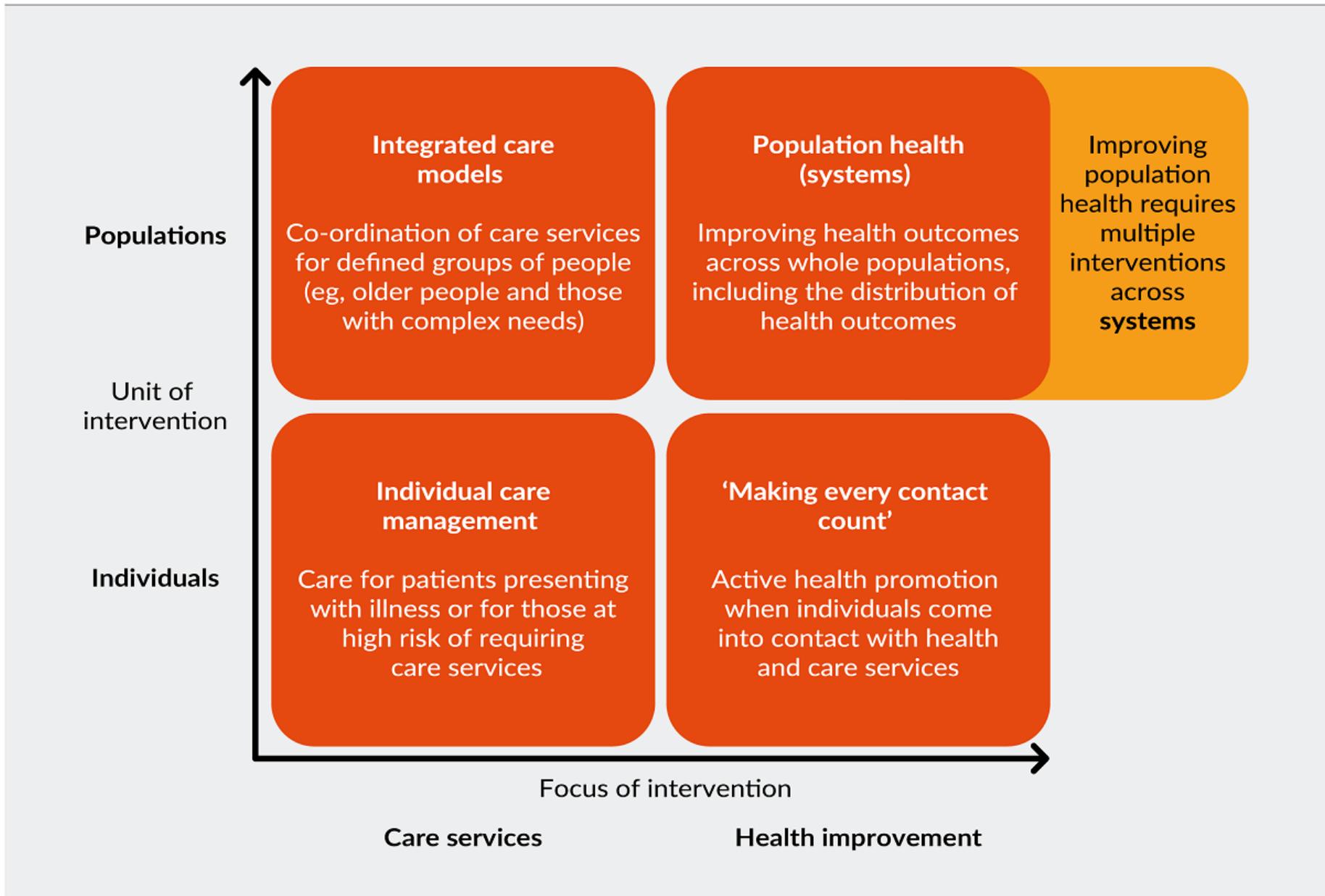
This section of our strategy outlines key information and associated priorities and deliverables in terms of our understanding of the local and national picture in terms of mental health need.

Our **Mental Health Integrated Care System** will respond **pro-actively and with compassion** to the impact of mental health difficulties and mental illness on individuals, families, communities and our City delivering mental health promotion and local anti-stigma campaigns and initiatives that support self-help, peer support, autonomy, self-efficacy, personal growth and recovery across universal, primary, secondary and tertiary services.

Integrated Care is described by the Kings Fund (Ham, 2017) below:

‘Breaking down barriers means co-ordinating the work of general practices, community services and hospitals to meet the needs of people requiring care. This is particularly important for the growing numbers of people with several medical conditions who receive care and support from a variety of health and social care staff.....The NHS also needs to give greater priority to the prevention of ill health by working with local authorities and other agencies to tackle the wider determinants of health and wellbeing. This means tackling risk factors such as obesity and redoubling efforts to reduce health inequalities. And it means fully engaging the public in changing lifestyles and behaviours that contribute to ill health and acting on the recommendations of the Marmot report and other reviews to improve population health..... Integrated care happens when NHS organisations work together to meet the needs of their local population. Some forms of integrated care involve local authorities and the third sector in working towards these objectives alongside NHS organisations. The most ambitious forms of integrated care aim to improve population health by tackling the causes of illness and the wider determinants of health.’

The significance of understanding population need is demonstrated in the Kings Fund diagram below (Fig 3):



Local and national population based information has and will inform the development and implementation of our **Mental Health Integrated Care System**.

The report of the Mental Health Foundation **Thriving or Surviving (2017)** – “To help us all live mentally healthier lives” <https://www.mentalhealth.org.uk/sites/default/files/surviving-or-thriving-state-uk-mental-health.pdf> has highlighted that only a small minority of people in England (13%) report living with high levels of good mental health. **The figures show that the experience of poor mental health, while touching every age and demographic, is not evenly distributed. If you are female, a young adult, on low income or unemployed, living alone or in a large household, your risks of facing mental ill health are higher.**

In addition the **THRIVE WEST MIDLANDS an Action Plan to drive better mental health and wellbeing in the West Midlands (2016)**. <https://www.wmca.org.uk/media/1420/wmca-mental-health-commission-thrive-full-doc.pdf> describes the priorities for mental health and well-being for our City.

THRIVE is driven by the local government perspective on mental health which has been most recently articulated in the LGA 2017 Report “Being mindful of mental health – the role of local government in mental health and being.”

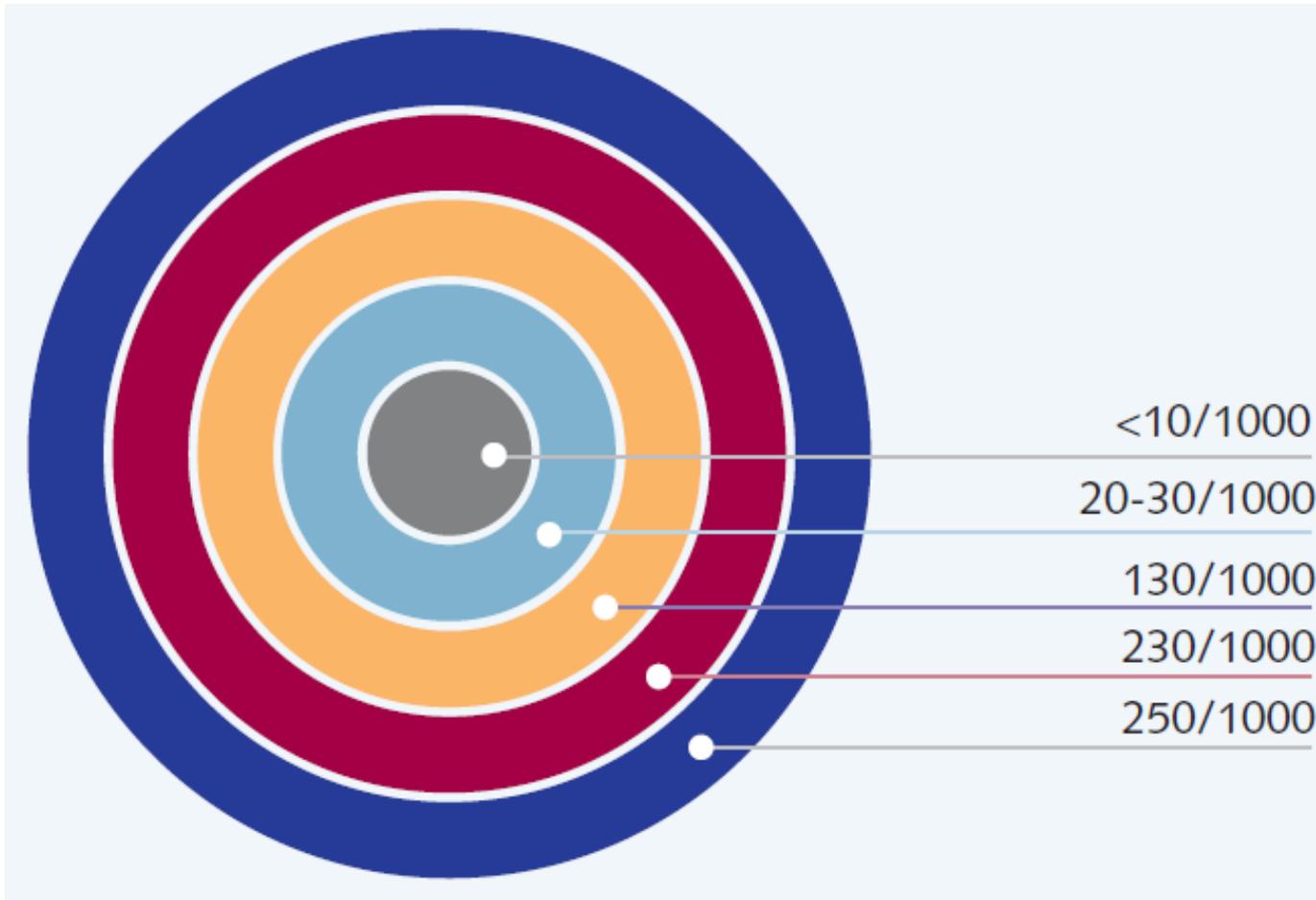
Our commissioning priorities outlined in this strategy re-fresh will respond to the critical issues and factors that exist in Wolverhampton in terms of levels of inequality in health and social outcomes and also address our knowledge and understanding of local levels and type of mental health need and our response to tackling inequalities and preventing mental health difficulties occurring wherever possible.

A local assessment of need is attached as Appendix 1.

A summary of some key demographic and local and national prevalence related data is described below.

The illustration below is taken from the Joint Commissioning Panel for Mental Health guidance 'Practical Mental Health Commissioning' (2011).

Numbers of people affected by mental health problems



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Mental health problems affect about one in four people – that is, 250 per 1000 at risk (see figure 4). Of those 250 people, the vast majority – about 230 – attend their general practice. Of these 230, about 130 are subsequently diagnosed as having a mental health problem, only between 20 and 30 are referred to a specialist mental health service, and fewer than 10 are ever admitted to a mental health hospital.

Number of people affected by mental health problems

The table below shows the number of people affected by mental health problems by applying the above prevalence to Wolverhampton’s 2011 census total population of 248,470, of whom adults are 186,508.

	Prevalence	Wolverhampton
Number of people at risk of mental health problem	250/1,000	46,627
Of those at risk attending GP	230/1,000	42,897
Subsequently diagnosed as having mental health problem	130/1,000	24,246
Referred to Specialist Mental Health Service	20-30/1,000	5,595
Admitted to Mental Health Hospital	<10/1,000	1865

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The following three tables show the number of patients on GP systems who are recorded as having general, common mental illnesses and severe mental illness by ethnic and age group

Age	0-16	17-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100+	Total
General												
Anxiety	42	42	243	329	377	351	287	226	100	18		2015
Depression	31	101	1477	2173	2534	2391	1574	954	432	82	1	11750
Phobias	2	1	23	36	34	34	34	13	7	1		185
OCD	11	10	62	82	71	44	31	18	5	1		335
Common Mental Illness												

DRAFT MENTAL HEALTH COMMISSIONING STRATEGY 2018/19-2020/21

Depressive Episode	53	159	2041	3191	3766	3624	2494	1568	725	148	5	17774
General	6	4	47	55	89	77	79	66	31	7		461
Mixed	8	11	59	103	115	148	102	66	32	6		650
Panic Disorder	2	5	17	42	44	46	35	21	13	2		227
PTSD	12	15	148	203	197	163	92	36	8	1		875
Severe Mental Illness												
Bipolar	2	3	51	106	111	126	84	60	20	2		565
Schizophrenia		1	13	43	61	64	45	32	15	2		276
Total	169	352	4,181	6,363	7,399	7,068	4,857	3,060	1,388	270	6	35,113

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Mental Health Illness by ethnic group

69.4% (n=24,383) of patients from white ethnic origin, 10.5% (n=3,687) Asian, 3.6% (1,278) Black, 14.1% (4,946) other and 2.3% (n=819) from mixed ethnic origin have mental health illnesses.

	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White	Grand Total
General						
Anxiety	273	73	36	309	1324	2015
Depression	1216	442	278	1456	8358	11750
Phobias	15	3	4	32	131	185
OCD	59	6	5	42	223	335
Common Mental Illness						
Depressive Episode	1656	593	407	2674	12444	17774
General	61	11	9	43	337	461
Mixed	79	19	12	77	463	650
Panic Disorder	39	5	3	33	147	227

DRAFT MENTAL HEALTH COMMISSIONING STRATEGY 2018/19-2020/21

PTSD	139	67	30	160	479	875
Severe Mental Illness						
Bipolar	91	25	22	84	343	565
Schizophrenia	59	34	13	36	134	276
Total	3,687	1,278	819	4,946	24,383	35,113

Mental Health Illness by gender

Women predominantly have more (62.5%) recorded mental health illnesses compared to men (37.5%).

	Female	Male	Total
General			
Anxiety	1198	817	2015
Depression	7510	4240	11750
Phobias	100	85	185
OCD (Obsessive compulsive disorder)	175	160	335
Common Mental Illness			
Depressive Episode	11297	6477	17774
General Episode	249	212	461
Mixed anxiety and depressive disorder	393	257	650
Panic Disorder	160	67	227
PTSD (post traumatic distress disorder)	428	447	875
Severe Mental Illness			
Bipolar	318	247	565
Schizophrenia	102	174	276
Total	21,930	13,183	35,113

The Wolverhampton 2011 census describes our resident population as 248,470. The average age in Wolverhampton is 39 years, which is similar to the England average; however Wolverhampton has a slightly higher proportion of children aged under 16. In terms of ethnicity, 68% Wolverhampton residents are from a white ethnic background with the remaining 32% of residents belonging to black minority ethnic backgrounds (BAME). Wolverhampton has high numbers of new arrivals arriving into the City each year including traveller families (estimated 2700 families in 2012). In terms of levels of deprivation in our City Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the more affluent wards in the west of the city. A number of sources of evidence suggest that a number of equalities and demographic factors can have a significant effect on the local need and uptake of mental health services, including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender (LGBT+)
- Substance misuse

- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

Interventions to support the specific needs and vulnerabilities of key groups should include disabled people, people with learning difficulties and older people both in terms of social isolation and self-efficacy and barriers to accessing appropriate levels of support (including barriers to communication in the case of people with sensory impairments and c/ or physical disabilities and / or LTCs for example). We will extend our support to carers both in terms of access to and responsiveness of services but also by ensuring there are adequate and supportive 'carers care plans' especially for carers of people with high levels of need including people subject to Section 117 Mental Health Act 1983 and the Care Programme Approach (CPA).

In addition we wish to place a particular focus upon the needs of people of all ages with conditions such as Autism and Attention Deficit Hyperactivity Disorder, Personality Disorder and Veterans and Serving Members of Her Majesty's Armed Forces and their families. We will also focus specifically upon the needs of both Older People and Children and Young People transitioning to Adult Mental Health Services, all of whom are at risk of falling between gaps in services or lack of connectivity across / between services.

Mental health services and care pathways and services should also specifically consider and address the mental health needs of pre and post-natal mothers, people with co-morbid substance misuse and people with learning disabilities (national prevalence of people with learning disabilities with co-occurring mental health problems is estimated to be 25–40%, 'No Health without Mental Health', 2011).

Perinatal Mental Health

The impact of perinatal mental ill health is highlighted in Future in Mind (2015) as per the information below:

‘There is a strong link between parental (particularly maternal) mental health and children’s mental health. For this reason, it is as important to look after maternal mental health during and following pregnancy as it is maternal physical health. According to a recent study, maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country.³⁶ Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother. Some £1.2 billion of the long-term cost is borne by the NHS.’

As referenced in earlier and later sections of this document over the past 18 months WOLVERHAMPTON CCG has hosted a project on behalf of our BC&WB STP and LMS partners. We have successfully applied for NHS ENGLAND TRANSFORMATION FUNDING to develop a Specialist Perinatal Community Mental Health Service operating across our BC&WB footprint to enable our health and social care community to pro-actively respond to local/national risk factors and train staff across our maternity, health visiting and primary and secondary care mental health system in rapid identification of risk and evidence based assessment.

We expect the majority of referrals into our SPA to come from ante and post-natal screening by midwives and also health visitors, GPs and staff in primary and secondary mental health services. Self-referral is accepted. (There are 20,000 births per annum (ONS) across the BC&WB STP- 5% of these women will be seen by the SCPMHS).

We have worked to pro-actively target areas of particular need using local knowledge by GP surgery and electoral ward including key risk and deprivation markers in line with national and local risk factors/history as follows:

- Perinatal mental health difficulties

- Childhood abuse and neglect
- Domestic violence
- Poverty/deprivation/economically inactive/unemployed
- Poor housing/accommodation status
- Sexual violence/abuse
- Interpersonal conflict
- Inadequate social support
- Alcohol or substance misuse
- Unplanned or unwanted pregnancy
- Birth trauma, premature birth, child mortality, still birth
- Child removed/placed in care
- Children attaining poor developmental milestones
- Migration status/new arrivals
- People from Black and Minority Ethnic Groups
- Forced marriage
- Family dysfunction

To ensure our SPCMHS achieves the transformation required our service specification includes a focus upon multi-agency and multi-disciplinary person and family centred care ensuring that we:

- promote the self-efficacy and resilience of the patient, child, family, friends and carers

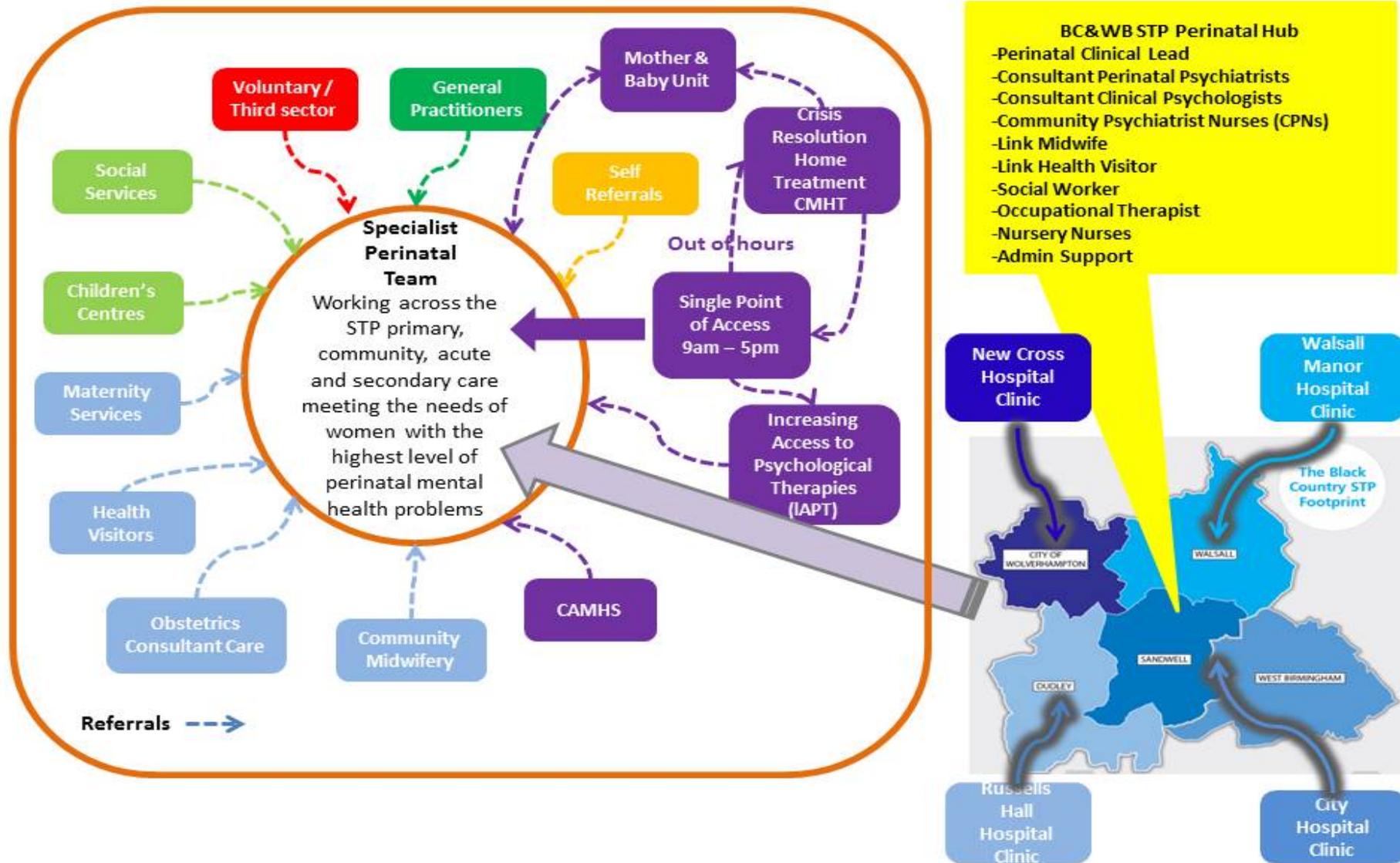
- provide evidenced-based treatment and care pathways across a range of bio-medico-psycho-social interventions and access to vocational/training/employment support
- reduce maternal/child deaths from psychiatric causes (suicide or substance misuse)
- use evidence based risk tools such as Whooley questions, Beck and Edinburgh Scale
- monitor outcomes via evidence based outcome and reporting tools includes PREMS, PROMS and CROMS
- enhance the experience/outcomes of women by promoting informed choice from preconception counselling to 1 year following their delivery, having the infant mother and their relationship triad as the paramount focus
- incorporate lived experience in shaping thereby improving the experience of service users

Our Black Country and West Birmingham Perinatal Mental Health Whole System is described in the diagram below:

Key outcome themes are:

- perinatal mental health parity of esteem
- Integrated care and multi-agency working
- Early detection and prediction of risk and promotion of mental health and wellbeing
- Rapid access to intervention
- Access to perinatal mental health bio-medico-psycho-social therapies
- Support for mothers, their partners, children and wider family including stigma reduction

Black Country and West Birmingham (BC&WB) STP Specialist Perinatal Community Mental Health Service Model



Black and Minority Ethnic Groups

The over representation of people from BAME groups has locally and nationally focussed upon the need to commission culturally sensitive services particularly for particular groups of men and women including new arrivals. In Wolverhampton we need to continue to address over representation of key groups specifically in relating to formal admission under the Mental Health Act 1983. The relatively low prevalence of numbers of children from BAME groups referred to Tier 2 and Tier 3 CAMHS (less than 20% of referrals, compared with 41% of the population of children and young people in our City) suggests that prevention and early intervention should include a focus upon targeted interventions for children and young people and their parents and carers from BAME groups and communities of new arrivals.

Dual Diagnosis

The term “Dual Diagnosis” covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. Supporting people with mental health difficulties and substance misuse difficulties can be a significant challenge affecting the diagnosis, care and treatment of service users. Substance misuse should be understood to be usual rather than exceptional amongst people with severe mental health difficulties (Mental Health Policy Implementation Guide, Dual Diagnosis Good Practice Guide, 2002). Substance misuse and mental health difficulties may interact in a way which makes diagnosis, treatment and recovery more complex.

The term Dual Diagnosis can apply to people who:

- Develop mental health symptoms after problematic substance misuse use.
- Have a pre-existing mental health problem and then start using substances problematically.

Fragmented care across a number of different services can cause people to fall out of services, receive an inadequate or inappropriate type or level of service, or no service at all. An integrated approach provides better outcomes, providing locally agreed, evidence based care pathways for targeted groups within mainstream mental health and substance misuse services.

Substance Use and Psychiatric Syndromes (Rassool 2009):

- 74.5% of users of drug services, and 85.5% of users of alcohol services experienced mental health problems.
- Most experienced affective disorders i.e. anxiety / depression or psychosis.
- 38.5% were receiving no treatment for their mental health difficulty.
- 44% of mental health service users reported drug / alcohol use at hazardous or harmful levels in the past year.

Key Findings Cannabis and Psychosis Study - University Kings College London Study 2015

- 24% of all new psychosis patients were using potent cannabis such as 'skunk'
- Risk for users of cannabis developing psychosis three times higher and five times higher for daily users

'Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population. In addition, people with coexisting substance misuse have a higher risk of relapse and hospitalisation, and have higher levels of unmet needs compared with other inpatients with psychosis who do not misuse substances.'

'People with psychosis commonly take various non-prescribed substances as a way of coping with their symptoms, and in a third of people with psychosis, this amounts to harmful or dependent use. The outcome for people with psychosis and coexisting substance

misuse is worse than for people without coexisting substance misuse, partly because the substances used may exacerbate the psychosis and partly because substances often interfere with pharmacological or psychological treatment.’

(NICE Clinical Guideline, 2011)

Rassool (2009) – Problems associated with Dual Diagnosis

- Increased likelihood of self-harm
- Increased risk of HIV infection
- Increased use of institutional services
- Poor compliance with medication or treatment
- Homelessness
- Increased risk of violence
- Increased risk of victimisation or exploitation
- Higher recidivism
- Contact with the criminal justice system
- Family problems
- Poor social outcomes including impact on family and carers
- Denial of substance of misuse
- Negative attitudes of healthcare professionals
- Social exclusion

Why do Substance Use and Psychiatric Disorders Commonly Co-Occur? (Rassool 2009, adapted from NIDA, 2007)

‘Developmental Disorders – they often begin in adolescence or even childhood, periods when the brain is undergoing dramatic developmental changes. Early exposure to drugs of addiction can change the brain in ways that increase the risk for mental illness just as early symptoms of psychiatric disorder may increase vulnerability to alcohol and drug use.’

Genetic vulnerabilities – Evidence suggests that common genetic factors may pre-dispose individuals to both psychiatric disorders and addiction or to having a greater risk of the second disorder once the first appears.’

‘Environmental triggers – Stress, trauma (for example physical or sexual abuse) and early exposure to drugs are common factors that can lead to addiction and to psychiatric disorders particularly in those with underlying genetic vulnerabilities.’

Alcohol and Mental Health (Rassool 2009)

- 85.5% of users of alcohol services experienced mental health problems (Weaver et al 2002)
- Most had affective disorders (depression), anxiety and psychosis.
- Common links include depression, suicidal behaviour, OCD, anxiety disorders, bipolar disorders, schizophrenia and personality disorders.
- Alcohol is used to medicate psychological distress or symptoms (self-medication).

Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual

In 2013 a survey of Wolverhampton’s LGBT+ community highlighted significant mental health difficulties and concerns amongst respondents, in excess of what is understood nationally regarding higher levels of suicide, depression and self-harm within this group (LGBT+ Wolverhampton, 2013). The survey highlighted the prevalence of self-harm, suicidal ideation, depression and experience of bullying amongst the LGBT+ community locally and the important role of peer support in terms of improving outcomes and facilitating access to care pathways and services within the City.

Autism and Suicide

A 2016 study in Sweden revealed suicide is a leading cause of premature death in people with autism spectrum disorder, while research from Coventry University in 2014 showed 66% of adults newly diagnosed with Asperger Syndrome reported having contemplated ending their own lives.

It is estimated that 1 to 1.5 percent of the population has an autism spectrum condition. Approximately 50 per cent of people with autism also have a learning disability, and 30 per cent of people with autism experience severe mental health difficulties. National and local data indicate that people aged 55 and over with autism who probably have never received a diagnosis are the least likely of all age groups to access the support they may require. Most people with autism will not require long-term specialist health and social services, but they may need support at certain stages of their life to learn to manage and overcome their social, communication and sensory difficulties. In addition, the lives of people with autism could be significantly enhanced if their needs are known and recognised and those who interact with them have an awareness of the condition. Only 15% of adults diagnosed with autism in the UK are in full-time paid employment. National data show that children and young people with autism are more likely to experience difficulties at school. 27 per cent had been excluded from school and 50 per cent had changed schools other than age related transitions. This affects their lives as adults which this strategy addresses.

The Wolverhampton Joint Autism Strategy 2016 -2021 identified nine key objectives, with associated priorities:

1. Understanding local needs by collecting accurate data about autism
2. Providing access to high quality information, advice and support

3. Developing a clear and consistent diagnostic pathway, including post-diagnostic support
4. Increasing awareness and understanding of autism
5. Supporting children and young people with autism in preparing for adulthood
6. Enabling access to lifelong learning, increasing skills and inclusive employment
7. To help people with autism to keep healthy
8. Living well and increasing independence for people with autism
9. Access to support for families, parents and carers of people with autism

Adult Attention Deficit Hyperactivity Disorder symptoms may include:

- Impulsiveness
- Disorganization and difficulties prioritising tasks
- Poor time management skills
- Difficulties focusing on a task
- Difficulty multitasking
- Excessive activity or restlessness
- Poor planning
- Low frustration tolerance

- Frequent mood swings
- Problems following through and completing tasks
- Hot temper
- Trouble coping with stress

ADHD has been linked to:

- Poor school or work performance
- Unemployment
- Contact with the criminal justice system
- Alcohol or other substance abuse
- Frequent car accidents or other accidents
- Unstable relationships
- Poor physical and mental health
- Poor self-image
- Suicide attempts
- Coexisting conditions

Mood disorders - Many adults with ADHD also have depression, bipolar disorder or another mood disorder. While mood problems aren't necessarily due directly to ADHD, a repeated pattern of failures and frustrations due to ADHD can worsen depression.

Anxiety disorders - Anxiety disorders occur fairly often in adults with ADHD. Anxiety disorders may cause overwhelming worry, nervousness and other symptoms. Anxiety can be made worse by the challenges and setbacks caused by ADHD.

Other psychiatric disorders - Adults with ADHD are at increased risk of other psychiatric disorders, such as personality disorders, intermittent explosive disorder and substance abuse.

Learning disabilities - Adults with ADHD may score lower on academic testing than would be expected for their age, intelligence and education. Learning disabilities can include problems with understanding and communicating.

SF DON'T FORGET REFERENCE

Sexual Abuse

Data highlighted in 'No Health without Mental Health' (2011) identifies that although women are at greater risk of childhood sexual abuse and sexual violence (an estimated 7–30% of girls), 3–13% of boys have also experienced childhood sexual abuse. Whilst we need to understand more about the impact of sexual violence locally, nationally it is understood that 1 in 10 women have experienced some form of sexual victimisation, including rape and some studies have shown that 50% of female patients in psychiatric wards have lifetime experience of sexual abuse 'No Health without Mental Health' (2011).

Personality Disorder

Personality Disorder

The Community Mental Health Profile for Wolverhampton identifies that Wolverhampton is '**significantly worse**' than the England average in the following key factors in terms of deprivation and indicators of mental health prevalence and performance against key outcomes:

- Working age adults who are unemployed
- Percentage of the relevant population living in the 20% most deprived areas in England
- Episodes of violent crime
- Statutory homeless households
- Percentage of 16-18 year olds not in employment, education or training
- Percentage of the population with a limiting long term illness
- Percentage of adults (18+) with learning disabilities
- Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders
- Rate of Hospital Admissions for alcohol attributable conditions
- Percentage of referrals entering treatment from Improving Access to Psychological Therapies
- Numbers of people on a Care Programme Approach, rate per 1,000 population

The Community Mental Health Profile for Wolverhampton identifies that Wolverhampton is '**significantly better**' or '**not significantly different**' than the England average in the following key factors:

- Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population (**significantly better**)
- First time entrants into the youth justice system 10 to 17 year olds
- Percentage of adults (16+) participating in recommended level of physical activity
- Percentage of adults (18+) with dementia
- Ratio of recorded to expected prevalence of dementia
- Percentage of adults (18+) with depression (**significantly better**)
- Directly standardised rate for hospital admissions for mental health (**significantly better**)

- Directly standardised rate for hospital admissions for unipolar depressive disorders
- Directly standardised rate for hospital admissions for Alzheimer's and other related dementia (**significantly better**)
- Allocated average spend for mental health per head
- In-year bed days for mental health, rate per 1,000 population (**significantly lower**)
- Number of contacts with Community Psychiatric Nurse, rate per 1,000 population (**significantly better**)
- Number of total contacts with mental health services, rate per 1,000 population (**significantly higher**)
- People with mental illness and or disability in settled accommodation (**significantly better**)
- Indirectly standardised mortality rate for suicide and undetermined injury
- Improving Access to Psychological Therapies - Recovery Rate
- Excess under 75 mortality rate in adults with serious mental illness (**significantly better**)

The Right Care Data identifies the following key issues / areas for improvement for WOLVERHAMPTON

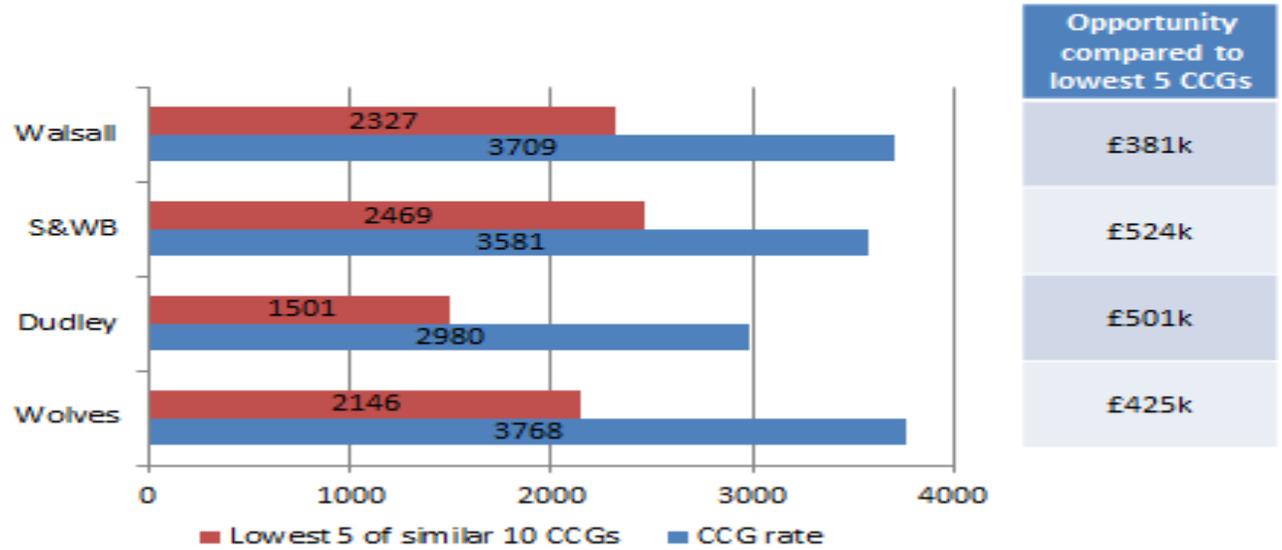
(Dear All please note I have asked NHS E for the refreshed Right Care information as some of this is no longer valid / out of date e.g. EIP)

Severe mental illness pathway

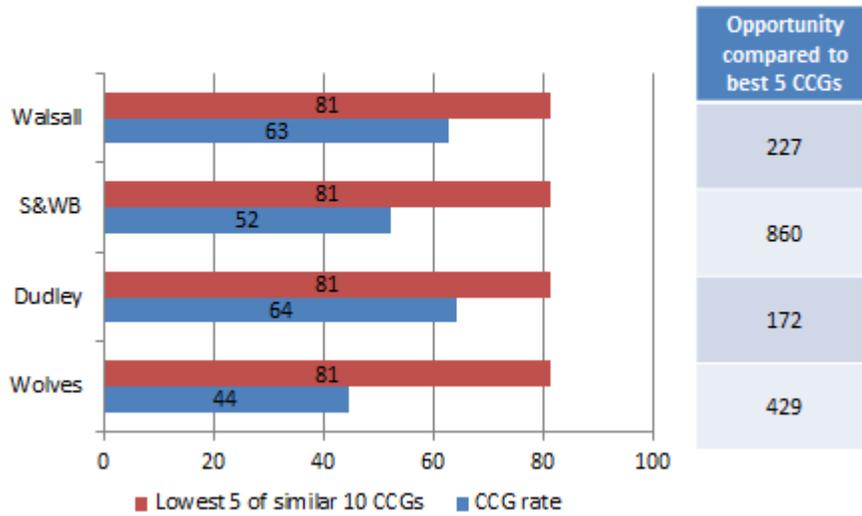


	2015	2012	2015/16	2015/16	2014/15	April 2015- August 2016	April 2015- August 2016	2015/16 Q4 (Year End)	2015/16 Q2	2015/16 Q4	2015/16 Q4	2014/15	2015/16 Q2	2015/16 Q2	2015/16 Q2
	Deprivation	Estimate of people with a psychotic disorder	People with SMI known to GPs: % on register	Primary care prescribing spend	Physical health checks	% of EIP referrals waiting <2 wks to start treatment (Complete)	% of EIP referrals waiting >2 wks to start treatment (Incomplete)	New cases of psychosis served by Early Intervention teams	People treated by Early Intervention Teams	People on Care Programme Approach	% Service users on CPA	Mental health hospital admissions	People subject to mental health act	People on CPA in employment	% adults on CPA in settled accommodation
STP opportunity (to Best 5)					840 Pats.	17 Pats.	12 Pats.				1,216 Pats.	807 Adm.	112 Ppl.	102 Ppl.	80 Ppl.
Wolverhampton	▲	△	▲	▲	■	■	▽	▽	▽	▽	▽	■	■	▽	■
Walsall	▲	▽	▽	▲	△	△	△	▽	▽	▽	▲	■	■	▽	■
Dudley	▲	▲	▲	▲	▽	△	▽	▲	▲	▽	▲	■	■	■	■
Gandwell and West Birmingham	▲	▲	▲	▲	■	■	△	▽	▲	▽	▽	■	△	▽	△

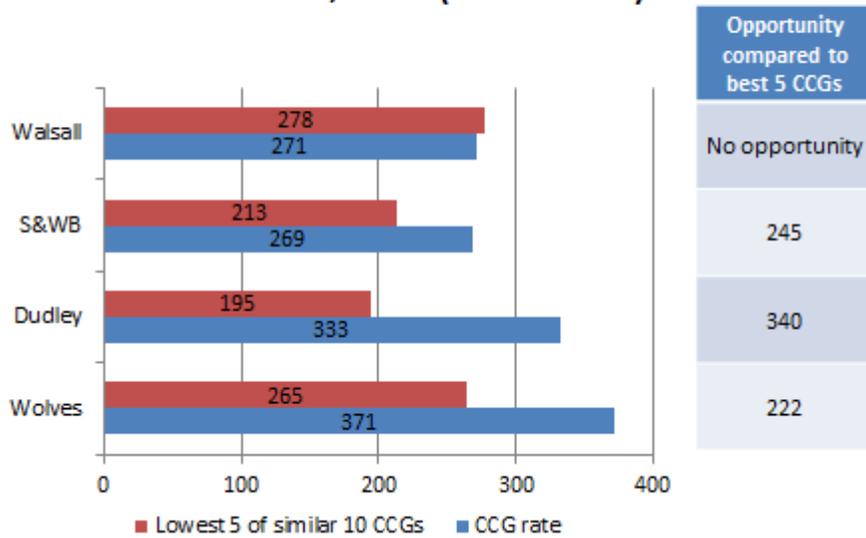
Psychosis primary care prescribing per 1,000 ASTRO-PU population (2015-16)



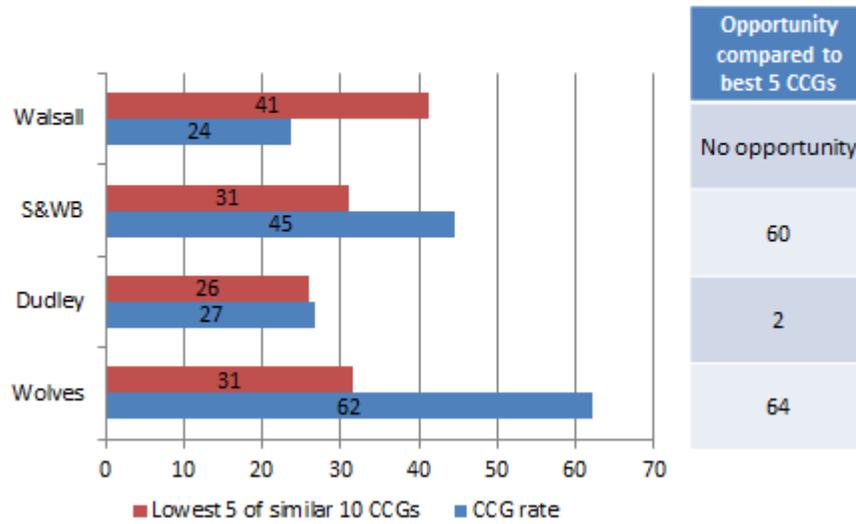
Percentage of people in the psychosis superclass who are on CPA (2014-15)



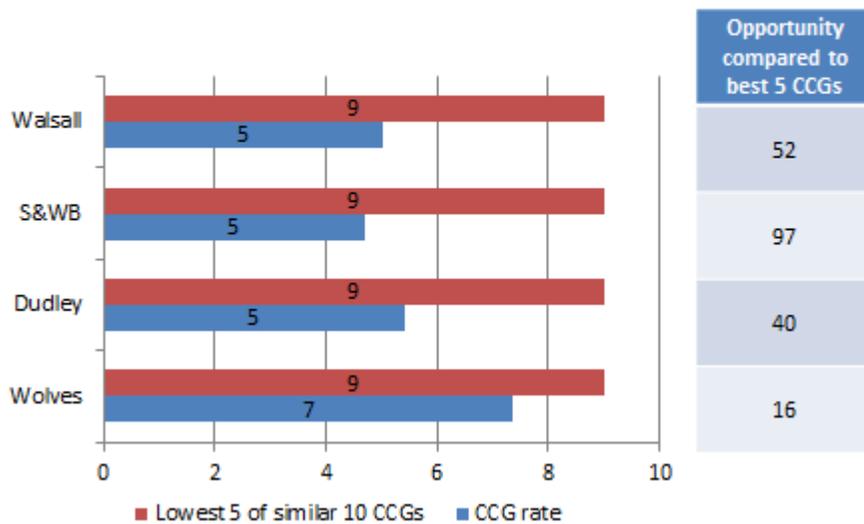
Mental Health hospital admissions per 100,000 (2014-15)



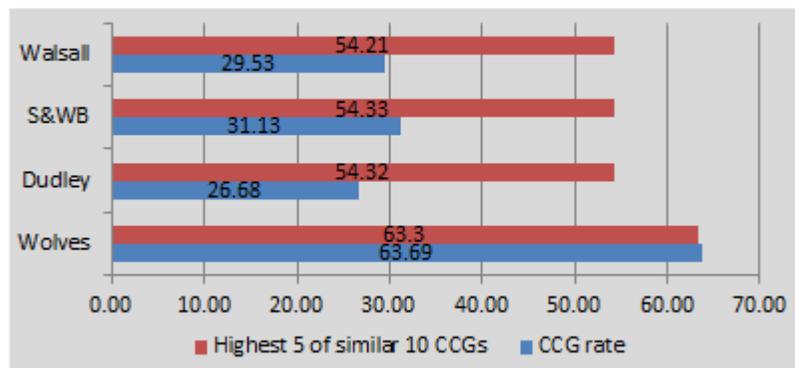
People subject to the Mental Health Act per 100,000 (2014-15)



Percentage of people on CPA in employment (2014-15)

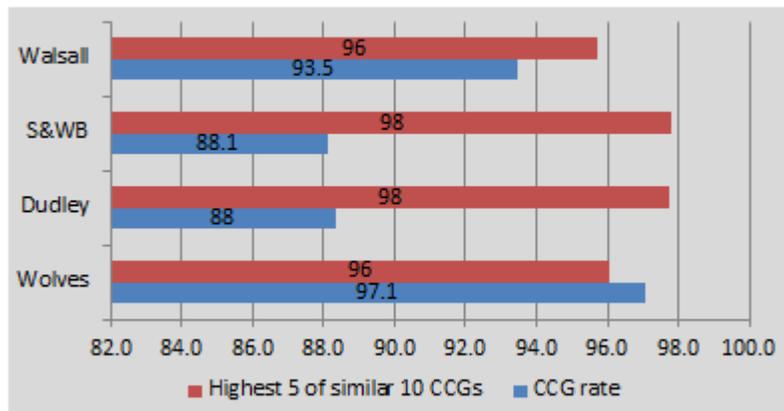


Percentage of people in contact with mental health services with their accommodation status recorded (2015/16 Q2)



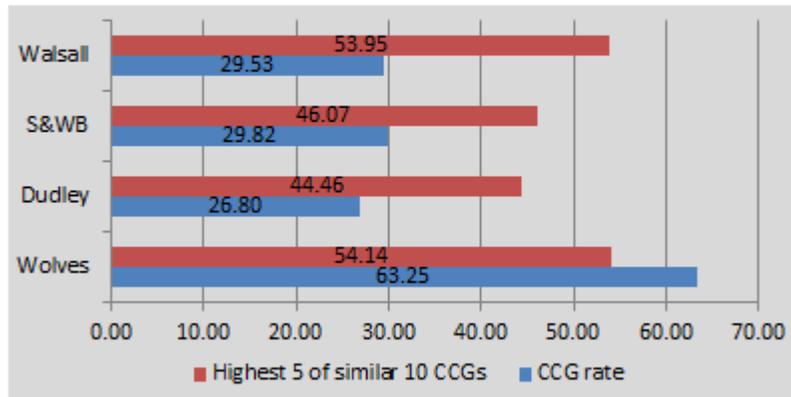
Opportunity – 4824 more people with accommodation status recorded. NB. Wolverhampton higher than average of highest 5 and therefore not included.

Percentage of cases where the ethnicity of the patient have been recorded (2014/15)



Opportunity – 2705 more cases with ethnicity recorded.

Percentage of people in contact with mental health services with their employment status recorded (2015/16 Q2)



Opportunity – 3608 more people with employment status recorded. NB. Wolverhampton higher than average of highest 5 and therefore not included.

Further detail regarding Right Care information is provided with the needs assessment information in Appendix 1.

The above information identifies key priorities however which are to:

- Reduce numbers of people accessing hospital based care –increasing community based support – reducing relapse and readmission rates
- Increase numbers of patients receiving CPA based care with crisis care plans and carers care plans

- Reduce numbers of people detained under the Mental Health Act
- Improve primary care based support (high numbers of primary care based prescribing)
- Improve Early Intervention in Psychosis access rates
- Improve SMI Physical Health Checks in Primary Care
- Ensure Care Plans are culturally competent – responding to ethnicity and cultural requirements of the patient and family and address housing and employment needs

Key national prevalence detail from the Five Year Forward View for Mental Health (2016) is outlined below

Young People

‘Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison.’

Mothers

‘One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have longstanding effects on children’s emotional, social and cognitive development.’

Physical Health

‘Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.’ In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.’

Stable employment and housing

‘Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.’

Veterans

‘Only half of veterans of the armed forces experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. ... It is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.’

Older People

‘One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.’

The University of Wolverhampton held an international conference on loneliness in February 2018 (more information at: <https://www.wlv.ac.uk/research/institutes-and-centres/centre-for-film-media-discourse-and-culture/loneliness/> Loneliness can occur at any age and not just amongst older people. The City of Wolverhampton Council has commissioned a provider to support our work to address this issue cf. <http://www.thesocialhub.org.uk/wolverhampton.html>.

Marginalised Groups

‘People in marginalised groups are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems. People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk. As many as nine out of ten people in prison have a mental health, drug or alcohol problem.’

Suicide

‘Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death. More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013.’

The above national prevalence information has also been used to inform our strategic vision and direction of travel.

In line with the Mental Health Five Year Forward View and the WOLVERHAMPTON CRISIS CONCORDAT our implementation plan will include specific actions to substantially reduce Mental Health Act detentions and also include targeted work to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates.

In addition we will work with BAME communities to develop trust in services and ensure pro-active community support. We will work with the voluntary and community sector that play a critical role in supporting groups that are currently less well served by services such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs. This will include developing peer support which is highly valued, especially by young people and BAME adults, and should be developed as a core part of the multi-disciplinary team. In addition The NHS Workforce Race Equality Standard (WRES) has no equivalent for people accessing services. The Five-year Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health

care (The Five Year Forward View for Mental Health, 2016). We will use our new Strategy and Strategy Implementation Plan for a local re-focus on this priority.

The Five Year Forward View for Mental Health emphasises that severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups, and that some groups are disproportionately represented in detentions to acute and secure inpatient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average suggesting a failure to ensure equal access to earlier intervention and crisis care services.

3. VISION AND VALUES

Our vision for mental health services in Wolverhampton is to develop a Mental Health Integrated Care System of health and social care pathways and services that will deliver mental health promotion, early intervention and prevention, assessment and diagnosis and care, treatment and intervention whilst also promoting independence, autonomy, self-efficacy and recovery across the life course.

Our aim is to work with service users and carers and across all partners and stakeholders to prevent people entering statutory services where possible and to provide care pathways into and through services to provide the right care in the right place and at the right time when this is required, including across Universal, Primary, Secondary, Tertiary statutory

and non-statutory services and with a focus upon mental health promotion, self-help, peer support and public mental health as part of our Prevention Concordat Strategy.

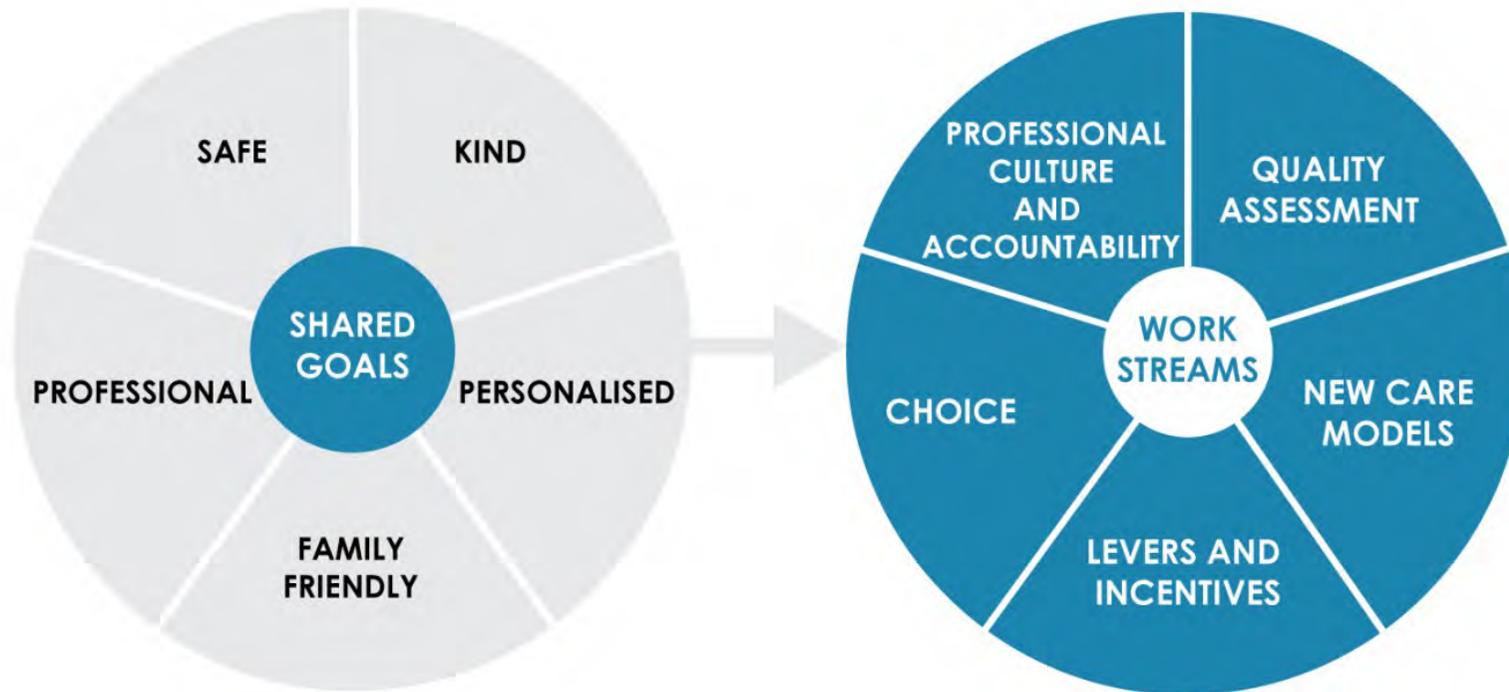
Coproduction with all service users and carers and staff across our Mental Health Integrated Care System is a key and important focus of our vision and values. We will all work together to establish the self-efficacy and recovery of our system, remove the stigma associated with mental health and support each other to thrive and grow.

Our commissioned model will meet the requirements of the Five year Forward View for Mental Health and the GP Five Year Forward View and the LGA 2017 Report “Being mindful of mental health – the role of local government in mental health and being;” and in addition support the delivery of aligned health and social care outcomes in line with the Better Care Fund to promote independence, improve physical health, optimise self-efficacy recovery and increase social inclusion at all stages of the care pathway and across the Mental Health Integrated Care System.

MAKING EVERY CONTACT COUNT we will develop a Mental Health Integrated Care System which provides pro-active care and support from the very first point of contact with the system so that from referral / self-referral service users and carers feel appropriately supported, signposted and directed as they access / egress care pathways with ease. We will develop a Mental Health Integrated Care System which will deliver evidence based, timely and responsive assessment diagnosis intervention treatment care and support with professionalism, accountability, kindness and compassion and providing opportunities for recovery, self-efficacy and growth, supporting people of all ages to achieve personal aspirations, hopes, dreams and goals.

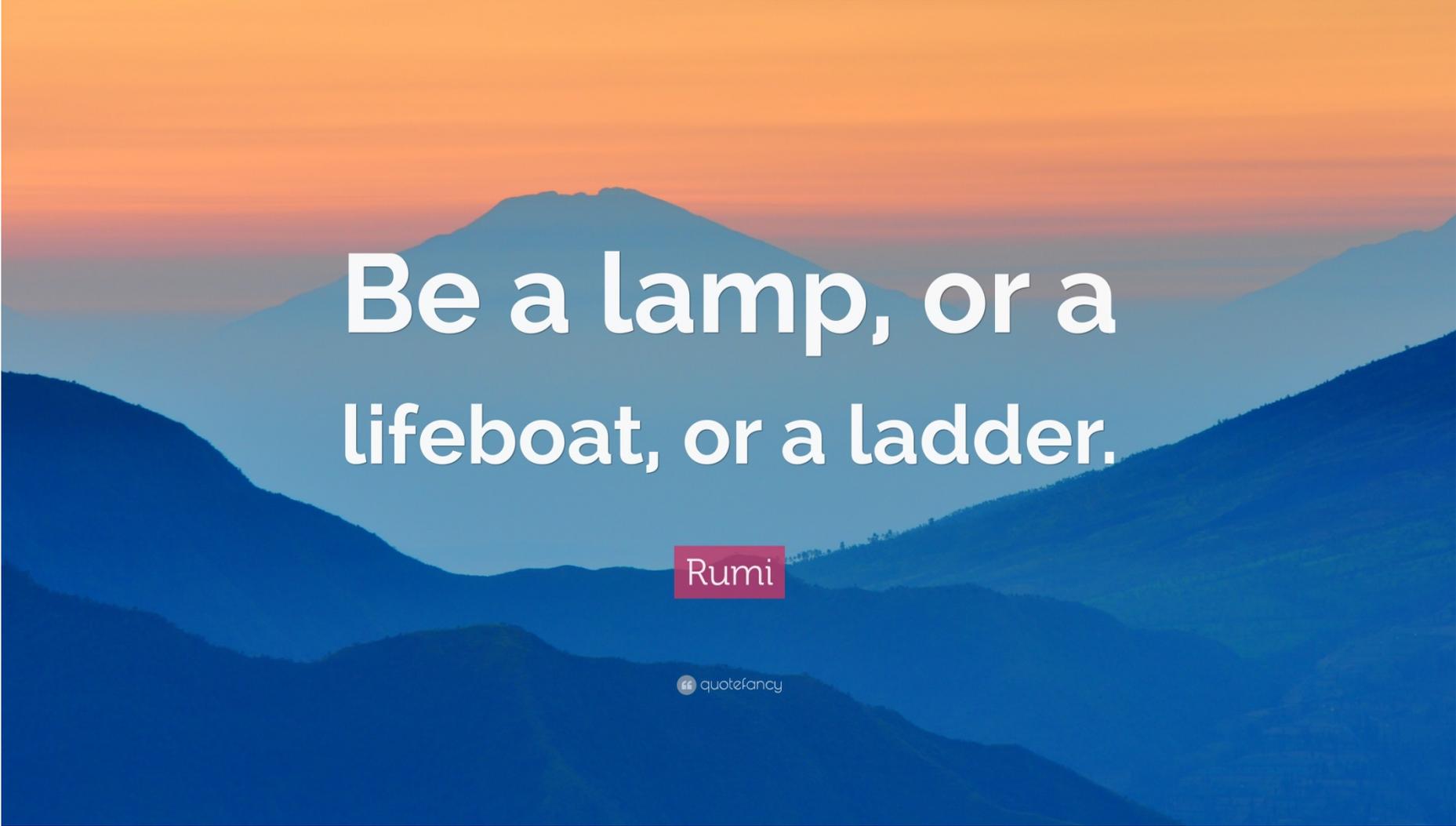
The aspirations of our vision and values and new care model are outlined in the diagram below:

(I HAVE PUT THE FOLLOWING DIAGRAM ABOUT VALUES IN AS AN EXAMPLE THAT I LIKE IT'S FROM BETTER BIRTHS – I'M WORKING ON ONE OF MY OWN)



Our Mental Health Integrated Care System will be a lamp, a lifeboat and a ladder.

(BCPFT are asking patients to do art work for this bit)



Be a lamp, or a
lifeboat, or a ladder.

Rumi

quote fancy

Key aspirations of our vision

Our vision is based on national and local prevalence and risk issues as well as local and national policy and strategic priorities and imperatives have informed our commissioning mental health strategy for Wolverhampton. This includes the mandate to NHS England that sets out the Government's commitment to give mental health parity of esteem with physical health and for us in WOLVERHAMPTON includes a commitment to:

- Removing the stigma attached to mental illness and mental ill health.
- Improving the access, responsiveness quality and of mental health services across the lifespan in line with the Five Year Forward View for Mental Health (removing the quality, treatment and evidence base gap) and ensuring that all patients have access to NICE compliant care
- A Primary Care Mental Health Revolution in line with the Five Year Forward View for Mental Health and the GP Forward View so that mental health services are interoperational with and embedded across primary care allowing access to shared systems such as graph net and doc man to improve the speed and accessibility of information sharing and to deliver e referrals and e discharge and advice and guidance across primary and secondary care and with primary care mental health therapists working across primary and secondary care
- A focus upon better integration of mental and physical health services across Primary Care Mental Health services and Acute and Community Services with a specific focus upon developing Mental Health Liaison CORE 24, improving the life expectancy of people with Severe Mental Illness (SMI) and also all people with mental health difficulties and delivering the IAPT programme for people with Long Term Conditions
- A Perinatal Mental Health programme delivered with Black Country and West Birmingham STP colleagues and the University of Wolverhampton that focuses upon integrated care across Maternity Womens and Childrens Services to improve the health of the mother, child, siblings, father and wider family in line with the BC&WB LMS

- A specific focus on mental health and wellbeing and mental health promotion across the lifespan and across universal primary secondary and tertiary services so that people are better able to access advice and guidance peer support self-help and self-management at every stage of the care pathway
- Improved data collation in line with the Five Year Forward View for Mental Health and the revised Mental Health Standard Data Set to ensure reporting and exponential improvements across new waiting times and access services and compliance with the Mental Health Five Year Forward View
- An information revolution so that people of all ages have better access to advice and information of all types so that people are better able to access advice and guidance peer support self-help and self-management at every stage of the care pathway. **This includes a specific focus on alcohol and substance misuse and the mental health related risks associated with both alcohol and substance misuse but also targeted interventions for individuals / communities with specific risks such as physical ill health and disability and / or neurological conditions, people from lesbian, gay, bisexual or transgender intersex or asexual groups, people experiencing poverty deprivation unemployed or who are economically inactive, people who are lonely and isolated, people who are homeless or in unsuitable accommodation, new arrivals into our City, veterans people who are homeless and people who are victims of bullying harassment and / or physical and / or sexual abuse and/ or trauma and people at risk of exploitation of any form.**
- Alignment with our dedicated transformation programme for children and young people's services to enhance access to evidence-based therapies (the Wolverhampton Local CAMHS Plan).
- Providing settled accommodation for people with mental illness to support their recovery and a pathway across, hospital based care, residential and nursing care, supported accommodation, domiciliary care and general needs housing.
- Improved access to joined-up and integrated health and social care as part of Section 117 MHA 1983 arrangements.

- Improving access to both Primary and Secondary IPS for people with mental health and / or physical health difficulties in line with our WMCA hosted RCT and our STP Secondary IPS model
- Support for CCG's commissioning Mental Health services from NHS England to commission evidence based services locally that are compliant with NICE Guidance and Quality Standards.
- Improved offender mental health – improve connectivity across our mental health and criminal justice services and NHS England commissioned Secure Care, Prison In-reach and the Reach Out Programme.
- Using the Friends and Family Test to allow all patients to comment on their experience of mental health services – including children's mental health services
- Developing use of PROMS CROMS PREMS and QALYS
- Delivery of our Better Care Fund Mental Health Urgent and Planned Care Pathways
- Delivery of our Better Care Fund Dementia Care Pathway – in line with our refreshed Dementia Strategy
- Delivery of our Autism Strategy with a focus upon staff training and support and alignment with access to employment and suicide prevention initiatives specifically to address high prevalence for people with autism in suicide and unemployment statistics
- Improved access to diagnosis care and support for people with ADHD – with focus on criminal justice support for people who have offended and focus on people at risk of offending and focus on people who misuse alcohol and or other substances to manage ADHD symptoms.
- Improved access to diagnosis care and support for people with Personality Disorder
- A refresh of our City's CPA Policy to ensure compliance with national guidance and deliver robust care plans and crisis plans for patients and carers across primary secondary and tertiary care
- Reducing Out of Area Treatments to zero by 2020/21 in line with the Five Year Forward View for Mental Health Mental Health

- A focus upon improve care pathways for high volume services uses building on the national CQUIN from 2017/18 and across 2018/19 to ensure pro-active support and intervention to reduce hospital and A&E attendances and admissions to RWT.
- A better and more comprehensive care pathway for people who have dual diagnosis i.e. mental health and alcohol and / or substance misuse that includes a specific function for specialist support and also three levels of staff training to ensure patients receive the right care in the right place and at the right time that is compassionate and NICE compliant and that patients do not fall through gaps
- WORKFORCE – support the development of the next generation of practitioners and leaders through continued participation in the Think Ahead programme for Social Workers working in Mental Health and other areas across the NHS.
- Deployment of a city-wide mental health social work team to help people with access to the provisions of the Care Act 2014, working with communities to provide or arrange support that help keep people with mental health needs well and independent.

The vision outlined above includes all elements of commissioned service delivery, including Health, Social Care, Education, Voluntary and Community and Third Sector and Independent Sector Services, Out of Area Treatments (OATs), mental health services commissioned by NHS England such as Secure Services and other specialised mental health services including CAMHS TIER 4 and In-patient Eating Disorder Services and In-patient Perinatal Mental Health Services and services to support veteran and serving members of the Armed Forces mental health and Prison In-reach Mental Health Services . The service development changes outlined in our priorities and implementation plan will increase capacity and capability within services locally to improve individual, familial and community resilience by increasing protective factors and promoting independence, increasing self-efficacy, reducing risk and enabling recovery.

For our local Wolverhampton **Mental Health Integrated Care System** to work effectively services will have a clear role, work to a defined set of clear system wide values and understand how the workings of each component part are connected to the delivery and ambitions and aspirations of the whole system, to deliver a set of clear care pathways and specified outcomes to meet the needs of our population. This will involve commissioning to increase the effectiveness and efficiency of services, improve care pathways and communication across the whole system and reduce duplication across service providers. This will include increasing capacity and capability locally to support people with severe and enduring and / or complex mental health needs and ensure effective and robust care coordination using the Care Programme Approach guidance 'Refocusing the Care Programme Approach Policy and Positive Practice Guidance' (HM Government 2008) and in addition respond to the independent review on the use of the Mental Health Act (cf. <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>).

It will also include interventions and actions that support the needs and requirements of people in Wolverhampton that have particular vulnerabilities including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism

- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender (LGBT+)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

The key building blocks of our refreshed and broader approach will include:

- **More appropriate and responsive services** – achieved by improving services and up skilling the workforce across the stepped care model to better respond to the needs of key groups to enable all members of the population to access all of our services equally and by working with all key stakeholders to that ensure that together we have a joined up approach to challenging and addressing the broader determinants of mental ill-health and stigma and discrimination and promote parity of esteem, compassion, equality and respect diversity and human rights. .
- **Wider community engagement** – achieved by extending stakeholder engagement to capture agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health and embedding agreed key deliverables into the Resilience Plan and Implementation Plan. Supported by our Community Development Workers. In the Local Authority, an Equality Analysis is required for every policy and strategy and one has been undertaken in respect of this Strategy to support CCG and Council partnership. More information at <http://www.wolverhampton.gov.uk/corporate/equalities-and-diversity>
- **Better information, communication and marketing** - achieved by improved data collation, capture and analysis of the City's vulnerable groups, mapping their needs and requirements and monitoring agreed actions via the implementation plan.

This will include a regular census of mental health patients and public mental health needs across the City and delivery of a pro-active marketing campaign aligned to parity of esteem and national campaigns such as Beat Bullying, Time to Change, Health Poverty Action, and Child Sexual Exploitation of the NSPCC.

4. OUR MODEL OF CARE

Our **Mental Health Integrated Care System** will allow service users to transition through and into and out of secondary mental health services and into primary care, and re-enter components of the system if / as required. Fundamental principles underlining this approach will include:

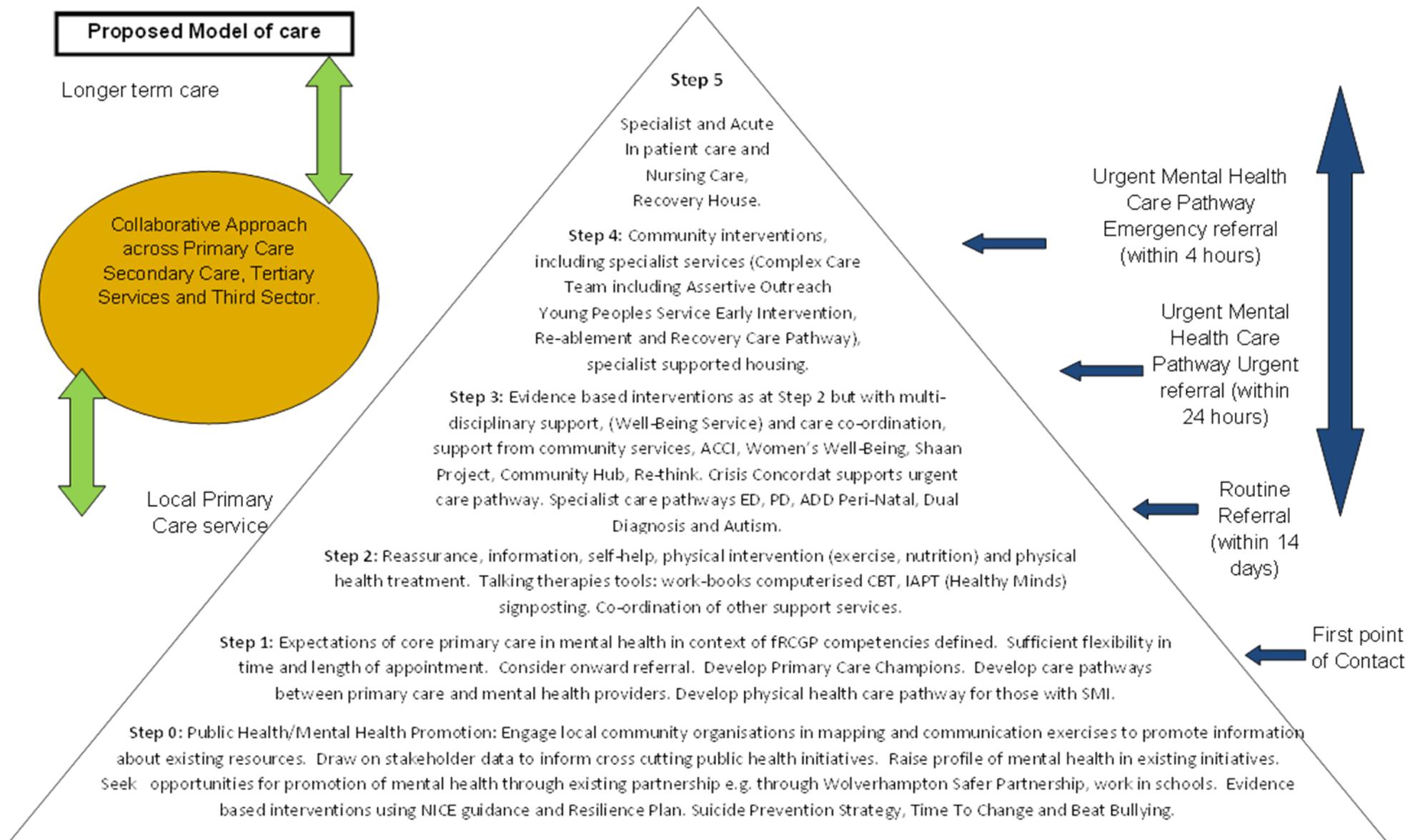
- A mental health 'whole system' of care pathways and services delivering recovery orientated interventions and support.
- The Mental Health Better Care Fund Urgent and Planned Mental Health and Dementia Care Pathways delivering integrated health and social care
- Improved connectivity and joined up ness across and communication with universal, primary care, secondary and tertiary mental health services.
- A set of services and care pathways collaboratively commissioned across our Black Country and West Birmingham STP
- Clear access and / or referral criteria at every stage of the patient journey
- Transition into and out of services as appropriate and in keeping with the Care Programme Approach.
- Access to services 24/7 365.
- Greatest level of service provision for those with the highest levels of need.
- Promoting independence autonomy self-efficacy and improving recovery rates across the whole service model.

- Increased flexibility regarding the application of the care cluster model in terms of access to and treatment with health services.
- Age appropriate services with transition protocols from Children and Young Peoples Services to Adult Services and from Adult to Older Adult Services as appropriate / required

Our refreshed model is described across TIERS 1-5 in the diagram below

The TIERS of our MENTAL HEALTH INTEGRATED CARE SYSTEM are described as follows in the diagram below:

- **Tier 1 Universal Services**
- **Tier 2 Primary Care / Primary Care facing Services**
- **Tier 3 Secondary Community Mental Health Services including some specialist Community Mental Health Services provided on a wider i.e. STP footprint**
- **Tier 4 Tertiary Mental Health Services including Nursing and Residential and In-patient Services**
- **Tier 5 and above NHS England commissioned services such as Highly Specialist In-patient Services such as and including Secure Care, Perinatal Mental Health and Eating Disorder In-patient Services**



Universal Services

The prevention concordat aims to ‘deliver a tangible increase in the adoption of public mental health approaches’ across local authorities, the NHS, employers and other public, private and voluntary sector organisations. Our Wolverhampton Prevention Concordat will aim to ensure that we improve mental health across the wider determinants of mental health, such as housing, education, employment alcohol and substance misuse, physical ill health and / or disability and poverty and deprivation.

The Prevention Concordat for Better Mental Health Programme aims to facilitate local and national action around preventing mental health problems and promoting good mental health. (The Prevention Concordat for Better Mental Health programme of work is one of the recommendations in the ‘Five Year Forward View for Mental Health’, 2016).

We will utilise the resource planning guide to put in place effective prevention planning arrangements working with our partners and stakeholders across our Mental Health Integrated Care System to improve mental health and wellbeing and prevent mental health difficulties and reduce and eliminate the stigma attached to mental ill health. We will align this with our public health interventions regarding obesity, smoking, and alcohol and substance misuse are all strongly associated with poor mental health (Kings Fund, Getting Serious about Public Mental Health, 2017).

Primary Care Mental Health and Primary Care facing Mental Health Services and Developments and including Alignment with the General Practice Forward View

The **GENERAL PRACTICE FORWARD VIEW** (2016) describes the need to increase mental health therapists embedded in Primary Care and to develop co-located multidisciplinary teams, working across several practices, providing an enhanced level of

care to patients with complex needs including older and frailer people and people with multiple co-morbidities both at home and in supported housing, including care homes, identified via a risk stratification approach, including people with mental health difficulties.

The NHS WOLVERHAMPTON CLINICAL COMMISSIONING GROUP PRIMARY CARE MODEL is outlined in the diagram below:

V12 November 2017

New Models of Care (Wolverhampton)



Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

Primary & Acute Care Systems (PACs/VI)

This model is based on:-

- Collaboration between NHS Trusts and GP Practices
- Practices have entered into a sub-contract agreement with the trust (GMS/PMS)
- Meet the needs of registered list(s) of patients
- Opportunity for trust's to kick-start primary care expansion but reinforce out of hospital care
- Potential to take accountability for all health needs of a registered list of patients.
- Greater level of back office support which is intended to improve the business element of General Practice.

Primary Care Home is a joint NAPC and NHS confederation programme.

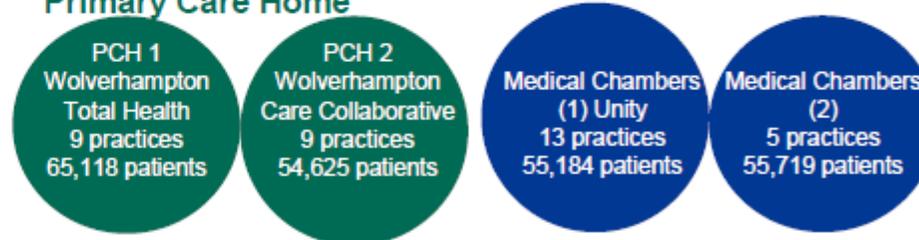
The model is based on:-

- Care hubs/neighbourhood approach
- Practices working together at scale to provide care closer to home
- Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people
- Function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care
- Combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.

Vertical Integration (VI)



Primary Care Home



Data based on Practice Actual List Size(s) July 2017

In WOLVERHAMPTON we will deliver a set of interoperational process systems care pathways and services across primary secondary and tertiary care to ensure more pro-active and responsive approaches within primary care for people with mental health difficulties – delivered by staff and NICE compliant services with mental health expertise in line with the General Practice Forward View. We aim to – blur some boundaries across primary and secondary care for people with mental health difficulties and improving systems and processes for better shared care including access to prescriptions across primary and secondary care with consideration given to Nurse Prescribers in Primary Care. Our aim is to create ‘fuzziness’ and flexibility to deliver a more responsive system that can respond pro-actively to make ‘every contact count’.

This will involve inclusion of mental health staff working in and embedded in primary care services and primary care and mental health multi-disciplinary team meetings in each GP practice and in every Primary Care Group including the Vertical Integration with the Royal Wolverhampton NHS Trust. There will be a particular focus upon improving access and responsiveness to evidence based care including physical health checks for people with SMI (Severe Mental Illness), improved care pathways for people with co-occurring mental health problems and physical ill health including Long Term Conditions (LTCs), shared care and improved information sharing, improved referral processes for mental health secondary care generally but including a focus on improved referral processes for primary care and social care staff and staff working in statutory and non-statutory services and looking at ways to support and improve self-referral and access support and advice for carers.

This is to ensure that GPs will have greater access to mental health treatment pathways, and greater support embedded in primary care and improved and more rapid processes including e-referral and e-discharge and advice and guidance. .

Key services include:

- Primary Care Counselling Service (Relate and partners)

- IAPT, PERINATAL IAPT and IAPT LTC Wolverhampton Healthy Minds (BCPFT) IAPT for BAME Groups Older People and Carers
- Base 25 Counselling and Drop In Services
- Secondary IPS (DWMHPT)
- Primary IPS RCT (with WMCA) (Reemploy)
- Social Prescribing Pilot (WOLVERHAMPTON VSC)
- Depression Care Pathway (BCPFT)
- Physical Health Checks and Care Pathway in keeping with the Lester Guidance for example and NICE Clinical Guidance and Quality Standards (Shared Care BCPFT and Primary Care)

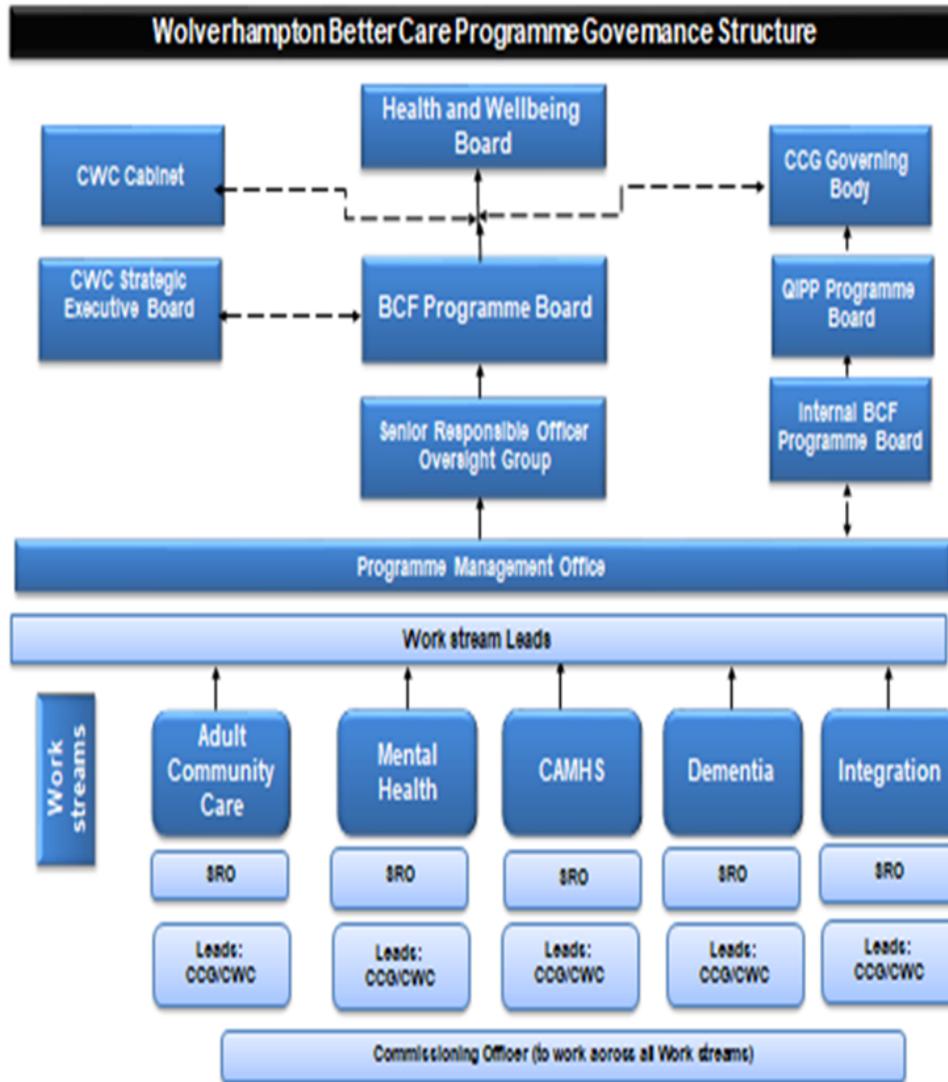
The Better Care Fund

The Mental Health Better Care Fund work stream focuses on developing responsive and effective integrated care pathways to ensure that people have access to early intervention and prevention, treatment, care and support – ensuring robust and evidenced based out of hospital and hospital based care.

There is connectivity across primary care, mental health and physical health care ‘joining up’ with initiatives that are and / or will be commissioned on a BC&WB STP footprint.

There must be a strong consideration / focus on self-efficacy personalised care access to evidence based care and accommodation and employment focussed support and also pro-actively supporting carers .

The WOLVERHAMPTON BETTER CARE FUND GOVERNANCE STRUCTURE is outlined in the table below:



The Better Care Fund provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for mental health services in Wolverhampton. Wolverhampton's Better Care Plans include three integrated care pathways in mental health services, the **Mental Health Urgent Care Pathway, Mental Health Planned Care Pathway and the Dementia Care Pathway**. (Please note that the Better Care Fund Dementia Care Pathway is addressed in detail in our Dementia Strategy)

The **Mental Health Urgent Care Pathway** provides emergency and urgent assessment, treatment, intervention and care and support within an integrated health and social care model for people who are 16 plus with acute and severe mental health difficulties who require high levels of care and support in urgent and / or emergency situations. This will be aligned with our Crisis Concordat Action Plan and Declaration (adolescents who are 16 and 17 but remain school / full time education will receive urgent care support from CAMHS) with a transition plan to adult services. There is a focus upon a pathway of services that holds people in crisis in supportive services whilst pro-actively delivering interventions to swiftly increase recovery promote independence, self-efficacy and self-management whilst delivering personalised and evidenced based care.

Key services include:

- SINGLE POINT OF ACCESS (SPA)
- STREET TRIAGE (commissioned on STP footprint across BC&WB)
- MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS)
- SECTION 136 MHA SUITE
- CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund Dementia Care Pathway)

- MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, Acute Overspill Out of Area Treatments – OATs)
- PSYCHIATRIC INTENSIVE CARE (PIC)
- DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse)

The Mental Health Planned Care Pathway provides assessment, treatment, intervention and care and support within an integrated health and social care model for people who are 16 plus with continuing and enduring mental health difficulties who require high levels of care and support as the journey to full and / or optimum recovery continues . This will be aligned with our Crisis Concordat Action Plan and Declaration (adolescents who are 16 and 17 but remain school / full time education will receive planned mental health care support from CAMHS) with a transition plan to adult services. There is a focus upon the development of robust multi-agency discharge planning and packages of care delivered via the Care Programme Approach and in partnership with Primary Care and non-statutory and Voluntary and Community Sector Services to allow people to receive support across a pathway of services including accommodation based support that promotes independence, self-efficacy and self-management whilst delivering personalised and evidenced based care.

Key services include:

- COMMUNITY RECOVERY SERVICE and PERSONALITY DISORDER HUB (including ASSERTIVE OUTREACH TEAM, encompassing services currently known as the WELL-BEING SERVICE and COMPLEX CARE)
- SECTION 117 MENTAL HEALTH ACT 1983 COMMUNITY CARE PACKAGES
- SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION and STEP DOWN
- SPECIALIST NURSING and RESIDENTIAL and DOMICILIARY CARE

- MENTAL HEALTH IN-PATIENT CARE (including more specialist hospital placements for people stepping down from NHS England funded Secure Care and / or people requiring specialist In-patient support and treatment including Rehabilitation and / or Personality Disorder In-patient Care)
- DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse)

Better Care Fund Key Activity for 2018 -2019 and beyond Urgent and Planned Mental Health

Completed 2017/18 programme	Community Prevention Support	Integrated Discharge Planning
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Activity:

- On-going implementation of Mental Health Liaison & Crisis Resolution Home Treatment moving toward fidelity with CORE Model/s (as per FVYRFWMH) with focus on high volume service users as per national CQUIN.
- Designated SW role in Mental Health Urgent Care Pathway (A&E Delivery Board funded) focusing on improved patient flow.
- Service mapping and gap analysis –focus on prevention of crisis.

Activity:

- Using mapping and scoping to improve information and guidance and pathway support for people with mental health difficulties to better prevent crisis and relapse and optimise early intervention support
- Develop a shared vision for urgent and planned mental health which can be really joined up with primary care voluntary and community sector and tertiary care
- Ensure a focus upon dual diagnosis care urgent and planned care which ensures that people do not ‘fall through gaps’

Activity:

- Develop shared vision regarding multi- agency discharge and care planning that is compliant with the Care Programme Approach (CPA)
- Agree Section 117 Protocols and Processes as enablers to delivering improved patient flow and recovery focussed services
- Consider dedicated resource to aid patient flow in the planned care process (replicating urgent care dedicated resource and further embedding joint / integrated practice)

The Dementia Care Pathway

The work stream focuses on developing a responsive and effective integrated care pathway that makes sure people have access to early intervention and prevention, treatment, care and support. Care pathway design, implementation and delivery will form the basis of the City's refreshed Dementia Strategy. There will be connectivity across primary care, mental health and physical health care 'joining up' initiatives for frailty, LTCs and Dementia preventing hospitalisation. There must be a strong consideration / focus on personalised care and living well and supporting carers.

The NHS England Well Pathway for Dementia is described in the diagram below.

NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA				
<p>PREVENTING WELL</p>  <p>Risk of people developing dementia is minimised</p>	<p>DIAGNOSING WELL</p>  <p>Timely accurate diagnosis, care plan, and review within first year</p>	<p>SUPPORTING WELL</p>  <p>Access to safe high quality health & social care for people with dementia and carers</p>	<p>LIVING WELL</p>  <p>People with dementia can live normally in safe and accepting communities</p>	<p>DYING WELL</p>  <p>People living with dementia die with dignity in the place of their choosing</p>
<p>"I was given information about reducing my personal risk of getting dementia"</p>	<p>"I was diagnosed in a timely way"</p> <p>"I am able to make decisions and know what to do to help myself and who else can help"</p>	<p>"I am treated with dignity & respect"</p> <p>"I get treatment and support, which are best for my dementia and my life"</p>	<p>"I know that those around me and looking after me are supported"</p> <p>"I feel included as part of society"</p>	<p>"I am confident my end of life wishes will be respected"</p> <p>"I can expect a good death"</p>
<p>STANDARDS:</p> <p>Prevention⁽¹⁾ Risk Reduction⁽⁵⁾ Health Information⁽⁴⁾ Supporting research⁽⁵⁾</p>	<p>STANDARDS:</p> <p>Diagnosis⁽¹⁾⁽⁵⁾ Memory Assessment⁽¹⁾⁽²⁾ Concerns Discussed⁽³⁾ Investigation⁽⁴⁾ Provide Information⁽⁴⁾ Integrated & Advanced Care Planning⁽¹⁾⁽²⁾⁽³⁾⁽⁵⁾</p>	<p>STANDARDS:</p> <p>Choice⁽²⁾⁽³⁾⁽⁴⁾. BPSD⁽⁶⁾⁽²⁾ Liaison⁽²⁾. Advocates⁽³⁾ Housing⁽³⁾ Hospital Treatments⁽⁴⁾ Technology⁽⁵⁾ Health & Social Services⁽⁵⁾ Hard to Reach Groups⁽³⁾⁽⁵⁾</p>	<p>STANDARDS:</p> <p>Integrated Services⁽¹⁾⁽³⁾⁽⁵⁾ Supporting Carers⁽²⁾⁽⁴⁾⁽⁵⁾ Carers Respite⁽²⁾ Co-ordinated Care⁽¹⁾⁽⁵⁾ Promote independence⁽¹⁾⁽⁴⁾ Relationships⁽³⁾. Leisure⁽³⁾ Safe Communities⁽³⁾⁽⁵⁾</p>	<p>STANDARDS:</p> <p>Palliative care and pain⁽¹⁾⁽²⁾ End of Life⁽⁴⁾ Preferred Place of Death⁽⁵⁾</p>
<p>References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.</p>				
<p>RESEARCHING WELL</p> <ul style="list-style-type: none"> Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change. Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries. 				
<p>INTEGRATING WELL</p> <ul style="list-style-type: none"> Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer’s Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care. 				
<p>COMMISSIONING WELL</p> <ul style="list-style-type: none"> Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice. Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources. 				
<p>TRAINING WELL</p> <ul style="list-style-type: none"> Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community. Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes. 				
<p>MONITORING WELL</p> <ul style="list-style-type: none"> Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set ‘profiled’ ambitions for each. Use the Intensive Support Team to provide ‘deep-dive’ support and assistance for Commissioners to reduce variance and improve transformation. 				

Key aspirations / goals are as follows:

Implementing NHS E access and waiting time/s for dementia so people with dementia have equal access to diagnosis as for other conditions (setting the national average for an initial assessment at six weeks)

Achieving and maintaining the dementia diagnosis rate. NHS England agreed a national ambition for diagnosis rates that two thirds of the estimated number of people with dementia in England should have a diagnosis with appropriate post-diagnostic support. (dementia diagnosis rate is included in the CCG Assessment Framework).

Post diagnostic care and support. This includes:

- **Propose / implement measure/s of effectiveness of post-diagnostic care** in sustaining independence and improving quality of life.
- **Deliver improvements in post-diagnostic support**, for example **ensuring that people with dementia have a care plan** on discharge from secondary care services; and **increasing the health and wellbeing support offered to carers of patients** diagnosed with dementia
- **Local care pathway re-design in line with the NHS E `Well Pathway for Dementia`** which covers preventing well, living well, supporting well and dying well.

Compliance across services with the NHS I Dementia assessment and improvement framework - October 2017 – 8 STANDARDS which are as follows:

- diagnosis
- person-centred care
- patient and carer information and support
- involvement and co-design
- workforce education and training
- leadership
- environment
- nutrition and hydration.

Key Deliverables are as follows:

- Delivering Early Intervention and Prevention
- Delivering living well (life to years)
- Supporting people with highest level of need across primary mental health and physical health is our key challenge (including end of life)
- Joining things up across mental health physical health and primary care
- Reducing delayed discharges / unplanned admissions
- Ensuring connectivity with community and hospital based admission avoidance and frailty care pathways
- Delivering Personalisation (need a focus on both Personal Budgets and Personal Health Budgets)
- Implementing Mental Health Liaison CORE 24 is key challenge /opportunity (in line with FYRFVMH)

DRAFT MENTAL HEALTH COMMISSIONING STRATEGY 2018/19-2020/21

- Supporting nursing and residential care – home in-reach service
- Delivering annual care plan reviews in primary care (ensuring full alignment with new CPA Policy implementation across BCPFT)

Key services include:

- OLDER ADULTS COMMUNITY MENTAL HEALTH TEAM
- DAY SERVICES – BLAKENHALL DAY SERVICES and THE GROVES DAY HOSPITAL
- The MEMORY CLINIC
- EARLY ONSET DEMENTIA SERVICES
- MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS)
- The DEMENTIA OUTREACH TEAM
- CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund URGENT MENTAL HEALTH Care Pathway)
- OLDER ADULT MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, WARD C22 at RWT and Acute Overspill Out of Area Treatments – OATs)
- COMMUNITY CARE PACKAGES INCLUDING NURSING RESIDENTIAL AND DOMICILIARY CARE INCLUDING CONTINUING HEALTHCARE (CHC)

Better Care Fund Key Activity for 2018 -2019 and beyond Urgent and Planned Mental Health

Completed 2017/18 programme	Community Prevention Support	Integrated Discharge Planning
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<p>Activity:</p> <ul style="list-style-type: none"> • On-going implementation of Mental Health Liaison & Crisis Resolution Home Treatment moving toward fidelity with CORE Model/s (as per FVYRFWMH) with focus on high volume service users as per national CQUIN. • Designated SW role in Mental Health Urgent Care Pathway (A&E Delivery Board funded) focusing on improved patient flow. • Service mapping and gap analysis –focus on prevention of crisis. 	<p>Activity:</p> <ul style="list-style-type: none"> • Using mapping and scoping to improve information and guidance and pathway support for people with mental health difficulties to better prevent crisis and relapse and optimise early intervention support • Develop a shared vision for urgent and planned mental health which can be really joined up with primary care voluntary and community sector and tertiary care • Ensure a focus upon dual diagnosis care urgent and planned care which ensures that people do not ‘fall through gaps’ 	<p>Activity:</p> <ul style="list-style-type: none"> • Develop shared vision regarding multi- agency discharge and care planning that is compliant with the Care Programme Approach (CPA) • Agree Section 117 Protocols and Processes as enablers to delivering improved patient flow and recovery focussed services • Consider dedicated resource to aid patient flow in the planned care process (replicating urgent care dedicated resource and further embedding joint / integrated practice)
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Services that will be delivered locally but commissioned on a BC&WB STP foot print

The five work programmes of the BC&WB STP Mental Health Work Stream have developed following a series of meetings and workshops with commissioners and providers which began in May 2016 and have involved key clinical leads, including CCG GP

leads for Mental Health and Senior Managers and Clinicians within the Mental Health Provider Trusts. The 'Working as One Commissioner' work programme have agreed to collaboratively commission a set of services to strengthen and energise the CCGs delivery of the improvement blue print for Mental Health both in terms of the delivery of transformed service models and CCG targets.

Expected benefits include; pooling and best use of expertise and resources, efficiencies achieved through economies of scale, achieving a critical mass required for some more specialist services, reducing the need for out of area treatments and interventions including acute overspill and some regional and sub- regional specialisms, building on areas of best practice and optimising opportunities to achieve value for money via delivery of a clinically effective and efficient whole system.

Collaborative commissioning as per the BC&WB STP mental health plan will ensure that the health systems work together better to: eliminate duplication and gaps and ensure compliance with the 'mental health blue print' as outlined in Implementing the Five Year Forward View for Mental Health (2017) and the local needs and gap analysis that has informed development of the plan. This will provide for gaps in service from within the current financial envelope/s of the four CCGs of the BC&WB STP (NHS DUDLEY CCG, NHS SANDWELL CCG NHS WALSALL CCG and NHS WOLVERHAMPTON CCG) and allow joint applications for transformation funds from NHS England. This approach will ensure that whilst services are delivered locally they can be commissioned on a critical mass basis – pooling expertise and resources and ensuring value for money – and preventing high cost OATs wherever possible and / or appropriate.

Improving the quality and responsiveness of key services with adherence to an agreed evidence base across a broader footprint is a key area of risk mitigation. This will allow commissioners to improve the clinical effectiveness of services whilst achieving value for money by driving down costs associated with sub-optimal delivery models. This includes a focus upon improving services associated with frequent relapse rates and re-admissions, lengths of stay and discharge delays and inefficient mental / physical

health care pathways including those for people with long term conditions and /or people who self-harm for example (including high volume service users). A copy of the BC&WB FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH PLAN is attached as Appendix 3.

The link to the full BC&WB STP Plan can be found below:

http://sandwellandwestbhamccg.nhs.uk/images/161020_Black_Country_STP_-_October_Submission_V0_8_clean.pdf

The current portfolio of services to be delivered on a BC&WB STP wide basis are:

- EARLY INTERVENTION IN PSYCHOSIS (EIP) (14-65 years)
 - EATING DISORDERS (ED) (all age)
 - SPECIALIST PERINATAL MENTAL HEALTH COMMUNITY SERVICE
 - SPECIALIST COMMUNITY PERSONALITY DISORDER SERVICE
 - SPECIALIST COMMUNITY AUTISM AND ADHD SERVICES (including assessment and diagnosis and on-going support for people with high levels of need)
 - VETERANS CARE PATHWAY (ALIGNMENT WITH NHS E COMMISSIONED SERVICES)
 - STREET TRIAGE
 - MENTAL HEALTH CRIMINAL JUSTICE CARE PATHWAYS AND SERVICES (including LIAISON and DIVERSION SERVICES and THE FORENSIC LIAISON SCHEME) ensuring alignment with Secure Services and Prison In-reach Services commissioned by NHS ENGLAND.
 - PSYCHIATRIC INTENSIVE CARE (PIC)
 - ALIGNMENT of INITIATIVES CARE PATHWAYS AND SERVICES with the WEST MIDLANDS COMBINED AUTHORITY
- THRIVE ACTION PLAN**

Overall the full complement of re-modelled services is as follows

<u>Mental Health Services</u>	<u>Commence</u>	<u>Complete</u>
<p><u>Universal Services</u></p> <p>The prevention concordat aims to ‘deliver a tangible increase in the adoption of public mental health approaches’ across local authorities, the NHS, employers and other public, private and voluntary sector organisations. Our Wolverhampton Prevention Concordat will aim to ensure that we improve mental health across the wider determinants of mental health, such as housing, education, employment alcohol and substance misuse, physical ill health and / or disability and poverty and deprivation.</p> <p>The Prevention Concordat for Better Mental Health Programme aims to facilitate local and national action around preventing mental health problems and promoting good mental health. (The Prevention Concordat for Better Mental Health programme of work is one of the recommendations in the ‘Five Year Forward View for Mental Health’, 2016).</p> <p>We will utilise the resource planning guide to put in place effective prevention planning arrangements working with our partners and stakeholders across our</p>	2018/19	2020/21

<p>Mental Health Integrated Care System to improve mental health and wellbeing and prevent mental health difficulties and reduce and eliminate the stigma attached to mental ill health. We will align this with our public health interventions regarding obesity, smoking, and alcohol and substance misuse are all strongly associated with poor mental health (Kings Fund, Getting Serious about Public Mental Health, 2017).</p>		
<p><u>Primary Care Mental Health Services</u></p> <p>Refreshing evidence based care pathways to deliver early intervention and prevention and the GP Five Year Forward View and the Five Year Forward View for Mental Health deliverables including IAPT PERINATAL IAPT and LTC IAPT IPS & SMI Physical Health Checks in Primary Care and also delivering Primary and Secondary Care MDT meetings in each Primary Care Group including the Vertical Integration. There will be a focus upon improving BAME and Older People IAPT access and outcomes</p> <p><u>Services in Scope</u></p> <ul style="list-style-type: none"> • Primary Care Counselling Service (Relate and partners) • IAPT, PERINATAL IAPT and IAPT LTC Wolverhampton Healthy Minds (BCPFT) IAPT for BAME Groups Older People and Carers • Base 25 Counselling and Drop In Services 	<p>2018/19</p>	<p>2019/20</p>

<ul style="list-style-type: none"> • Secondary IPS (DWMHPT) • Primary IPS RCT (with WMCA) (Remploy) • Social Prescribing Pilot (WOLVERHAMPTON VSC) • Depression Care Pathway (BCPFT) • Physical Health Checks and Care Pathway in keeping with the Lester Guidance for example and NICE Clinical Guidance and Quality Standards (Shared Care BCPFT and Primary Care) 		
<p><u>Better Care Fund Mental Health Urgent and Planned Care Pathways</u></p> <p>Refreshing evidence based care pathways which integrate health, social care and to improve acute and crisis based support and on-going planned person centred care to achieve the Five Year Forward View for Mental Health deliverables and compliance with NICE GUIDANCE and the CPA.</p> <p><u>Services in scope</u></p> <ul style="list-style-type: none"> • SINGLE POINT OF ACCESS (SPA) (BCPFT) 	<p>2018/19</p>	<p>2020/21</p>

<ul style="list-style-type: none"> • STREET TRIAGE (commissioned on STP footprint across BC&WB) • MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS) (BCPFT) • SECTION 136 MHA SUITE (BCPFT) • CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund Dementia Care Pathway) (BCPFT) • MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, Acute Overspill Out of Area Treatments – OATs) (BCPFT, Cygnet Healthcare and NCA) • PSYCHIATRIC INTENSIVE CARE (PIC) (BCPFT and NCA) • DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse) (BSMHFT and BCPFT) • COMMUNITY RECOVERY SERVICE and PERSONALITY DISORDER HUB (including ASSERTIVE OUTREACH TEAM, encompassing services currently known as the WELL-BEING SERVICE and COMPLEX 		
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<p>CARE)</p> <ul style="list-style-type: none"> • SECTION 117 MENTAL HEALTH ACT 1983 COMMUNITY CARE PACKAGES • SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION and STEP DOWN (including ACCI and VICTORIA COURT) • SPECIALIST NURSING and RESIDENTIAL and DOMICILIARY CARE (including ACCI and VICTORIA COURT) • MENTAL HEALTH IN-PATIENT CARE (including more specialist hospital placements for people stepping down from NHS England funded Secure Care and / or people requiring specialist In-patient support and treatment including Rehabilitation and / or Personality Disorder In-patient Care, such as Cygnet Healthcare) • DUAL DIAGNOSIS CARE PATHWAY (Mental Health and Alcohol and Substance Misuse) (BSMHFT and BCPFT) • Approved Mental Health Practitioners (AMHPs) including those from the Council who undertake assessments under the Mental Health Act 		
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<p>1983, the Mental Capacity Act 2005 and the Care Act 2014 (CWC.)</p> <ul style="list-style-type: none">• Other Council contributions such as the deployment of council care services across a range of community hubs, housing support and public health initiative (CWC.) <p><u>Better Care Fund Dementia Care Pathway</u></p> <p>Refreshing evidence based care pathways which integrate health, social care and to improve diagnosis and post diagnosis intervention and support to deliver the NHS England Well Pathway for Dementia and the NHS I Dementia Standards ensuring a focus upon personalisation, living well and ensuring pro-active and responsive support for people with high levels of need and their carers to achieve the Five Year Forward View for Mental Health deliverables and compliance with NICE GUIDANCE and the CPA.</p> <p><u>Services in scope</u></p> <ul style="list-style-type: none">• OLDER ADULTS COMMUNITY MENTAL HEALTH TEAM (BCPFT)• DAY SERVICES – BLAKENHALL DAY SERVICES and THE GROVES DAY HOSPITAL (BCPFT)• The MEMORY CLINIC (BCPFT)		
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<ul style="list-style-type: none"> • EARLY ONSET DEMENTIA SERVICES (BCPFT) • MENTAL HEALTH LIAISON SERVICE (MHLS) ENHANCED / CORE 24 (24/7 365) (including Older Adult MHLS) (BCPFT) • The DEMENTIA OUTREACH TEAM (RWT) • CRISIS RESOLUTION HOME TREATMENT (CRHT) CORE (24/7 365) (including Older Adult CRHT which also forms part of the Better Care Fund URGENT MENTAL HEALTH Care Pathway) (BCPFT) • OLDER ADULT MENTAL HEALTH IN-PATIENT CARE (including Penn In-patient Wards including Older Adult Services, WARD C22 at RWT and Acute Overspill Out of Area Treatments – OATs) (BCPFT, RWT and others) • Community care packages including Nursing Residential and Domiciliary Care including Continuing Healthcare (CHC) (various) 		
<p>BC &WB STP Commissioned Services</p> <p>Refreshing evidence based care pathways to achieve the Five Year Forward View for Mental Health deliverables on an STP footprint to pool expertise and</p>	<p>2018/19</p>	<p>2020/21</p>

resources and improve the capacity and capability of the system.

Services in scope

- **Early Intervention in Psychosis - 14-65 years (BCPFT & DWMHPT)**
- **Eating Disorders – all age (BCPFT)**
- **Specialist Perinatal Mental Health Community Service all age (BSMHFT, BCPFT &DWMHPT)**
- **Specialist Community Personality Disorder Service (BCPFT & DWMHPT)**
- **Specialist Community Autism and ADHD Service (DWMHPT)**
- **Street Triage (BCPFT & DWMHPT)**

- **Mental Health Criminal Justice Care Pathways and Services including liaison and diversion services and the Forensic Liaison Scheme (BCPFT & DWMHPT)**
- **Secondary IPS (DWMHPT)**
- **Psychiatric Intensive Care (BCPFT – Male – Female currently NCA)**

<ul style="list-style-type: none">• Veterans Care Pathway (alignment with NHS E commissioned services)• Alignment with the West Midlands Combined Authority THRIVE Action Plan		
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5. **KEY PRIORITIES**

The priorities for implementation will be aligned with those outlined in the CCG Operational Plan/s, the BC&WB STP Plan and the Joint Health and Well-being Strategy. In summary the key issues and priorities include the following:

- Integrated and / or aligned health and social care pathways are required across all stages of the service user journey, including universal, primary, secondary and tertiary care. This will require remodelling some aspects of the commissioned service provision.
- Clear pathways for engagement with primary care are also needed to support the mental and physical health needs of people with Mental Health difficulties and / or a Learning Disability to ensure parity of esteem and reduce inequalities. This

will require dedicated mental health support in primary care, primary care multi-disciplinary mental health team meetings and primary care champions in all secondary and tertiary services.

- Consultant Psychiatry and medical support and expertise require re-focussing and balancing across the primary, secondary, and tertiary care elements of the system. Our re-commissioned model will require increased access to Consultant Psychiatry expertise across our **Mental Health Integrated Care System** with improved referral processes to access clinical and medical support, improved clinician to clinician communication across primary care and mental and physical health services to improve access to assessment and treatment interventions and to achieve parity of esteem. Medical staffing across some services and care pathways may require some review to ensure an appropriate distribution of senior clinicians across the primary, secondary and tertiary care i.e. community and In-patient services to deliver fidelity with the evidence base and deliver highest standards of evidenced based care and admission avoidance for example. This will involve developing the role of Primary Care Mental Health staff as Advanced Nurse Prescribers (ANPs).
- Greater flexibility is needed regarding the application of the care cluster model (this is the model that is the framework for the payment system that is mental health payment by results). This is required both in terms of access to and treatment with health services so that the unique and specific needs of people are adequately supported and to allow greater alignment between services where the cluster model does not apply such as CAMHS, Learning Disabilities and Neurological Disorders.
- Achieving and sustaining recovery within the health model for patients of all clusters and especially for those patients clusters 3 and above experiencing non-psychotic conditions should re-focus to move include treatment support and interventions beyond an IAPT model of care and to provide continuing support as required. A refreshed approach to the care cluster model is required to allow greater flexibility across the service model and to ensure that people receive the right level of continuing support and achieve sustained recovery.

- The application of the Care Programme Approach must be re-focussed across the **Mental Health Integrated Care System** to ensure appropriate levels of community support, relapse prevention and crisis plans and support for carers. Our re-commissioned must achieve an approach to CPA locally that is consistent with national guidance.
- An 'all age approach' is required in keeping with national guidelines so that there is flexibility regarding transition into age specific services and the unique needs of individuals are recognised and to achieve parity of esteem across the life span with improved planning at times of transition. Improved joint working across adults and children's services is required to ensure that the needs of families in contact with mental health services are addressed in entirety, and that the needs of children and young people are assessed and monitored when parents / guardians are experiencing mental health difficulties and vice versa.
- There is a need to improve access to assertive support and treatment at home, and increase capacity and capability within drop in and day services and step-down services, to increase recovery rates, support sustained recovery and reduce relapse and prevent admission to hospital wherever possible.
- Access to and egress from care pathways including those providing access to specialised services and / or services commissioned by NHS England nationally must be un-impeded by and differing commissioning arrangements for different elements of the care pathway (i.e. into and out of secure and specialised care).
- Further development of local care pathways for people with Autism, Attention Deficit Disorder, Personality Disorders, Dual Diagnosis and Perinatal Mental Health is required to provide access to specialised assessment and treatment that is co-ordinated with across primary, secondary and tertiary care.
- Access to services and support across providers of supported accommodation and nursing residential and domiciliary care services should be commissioned using a care pathway approach that improves access to the correct level of support and

allows transition through services to services to promote independence and facilitate recovery and optimise effective and efficient use of resources within the market locally.

- BC&WB STP wide access to local female Psychiatric Intensive Care (PIC) is required to improve patient care pathways and quality of experience and reduce / remove Acute Overspill Out of Area Treatments (OATs).
- An STP wide collaborative approach with other local commissioners of mental health services is required, to pool resources and provides economies of scale.
- Improved access to information and communication for service users and carers and all key stakeholders regarding all matters pertaining to mental health and emotional wellbeing is required. This should harness and optimise the potential of the internet and social media and simple tele-health.
- Improved and co-ordinated commissioning approaches with substance misuse commissioning colleagues is required to ensure clearly commissioned care pathways between and across mental health and substance misuse services, and to co-ordinate health promotion campaigns as part of the Dual Diagnosis Care pathway.

Responding to the specific needs and requirements of key vulnerable groups will form a key element of the Wolverhampton **Suicide Prevention Plan** and the **Wolverhampton Crisis Concordat Declaration and Wolverhampton Crisis Concordat Action Plan**. The Wolverhampton suicide prevention plan is known as the Wolverhampton Mental Health Resilience Plan and describes those interventions highlighted within the Wolverhampton Health and Well-Being Strategy that focus upon mental health promotion, early intervention and prevention and are detailed within the table below and which will be aligned with the Mental Health Strategy Implementation Plan and our WOLVERHAMPTON CRISIS CONCORDAT Declaration and Action Plan:

Neeraj to insert SUICIDE PREVENTION SUMMARY here

Sarah to insert CRISIS CONCORDAT HERE

In response to the above identified key issues an implementation plan is included as Appendix 2.

In addition to the above it is important that care commissioned and delivered meets the requirements of the **CARE PROGRAMME APPROACH**. Refocusing the Care Programme Approach - Policy and Positive Practice Guidance (2008) identifies the following **issues to consider when deciding if support of CPA needed:**

Severe mental disorder (including personality disorder) with high degree of clinical complexity

Current or potential risk(s), including:

- Suicide, self-harm, harm to others (including history of offending)
- Relapse history requiring urgent response
- Self-neglect /non concordance with treatment plan

Vulnerable adult /child safeguarding including for example:

- exploitation e.g. financial/sexual
- financial difficulties related to mental illness
- disinhibition
- physical/emotional abuse
- cognitive impairment
- child safeguarding issues
- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse
- learning disability

- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- Significant reliance on carer(s) or has own significant caring responsibilities

Experiencing disadvantage or difficulty as a result of:

- Parenting responsibilities
- Physical health problems/disability
- Unsettled accommodation/housing issues
- Employment issues when mentally ill
- Significant impairment of function due to mental illness
- Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices);
- Sexuality or gender issues

Refocusing the Care Programme Approach - Policy and Positive Practice Guidance (2008) provides the following Statement of Values and Principles:

- The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery.
- It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties.
- It recognises the individual as a person first and patient/service user second.

- Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.
- Self-care is promoted and supported wherever possible.
- Action is taken to encourage independence and self determination to help people maintain control over their own support and care.
- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.
- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care.
- The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.
- Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

Refocusing the Care Programme Approach - Policy and Positive Practice Guidance (2008) provides the following summary of the main similarities and differences between service responses to service users needing the support of (new) CPA and those that do not:

Service users needing (new) CPA	Other service users
<p><u>An individual's characteristics:</u> Complex needs; multi-agency input; higher risk.</p>	<p><u>An individual's characteristics:</u> More straightforward needs; one agency or no problems with access to other agencies/support; lower risk.</p>
<p><u>What the service users should expect:</u></p> <ul style="list-style-type: none"> • Support from CPA care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload). • A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks. • An assessment of social care needs against FACS eligibility criteria (plus Direct Payments). • Comprehensive formal written care plan: including risk and safety/contingency/crisis plan. • On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly • At review, consideration of on-going need for (new) CPA support • Increased need for advocacy support. • Carers identified and informed of rights to own 	<p><u>What the service users should expect:</u></p> <ul style="list-style-type: none"> • Support from professional(s) as part of clinical/practitioner role. Lead professional identified. • Service user self-directed care, with support. • A full assessment of need for clinical care and treatment, including risk assessment. • An assessment of social care needs against FACS eligibility criteria (plus Direct Payments). • Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter). • On-going review as required. • On-going consideration of need for move to (new) CPA if risk or circumstances change. • Self-directed care, with some support if necessary. • Carers identified and informed of rights of own assessment.

assessment.

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6. IMPLEMENTATION , NEXT STEPS AND 14 KEY GOALS

Our **WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM** will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public.

For the purposes of delivery of a **Mental Health Integrated Care System** the implementation plan attached as Appendix 2 is structured across the **14 Key Goals** described below.

1. **DEVELOP AN ALL AGE APPROACH ACROSS OUR SERVICE MODEL THAT INCORPORATES THE NEEDS OF PEOPLE UNDER 18 YEARS WHO REQUIRE TRANSITION TO ADULT MENTAL HEALTH SERVICES.**

We will develop a commissioning plan / care pathway/s that align all initiatives within the MENTAL HEALTH STRATEGY

IMPLEMENTATION PLAN with existing and future plans regarding CAMHS as described in the WOLVERHAMPTON CAMHS PLAN ensuring that there is safe sound support transition to Adult Services that are consistent, seamless, age appropriate and inclusive and support the needs of Children and Young People at transition and preparing for transition to ADULT SERVICES in line with good practice as outlined in NICE GUIDANCE the CPA, CONTINUING CARE and CONTINUING HEALTHCARE GUIDANCE.

LEAD MULTI-AGENCY FORUM/S – CAMHS TRANSFORMATION BOARD AND WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

2. DEVELOP AN ALL AGE APPROACH ACROSS OUR ADULT AND OLDER ADULT SERVICE MODEL THAT INCORPORATES AND ADDRESSES THE NEEDS OF PEOPLE OVER 65 YEARS WHO REQUIRE TRANSITION TO OR ACCESS / ENTRY TO OLDER ADULT MENTAL HEALTH SERVICES.

We will develop care pathway/s and services that align all initiatives within the implementation plan across Adult and Older Adults Mental Health Services so that services are consistent, seamless, age related and inclusive. Service re-design and delivery across the BETTER CARE FUND URGENT AND PLANNED AND DEMENTIA CARE PATHWAYS will be joined up and coterminous. Our refreshed Dementia Strategy will sit aside our Mental Health Strategy and will respond to relevant NICE GUIDANCE and CARE PATHWAYS and we will ensure older people and/ or people with dementia have equity of access to mental and physical health services and that care plans in both primary and secondary meet the requirements of the CPA for service users and carers.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

3. DEVELOP A LOCAL PREVENTION CONCORDAT

We will develop a local PREVENTION CONCORDAT with key stakeholders via the MENTAL HEALTH STAKEHOLDER FORUM. This will help us to deliver targeted mental health promotion and early intervention and prevention interventions cross our commissioned services, and to work with partners across universal primary secondary and tertiary care and partners and stakeholders in education, employment, leisure and housing and voluntary and community sector services, for example to focus initiatives upon the wider determinants of health and mental and physical health promotion. Our information revolution will provide signposting navigation advice and guidance and self-management self-care and peer support. This approach will include initiatives to address the broader determinants of mental ill-health including issues pertaining to:

- Parental mental health
- Mental Health Promotion
- Physical health and disability
- Leisure and physical activity
- Bullying
- Mental Health in the work place
- Self-harm
- Substance misuse
- Improved information and communication
- Targeted Interventions for carers
- Targeted interventions for at risk groups (BAME, LGBT+)
- Debt Advice
- Un-employment
- Educational attainment

- Ending stigma attached to mental health

In addressing those issues highlighted above the Resilience Plan will incorporate the Suicide Prevention Plan and will assess, map and scope the needs of the City's key vulnerable groups people affected by vulnerabilities related to and including:

- Age and gender
- Black and minority ethnic communities
- Persons in prison or in contact with the criminal justice system
- Service and ex-service personnel
- Deprivation
- Unemployment
- Housing and homelessness
- Refugees and asylum seekers (new arrivals)
- People with long term conditions or physical and or learning disabilities including autism
- Lesbian, gay, bisexual and transgender people (LGBT+) and / or children and young people who are questioning their sexual orientation and / or gender (LGBT+)
- Substance misuse
- Victims of violence, abuse and crime including domestic violence and bullying including victims of sexual abuse and violence and exploitation and school, higher education and work place bullying

4. MAINTAIN OUR WOLVERHAMPTON SUICIDE PREVENTION STRATEGY

We will maintain our local multi-agency Suicide Prevention Strategy with key stakeholders. This will be aligned with the WOLVERHAMPTON CRISIS CONCORDAT and will respond to local needs across each of the National Suicide Prevention

Strategy areas for action:

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

This will incorporate learning from the Preventing Suicide in England: One year on First Annual Report (2014), and local data regarding current trends and new messages from research, including the use of social media, learning regarding 7 day follow up, health and social care assessments, treatment and clinical interventions for people with depression and people at risk of self-harm, and specific vulnerabilities related to age, gender and ethnicity and the specific needs of the LGBT+ community and people who misuse substances.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON SUICIDE PREVENTION STAKEHOLDER FORUM

5. DEVELOP PRIMARY CARE MENTAL HEALTH

To ensure best practice in terms of early intervention and prevention, improving the physical health of people with mental health difficulties and improving care pathways into and out of secondary services for people of all ages, we will commission mental health care pathways in primary care supported by primary care champions and workers in primary care facing and secondary services. This will include pathways of care for people with specialised mental health needs such as autism, attention deficit disorder, eating disorders, perinatal mental health, depression and personality disorder, dual diagnosis and the primary care support needs of people taking anti-psychotic medication. This will include review of all of our well-being and support services commissioned from

community and voluntary sector organisations and third sector organisations to strengthen early intervention and prevention initiatives. This includes delivery of IAPT, LTC IAPT, increasing IPAT access for BAMES and PERINATAL IAPT and delivering SMI PHYSICAL HEALTH Checks and social prescribing pilot. This will also include delivery of e referrals and e discharge and advice and guidance across primary and secondary care.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

6. DELIVER THE BETTER CARE FUND URGENT MENTAL HEALTH CARE PATHWAY

As part of our Better Care Fund development plans to implement the Integrated Mental Health Urgent Care Pathway we will review the current model. We will re-commission MENTAL HEALTH LIAISON ENHANCED CORE 24 and CRISIS RESOLUTION HOME TREATMENT fidelity with NHS E CORE. We will review the capacity and capability of the health and social care urgent mental health care pathways to increase the capacity and capability of the service to meet the needs of people of all ages outside normal working hours and respond to requests for assessment under the Mental Health Act. We will commission a service model and care pathway that provides an integrated collocated and aligned approach to mental health urgent care within a multi-disciplinary context, including access in an emergency to specialist medical and Consultant Psychiatry support that is consistent with Royal College guidelines and the Care Programme Approach. We will deliver our WOLVERHAMPTON CRISIS CONCORDAT DECLARATION AND ACTION PLAN through this work stream.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

7. DELIVER THE BETTER CARE FUND PLANNED MENTAL HEALTH CARE PATHWAY

We will re-commission and implement an integrated planned care pathway promoting independence, self-efficacy and recovery as part of our Better Care Fund plans. This will promote independence, facilitate recovery and allow service users to progress along the care pathway and prevent relapse and re-admission. The integrated pathway will also allow pooled and effective deployment of and efficient use of resources across the 'whole system' that responds to local need and demand management. This will facilitate step-down from in-patient, specialised and secure care, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches for people requiring continued support in supported housing, nursing and residential care and hospital placements into an aligned care pathway of continued support. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery, and will allow the re-allocation of resources from acute, specialised, 'out of area' placements to local community based services maintaining recovery and promoting independence, self-efficacy autonomy and recovery in the mid to long term. We will review our current commissioning model of the Complex Care Service and Well-Being Service. This will include reviewing the capacity and capability of the service to offer support and interventions of an assertive outreach model, the function of the personality disorder hub and the forensic team. This is to increase the capacity and capability of local services to support people with the highest levels of need, and provide step-down from secure care and specialised services locally and 'out of area' and reduce relapse and re-admission/s. The model will also be reviewed to allow patients to receive on-going support from the service and for services users in the service to receive care planning support and interventions that are compliant with the national guidance regarding the Care Programme Approach.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

8. MAINTAIN OUR WOLVERHAMPTON CRISIS CONCORDAT

We will maintain our local multi-agency WOLVERHAMPTON CRISIS CONCORDAT ensuring connectivity with this initiative and the Suicide Prevention Strategy and the Better Care Fund Mental Health Urgent and Planned Care and Dementia Strategies and the WOLVERHAMPTON Local CAMHS Plan. We will ensure minimum 6 monthly reviews of the WOLVERHAMPTON CRISIS CONCORDAT DECLARATION and ACTION PLAN with all service user and carer groups.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

9. DELIVER SOME MORE SPECIALIST MENTAL HEALTH CARE PATHWAYS AND SERVICES ACROSS A BC&WB STP FOOTING

Collaborative commissioning as per the outputs of the BC&WB STP Mental Health Work Stream will ensure that the health needs of people with mental health difficulties will be met in a timely and holistic manner as per NICE guidance and from diagnosis to early intervention and care, treatment and support, improving quality of life. We will pool resources and expertise to deliver a critical mass of specialist services that are locally delivered and financially sustainable across our BC&WB footprint. We work with providers of health and social care services to commission and implement specialist care pathways for the following:

- Eating Disorders
- Early Intervention in Psychosis
- Personality Disorder
- Perinatal Mental Health
- Attention Deficit Disorder and Autism
- Psychiatric Intensive Care
- Street Triage

- Criminal Justice Mental Health (including Court Diversion and Liaison and the Forensic Liaison Scheme)
- Veteran Mental Health
- Alignment with the West Midlands Combined Authority THRIVE Action Plan

This will increase capacity and capability, providing specialist assessment and intervention within mainstream mental health services within the local system and facilitating effective liaison with specialist services commissioned by NHS England. This will include review of our current commissioning of all out of area mental health admissions to identify opportunities to maximise the resources available within local services as alternatives to out of area admissions and to identify 'preferred providers' for Female Psychiatric Intensive Care (PIC) in the short term, whilst liaising with local providers and commissioners regarding a medium to longer term solution. We will optimise the available capacity and capability within community recovery and promoting independence services within our local health and social care economy both with the public sector and independent sector services as an integral part of the local 'whole system' as required. We will realise cost efficiency savings by reducing the numbers of all types of out of area placements and reducing lengths of stay. We will work with local providers to develop capacity and capability of locally commissioned services to meet the needs of people who are discharged and / or transferred from secure and specialised services, so that we can optimise deployment of and efficient use of resources across the 'whole system' that is consistent with local need, allow repatriation to local services from 'out of area placements' and consolidate commissioning approaches sub –specialisms including hospital placements for rehabilitation. Our commissioned integrated care pathway will provide capacity and capability locally to support people with the highest levels of need, promoting independence and recovery.

**LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM and BC&WB STP
MENTAL HEALTH WORKSTREAM**

10. DELIVER ROBUST CARE PATHWAYS ACROSS PRIMARY, SECONDARY AND TERTIARY CARE TO ENSURE THAT

PEOPLE WITH A LEARNING DISABILITY / AND OR AUTISM AND CO-OCCURRING MENTAL HEALTH DIFFICULTIES CAN ACCESS APPROPRIATE AND SEAMLESS HELP, CARE, TREATMENT AND SUPPORT

In line with Transforming care: A National response to Winterbourne View Hospital (2012), Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (2015) we will develop robust care pathways across Learning Disability and Mental Health Services to support the specific needs of people with a learning disability / and or autism and co-occurring mental health difficulties to ensure equal access to assessment and diagnosis and post diagnosis care treatment and support and this will be delivered in line with the requirements of the Care Programme Approach (CPA) as appropriate / required.

11. DELIVER TARGETED INTERVENTIONS TO SUPPORT THE NEEDS OF MARGINALISED AND / OR SELDOM HEARD GROUPS INCLUDING SPECIFIC ACTIONS TO REDUCE THE NUMBERS OF BAME PEOPLE DETAINED UNDER THE MENTAL HEALTH ACT

In line with the Mental Health Five Year Forward View and the WOLVERHAMPTON CRISIS CONCORDAT we will include work across partners and with local community groups to provide a dedicated focus upon people who are marginalised, people who have particular vulnerabilities, and people who have difficulties accessing right care in the right place at the right time including people for example with Autism / and or ADHD, people with a Learning Disability, people with Dual Diagnosis and / or a Personality Disorder and people from BAME and LGBT+ groups and Veterans, refugees new arrivals and asylum seekers and Serving Members of Her Majesty's Armed Forces and their families for example to ensure improved access to and support and treatment from mental health services providing right care at the right time in the right place . This will include specific actions to substantially reduce Mental Health Act detentions and also include targeted work to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

12. DELIVER A WORK FORCE PLAN & ALIGN ACROSS BC&WB STP FOOTING

We will develop a work force plan in line with Stepping Forward to 2020 and align with developments and initiatives across our STP to allow development of recruitment and retention and training, supervision and mentorship of all staff across our **Mental Health Integrated Care System** to develop capacity and capability to support and deliver new service models and facilitate delivery of local priorities and the priorities of the Five Year Forward View for Mental Health. As we do this we will develop and demonstrate sound processes to support and recruit staff with lived experience of mental difficulties and support the mental health and emotional well-being of all our staff.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM

13. DELIVER A FINANCIAL PLAN & ALIGN ACROSS BC&WB STP FOOTING

We will develop a Mental Health Strategy Financial Plan and align with developments and initiatives across our STP to deliver financially sustainable services and deliver value for money whilst covering critical gaps and meeting the mental health investment

standard. New or revised services and service specifications will be delivered within the financial envelope our commissioning authorities i.e. NHS W CCG and CWC. Resources – including key elements of our workforce - will be used to best effect with strong clinical and medical leadership evident at each part of the Mental Health Integrated Care System. This is in addition to any transformation funds applied for and received from NHS England for example including ‘Winter Pressures’ and A&E Delivery Board funding used to ‘pump prime’ change. Compliance with the Mental Health Investment Standard will be supported across all CCG commissioned activity.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM

14. DELIVER A GOVERNANCE, COMMUNICATION AND ENGAGEMENT PLAN AND ALIGN WITH WORK ACROSS AN BC&WB STP FOOTING

We will develop a governance, communication and engagement plan and align with developments and initiatives across our STP to ensure co-production with and continuing engagement with all relevant forums and service users and carers and the general public to support delivery of our strategy including the anti-stigma, mental health promotion and advice and guidance elements to achieve parity of esteem with physical health and improve our City’s mental health.

LEAD MULTI-AGENCY FORUM – WOLVERHAMPTON MENTAL HEALTH STAKEHOLDER FORUM and BC&WB STP MENTAL HEALTH WORKSTREAM

Summary

The priorities outlined in our Joint Commissioning Mental Health Strategy to achieve our **Mental Health Integrated Care System** have been developed from our knowledge of local need and national best practice and policy implementation guidance and the directives of the **Five Year Forward View for Mental Health**. The priorities outlined and deliverables outlined in this document will

commission a 'whole system' of integrated mental health and social care fit for the future to offer parity of esteem and the right care, in the right place at the right time. This will include targeted supportive and preventative interventions to strengthen self-efficacy, independence and autonomy and resilience and a programme of investment in evidence based services, care pathways and initiatives to deliver improved access across universal primary urgent planned and specialist care to ensure improved service user and carer outcomes personal growth and recovery. This will achieve 'parity of esteem' for mental health services and care pathways in comparison with physical health services in terms of access to evidence based services, quality of service user and carer experience and service user outcomes and promote and ensure integrated approaches with physical health which are fit for the future and ensure improved information sharing improved connectivity across systems and processes including digital records and care plans. Our values driven approach will focus upon empowerment, self-efficacy and improving accessibility effectiveness and responsiveness whilst delivering transformation and modernity supporting our service users and carers to live happy and fulfilling lives.

“Quality of care can become synonymous with quality of life and satisfaction with care an important component of life satisfaction”. (Locker and Dent - 1978)

6. LIST OF APPENDICES

- Appendix 1 – Needs Assessment Information
- Appendix 2 – Strategy Implementation Plan
- Appendix 3 BC&WB Five Year Forward View For Mental Health Delivery Plan

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Wolverhampton Mental Health Stakeholder Forum



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WOLVERHAMPTON CCG
Governing Body Meeting
July 10th 2018
Agenda item 10

TITLE OF REPORT:	Joint Public Mental Health & Wellbeing Strategy for Wolverhampton
AUTHOR(S) OF REPORT:	Lina Martino - Consultant in Public Health City of Wolverhampton Council
MANAGEMENT LEAD:	John Denley, Director of Public Health - City of Wolverhampton Council
PURPOSE OF REPORT:	The purpose of this report is to provide an update for the Governing Body regarding the Public Mental Health & Wellbeing Strategy 2018/19 – 2020/21.
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 Joint Public Mental Health & Wellbeing Strategy is an overarching document that incorporates City of Wolverhampton Council and NHS Wolverhampton CCG's Joint Mental Health Commissioning Strategy for 2018/19 – 2020/21. • It includes not just commissioned services to support people with mental health problems, but wider public services and workstreams to prevent mental ill health and promote population wellbeing. • This report describes the aims and scope of the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton, produced by City of Wolverhampton Council and NHS Wolverhampton CCG.

RECOMMENDATION:	It is recommended that the Governing Body note the development of the Joint Public Mental Health & Wellbeing Strategy for Wolverhampton and the proposed next steps.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The overarching Joint Public Mental Health & Wellbeing Strategy incorporates City of Wolverhampton Council and NHS Wolverhampton CCG's Joint Mental Health Commissioning Strategy for 2018/19 – 2020/21. Quality Impact Assessments (QIAs) have been conducted as part of the Joint Mental Health Commissioning Strategy.
2. Reducing Health Inequalities in Wolverhampton	A reduction in health inequalities is an overarching aim of the Strategy. Commissioning mental health services that are mental health blue print compliant and are also compliant with NICE Clinical Guidance and Quality Standards will support this aim. Equality Impact Assessments (EIAs) have been conducted as part of the Joint Mental Health Commissioning Strategy.
3. System effectiveness delivered within our financial envelope	Maximising system effectiveness through partnership working and better integration of services across the health, social care and the wider system is a key aim of the Joint Public Mental Health & Wellbeing Strategy.

1. BACKGROUND AND CURRENT SITUATION

Overview

- 1.1. Mental health is integral to overall health, and recognised as being fundamental to growth, development, learning and resilience. Accordingly, the social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health.
- 1.2. The cross-Government strategy *No Health Without Mental Health* (2011) set out ambitions for mental health to be given equal importance to physical health ('parity of esteem'), and to become 'everyone's business' – that is, for health services, local authorities, education, employers, third sector organisations and communities to work in partnership to address the causes and consequences of poor mental health and promote mental wellbeing in populations.

- 1.3. The Mental Health Five Year Forward View (2016) emphasises the need for a shift towards prevention and better integration of care in order to improve outcomes and experiences for people with mental health problems and their carers, and reduce health inequalities. This aligns with priorities outlined in the Wolverhampton Health & Wellbeing Board Strategy and NHS Wolverhampton Clinical Commissioning Group (CCG) Operational Plan.
- 1.4. The Joint Public Mental Health & Wellbeing Strategy is an overarching document that incorporates City of Wolverhampton Council and NHS Wolverhampton CCG's Joint Mental Health Commissioning Strategy for 2018/19 – 2020/21. It includes not just commissioned services to support people with mental health problems, but wider public services and workstreams to prevent mental ill health and promote population wellbeing. The Joint Public Mental Health & Wellbeing Strategy is attached as Appendix 1.
- 1.5. This report describes the aims and scope of the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton, produced by City of Wolverhampton Council and NHS Wolverhampton CCG.

National and local context

- 1.6. Half of all mental health problems emerge by age 14, rising to 75% by age 24. People with severe and prolonged mental illness die 15-20 years earlier on average than others – two thirds of these deaths are due to avoidable physical illness, including heart disease and cancer linked to smoking. At all ages traumatic experiences, poor housing or homelessness, being part of a marginalised group, or having multiple needs such as a learning disability or autism are all associated with increased risk of mental health problems, and may also limit access to support.
- 1.7. In Wolverhampton:
 - 66 people died by suicide between 2014 and 2016
 - There were 19,815 adults with depression known to their GP (2016/17), and 2,683 adults with severe mental illness (2015/16)
 - An estimated 3,906 children aged 5-16 had a diagnosable mental health disorder (2015)
 - Just 50.9% of adult social care users and 25.2% of adult carers report having as much social contact as they would like (2016/17)
 - Among people in contact with secondary mental health services, only 27% live in stable and appropriate accommodation (2016/17)



- 1.8. A recent report by the Mental Health Foundation (2017) found that that only 13% of people in England consider themselves to have good mental health. This highlights the importance of improving mental health and wellbeing at population level, beyond the prevention of diagnosable or definable conditions.

2. JOINT PUBLIC MENTAL HEALTH AND WELLBEING STRATEGY

- 2.1. While it is essential to provide high quality services for people experiencing mental health problems, and to ensure timely and equitable access to these services, it is equally important to prevent the onset of mental health problems and to support vulnerable people before referral to specialist services becomes necessary.
- 2.2. However, it is also important that available support and pathways are clear to individuals and professionals, and that work is joined up across the wider system. This helps to avoid unnecessary duplication and allows the identification of any gaps or unmet need.
- 2.3. The Joint Public Mental Health & Wellbeing Strategy provides a high-level summary of current and planned workstreams across the Council and CCG to promote population wellbeing and improve mental health. It follows a life course approach, covering all levels of support from universal prevention through to tier 5+ specialist services. This includes but is not limited to:
- Joint Mental Health Commissioning Strategy and Stakeholder Forum
 - Child & Adolescent Mental Health Services (CAMHS)
 - Social, emotional and mental health needs in schools
 - Suicide Prevention Stakeholder Forum and action plan
 - Workplace wellbeing and mental health & work
 - Dementia Strategy and Autism Strategy
 - Reducing social isolation among carers
 - Improving the built environment and access to green spaces
- 2.4. The aim is to not only meet the specific needs of different age groups, but also to reduce cumulative disadvantage associated with poor mental health and wellbeing and related risk factors.

3. CLINICAL VIEW

- 3.1. Clinical views will be established during the consultation process.

4. PATIENT AND PUBLIC VIEW

- 4.1. The report Mental Wellbeing in Wolverhampton – an assessment of needs (2017) reported evidence from responses to a survey of users about their experiences of mental health services, with the following key findings:
- **Groups at higher risk of poor mental wellbeing:** unemployed, LGBT+, homeless, BME groups, refugee and migrants, students, ex-offenders, carers
 - **Key issues highlighted:** isolation, access to support groups, housing, employment, financial stability, physical health
 - **Stigma:** lack of understanding from front line services, lack of support for coming back into work.
- 4.2. Our Wolverhampton Mental Health Stakeholder Forum will deliver engagement across partners, agencies and service users and their carers and co-ordinate delivery of our implementation plan and engagement across partners, stakeholders, service user and carer groups and the wider general public.

5. KEY RISKS AND MITIGATIONS

- 5.1. The attainment of good mental health and wellbeing is a key objective for our City, addressing the wider determinants of mental health and well-being is a key deliverable and part of the risk mitigation process.

6. IMPACT ASSESSMENT

Financial and Resource Implications

- 6.1. The Joint Public Mental Health & Wellbeing Strategy and Joint Mental Health Commissioning Strategy will be delivered within the existing financial envelope of the Council and the CCG. Resources – including key elements of the workforce - will be used to best effect at each part of the ‘whole system’. NHS England planning guidance for 2018/19 outlines that the CCG is required to continue to focus on investment in mental health services to ensure parity with other areas of investment by complying with the mental health investment standard previously known as ‘parity of esteem’.
- 6.2. In addition the CCG also has opportunities to apply for transformation and new models of care funding to achieve compliance with the Mental Health Five Year Forward View (2016) in partnership with commissioners and providers that form part of the Black Country and West Birmingham Sustainability and Transformation Partnership (BC&WB STP). The CCG has successfully applied for and received

£1.4M transformation funds for perinatal mental health – as the STP lead agency (June 2018) for example.

Quality and Safety Implications

- 6.3 The Joint Mental Health Commissioning Strategy ensures that commissioned mental health services are compliant with NICE Clinical Guidance and Quality Standards. Quality Impact Assessments (QIAs) have been conducted as part of the Joint Mental Health Commissioning Strategy.

Equality Implications

- 6.4. A reduction in health inequalities is an overarching aim of the Strategy. Equalities impact assessments will be carried out as appropriate within the work programmes that make up the overarching Strategy.
- 6.5. Commissioning mental health services that are mental health blue print compliant and are also compliant with NICE Clinical Guidance and Quality Standards will reduce health inequalities. Equality Impact Assessments (EIAs) and QIAs have been conducted as part of the Joint Mental Health Commissioning Strategy. These focus upon the requirements of the needs of protected groups and groups who require targeted engagement and interventions. CCGs are working with NHS England and colleagues in Public Health to utilise refreshed Right Care benchmarking to support the needs analysis and service specification development process and the further production of EIAs and QIAs.

Legal and Policy Implications

- 6.6. The CCG has statutory obligations to commission safe, effective services that deliver value for money in partnership with key stakeholders and in response to levels of need and service user and carer views. This is in keeping with the seven key principles of the NHS Constitution (2015) and also with operational and planning guidance as laid out in the mandate to NHS England by the Department of Health.
- 6.7. The Health and Wellbeing Board is a statutory board established under the Health and Social Care Act 2012. It has a statutory duty to promote the integration of commissioning.
- 6.8. The Health and Social Care Act 2012 led to the transfer of public health services to local authorities in order to strengthen links to the wider determinants of mental and physical health which encompass the approach taken in this strategy.

6.9. The Mental Health Acts 1983 and 2007 and the Care Act 2014 are the main laws relating to assessment and meeting need of individuals with mental health needs.

Other Implications

6.10. None identified.

ATTACHED:

Joint Public Mental Health & Wellbeing Strategy for Wolverhampton 2018 – 2021 (draft)
Joint Mental Health Commissioning Strategy 2018/19 – 2020/21 (draft)

RELEVANT BACKGROUND PAPERS

Mental Health Five Year Forward View (2016)
Wolverhampton Health & Wellbeing Board Strategy
NHS Wolverhampton CCG Operational Plan.

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		
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)		



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Joint Public Mental Health and Wellbeing Strategy 2018 – 2021

City of Wolverhampton Council
NHS Wolverhampton CCG

DRAFT



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Foreword

Mental health is integral to overall health, and recognised as being fundamental to growth, development, learning and resilience. Accordingly the social, physical and economic environments in which people are born, grow, live, work and age have important implications for mental health. The support needs of people experiencing mental health difficulties therefore extend beyond health service provision and into wider public services.

This Joint Public Mental Health & Wellbeing Strategy for Wolverhampton follows a life course approach, covering all tiers of service provision and support for all ages. In addition, it sets out key programmes and strategies acting on the wider social, environmental and economic determinants of health to create mentally healthy places and keep people well.

The aim is to not only meet the specific needs of different age groups, but also to reduce cumulative disadvantage associated with poor mental health and wellbeing and related risk factors.

The Strategy brings out key strategic and delivery themes across Council and CCG workstreams to articulate a cohesive, population-based approach to promote wellbeing and improve mental health in the city.



**Councillor
Hazel Malcolm**
**Cabinet Member for
Health & Wellbeing**
City of Wolverhampton
Council



John Denley
Director of Public Health
City of Wolverhampton
Council



Helen Hibbs
Chief Officer
NHS Wolverhampton
CCG

Vision and values

Our vision is for every resident in the City of Wolverhampton to have the best mental health that they can at every stage of their life.

We will promote an approach that prevents and treats mental health problems with the same drive, passion and commitment as for physical health problems, embedding mental health and wellbeing across the health, care and wider system. This approach recognises the importance of enabling everyone to feel good and function well throughout their everyday lives.

This will be achieved through the following key objectives, drawing upon the wealth of skills and expertise across the Council, NHS and partner organisations:

- Focus on mental health promotion, mental illness prevention and recovery throughout the life course
- Promote resilience in individuals, families and communities through asset-based working and the wider social determinants of health
- Deliver timely, person-centred, effective services that align health and social care outcomes to provide integrated, responsive services and care
- Improve people's experiences of mental health and social care services
- Reduce inequalities in mental health and wellbeing and in access to care and support
- Challenge stigma and discrimination related to mental health problems

Key strategic and policy drivers

- **Five Year Forward View for Mental Health (2016)** emphasises the need for a shift towards prevention and better integration of care in order to improve outcomes and experiences for people with mental health problems and their carers, and reduce health inequalities.
- **Prevention Concordat for Better Mental Health (2016)** advocates a prevention-focused approach to mental health improvement in populations through evidence-based planning and commissioning. It also acknowledges the active role played by people with lived experience of mental health problems.
- **Care Act 2014** places statutory duties on Local Authorities to promote wellbeing, ensuring personal dignity; physical and mental health and emotional wellbeing; protection from abuse and neglect; control by the individual over their day-to-day life; participation in work, education, training or recreation; social and economic wellbeing; domestic, family and personal domains; suitability of the individual's living accommodation; and the individual's contribution to society.
- **No Health Without Mental Health:** a cross-government outcomes strategy (2011) set out ambitions for mental health to be given equal priority to physical health ('parity of esteem'), and to become 'everyone's business' – that is, for health services, local authorities, education, employers, third sector organisations and communities to work in partnership to address the causes and consequences of poor mental health and promote mental wellbeing in populations.
- **Better Care Fund (BCF)** is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.
- **Transforming children and young people's mental health provision: a green paper (2017)** sets out the ambition that children and young people who need help for their mental health are able to get it when they need it.
- **Suicide Prevention Strategy for England (2012)** sets out plans for reducing suicide rates and supporting people affected by suicide.

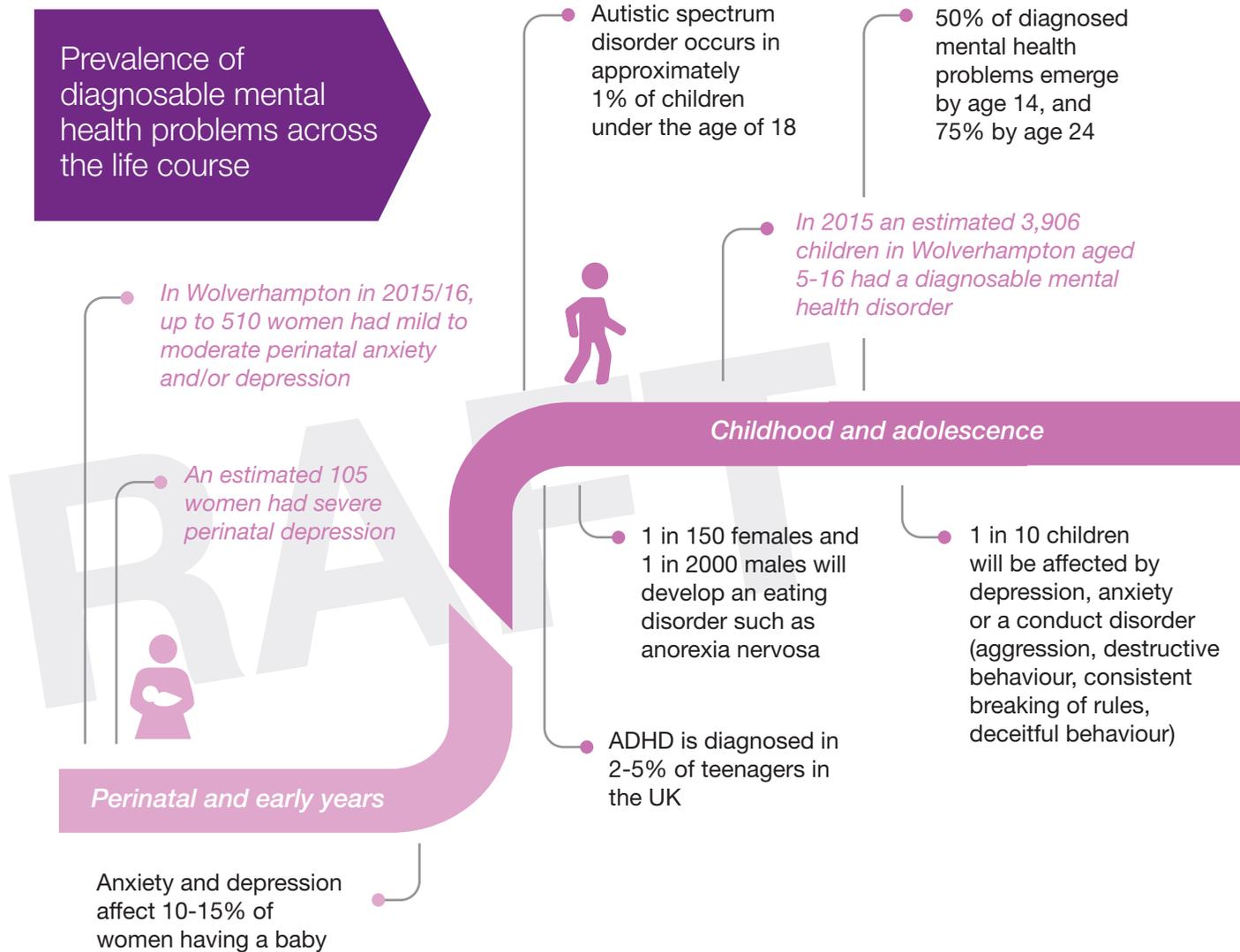
Local and national context

Mental health problems have very high rates of prevalence, estimated to affect around **1 in 4 people every year**. They are often of long duration, even lifelong in some cases and have adverse effects on many aspects of people's lives.

Nationally, poor mental health is estimated to cost the economy approximately **£105 billion per year**, including **£34 billion on dedicated mental health support and services**.

Prevalence of diagnosable mental health problems across the life course

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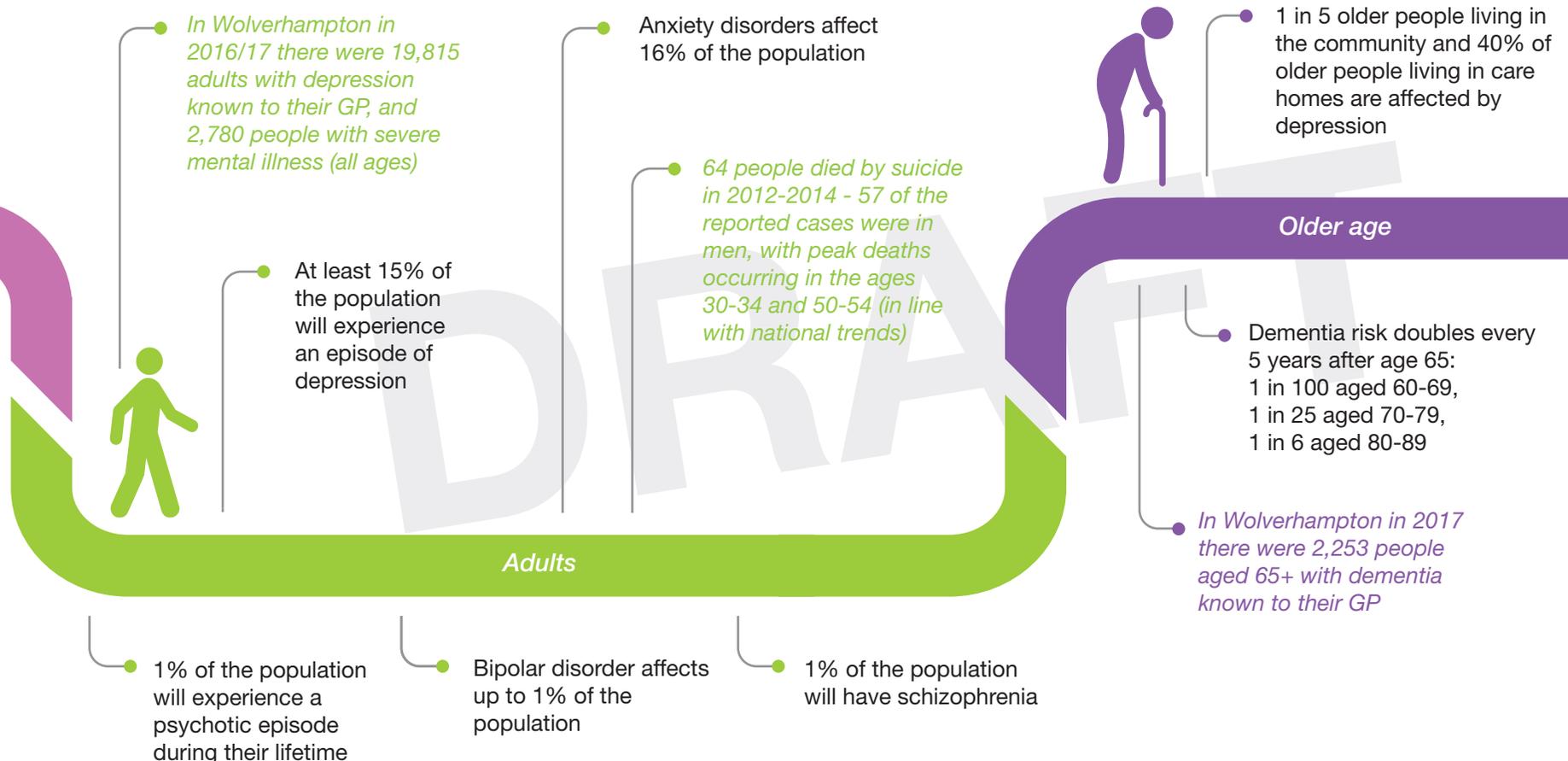


¹ NHS England internal analysis – Five Year Forward View for Mental Health (2016).

² Sources: Public Health Profiles: Mental Health, Dementia & Neurology; Mental Health Foundation.

Approximately 1 in 4 people in the UK will experience a mental health problem each year

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³ 5 Year Forward View for Mental Health (2016)





Wellbeing

Wellbeing encompasses social, emotional and mental wellbeing. It can be best summarised as **feeling good and functioning well**.

A recent report by the Mental Health Foundation (2017) found that that only 13% of people in England consider themselves to have good mental health. This highlights the importance of improving mental health and wellbeing at population level, beyond the prevention of diagnosable or definable conditions.



Creating the conditions for mental health and wellbeing

Poor mental health is both a cause and consequence of overall health inequalities due to its associations with physical health, employment, housing and lifestyle factors. People with severe and prolonged mental illness die 15-20 years earlier on average than others – two thirds of these deaths are due to avoidable physical illness, including heart disease and cancer linked to smoking.

At all ages **traumatic experiences, poor housing or homelessness, being part of a marginalised group**, or having **multiple needs** such as a learning disability or autism are all associated with increased risk of mental health problems, and may also limit access to support.⁴

⁴Prevention Concordat for Better Mental Health (2016)



Best start in life

- Adverse Childhood Experiences (ACEs) describe childhood trauma through abuse, neglect and difficulties in the home environment. ACEs are linked to poorer health and social outcomes, including smoking, substance use and incarceration.
- Children in care are 4 times more likely than their peers to have a mental health difficulty, which may be exacerbated with placement breakdown.
- Resilience factors such as feeling loved and having good social support network can help protect against the effects of childhood trauma.
 - We are developing ways to systematically capture information on ACEs, and intervene early to reduce the occurrence and impact of ACEs and prevent intergenerational problems as part of the **Early Years Strategy** and Healthy Child Programme.

Housing

- Among people in contact with secondary mental health services, only 27% in Wolverhampton live in stable and appropriate accommodation (2016/17).
- This is lower than both the regional average (45%) and national average (54%).
- We are actively working to improve the quality of rented accommodation, and to reduce homelessness - working in partnership with mental health services – as part of the **Housing Strategy**.



Community

- Just 50.9% of adult social care users and 25.2% of adult carers in Wolverhampton report having as much social contact as they would like (2016/17).
- We are developing a system to measure social isolation locally, and mobilise the community to meet these needs (e.g. through social prescribing).
- Young offenders are known to be a key group at increased risk of mental health issues. Our Reducing Gangs & Youth Violence Strategy will be incorporated into a wider **Exploitation Strategy** in 2019.



Schools

- School ethos, bullying and teacher wellbeing all have an influence on children's mental health. An average classroom of 30 pupils is likely to include 3 with a mental health problem, 7 who are being bullied, and 6 who are self-harming.⁵
- The **Social, Emotional & Mental Health (SEMH) Plan** for schools sets out actions for identifying and responding to SEMH needs. This includes workforce development and training, and off-site and on-site enhanced or alternative provision for pupils with identified SEMH needs.

⁵ Lavis P (2015). Promoting children and young people's emotional health and wellbeing: A whole school and college approach. London: Public Health England.



Employment

- As of November 2017, there were 12,010 Employment Support Allowance (ESA) claimants living in Wolverhampton.
- It is estimated that approximately 5,525 of these are due to mental health problems.⁶
- We are strengthening pathways across health and employment services to improve access to employment for people with mental health problems.



Environment

- Access to green spaces has a lasting positive effect on mental wellbeing for all ages and socioeconomic groups. However, these spaces are not equally distributed and are not always safe or accessible within deprived areas.⁷
- We are working to improve access to green spaces for wellbeing and physical activity through the **Open Spaces Strategy and Action Plan**.

⁶ Data from 2016 identified 46% of ESA claimants cited mental illness as the reason for being unable to work.

⁷ Better Mental Health For All: A Public Health Approach to Mental Health Improvement (2016). London: Faculty of Public Health and Mental Health Foundation.



Physical health problems

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Physical and mental health are inextricably linked. Mental wellbeing and resilience are protective factors for physical health as they reduce the prevalence of risky behaviours such as smoking, substance misuse and unhealthy eating, which are often used as coping mechanisms in the absence of other support. Conversely, people with cancer, diabetes, asthma and high blood pressure are at greater risk of a range of mental health problems such as depression, anxiety and PTSD.

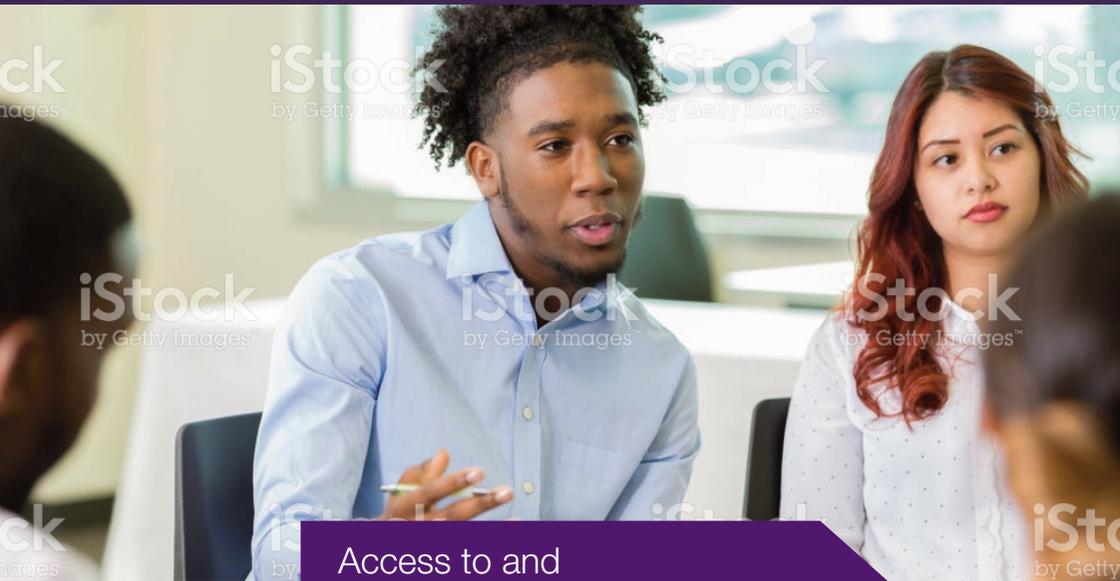
People with long term physical health conditions are more likely to have poor mental health compared with the general population, indicating a need to ensure approaches

to improve mental wellbeing are integrated into physical care pathways.

- 30% of the UK population live with one or more long-term health conditions. Of these, approximately 27% will also have a mental health problem.⁸
 - This means that approximately 20,664 people in Wolverhampton with a long-term health condition also have a mental health problem.⁹
- In Wolverhampton smoking prevalence in people with severe mental illness is 46.5%, compared with 16.5% in the general population. This is similar to the national average.

⁸ Naylor C et al (2012). Long-term conditions and mental health – The cost of co-morbidities. London: The King's Fund & Centre for Mental Health.

⁹ Based on mid-year population estimate of 255,106 (ONS)



Access to and experience of services

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Mental Wellbeing in Wolverhampton – an assessment of needs (2017) reported evidence from responses to a survey of users about their experiences of mental health service highlighted the following:

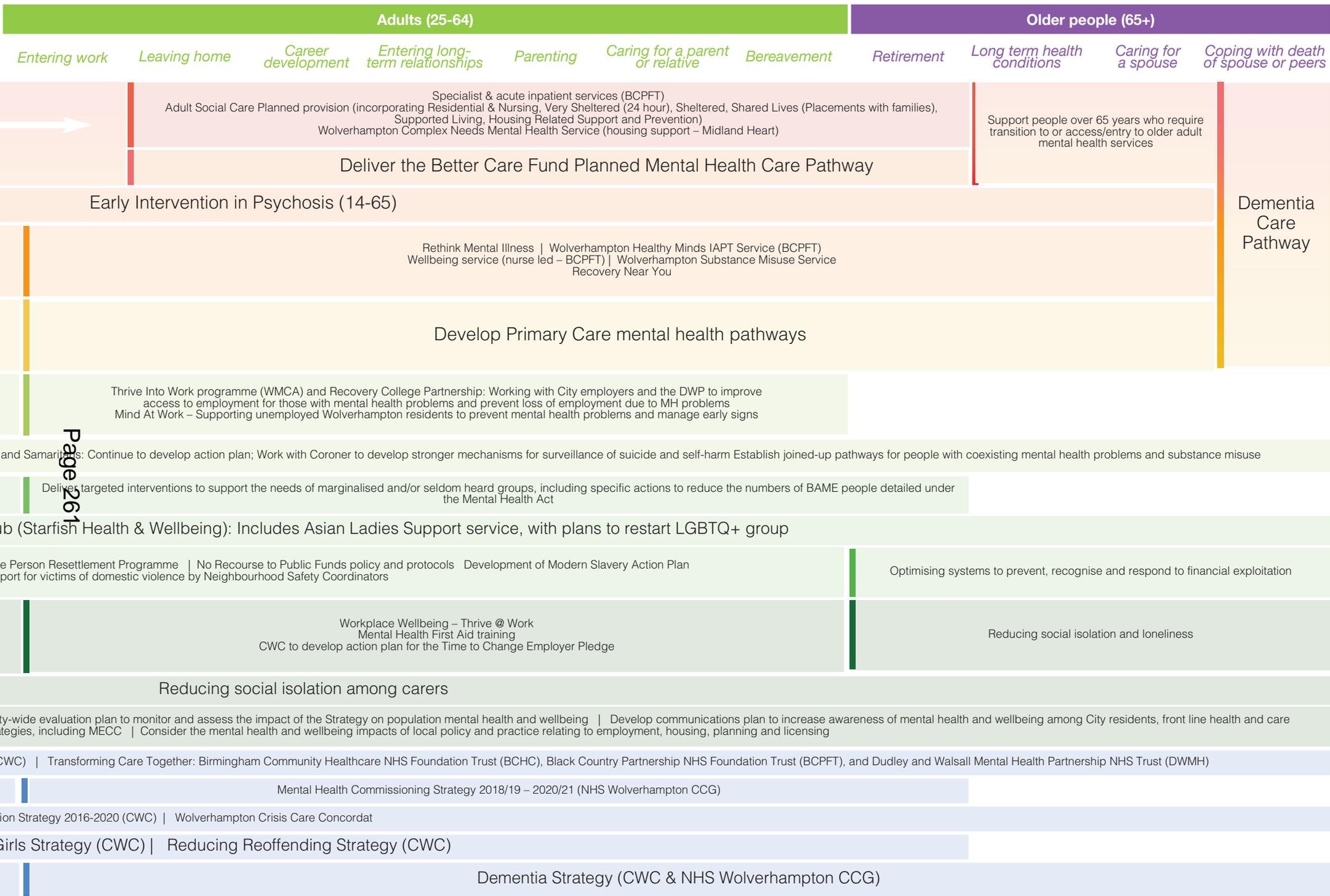
- **Groups at higher risk of poor mental wellbeing** - unemployed, LGBTQ+, Homelessness, BAME groups, refugee and migrants, students, ex-offenders, carers
- **Key issues highlighted:** isolation, access to support groups, housing employment, financial stability, physical health
- **Stigma:** lack of understanding from front line services, lack of support for coming back into work.

There was concern around people wanting support but not meeting the threshold for accessing services, and accessing difficulty in getting timely access to appropriate services. The report also indicated a need to raise awareness of where the public can get help, whether signposts or more information on mental health issues.

A life course approach to population mental health and wellbeing

This Strategy places mental health care and support within a broader Public Mental Health & Wellbeing framework, taking into account activity across the wider system to improve population wellbeing across the life course. This includes initiatives across a regional or STP footprint as well as local provision.

		Families & early years (0-5)			Children & young people (6-19/24)					
Major life changes & milestones		Acquiring language skills	Developing impulse control	Entering school	Learning to read & write	Developing social skills	Entering puberty	Forming friendships & relationships	Further/ higher education	Developing independence
Health & care system	Tier 5+ Specialist & Acute services	Children's social care				CAMHS Crisis and CAMHS Inpatient				Support young people under 18 years who require transition to adult mental health services
	Tier 4: Tertiary Mental Health Services					CAMHS Inpatient				
	Tier 3: Secondary Community Mental Health Services			Specialist Perinatal Team (BC&WB STP)		CAMHS: Core CAMHS – LAC, Inspire (LD), Eating Disorder service (14+), CAMHS Crisis				
	Tier 2: Primary Care / Primary Care facing Services			GPs/Health Advisers/Health Visitors		Develop an all age approach across the service model that incorporates the needs of young people under 18 years who require transition to adult mental health services				
Prevention	Indicated (Tier 1) For people with early detectable signs of mental health stress or distress; targeting people at the highest risk of mental health problems	Develop a local Prevention Concordat		Special educational needs support if in nursery or school Voluntary organisations – mental health specific and wider support		Headstart, GPs/Health Visitors/School Nurses, Substance Misuse/ 'The Way' Base 25, Believe 2 Achieve, Strengthening Families, PRUs, Counselling in schools, Educational Psychologists, Family Support Workers, EWO/SENCO, 10-12 Universal plus offer from Headstart, A&E, PAU, Community Paediatrics, Family Nurse Partnership, Substance Misuse, COT (Disability), YOT/YOT Nurse/Worker, CAMHS link workers (Headstart), Intensive Therapeutic Family Support (Barnado's) Emotional Health and Wellbeing Service (Children's Society)				
	Selective / Early Help For people in groups, demographics or communities with higher prevalence of mental health problems; targeting individuals or subgroups of the population based on vulnerability and exposure to adversity.			Strengthening Families Hub Submit bid for funding to identify and support children of parents with alcohol dependence, in partnership with Commissioning, Children's services and Strengthening Families team		Develop a Substance Misuse Strategy and resurrect the Substance Misuse Alliance Suicide Prevention Forum led by CWC				
	Universal For everyone; targeting the whole population, groups or settings where there is an opportunity to improve mental health such as schools or workplaces.			Healthy Child Programme 0-5: Improving the mental health & wellbeing of young children through promoting positive parenting and strong attachments Developing ways to systematically capture information on ACEs, and intervene early to reduce the occurrence and impact of ACEs and prevent intergenerational problems		Healthy Child Programme 6-19: Health & wellbeing reviews HeadStart (10-16 year olds – universal offer)				
				Developing the 'Community Offer' and asset-based approaches to promoting and supporting wellbeing in local communities, including asset mapping of community and voluntary sector support Develop a C... professionals, and employers Embed public mental health across universal health improvement programmes and stra						
Strategic context		Autism Strategy (CWC) Shaping Futures – Changing Lives - People Directorate Commissioning Strategy 2018-2021 (CWC) Open Spaces Strategy & Action Plan (CWC) Housing Strategy (C)			Child & Adolescent Emotional Health & Wellbeing Refresh (NHS Wolverhampton CCG) Early Help Strategy Thresholds of Need and Support in Wolverhampton					Wolverhampton Suicide Prevent
										Violence Against Women & G
		Early Years Strategy (CWC)			Social, Emotional & Mental Health Needs in Schools Plan (CWC) Reducing Gangs and Youth Violence Strategy(CWC) – to be replaced by wider Exploitation Strategy April 2019					



Outcome measures

An overarching evaluation and monitoring framework will be developed as part of this Strategy. This will include indicators relating to wider determinants, vulnerable groups, service activity and outcomes.

Wider determinants

Reduce the number of 16-18 year olds not in employment, education or training

Increase use of green spaces for physical activity

Increase self-rated population wellbeing scores

Vulnerable groups

Increase access to employment for people with mental health problems

Increase numbers of people with mental illness and/or disability in settled accommodation

Reduce episodes of violent crime

Reduce the number of first time entrants to the youth justice system

Increase the wellbeing of carers

Service activity

Increase rates of completed treatment and recovery, including drug and alcohol treatment

Reduce inequalities in access to treatment and support

Reduce emergency admissions due to mental health problems, including substance misuse

Reduce in-year bed days for mental health

Health and care outcomes

Reduce the incidence and prevalence of mental health problems, and inequalities in the population

Reduce inequalities in physical health outcomes between people with mental health problems and the general population

Reduce the number of suicides

DRAFT

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Wolverhampton WV1 1SH



BLACK COUNTRY JOINT COMMISSIONING COMMITTEE

Agenda item 11

Date of committee meeting: 10th May 2018

TITLE OF REPORT	Black Country Joint Commissioning Committee (BCJCC) Assurance Report
EXECUTIVE SUMMARY:	This report provides a summary of business considered at the Black Country Joint Commissioning Committee meeting on 10 th May 2018, for assurance.
IMPLICATIONS	
RECOMMENDATION TO THE COMMITTEE:	To note the contents of the report for update on activity and assurance
CONFLICT OF INTEREST MANAGEMENT	None identified
COMMITTEE ACTION REQUIRED:	Assurance
REPORT WRITTEN BY:	Angela Poulton, JCC Programme Director
REPORT PRESENTED BY:	Helen Hibbs, Accountable Officer
REPORT SIGNED OFF BY:	Dr Anand Rischie, Chair – Walsall CCG/Chair Black Country JCC
CONSENT AGENDA	Suitable for consent agenda
PREVIOUS COMMITTEES, DISCUSSION OR CIRCULATION	This report has not been to any other committee

The CCG has a duty to promote the NHS Constitution. Principles of the NHS Constitution this report supports:	
The NHS provides a comprehensive service available to all	Yes
Access to NHS services is based on clinical need, not an individual's ability to pay	Yes
The NHS aspires to the highest standards of excellence and professionalism	Yes
The NHS aspires to put patients at the heart of everything it does	Yes
The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population	Yes
The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources	Yes
The NHS is accountable to the public, communities and patients that it serves	Yes

Positive general duties - Equality Act 2010	
The CCG is committed to fulfilling its duty under the Equality Act 2010 and to ensure its commissioned services are non-discriminatory. This report is intended to support delivery of our duty to have a continuing positive impact on equality and diversity The CCG will work with providers, communities of interest and service users to ensure that any issues relating to equality of service within this report have been identified and addressed	
Please indicate if there have been any equality of service issues identified in this report	No

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1.0 Action Log and Matters Arising

- 1.1 There had been satisfactory progress on all items. The need to identify resources with the skills and capacity to progress the GPFV workforce planning work had been agreed and discussions continue regarding how to resolve.

2.0 Clinical Leadership Group (CLG) Update

- 2.1 Dr Anand Rischie fed back that the focus of the April meeting had been to agree the approach to developing the clinical strategy and to consider the opportunities to improve care for people with frailty. A comprehensive presentation on frailty showing comparative performance information for the 4 CCGs was made by Right Care Partner Lucy Heath, and it was evident that there is good practice that could transfer to other CCGs.

- 2.2 Angela Poulton referred members to the 'Addressing Clinical Priorities across the Black Country' paper, and the following recommendations were agreed by the CLG:

- 1. Review the list of clinical priority areas, to identify where further work is required to support the rationale for prioritisation and to agree a recommendation to the JCC/STP;*
- 2. Consider commissioning an initial piece of work that collates existing local sources that address the levels at which services should be provided and produce a gap analysis of where further work is required.*

CLG agreed to establish a frailty working group, and have requested a Black Country commissioning lead. Angela Poulton confirmed there are two other working groups, Respiratory and Hypertension supported by identified commissioning leads and Right Care. Peter Price raised the link to housing and other wider determinants and the need for this to be considered as part of the work. The need to ensure Finance involvement in CLG groups was agreed.

- 2.3 Paul Maubach raised the need to align the work undertaken as part of the forthcoming Acute Sustainability Review with the clinical strategy work. The need for estates and capital bids to be aligned was discussed.

3.0 Collective Responsibilities

- 3.1 Dr Anand Rischie discussed the importance of the Committee needing to identify services and activities for which the 4 CCGs have collective responsibility. The work being undertaken via the CLG will help to inform this. Dr Helen Hibbs referred members to the work that is just starting to provide NHSE with the Black Country roadmap to strategic commissioning which is required by 21st May. An Executive lead from each CCG will be identified to work on developing the roadmap.
- 3.2 There was discussion about the need to engage 'hearts and minds' to the joint commissioning agenda and the need for something significant to happen to make it happen. Andy Williams referred members to the need for relationships between NHSE and the STP leadership to establish, the place-based work that is progressing and suggested the need for the nature of strategic commissioning to be more clearly defined. Dr Helen Hibbs

referred the Committee to the Price Waterhouse Cooper Integrated Care Systems development programme as a mechanism for this to be considered.

4.0 Programme Performance

- 4.1 Angela Poulton referred members to the latest Black Country STP performance reports and remarked that by comparison to other STPs the Black Country were performing well, and that all STPs were 'red' for 4-hour A&E performance. It was agreed that this information would be routinely provided to the Committee and that its importance lies in what actions are taken in response to it going forward. There was a discussion about the current NHSE emphasis on how CCGs and providers are working, and that where there are opportunities to respond to performance issues in a collective way there is the need to establish the working environment that enables this to be done.
- 4.2 Dr Helen Hibbs provided an update on the Transforming Care Programme. The Programme has failed to deliver the agreed trajectories. Dr Helen Hibbs has taken over as Chair for the Programme Board and is being supported by an NHSE Programme Manager with a small team. There are a few long stay patients that may not be discharged in the life of the Programme. Discussions with Ray James which were escalated to Simon Stevens have not resulted in a change in the trajectories or the life of the Programme. Internal scrutiny of the patients predicted to date as those unlikely to be discharged during the life of the programme has been undertaken. NHSE has organised external scrutiny panels which are convening in the next few days. Members were referred to the revised delivery plan submitted to NHSE. Matt Hartland reported on the financial position, there being a potential £4.4m risk identified across organisations. The cost of beds has been agreed and discussions continue in relation to delivering the community model and regarding how to apportion the risks across the 4 CCGs.
- 4.3 Angela Poulton raised the issue of governance for the Programme. Rita Symons, NHSE Programme Manager, had contacted her as there is the need for clearer arrangements. Currently, the JCC only has delegated responsibility for ensuring the transitional funding is spend appropriately and for oversight of the case reviews being undertaken. Dr Hibbs confirmed that NHSE are potentially seeking the 'one commissioner' approach to Learning Disabilities. It was agreed that the Accountable Officers would discuss further outside of the meeting.

5.0 Specialised Services

- 5.1 Angela Poulton referred members to the Black Country specialised services information which was based on Secondary Uses Service (SUS) data as there have been difficulties accessing the National Commissioning Data Repository (NCDR) hosted by Arden and Gem CSU (AGEM). Owing to the source being SUS, the activity/spend will be understated and the information does not give a sense of spend against budget or whether there are any contract performance issues. Angela Poulton confirmed she is continuing to work with Midlands and Lancashire CSU and AGEM CSU to obtain the information required.

5.2 There was discussion about the direction of travel for specialised services was not clear, and this needs to be part of the strategic commissioning roadmap. Dr Helen Hibbs agreed to meet with Rachel O'Connell to discuss.

6.0 STP/Integrated Care System (ICS) Update

6.1 Andy Williams was thanked for his work as STP which was acknowledged to have been extremely challenging. Dr Helen Hibbs confirmed that she had agreed to take up the role of STP Senior Responsible Officer (SRO) for the next few months, and that the interviews for the Independent Chair were scheduled for 15th May. Discussions were underway regarding the Portfolio Director appointment.

6.2 Dr Helen Hibbs referred to a letter summarising what had been agreed with timescales at the last NHSE STP stocktake:

- Strategic commissioning structure and roadmap by 21/5/18
- Clinical strategy by 28/6/18
- Acute Sustainability Review by 31/8/18
- Engagement including specialised commissioning
- JCC commissioning intentions for 2019/20 by 30/9/18

In addition, NHSE require NHS leaders to demonstrate a joint culture and behaviours.

6.3 Julie Jasper asked what the penal regime was associated to these requirements, to which Dr Helen Hibbs stated that she felt the plan would be delivered. Dr David Hegarty referred to the importance NHSE were placing on the how the system was working together. Discussion took place regarding the need for commissioners to drive acute integration, an area which is acknowledged to be challenging and reliant upon building positive working relationships.

7.0 Strategic Commissioning Roadmap & Proposed Joint Project Support Arrangements for Joint Commissioning

7.1 Dr Helen Hibbs confirmed that the work to develop the strategic roadmap was being undertaken through a group comprising an Executive Lead from each CCG, and would be reported at the June meeting. There was discussion about the need for more resources to support STP and JCC work, and arrangements to get work done and unblock issues. It was confirmed that STP funding that had been made available was non-recurrent and that CCGs would need to find a way to fund on-going arrangements. Andy Williams referred to the need for agreement to be reached regarding how far the remit for strategic commissioning extends beyond specifying, the scale of operations and consideration of involving local authorities and wider stakeholders. It was agreed that the Accountable Officers would meet outside the meeting to discuss further.

7.2 The Committee approved the establishment of a Black Country system Project Support Office based in Wolverhampton CCG, and for costs to be shared by the CCGs. Wolverhampton CCG to lead the recruitment process.

8.0 Personalised Care Demonstrator Site Bid

8.1 Angela Poulton referred to the update paper prepared by Laura Broster. The Committee had previously supported the Black Country becoming a Personalised Care Demonstrator Site, subject to each CCG agreeing the position on the Personalised Health Budget (PHB) position. The Committee endorsed the achievability of the targets for PHBs as advised by the PHB leads, agreed the targets and spending plan (revised down from £300,000 to £250,000 owing to the delay in commencement), and financial risk for non-delivery of £75,000. The proposal that the STP Portfolio Director leads this initiative was not agreed, the decision taken for the Accountable Officers to meet outside the meeting to identify a Black Country Personalised Care lead. Paula Furnival confirmed that she was working with other Director of Adult Services colleagues to gain support, and subject to this she would be the Local Authority representative lead.

9.0 Risk Register

9.1 Mr Jim Oatridge confirmed that the Governance Sub Group had been tasked by the Black Country Joint Commissioning Governance Group to review the risk registers of all four CCGs to identify items of commonality and shared strategies for management. The work had not been completed and a report would be given at a future JCC.

10.0 Consent Agenda Reports

10.1 The draft Black Country Joint Decommissioning/Disinvestment Policy and May 2018 Executive Development Session Summary were noted. Mike Abel requested that the final version be approved by each CCG prior to being presented to this Committee for approval supported by a note identifying the differences between each CCG's existing policy and the combined document. Angela Poulton agreed.

BLACK COUNTRY JOINT COMMISSIONING COMMITTEE

Agenda item 11

Date of committee meeting: 22 June 2018

TITLE OF REPORT	Black Country Joint Commissioning Committee (BCJCC) Assurance Report
EXECUTIVE SUMMARY:	This report provides a summary of business considered at the Black Country Joint Commissioning Committee meeting on 22 nd June 2018, for assurance.
IMPLICATIONS	
RECOMMENDATION TO THE COMMITTEE:	To note the contents of the report for update on activity and assurance
CONFLICT OF INTEREST MANAGEMENT	None identified
COMMITTEE ACTION REQUIRED:	Assurance
REPORT WRITTEN BY:	Angela Poulton, JCC Programme Director
REPORT PRESENTED BY:	Helen Hibbs, Accountable Officer
REPORT SIGNED OFF BY:	Dr Anand Rischie, Chair – Walsall CCG/Chair Black Country JCC
CONSENT AGENDA	Suitable for consent agenda
PREVIOUS COMMITTEES, DISCUSSION OR CIRCULATION	This report has not been to any other committee

The CCG has a duty to promote the NHS Constitution. Principles of the NHS Constitution this report supports:	
The NHS provides a comprehensive service available to all	Yes
Access to NHS services is based on clinical need, not an individual's ability to pay	Yes
The NHS aspires to the highest standards of excellence and professionalism	Yes
The NHS aspires to put patients at the heart of everything it does	Yes
The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population	Yes
The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources	Yes

The NHS is accountable to the public, communities and patients that it serves	Yes
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<p>Positive general duties - Equality Act 2010</p> <p>The CCG is committed to fulfilling its duty under the Equality Act 2010 and to ensure its commissioned services are non-discriminatory. This report is intended to support delivery of our duty to have a continuing positive impact on equality and diversity The CCG will work with providers, communities of interest and service users to ensure that any issues relating to equality of service within this report have been identified and addressed</p>	
Please indicate if there have been any equality of service issues identified in this report	No

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1.0 Action Log and Matters Arising

- 1.1 There had been satisfactory progress on all items. A revised JCC Risk Register template was agreed which will now be populated to include risks relating to areas formally delegated and risks of common interest that individual CCGs are best able to manage. The importance of ensuring an effective feedback loop from CCGs to the JCC for the purpose of managing the Risk Register was agreed.

2.0 Place-Based Commissioning Update – Dudley

- 2.1 Paul Maubach provided an update regarding the MCP procurement, explaining that the bid evaluation phase was underway as a joint process involving Dudley Council and the CCG. There are two National judicial reviews, which relate to the ACO contract, one of which has failed and the outcome of the other is awaited. Once the outcome of the bid evaluation is confirmed, the contract will be subject to a 9-month assurance process. A National public consultation on the contract will take be undertaken by NHS England later this year. Members were referred to the Health Select Committee report.

3.0 Clinical Leadership Group (CLG) Update

- 3.1 Angela Poulton confirmed that the first draft Black Country Clinical Strategy has been issued to CLG members, CCG clinical Chairs and leads, Medical Directors, Chief Nurses and Chief Executives/Accountable Officers. Feedback is starting to be received which will be considered by CLG when the document is reviewed on 29th June and will inform a further version. Dr Helen Hibbs confirmed that the Clinical Strategy will be the focus of the ICS Development Workshop scheduled for 2nd July.

4.0 Programme Performance

- 4.1 Angela Poulton referred members to the latest Black Country STP performance reports. A&E 4-hour performance continues to be challenging but it was noted that that Royal Wolverhampton are now meeting the standard with improvement being seen at Walsall. 62-day cancer target performance continues to not be met, partly due to tertiary referral delays but also capacity issues and reductions in the 104-day waits. The Cancer Alliance is involved and is going to put a manager into Royal Wolverhampton for support.
- 4.2 Dr Helen Hibbs reported that TCP trajectories continue to not be met owing to the number of admission and there is close monitoring by NHS England. There is a deep dive scheduled for the end of next week. The Pathway Group workshop held last week focussed on how to work differently and achieve a standardised approach. The providers are working better with CCGs. The new community model commissioning specifications have been sent to governing bodies. Discussions about the need for a longer term financial plan and the associated financial risks were discussed, and it was agreed that the Chief Financial Officers would undertake an options appraisal on the best way to approach their management to be reported at a future JCC meeting. There are challenges with regards Local Authority engagement arising out of the financial risk and risk posed by forensic

patients being in the community, and a meeting with the four Directors of Adult Social Services has been scheduled.

5.0 Specialised Services

5.1 Angela Poulton presented information on Specialised Services that had been sourced from Midlands & Lancashire CSU, based upon provider SUS data that Arden & Gem CSU had shared. Access to the National Commissioning Database Repository has not been possible. Owing to the significant data quality issues in the information presented, Angela Poulton recommended that the only way to obtain reliable and validated information is to request this directly from the Specialised Service team. The Committee shared their dissatisfaction at the lack of engagement by Specialised Services. Dr Helen Hibbs confirmed that a meeting is being scheduled with Rachel O'Connor.

6.0 Project Support Office Update

6.1 Dr Helen Hibbs confirmed that the advert has gone out for the STP Portfolio Director. A shared drive is being created to support the STP and JCC work using Wolverhampton staff on a temporary basis. Programme briefs with hi-level milestone plans are being developed with support from NHSE staff.

7.0 Cancer Alliance

7.1 The Committee received a report from Paul Tulley confirming Cancer Alliance governance arrangements and staff resources aligned to the cancer improvement work. The transformation funding was being used to appoint interim staff which was flagged as a concern as there is the need to find sustainable resourcing solutions.

8.0 Personalised Care Demonstrator Site Bid

8.1 Laura Broster confirmed that the bid had been approved and that adverts would be going out for the posts to support delivery.

9.0 Future Support for the JCC

9.1 Angela Poulton's secondment ends at the end of June. The Accountable Officers to agree future support.

10.0 STP Individual Placement Support Service

10.1 Steven Marshall gave an overview of the Individual Placement Support Service (IPS). The Five Year Forward View specifications outline key provisions for IPS across the STP. There are a number of waves for funding. The funding application was developed by Dudley and Walsall Mental Health Trust who are providers of this. There will be funding for two

years, and Finance Directors have been advised of the need to find funding for years 3 and 4.

10.2 The service specification has been agreed by Wolverhampton CCG Commissioning Committee as the lead commissioner, and will be shared with other CCG Governing Bodies.

11.0 Consent Agenda Reports

10.1 The consent reports were noted.

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WOLVERHAMPTON CCG
Governing Body
10th July 2018
Agenda item 12

TITLE OF REPORT:	Commissioning Committee – Reporting Period May and June 2018
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 May and June 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 May and June 2018.

2. MAIN BODY OF REPORT

2.1 Risks

Corporate level risks

CR14 – Developing Local Accountable Care Models – to remain red as ongoing work required to test and challenge.

Action - That Governing Body notes the update provided.

2.2 Sickle Cell & thalassaemia Support Project

The Committee was provided with an assurance report for the revised service and agreed to extend the current contract based on the revision from 1st July 2018 to 31st March 2020.

No issues were identified.

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

2.3 Anti-Coagulation Specification

The Committee was presented with the service specification and noted the development of the service. It was agreed that the specification was CV'd into the current contract.

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

2.4 Contracting Update

Royal Wolverhampton NHS Trust

2018/19 Contract Negotiations

The Committee noted the revised contracting arrangement agreed between the South Staffordshire CCGs and RWT. This is a new type of agreement and will be kept under review and closely monitored.

Black Country Partnership Foundation Trust (BCPFT)

Service Development Improvement Plan (SDIP)

The Committee noted the Joint Efficiency Review Group (ERG) for Adult Mental Health Services had been re-established and will review the current SDIP to ensure it is fit for purpose.

Sandwell and West Birmingham (SWB) CCG have shared a plan for reviewing the mental health specs in line with the STP but more locally for both CCGs. This has been shared with all commissioners from both CCGs to update on their current status with specific specifications. Once this has been reviewed a further meeting will be required to discuss the further development of those specs that remain out of date.

Finance Activity

The Committee received an update regarding a revised set of contract principles which had been agreed with the Provider following the agreement of a new contracting approach for adult/older adult inpatients.

Urgent Care Centre

The Provider has shown a demonstrable improvement in performance in the last quarter. There are currently no live contract notices. It was noted that work is ongoing, including RWT, to map pathways into the Urgent Care Centre.

Thrive Into Work – Independent Placement Support

The Committee was presented with the revised service specification for short breaks/respite care and the new service specification for Hospice at Home for Children and Young People. This was noted and the service specifications approved with the caveat that any comments were fed back following the meeting.

Action - That Governing Body notes to above.

2.4 Special Educational Needs and/or Disabilities (SEND)

The Committee was presented with an update on the progress in respect of implementing the CCG's key duties and responsibilities arising from the Children and Families Act 2014 SEND Code of Practice. The CCG has the required SEND Action Plan in place to ensure associated actions are considered. It was noted that the CCG is aiming to meet compliance with the SEND reforms.

Action - That Governing Body notes to above.

2.5 Smoking Cessation in Pregnancy Investment Report

The Committee considered the pilot proposed to reduce the number of women smoking during pregnancy. Approval was given for this to be implemented with an end date of March 2020.

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

June 2018

2.6 Community Continence Service

The committee received an Equality Analysis form service specification and noted the development of the service. It was agreed that the specification is to be imported into the current contract.

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

2.7 Review of Risks

The committee received an update of the risk register highlighting the current risks.

2.8 Contracting Report

The committee received an update on the following contractual arrangements –

Cancer targets failed by RWT except for 31 days for subsequent treatment (surgery), trajectories have been submitted to NHSI for cancer for clarity of referral to treatment time. The RTT and A&E are currently under review by the CCG. Extra pressure will be forthcoming on RWT as referrals from Shropshire and Telford whom are unable to meet the 2 week appointment targets.

Clarity is also being sought on National KPIs and what is expected on the monthly performance sanctions process.

Black Country Partnership Foundation Trust (BCPFT)

Service Development Improvement Plan (SDIP)

The committee's attention was brought to the provider seeking investment for a new neuro rehab service proposal which will be submitted at a later date and will be reviewed by the efficiency needs group.

WMAS non-essential patient transports which was consuming manpower is improving in performance

Service discussions are currently ongoing with For Care who are contacted for intervention on behalf of the WCCG.

3. RECOMMENDATIONS

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

Name: Dr Manjit Kainth

Job Title: Lead for Commissioning & Contracting

Date: 29th June 2018

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WOLVERHAMPTON CCG
GOVERNING BODY MEETING
10TH JULY 2018

Agenda item 13

TITLE OF REPORT:	Quality and Safety Assurance Report
AUTHOR(S) OF REPORT:	Sally Roberts Chief Nurse & Director of Quality Yvonne Higgins, Deputy Chief Nurse
MANAGEMENT LEAD:	Sally Roberts Chief Nurse & Director of Quality
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).
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.
KEY POINTS:	<p>This report provides an update of Quality and safety activities and discusses issues raised through Q&S Committee, these are described as:</p> <ul style="list-style-type: none"> • Update on progress for Vocare Urgent Care provider • Cancer performance remains challenged • Mortality indicators deteriorating and requiring further understanding and assurance • Maternity performance issues showing improvement, further understanding of caesarean section rates required • Further assurance received relating to Never Event occurrence and actions undertaken • The QSC received reports relating to Safeguarding activity and assurance, Medication Optimisation update, SPACE update and Primary care assurance. No key risks or issues were identified by committee.
RECOMMENDATION:	Provides assurance on quality and safety of care, and inform the Governing Body as to actions being taken to address areas of concern.



1. Key areas of concern are highlighted below:

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

Key issue	Comments	RAG
Quality and performance issues of Urgent Care Provider	<p>Vocare was rated 'Inadequate' by CQC following an inspection in March 2017 CQC. A further announced focused inspection was carried out by CQC in 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. The CQC re-visited Vocare in February 2018 and rated the provider as 'Requires Improvement'. An initial 8 week improvement plan was agreed between CCG and Vocare and progress achieved. A further revised 8 week improvement plan is now in place and weekly monitoring continues. Progress against the plan continues and improvements appear to be sustained.</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • 6 weekly Vocare Improvement Board meetings. • Announced and unannounced visits by WCCG. • No Serious incidents reported by Vocare since December 17. • Senior oversight of improvement plan by Vocare. • Triage response rates demonstrate an improving picture at 74% and four hour performance was reported as 98% for April 18. • Home visiting performance has improved to 88% for April 18 but the call back performance remains challenging. • Workforce capacity and demand review completed and shared with CCG along with recruitment and retention plan. • Appointment of senior operations manager has provided local leadership and oversight. • Clinical Rota Co-ordinator role now appointed to local position, all local dispatchers now appointed. • Two team leaders appointed, in addition to four GP roles. Two team leaders appointed, in addition to four GP roles. 	RAG



	<ul style="list-style-type: none"> • Process mapping exercise completed to determine effective triage process between RWT and Vocare, follow up meeting of actions planned for mid-July. 	
<p>Cancer Performance for 104 and 62 day waits is below expected target. This may impact on the quality and safety of care provided to patients.</p>	<p>Cancer performance at RWT against 62 and 104 day cancer pathways is not currently being achieved, in addition a range of other cancer performance measures, including 2 week referral target remain challenged. Assurance is required relating to potential or actual impact of harm for patients as a result of any delay.</p> <ul style="list-style-type: none"> • Remedial action plan now agreed between trust and CCG, including achievement of revised trajectories. • Weekly system wide assurance calls in place to provide updates on current performance and progress against agreed actions. • Assurance documentation received pertaining to harm review process undertaken by the trust, further assurance requested, including request for CCG clinical attendance at harm review. • Clinical CCG attendance at weekly cancer PTL meeting for further assurance and scrutiny of performance agreed with RWT. • Specialty level performance data now being received from Trust, allowing for closer scrutiny of individual clinical pathways. • Agreed focus of scrutiny with regards 104 day waits initially. • IST to undertake a review of tracker activity on behalf of the trust during May/June. • Agreement to utilise UHB tertiary referral forms agreed by the trust. • WCCG have received updates relating to the work undertaken by independent clinician for head and neck pathways to ascertain if some of the improvements would be transferrable to other cancer sites. • Additional capacity has been identified in radiotherapy for CT scanning although workforce may be challenging to support this. • Remains a high risk on both RWT and WCCG risk registers. • Cancer network and NHSE/NHSI are sighted on current performance and support the ongoing work with the trust. • NHSE review meeting planned for July with Trust and CCG. • West Midlands Maternity alliance providing support for the trust. 	



<p>Capacity within Maternity may impact on the quality and safety of care delivered.</p>	<p>The Provider has currently capped the maternity activity for the Trust; this does not apply to Wolverhampton women. The current Midwife to birth ratio is 1:30, with national rate standing at 1:28. Caesarean rates: Elective rate 10.9% (target is less than 12%) and Emergency rate 16.8% (target is less than 14%).</p> <p>Risk Mitigation:</p> <ul style="list-style-type: none"> • Continuous monitoring for SI's, complaints or any other emerging quality issues pertaining to maternity, no emerging themes or trends have been identified. • Awaiting outcome of review by National Team (Birth Rate Plus) – the Trust is expected to receive this April 2018, formal feedback will be provided at June 18 CQRM. • RWT undertaking an internal review of caesarean section performance and initial review has suggested that in 60% of cases (category 3 & 4) it was the acuity of the patients i.e. diabetes. A full report of these findings will be presented at July 18 CQRM.
<p>Mortality: RWT is currently reporting the highest Standardised Hospital Mortality Index in the country</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 is estimated to be 118 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. Following attendance at the trusts Mortality Assurance Group the Chief Nurse and Deputy Chief Nurse met with the Medical Director and Chief Nurse at the trust to gain further assurance and identify actions relating to reducing mortality.</p> <p>Actions agreed include:</p> <ul style="list-style-type: none"> • Establishment of a system wide mortality reduction group, to include Public Health and Social Care representation, with specific reference to patient deaths within 30 days of hospital discharge • Requirement to review end of life pathways to ensure they are robust. • Review of Nursing home admission data, to establish any common themes/trends with regards admission profile. • A review of internal mortality governance arrangements by the trust, to include Primary Care and commissioner representation.



	<ul style="list-style-type: none"> • A review of mortality reporting to include crude mortality and HSMR, ensuring a more robust assurance report. • Production of a remedial action plan by the trust. • Case note reviews of specific pathways already undertaken by independent reviewers last year. <ul style="list-style-type: none"> • Further pathway reviews to be undertaken with the use of an accredited external clinical reviewer, to review actions previously put in place and offer revised key areas for focused improvement initiatives. • External support to be enlisted to help identify areas for improvement and to facilitate improvement programmes. • Further understanding and more detailed work is required to identify concrete measures for monitoring progress and improvements. • Logged on the WCCG risk register as a high risk, also logged on RWT risk register and identified as a risk on trusts BAF risk register. • Agreement with PH to develop a system wide mortality reduction plan and system wide mortality review group to be established. TOR drafted. 	
<p>Increased number of NEs 16/17</p>	<p>6 Never Events have been reported by RWT for 2017/18. The trust has further reported 2 new Never Events for year 2018/2019 in this current reporting period.</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 senior exec board has met with RWT board on 18.04.2018 to seek board assurance of actions being undertaken by the trust to prevent/mitigate reoccurrence of never events. • 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. 	

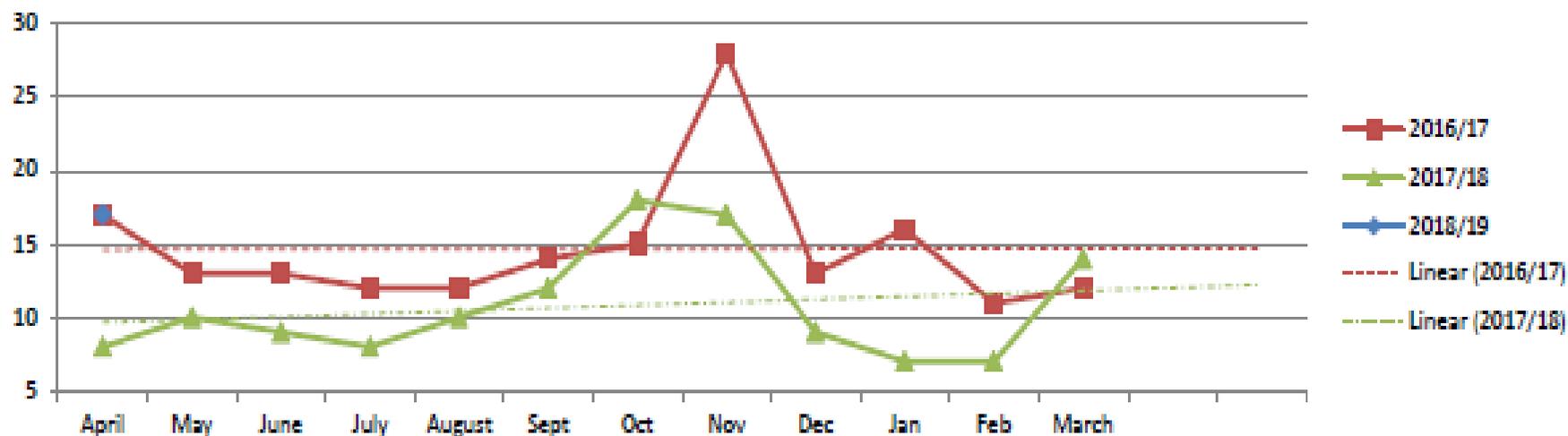


- CCG have instigated rapid responses to recent never events, including immediate assurance call with DON and unannounced visit to theatre area involved in recent never event.
- Failure to ensure robust 'Checking' process is identified as an emerging theme of never events.

2. ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

2.1 Serious Incidents

RWT Incidents 2016-2018 (excluding PI's)

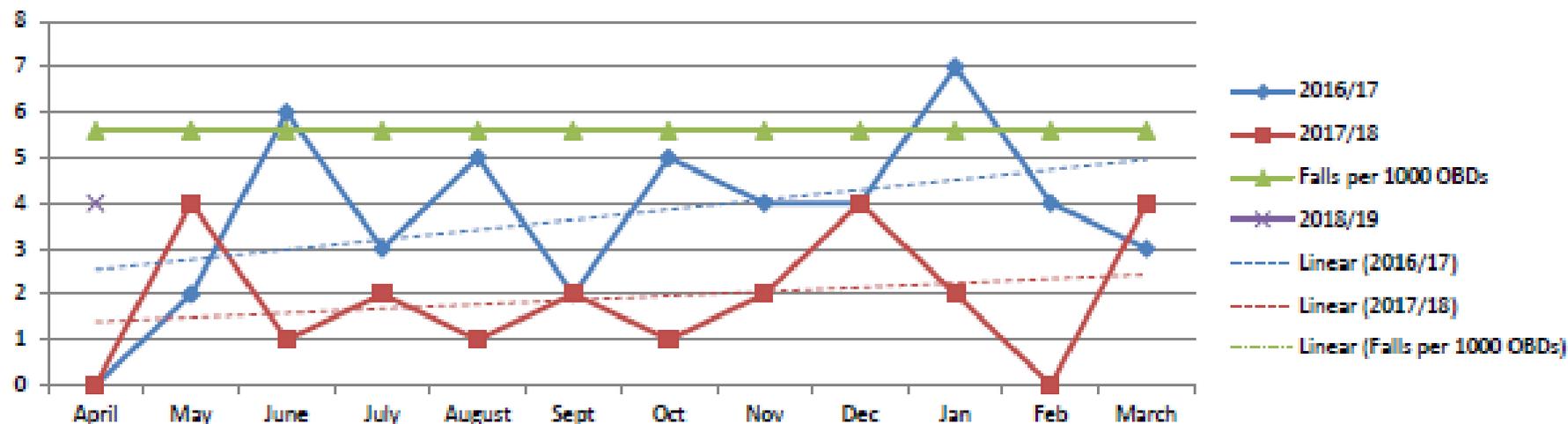


17 Serious Incidents were reported in April 2018, which is a slight increase compared to 14 SI's reported in March 18.



2.2 Slip Trip and Patient Falls SI's (RWT)

RWT - Slip Trip Falls, 2016-2018



There were 4 patient falls meeting SI criteria reported for April 18 which is similar to the number of falls reported in March 18. 2 out of 4 patient falls were deemed unavoidable and 2 patient falls were deemed avoidable.

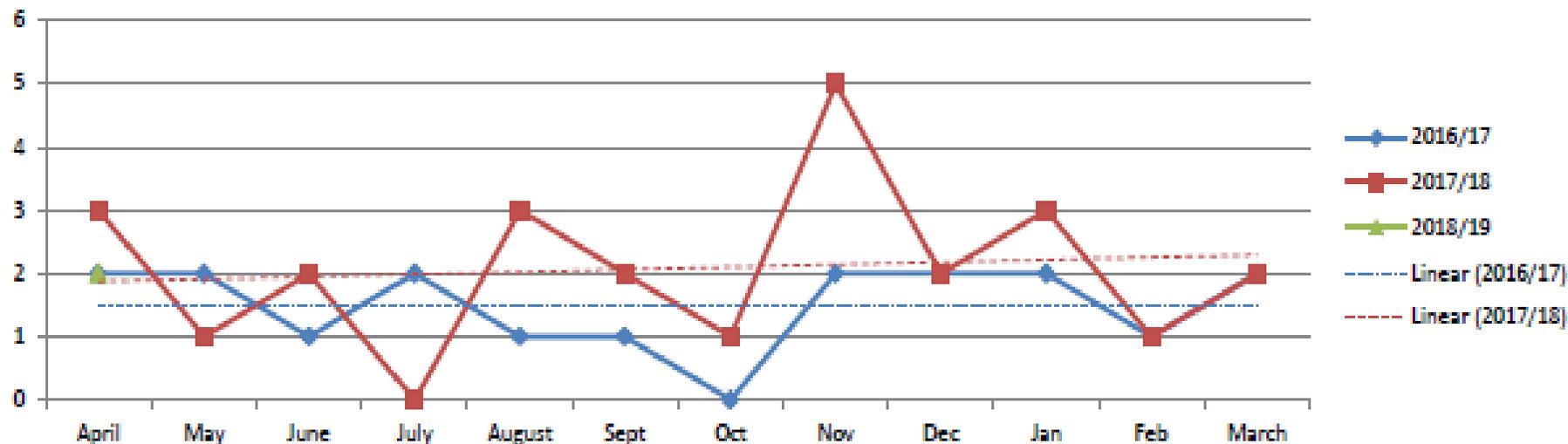
Assurance

The WCCG quality and safety manager attends the weekly falls accountability meeting and also attends the monthly falls steering group meeting to seek further assurance regarding falls prevention strategies within the trust. The trust has implemented tag nursing and arm's length nursing initiatives in an attempt to prevent patient falls. Following roll out of the NHSI falls collaborative the trust is undertaking the re-assessment of the early pilot wards to ensure sustainability of actions implemented.



2.3 Infection Prevention

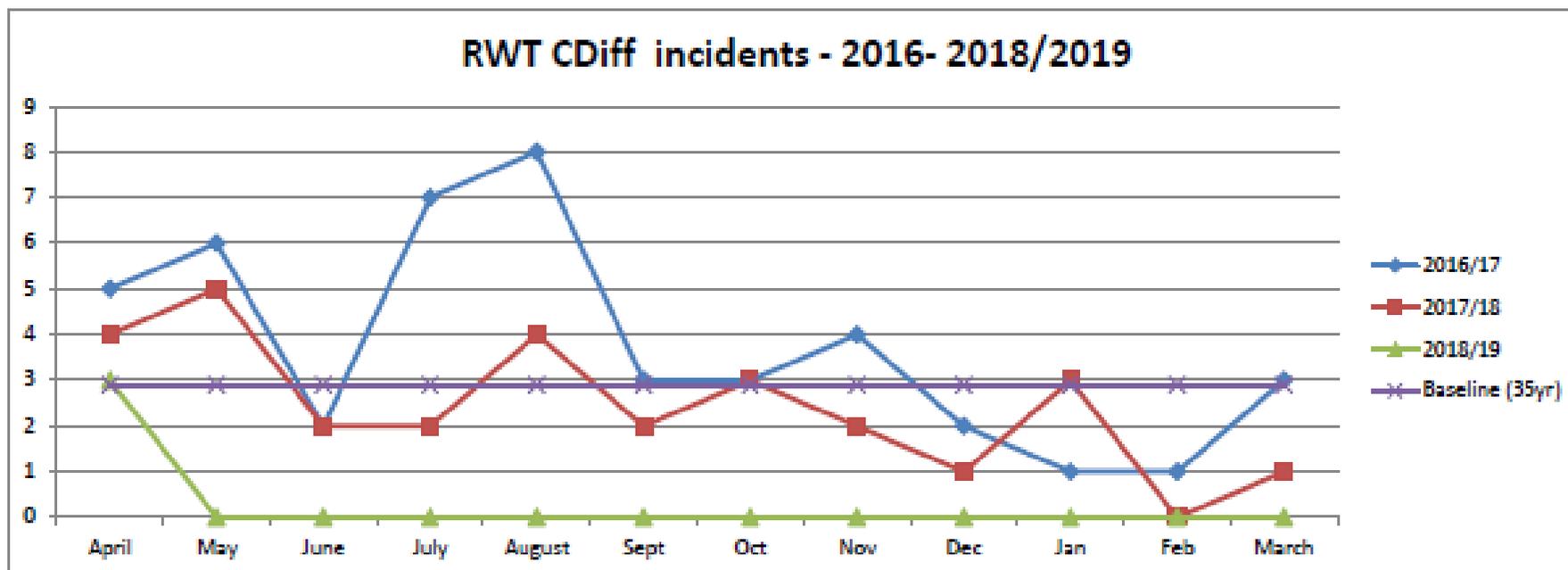
RWT HCAI/Infection control incidents 2016-2018



2 infection prevention serious incidents were reported for April 18 and both of these incidents related to wrong breast milk given to babies. The trust is currently undertaking RCAs to identify root cause and learning to prevent reoccurrence of these incidents.



RWT CDiff incidents - 2016- 2018/2019



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3 C Diff cases were reported by RWT using the external definition of attribution, against a target of 3 for April 18. The Trust is now zero cases ahead of target at the end of month 1.

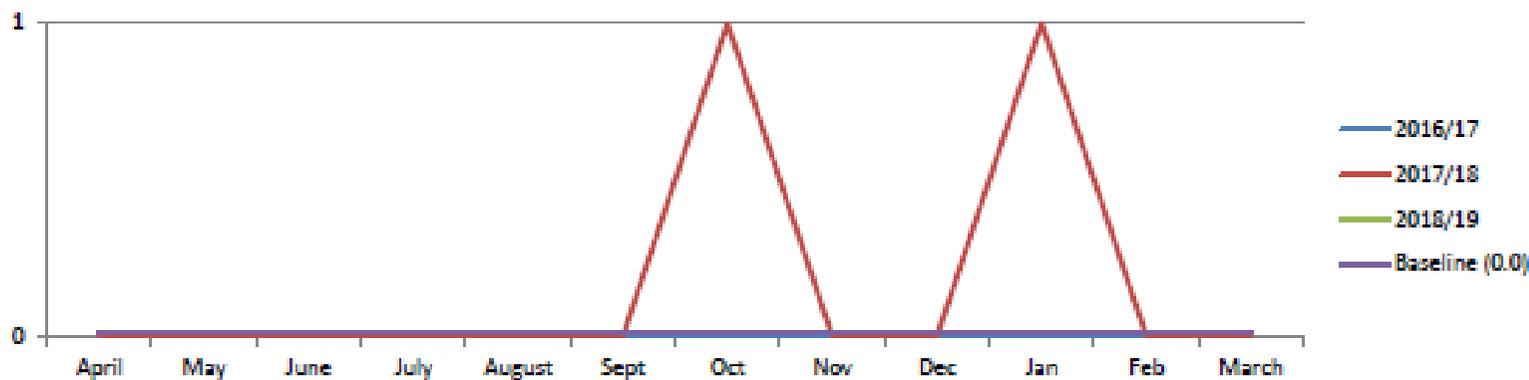
Assurance

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.



2.4 MRSA Bacteraemia

MRSA Bacteraemia 2016-2018/2019

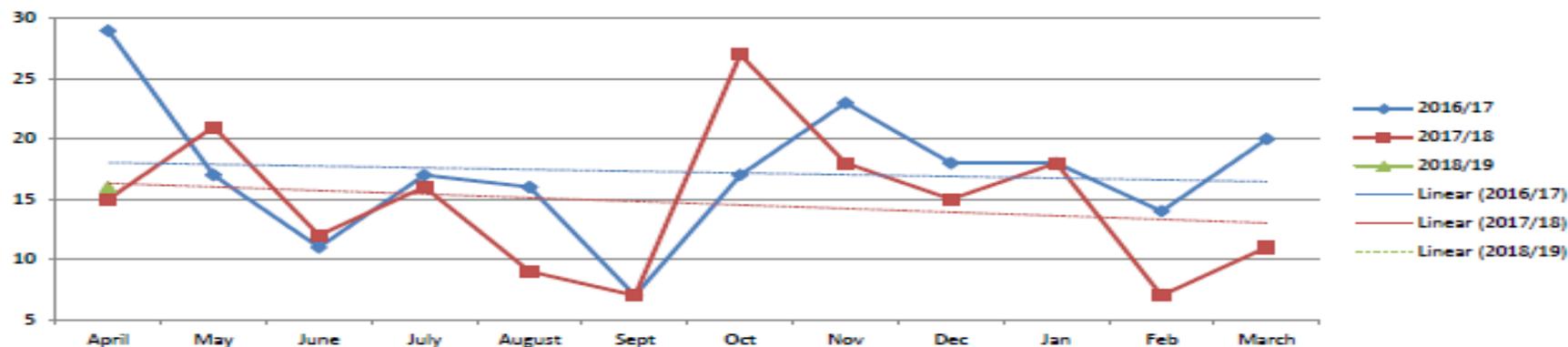


No new MRSA bacteraemia has been reported for April 18.

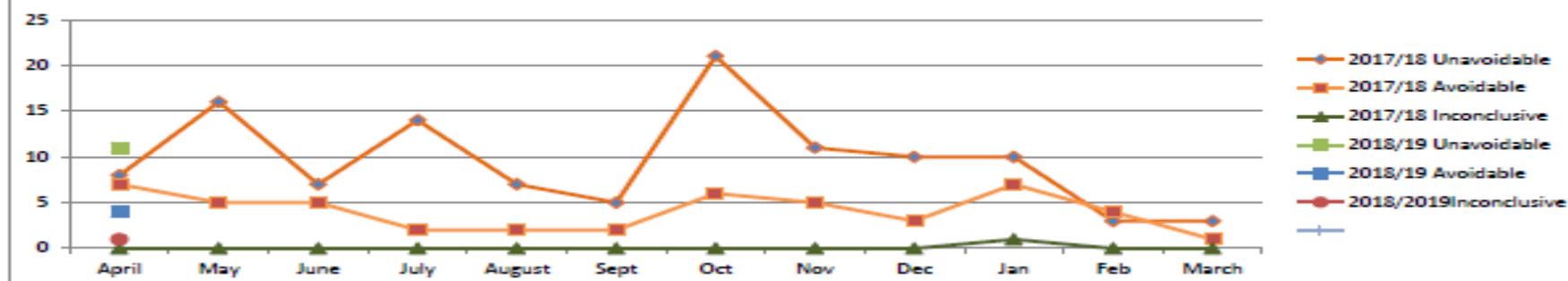


2.5 Pressure Injury Serious Incidents

RWT Pressure incidents G3/4, 2016-2018



Pressure Injury Outcomes - 2015-2018



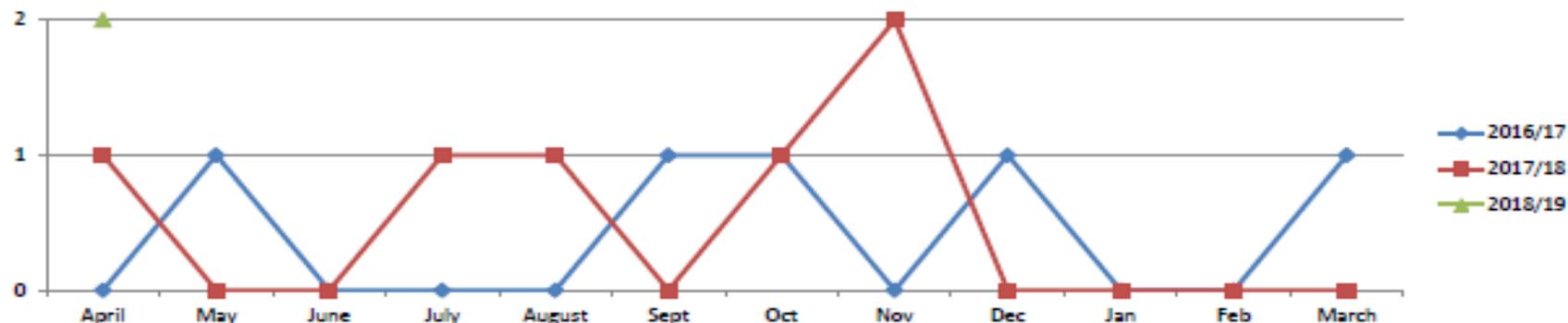
16 pressure injury incidents were reported for this reporting period which is an increase compared to 11 PI's reported in March 18. There were 14 category 3 and 2 category 4 pressure injuries reported for this reporting period. 4 pressure injuries were reported as avoidable, 11 pressure injuries reported as unavoidable and 1 pressure injury was deemed as inconclusive.

Assurance

The trust is currently undertaking full RCA into all these avoidable pressure injuries to identify learning and the final RCA's will be submitted to WCCG by June 18. The Q&S manager attends the weekly pressure injury scrutiny meetings to provide further scrutiny to the avoidability process. It has been identified that the use of semi compressed felt on heels is increasing tissue damage so this practice will be reviewed. Ward areas with an increase of incidents or recurrent avoidable incidents have had bespoke training on pressure injury prevention. The concordance pathway is being designed and tested before trust wide implementation.

2.6 RWT Never Events

Never Events at RWT 2015-18.



Apr 17	1	Retained foreign object post-procedure
July 17	1	Wrong site surgery
Aug 17	1	Wrong site surgery
Oct 17	1	Retained foreign object post-procedure
Nov 17	2	Wrong site surgery
April 18	2	Wrong site surgery



The trust has reported 2 never events for 2018/2019 and both of these were reported under surgical category i.e. wrong site surgery. The trust is currently undertaking full RCA into these SI's and the final RCA will be submitted to the WCCG by July 18.

Assurance:

- WCCG senior exec board has met with RWT board to seek board assurance of actions being undertaken by the trust to mitigate further never events from occurring.
- Continuous monitoring and scrutiny for all serious incidents and never events
- WCCG quality team attend monthly Quality & Safety intelligence group meeting to seek assurance relating to compliance of WHO surgical checklists and LOCSSIPS audits.
- RWHT have requested further support from AFPP (Association for Perioperative Practice) to review culture and practice within clinical theatre environment, including application of WHO checklist, to be reported back to CCG once review completed.
- CCG have instigated rapid responses to recent never events, including immediate assurance call with DON and unannounced visit to theatre area involved in recent never event.
- Agreement to seek wider learning event for Birmingham, Solihull and Black Country sought through QSG.
- Failure to ensure robust 'Checking' process is identified as an emerging theme of never events.



Maternity

2 maternity incidents were reported by the trust for this reporting period and these 2 incidents are related to wrong breast milk given to the babies. The trust is currently undertaking full RCA to identify root cause and learning actions to prevent reoccurrence of similar incidents happening again.

	Target	Quarter 4 2017/18			Quarter 1 2018/19		
		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Adms of Full Term Babies to Neo Natal Unit	0	0	1	3	2		
Elective C-Section Rates	<12%	11.4%	12.6%	12.2%	10.9%		
Emergency C-Section Rates	<14%	17.0%	20.8%	17.1%	16.8%		
Maternal Deaths	0	0	0	0	0		
Midwife to Birth ratio	≈/≈ 50	51	51	50	50		
Bookings at 12+6 weeks	≥90%	90.5%	89.6%	91.3%	90.8%		
Babies being cooled (Born here)	0	0	1	2	1		
Breast Feeding Initiated	>64%	61.0%	62.6%	66.6%	70.0%		
Early Neonatal Death (born here)	5	3	0	3	1		
Number of Mothers Delivered	≈/≈ 416	428	374	404	404		

C-Section Rates: Elective cases remain within target, emergency cases although above target are demonstrating a downward trend.

Midwife to Birth Ratio: A workforce review has been completed using Birth Rate Plus.

Bookings at 12+6 weeks: This indicator remains within target.

Early Neonatal Death: NPSA 0

Number of Mothers Delivered: Remains within target levels for the Trust.

Assurance

- Monthly discussion at CQRMs for assurance on actions i.e. recruitment plans, HR activity to address sickness, supervision and support for new staff.
- Improving dashboard performance.
- Deep dive review reported to April CQRM by Head of Midwifery.
- RWT and CCG entry on risk register.
- WCCG to attend RWT Maternity QRV visit planned for 2018/2019.
- Chief Nurse to meet with specialised commissioning local lead to determine key lines of enquiry for a collaborative neonatal unit visit.



2.7 Mortality

Mortality Indicators: The Royal Wolverhampton NHS Trust



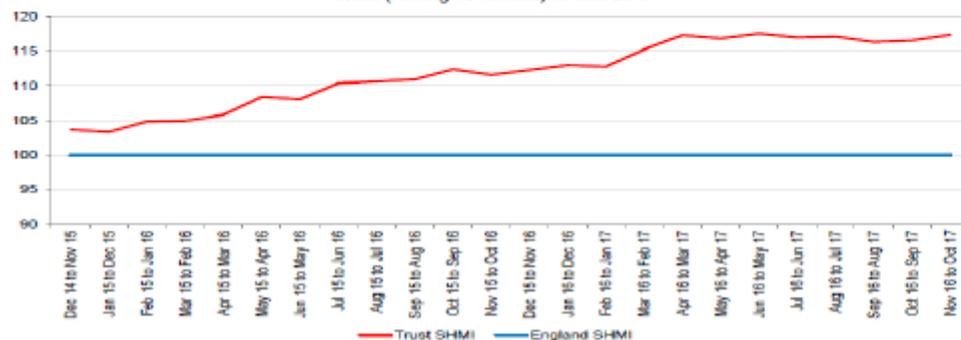
Published SHMI (HSCIC): Oct 2013 - Sep 2014 to Jul 2016 - Jun 2017

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	0.90	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%	3.2%	3.3%
Deaths in excess of expected	0	0	0	0	11	96	144	231	212	249	207	362
Lower Limit	0.90	0.91	0.91	0.90	0.91	0.90	0.89	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



SHMI (rolling 12 month) to Oct 2017



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	514.8	644	130.0



Statistically higher than average



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.

Assurance

Following attendance at the trusts Mortality Assurance Group the Chief Nurse and Deputy Chief Nurse met with the Medical Director and Chief Nurse at the trust to gain further assurance and identify actions relating to reducing SHMI. Actions agreed include:

- Establishment of a system wide mortality reduction group, to include Public Health and Social Care representation, with specific reference to patient deaths within 30 days of hospital discharge, ensuring end of life pathways are robust.
- A review of internal mortality governance arrangements, to include Primary Care and commissioner representation.
- A review of mortality reporting to include crude mortality and HSMR.
- Production of a remedial action plan.
- Case note reviews of specific pathways, reviews to include external clinical reviewers, to identify key areas for focused improvement initiatives
- External support to be enlisted to help identify areas for improvement and to facilitate improvement programmes
- Further understanding and more detailed work is required to identify concrete measures for monitoring progress and improvements.



Cancer Waiting Times/Cancer Target Compliance

Cancer Target Compliance	Target	Quarter 4 2017/18			Quarter 1 2018/19		
		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
2 Week Wait Cancer	93%	90.78%	93.97%	91.52%	79.03%		
2WW Breast Symptomatic	93%	93.33%	94.50%	88.33%	42.37%		
31 Day to First Treatment	96%	96.36%	97.22%	96.36%	93.04%		
31 Day Sub Treatment - Anti Cancer Drug	98%	100.00%	100.00%	100.00%	100.00%		
31 Day Sub Treatment - Surgery	94%	71.70%	84.38%	84.21%	89.74%		
31 Day Sub Treatment - Radiotherapy	94%	98.06%	100.00%	94.63%	94.00%		
62 Day Wait for First Treatment	85%	70.68%	67.54%	74.51%	69.41%		
62 Day Wait - Screening	90%	60.00%	91.67%	72.41%	68.42%		
62 Day Wait - Consultant Upgrade (local target)	88%	90.82%	88.41%	90.21%	89.71%		

Comments:

2 Week Wait: the breaches in month are as follows; 79.4% were due to internal issues (capacity) and 20.6% were patient choice.

Breast Symptomatic: all breaches in month were due to capacity issues.

31 Day to Treatment: 18 patient breaches in month, all of these were due to capacity issues.

31 Day Sub Surgery: 4 patient breaches in month; 3 due to capacity issues and 1 case had to be rescheduled due to no HDU bed being available.

62 Day to Treatment: 34 patient breaches in month; 12 x Tertiary referrals received between days 40 and 130 of the patients pathway (operating guidelines state referrals should be made within 42 days), 15 x Capacity issues, 2 x Patient Initiated and 5 x Complex Pathways.

Of the tertiary referrals received 1 (8%) was received before day 40 of the pathway, and 7 (58%) were received after day 62 of the patient pathway.

62 Day Screening: 7 patient breaches in month; 6 were due to capacity issues and 1 complex case.

Patients over 104 days - There are currently 18 patients at 104+ days on the cancer waiting list (compared with 21 reported in March), all of these patients have had a harm review and no harm has been identified.

RWT is currently predicting possible failure of the 2 week wait, 2 week wait Breast Symptomatic, 31 Day Frist Treatment, 31 Day Sub Surgery, 62 Day Screening and 62 Day wait for first treatment for April, and validation is on-going. Final cancer data is uploaded nationally 6 weeks after month end. Specific actions are:-

- Revised PTL process now underway - all patients on backlog discussed weekly to ensure pathway is correct, CCG attendance to offer scrutiny and challenge at PTL meeting.
- Capacity planning review completed in radiotherapy - plan now in place to recruit additional support
- Lower GI nurse pilot completed and evaluated - now looking to appoint to provide additional capacity

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.



Assurance

CCG Chief Nurse and Chief Operating Officer have met with RWT COO and lead cancer clinician to seek further assurance with regards performance, a range of actions are underway following the meeting, these include:

- Assurance documentation received pertaining to the harm review process undertaken by the trust, further assurance requested
- How evidence of duty of candour is supported
- Attendance at weekly cancer PTL meeting for further assurance and scrutiny of performance agreed with RWT
- Speciality level performance data received from Trust
- Agreed focus of scrutiny with regards 104 day waits initially
- IST to undertake a review of tracker activity on behalf of the trust during May/June
- Agreement to utilise UHB tertiary referral forms agreed by the trust
- The revised RAP has been agreed by the CCG with a revised trajectory set
- WCCG have received updates relating to the work undertaken by Millar Bowness for head and neck pathways to ascertain if some of the improvements would be transferrable to other cancer sites.
- Additional capacity has been identified in radiotherapy for CT scanning although workforce may be challenging to support this.
- Remains a high risk on both RWT and WCCG risk registers and Cancer network and NHSE/NHSI are sighted on current performance and support the ongoing work with the trust.
- Weekly system wide assurance calls in place to provide updates on current performance and progress against agreed actions.



Total Time Spent in Emergency Department (4 hours)

Urgent Care

Total Time Spent in Emergency Department (4 hours)

	Target	Quarter 4 2017/18			Quarter 1 2018/19		
		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
New Cross	95%	73.80%	76.08%	74.57%	84.09%		
Walk in Centre		100.00%	100.00%	100.00%	100.00%		
Cannock MIU		100.00%	100.00%	100.00%	100.00%		
Vocare		94.76%	96.29%	96.03%	98.56%		
Combined		84.73%	86.27%	85.08%	90.81%		

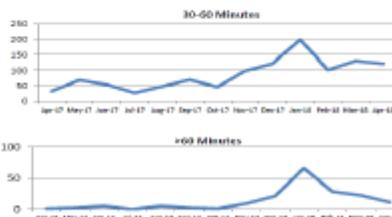
ED <4 Hour Performance



Ambulance Handover

	Quarter 4 2017/18			Quarter 1 2018/19		
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Number between 30-60 minutes	199	102	131	122		
Number over 60 minutes	66	28	22	11		

Comments: The fine for Ambulances during April was £35,400.00. This is based on 122 patients between 30-60 minutes @ £200 per patient and 11 patients >60 minutes @ £1,000 per patient. There were no patients who breached the 12 hour decision to admit target during April 2018.



The Trust failed to achieve both Type 1 and the All Types target for the month. RWT ranking for April was 32nd out of 136 trusts. There were no patients who breached the 12 hour decision to admit target during the month.

Ambulance handover saw an improvement during April 18 for both 30-60 minutes and >60 minute handover times. A small increase of 55 (1.43%) conveyances in month compared with the same period last year was noted.

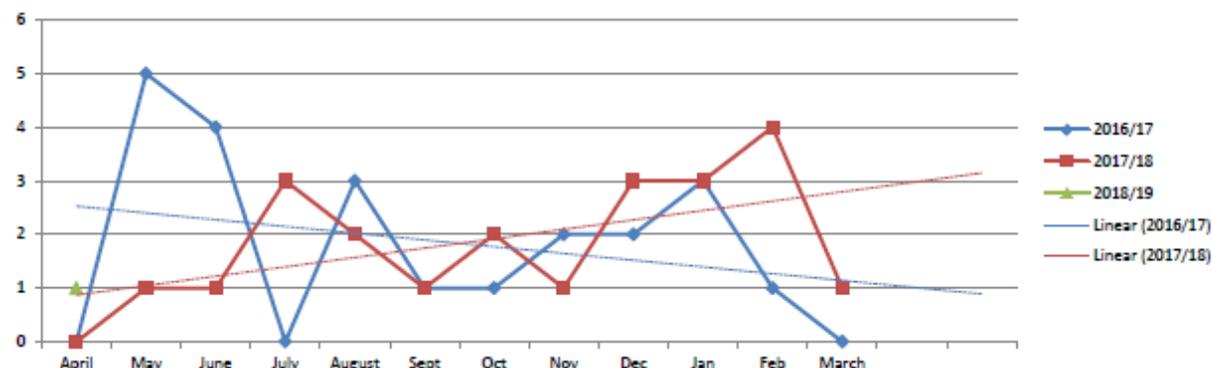


3. BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST

The Committee is asked to note the following:

Serious Incidents

BCPFT Incidents 2015-2018



1 serious incident was reported by Black Country Partnership Foundation Trust under the Apparent/actual/suspected self-inflicted harm meeting SI criteria category. The trust is undertaking a RCA and the final RCA will be submitted to WCCG for closure in July, 18.

BCPFT CQRM

Overview of the Children's, Young Persons and Families Quality & Safety (data April 2018)

- 26 incidents were reported across the CYPF Division.
- There was one medication error incidents reported during April 18.
- There was one STEIS reportable incident and no Never Events reported during April 2018 across the CYPF Division.
- There are currently 9 active risks for CYPF services.
- CQUINs are on track and Q4 data has been submitted.



- Sickness absence has shown a decrease as did turnover rates. The appraisal rates have shown an increase.
- Compliance rates for Induction, Mandatory Training, Safeguarding and Specialist Mandatory Training were met.

3.1 PRIVATE SECTOR PROVIDERS

VOCARE

There were no serious incidents reported by Vocare in April 2018. Performance is improving and actions against the improvement plan appear to be embedding.

Assurance:

- 6 weekly Vocare Improvement Board meetings.
- Announced and unannounced visits by WCCG
- No Serious incidents reported by Vocare since December 17
- Senior oversight of improvement plan by Vocare, triage response rates demonstrate an improving picture at 74% and four hour performance was reported as 98% for April 18.
- Home visiting performance has improved to 88. % for April 18 but the call back performance remains challenging.
- Workforce capacity and demand review completed and shared with CCG.
- Appointment of senior operations manager has provided local leadership and oversight.
- Clinical Rota Co-Ordinator role now appointed to local position, all local dispatchers now appointed.
- Two team leaders appointed, in addition to four GP roles. Monthly CQRM/CRM meetings.
- 6 weekly Vocare Improvement board meetings.

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 it was further escalated to NHSI by NHSE in January 18 and decision still 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

No serious incident was reported by Nuffield health for this reporting period.

A never event was reported by Nuffield Health in December 17 which relates to wrong side/site ankle nerve block. Nuffield has undertaken full RCA into this NE and the following root causes and learning actions has been identified from this RCA:

Root causes:

- A stop before you block moment was not carried out between the Anaesthetist and the Anaesthetic ODP just prior to the local anaesthetic injection for the ankle nerve block.
- Anaesthetic ODP was distracted preparing the ultrasound machine needed for the block process.
- Lack of disciplined partnership between the Anaesthetist and Anaesthetic ODP as a result failing to identify the correct ankle for the nerve block. The Anaesthetist mistook the black mark on the patient's left great toe as a surgical marking identifying the procedure site. The Anaesthetist is known to work quickly as identified in fact finding meetings for this investigation and had proceeded without the Anaesthetic ODP.

Learning actions:

1. Checks defined within LocSSIPs CL001 must be followed at the appropriate time with the anaesthetist and anaesthetic practitioner both in attendance.
2. Anaesthetist and ODP must have all equipment in place prior to the STOP moment.
3. The mark identifying the correct site surgery needs to be visible at all times when undertaking an anaesthetic block.
4. Raising awareness of the appropriate time and who should be present when undertaking and completing both the Who Checklist and CL001.



4. CHILDRENS SAFETY

4.1 Safeguarding Children

There are no exceptions to report within April 2018.

4.2 LAC Update.

The 2nd Named Nurse for LAC commenced in post at RWT early April. Following her Trust induction the new service arrangements will be implemented, with RWT expanding their coverage of health provision to all children placed within 50 miles of the City. The CCG will continue to commission placements for the small cohort of children placed further afield, and the Designated Nurse LAC will ensure a robust QA process remains in place.

With the TOR revised, representation from Public Health and LA Head of CIN/CP at April's LAC steering group strengthened partnership discussions and oversight of multi-agency roles around corporate parenting responsibilities. Action plans from this group will continue to feed into the City's Corporate Parenting Strategy.

5. ADULT SAFETY

5.1 Care Homes

Serious Incidents (SI)

Two SIs were reported during April 2018 from 2 nursing homes, there were none reported in March. One slip, trip and fall and 1 pressure injuries stage 4. All are yet to be concluded and signed off at June's Care Home SISG.

Five SIs were presented at April SISG, 4 pressure injuries which were deemed avoidable and 1 delayed treatment was substantiated.

Lessons learnt identified the need for good communication, training of agency staff, clinical oversight and audit of practice, use of photography as part of skin assessment and timely escalation. The learning for the 1 delayed treatment which was substantiated pertained to utilising advanced care planning in preference to EOL care plans and the need for staff awareness of the interventions required. The QI (quality improvement) facilitator will be working with the 4 homes to introduce QI in these areas.

Governing Body Meeting
10th July 2018

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Performance Data

Survey monkey data for April 2018 is awaited and will follow as an appendix.

Safeguarding Referrals

Nine safeguarding referrals were received to the QNAT during April. Two relate to the SIs and the remaining relate to neglect and acts of omission. Outcome of investigations and enquiries will be reported in subsequent reports.

One residential care home remains in suspension.

Outbreaks in care homes

No outbreaks reported during April.

Quality Improvement – SPACE

All 18 care homes are engaging well with the programme and taking the lead in identifying and initiating quality improvement initiatives supported by the QI facilitator. To date 350 care home staff have received training in quality improvement tools and techniques. On 24th April 2018 a care home sharing event was hosted to show case all the initiatives and improvements that were happening in care homes across Wolverhampton.

5.2 Adult Safeguarding

- **SAR – 01/2018** – A Practitioners Learning Event has been held. The first draft of the SAR report will be available in June 2018
- **Project update** – GP Domestic Violence training and Support Project – up to the 25th April, 88 Practice Staff have been trained across 17 Practices and 5 MARAC referrals have been made by GP's/Practice Nurses. Drop in sessions twice weekly continue to be available.



PRIMARY CARE QUALITY DASHBOARD

RAG Ratings:

1a Business as usual
1b Monitoring
2 Recovery Action Plan in place
3 RAP and escalation

Data for April 2018		
Issue	Concern	RAG rating
IP	Low IP audit rating for four practices (one in August review on-going and three in December). New cycle of audits has begun. NHS England have reported low ordering rates for flu vaccine to cover outstanding patients indicating uptake may be affected.	1b
MRHA	Nil to report	1a
FFT	Non submission for: <ul style="list-style-type: none"> • 2 practices • Zero submission for 1 practice • Suppressed data for 1 practice 	1b
Quality Matters	<ul style="list-style-type: none"> • 9 open Quality Matters identified • No new • 7 closures. 	1b
Complaints	<ul style="list-style-type: none"> • Details of 18 GP complaints reported to NHSE received since November 2017 • 2 complaints still open • 16 complaints closed 	1a
Serious Incidents	Two serious incidents recently closed – for referral to NHS England as per pathway.	1b
Escalation to NHSE	One incident was identified via NHSE complaints and will be managed via PAG.	1b
NICE	No issues to report.	1a
CQC	Two practices have received a " Requires Improvement" rating and are being supported and monitored.	1b
Workforce and Training	Working in Wolverhampton video for recruitment now complete awaiting final edit. Work around international recruitment continues.	1a



WOLVERHAMPTON CCG

GOVERNING BODY

Agenda item 14

Title of Report:	Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 26th June 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	Out turn	Variance o(u)	RAG
Expenditure not to exceed income	£9.986m surplus	£9.986m surplus	Nil	G
Capital Resource not exceeded	nil	nil	Nil	G
Revenue Resource not exceeded	£414.180m	£414.180m	Nil	G
Revenue Administration Resource not exceeded	£5.518m	£5.518m	Nil	G

Non Statutory Duties	YTD Target	YTD Actual	Variance o(u)	RAG
Maximum closing cash balance	£420k	£349k	(£71k)	G
Maximum closing cash balance %	1.25%	1.04%	(0.21%)	G
BPPC NHS by No. Invoices (cum)	95%	99%	(4%)	G
BPPC non-NHS by No. Invoices (cum)	95%	99%	(4%)	G
QIPP	£2.81m	£2.81m	Nil	G
Programme Cost *	£65,347k	£66,479k	£1,131k	G
Reserves *	£1,095k	£0k	(£1,095k)	G
Running Cost *	£920k	£920k	£0k	G

- The net effect of the three identified lines (*) is a small over spend in year and breakeven FOT.
- Programme Costs YTD are recording a small overspend which is anticipated to be recovered next month

- Royal Wolverhampton Trust (RWT) M1 data indicates a small under performance. However, M1 data is usually light and therefore the CCG is reporting break even at M2 and FOT.
- The CCG control total is £9.986m which takes account of the ‘good’ drawdown of £1.3m approved by NHS England.
- The CCG is reporting achieving its QIPP target of £13.948m.
- The QIPP deliverability report identifies the need to deploy reserves in order to reach the QIPP target.
- The CCG is currently reporting a nil net risk.

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

	Annual Budget £'000	YTD Performance M02						
		Ytd Budget £'000	Ytd Actual £'000	Variance £'000 o/(u)	Var % o(u)	FOT Actual £'000	FOT Variance £'000	Var % o(u)
Acute Services	197,893	32,982	34,094	1,112	3.4%	204,095	6,202	3.1%
Mental Health Services	36,907	6,151	6,150	(1)	(0.0%)	36,907	0	0.0%
Community Services	40,596	6,762	6,762	0	0.0%	40,596	0	0.0%
Continuing Care	15,095	2,516	2,511	(5)	(0.2%)	15,095	0	0.0%
Primary Care Services	52,279	8,713	8,703	(11)	(0.1%)	52,279	0	0.0%
Delegated Primary Care	36,186	6,031	6,092	61	1.0%	36,186	0	0.0%
Other Programme	13,152	2,192	2,167	(25)	(1.2%)	13,152	0	0.0%
Total Programme	392,108	65,347	66,479	1,131	1.7%	398,310	6,202	1.6%
Running Costs	5,518	920	920	0	0.0%	5,518	0	0.0%
Reserves	6,568	1,095	0	(1,095)	(100.0%)	366	(6,202)	(94.4%)
Total Mandate	404,194	67,362	67,398	37	0.1%	404,194	0	0.0%
Target Surplus	9,986	1,664	0	(1,664)	(100.0%)	0	(9,986)	(100.0%)
Total	414,180	69,026	67,398	(1,628)	(2.4%)	404,194	(9,986)	(2.4%)

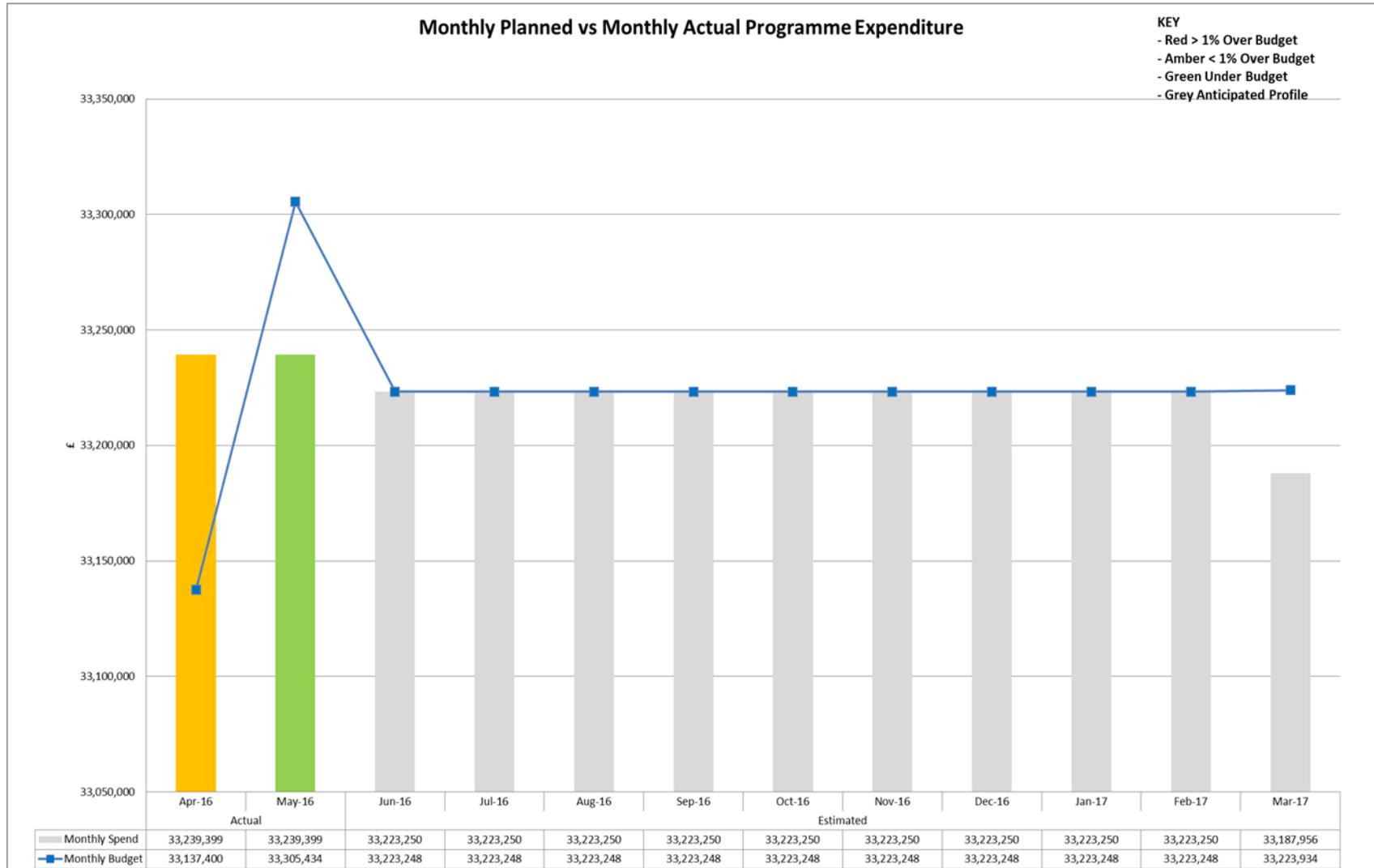
- Within the Forecast out turn there is a commitment of £1.107m of non recurrent investment to support the RWT transformational agenda.

- At this stage the forecast over performance on Acute contracts of £6.2m is offset by an under performance on reserves. Future reports will reflect the application of reserves to Service lines as appropriate.
- To achieve the target surplus the CCG has utilised both the Contingency Reserve (£2.021m) and the 1% reserve (£3.97m) . For 19/20 the CCG will need to reinstate the Contingency and 1% reserves which 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	2,021	0	2,021	(2,021)	0	(2,021)
1% Reserve	3,971	0	3,971	(3,971)	0	(3,971)
Delegated Primary Care 1%	366	0	366	0	0	0
Total	6,358	0	6,358	(5,992)	0	(5,992)

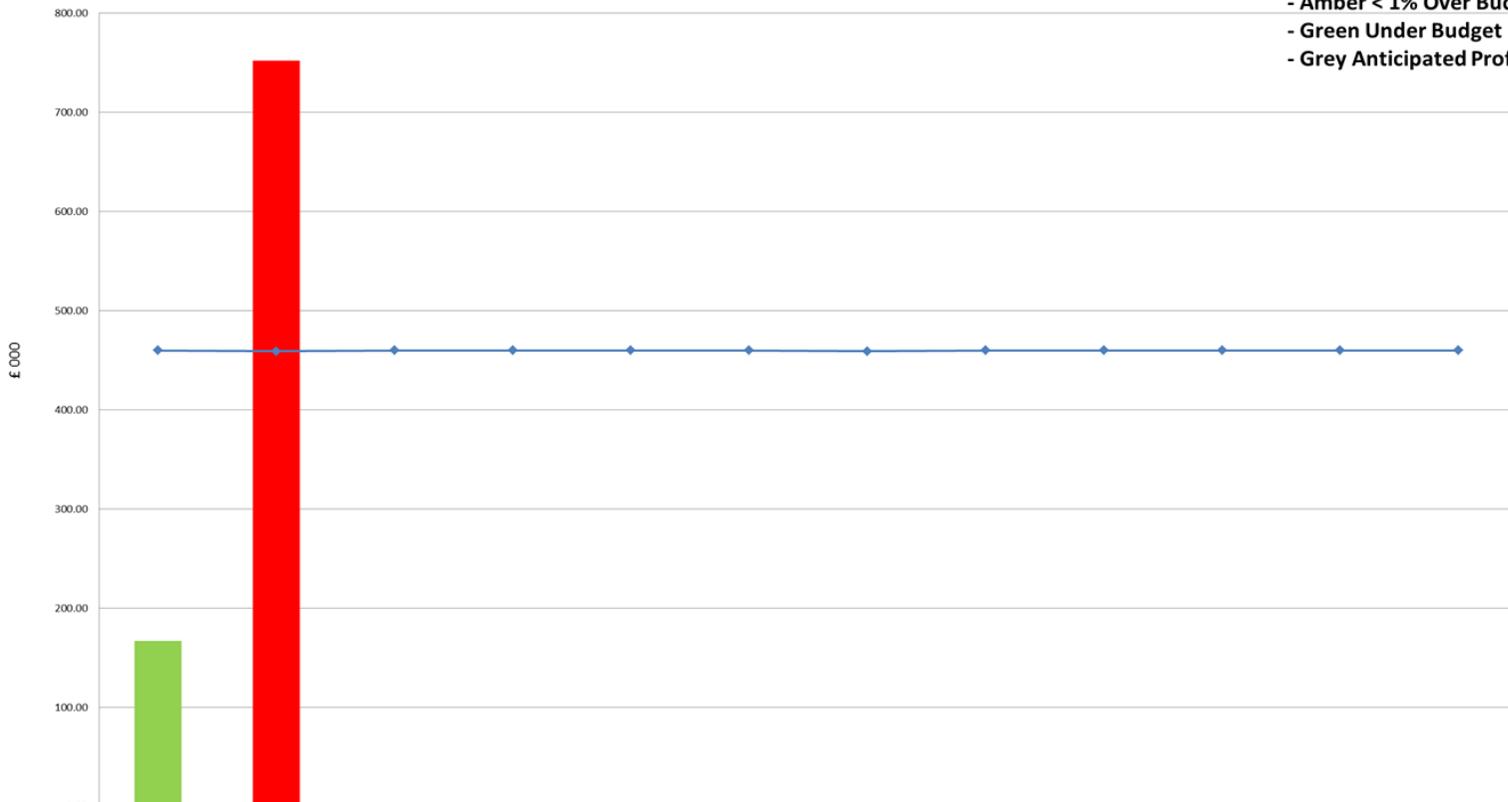
Monthly Planned vs Monthly Actual Programme Expenditure

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-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	Actual		Estimated									
Monthly Spend	167	752										
Monthly Budget	460	459	460	460	460	460	459	460	460	460	460	460

2. Delegated Primary Care

- Delegated Primary Care allocations for 2018/19 as at M02 are £36.552m. The forecast outturn is £36.552m delivering a breakeven position.
- The 0.5% contingency and 1% reserve are uncommitted in line with the 2018/19 planning metrics under other GP Services.

	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	3,674	3,718	44	22,043	22,043	0	●	0	0
General Practice PMS	316	245	(71)	1,899	1,899	0	●	0	0
Other List Based Services APMS incl	402	446	44	2,412	2,412	0	●	0	0
Premises	470	399	(70)	2,817	2,817	0	●	0	0
Premises Other	16	8	(7)	94	94	0	●	0	0
Enhanced services Delegated	148	121	(27)	887	887	0	●	0	0
QOF	634	589	(45)	3,802	3,802	0	●	0	0
Other GP Services	342	564	223	2,050	2,050	0	●	0	0
Delegated Contingency reserve	30	0	(30)	183	183	0	●	0	0
Delegated Primary Care 1% reserve	61	0	(61)	366	366	0	●	0	0
Total	6,092	6,092	0	36,552	36,552	0	●	0	0

- 2018/19 forecast figures have been updated on quarter 1 list sizes to reflect Global Sum, Out of Hours and MPIG.
- 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:

- The submitted finance plan required a QIPP of £13.948m or 3.5% of allocation.
- NHSE are focussing on QIPP delivery across Medicines Optimisation and Right Care schemes such as Respiratory, Diabetes and Paediatrics.
- The plan assumes full delivery of QIPP on a recurrent basis as any non-recurrent QIPP will potentially be carried forward into future years.
- For Month 2 QIPP is being reported as delivering on plan mainly as a result of M1 data being available for only a few key areas. Future months will have a more accurate position reported.
- The Committee discussed the QIPP programme as reflected in the Finance plan and the potential deliverability rules informed by the latest assessment of the QIPP forecast out-turn. Any shortfall will be met through a combination of additional QIPP deliver and the utilisation of reserves.
- The NHSE submission for QIPP due end of June will demonstrate that the CCG is on target to deliver its QIPP programme.

4. STATEMENT OF FINANCIAL POSITION

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

	31 May '18 £'000	30 April '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	1,821	1,252	569
Cash and Cash Equivalents	349	179	170
	2,170	1,431	
Total Assets	2,170	1,431	
Current Liabilities			
Trade and Other Payables	-33,595	-8,184	-25,411
	-33,595	-8,184	
Total Assets less Current Liabilities	-31,425	-6,753	
TOTAL ASSETS EMPLOYED	-31,425	-6,753	
Financed by:			
TAXPAYERS EQUITY			
General Fund	31,425	6,753	24,671
TOTAL	31,425	6,753	

Key points to note from the SoFP are:

- The increase in payables compared to April is due to the high number of accruals required at this point of the year relating to invoices awaited for both residual 2017/18 expenditure and 2018/19 expenditure. These accruals are not actioned in April since the focus is on the completion of the CCG's year-end accounts. This is a similar position with receivables but the values are much lower.
- The CCG is maintaining its high performance against the BPPC target of paying at least 95% of invoices within 30 days, (99% for both non-NHS invoices and NHS invoices);

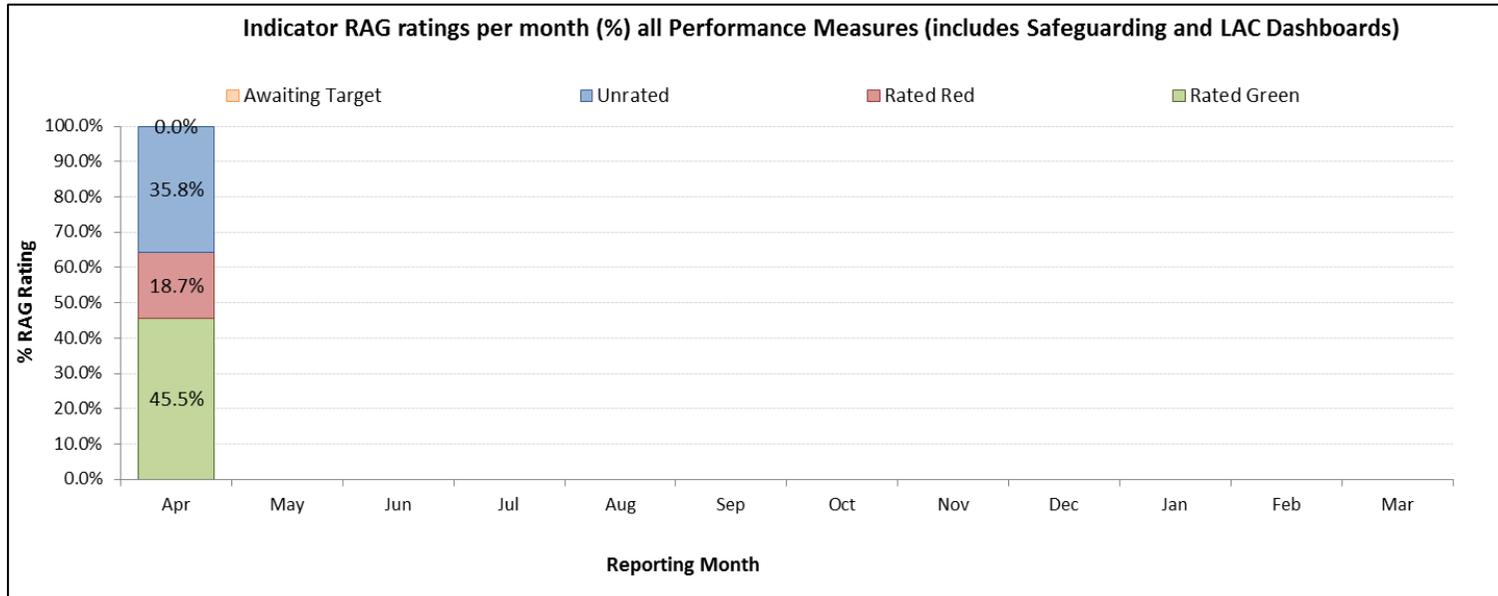
5. PERFORMANCE

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

Executive Summary - Overview

Apr-18

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC or n/a *	Total
NHS Constitution	N/A	12	N/A	11	N/A	1	N/A	0	24
Outcomes Framework	N/A	8	N/A	5	N/A	13	N/A	0	26
Mental Health	N/A	22	N/A	3	N/A	16	N/A	0	41
Sub Totals	0	42	0	19	0	30	0	0	91
RWT - Safeguarding	N/A	0	N/A	0	N/A	13	N/A	0	13
RWT - Looked After Children (LAC)	N/A	2	N/A	4	N/A	0	N/A	0	6
BCP - Safeguarding	N/A	12	N/A	0	N/A	1	N/A	0	13
Dashboard Totals	0	14	0	4	0	14	0	0	32
Grand Total	0	56	0	23	0	44	0	0	123



Exception highlights were as follows;

5.1. Royal Wolverhampton NHS Trust (RWT)

5.1.1. EB3 – Referral to Treatment Time (18weeks), EBS4 - 52 Week Waiters

- A revised performance trajectory for 18/19 has been submitted by the Trust is awaiting approval by the CCG with a stretch target (from 90.3% to 91.5% by year end and zero 52 week waiters).

- With a 617 increase in the number of patients seen during the month, the April 2018 performance reported at 90.38% (below the National 92% target - achieving current draft local stretch target of 90.3%) and an improvement on previous month performance (90.11%).
- The Trust continues to focus on reducing the backlog where possible and is working closely with Directorates.
- Zero 52 week waiters have been reported by the Trust, however there are 4 Wolverhampton patients waiting over 52 weeks at :

The Royal Orthopaedic (T&O) x 3

University Hospitals of North Midlands (T&O) x 1

- **Influence Factors : Demand management Plan, Clinical Peer Review**

5.1.2. Urgent Care (4hr Waits, Ambulance Handovers, 12 Hr Trolley Breaches)

- A revised A&E 4 Hour Wait performance trajectory for 18/19 has been submitted by the Trust is awaiting approval by the CCG with a stretch target (from 90.3% to 95.1% by year end).
- The number of A&E attendances has seen a -3.39% (decrease) from the previous month and an increase in performance to 90.81%. The Trust has confirmed that they achieved a ranking of 32nd out of 136 Trusts for April.
- Ambulance handovers continue to report above thresholds (122 >15, 15mins, 11 >60 minutes)
- There were no 12 hour Trolley breaches during April 2018.
- **Influence Factors : Public education in use of Primary Care, Pharmacy, Walk in Centres**

5.1.3. Cancer 2WW, 31 Day and 62 Day

- A revised 62 Day performance trajectory for 18/19 has been submitted by the Trust is awaiting approval by the CCG with a stretch target (from 73.9% to 85.2% by year end).
- There were 18 patients breaching 104 days (due to capacity, complex cases and late tertiary referrals). Discussions are on-going on a national level to set a zero trajectory for all providers against 104 day cancer waits.
- Current performance levels :

Ref	Indicator	Target	Performance
EB6	2 Week Wait (2WW)	93%	78.97%
EB7	2 Week Wait (2WW Breast Symptoms)	93%	42.37%
EB8	31 Day (1 st Treatment)	96%	90.10%
EB9	31 Day (Surgery)	94%	84.62%
EB10	31 Day (anti-cancer drug)	98%	100%
EB11	31 Day (radiotherapy)	94%	93.10%
EB12	62 Day (1 st Treatment)	M1=73.9%	69.05%
EB13	62 Day (Screening)	90%	72.22%

- **Influence Factors : GP Peer Review**

5.1.4. Electronic Discharge Summary

- Performance for the Electronic discharge summary for assessment units is currently showing as achieving the 85% target (89.54%) however, following concerns regarding the assessment units failure to achieve targets in 17/18, a draft trajectory change has been proposed with a stretch from 90% to 95.0% and highlights the requirement that GPs require information from assessment units from the emergency portal.
- Based on the draft trajectory, the April performance remains RED. Performance (excluding assessment units) continues to achieve above the 95% target (96.31%)

5.1.5. Delayed Transfers of Care

- Delays for the Royal Wolverhampton NHS Trust continue to achieve (based on 17/18 threshold) and excluding Social Care (0.91%).
- Delays including Social Care also remain below the 3.5% combined threshold.
- A revised trajectory for 18/19 is awaiting approval for a 2% threshold each month.

5.1.6. Serious Incident Breaches (SUIs) - RWT

- 3 breaches were identified for April (see table below)
- 2 Never Events (both Surgical/Invasive Procedures)

Ref	Indicator	Performance
LQR4	SUIs reported no later than 2 working days	1
LQR5	SUIs 72 hour review within 3 working days	0
LQR6	SUIs Share investigation and action plan within 60 working days	2

5.1.7. Safeguarding

- 13 out of the 19 Safeguarding and Look After Children were not submitted as part of the April report as the Trust are to forward a proposal for changes to the recording of Safeguarding and a request that fines be suspended whilst this is implemented.

5.2. Black Country Partnership NHS Foundation Trust – (BCPFT)

5.2.1. Early Intervention Care Package within 2 weeks (EH4)

- 33% of patients achieved the 2 week threshold in April (against a target of 53%).
- Exception report has been received and agreed via the Contracts Review Meeting (CRM)
- Performance is affected by a small cohort of patients and relates to 2 individual patients.

5.2.2. IAPT Access (LQIA05)

- April failed to achieve the 2018/19 in-month target of 1.58% with 1.16%; however indicator is an annual (Year End) target of 19%.
- Following data quality queries in 2017/18, this indicator is discussed monthly as part of the Data Quality Improvement Plan (DQIP) and includes discussions on the addition of Long Term Condition referral figures.

5.2.3. Crisis Management Plan on Discharge (LQGE01b)

- Performance for April was reported as 93.3% (against a target of 100%).
- The 7 day target is affected by small number variations and relates to 1 individual patient whose care co-ordinator was on leave.
- An Exception report has been received and agreed via the Contracts Review Meeting (CRM).

6. RISK and MITIGATION

The CCG submitted a M2 position which included £2.5m risk which has been fully mitigated.

The key risks remain as below:

- Likely over performance in Acute contracts excluding RWT as it is assumed a Gain/Risk share will be agreed and will remove the main areas of risk;
- Transforming Care Partnerships, TCP, is presenting a real financial challenge and currently presents a risk of c £1m;
- Costs of drugs now off patent are increasing therefore Prescribing may over spend and the risk presented is c £500k.

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CCG RISKS & MITIGATIONS	Forecast Net Expenditure				RISKS (enter negative values only)						MITIGATIONS (enter positive values only)								TOTAL NET (RISK) / MITIGATION	Of Which: RECURRENT	Risk Adjusted Forecast Variance				
	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			£m	£m	£m	£m	%
REVENUE RESOURCE LIMIT (IN YEAR)	404.194																								
REVENUE RESOURCE LIMIT (CUMULATIVE)	414.180																								
Acute Services	196.977	203.179	(6.202)	(3.1%)	(1.000)	-				(1.000)	1.000									1.000	-		(6.202)	(3.1%)	
Mental Health Services	36.907	36.907	-	0.0%	(1.000)	-				(1.000)	1.000									1.000	-		-	0.0%	
Community Health Services	40.596	40.596	-	0.0%																	-		-	0.0%	
Continuing Care Services	15.095	15.095	-	0.0%																	-		-	0.0%	
Primary Care Services	52.279	52.279	-	0.0%				(0.500)		(0.500)				0.500						0.500	-		-	0.0%	
Primary Care Co-Commissioning	36.552	36.552	-	0.0%																	-		-	0.0%	
Other Programme Services	20.270	14.068	6.202	30.6%																	-		6.202	30.6%	
Commissioning Services Total	398.676	398.676	(0.000)	(0.0%)	(2.000)	-	-	(0.500)	-	(2.500)	2.000	-	-	-	0.500	-	-	-	-	2.500	-	-	(0.000)	(0.0%)	
Running Costs	5.518	5.518	-	0.0%																	-		-	0.0%	
Unidentified QIPP																					-		-	0.0%	
TOTAL CCG NET EXPENDITURE	404.194	404.194	(0.000)	(0.0%)	(2.000)	-	-	(0.500)	-	(2.500)	2.000	-	-	-	0.500	-	-	-	-	2.500	-	-	(0.000)	(0.0%)	
IN YEAR UNDERSPEND / (DEFICIT)	-	-	-	0.0%																					
CUMULATIVE UNDERSPEND / (DEFICIT)	9.986	9.986	-	0.0%																					

The key mitigations are as follows:

- The CCG holds a Contingency Reserve of c £2m. This will be held to cover the risk on Acute and Mental Health Services.
- The CCG also holds SOFP flexibilities which will be used to offset Prescribing risk.

Further work is being undertaken to assess the levels of risks and further mitigations and a verbal update will be available at Committee.

In summary the CCG is reporting:

	£m Surplus(deficit)	
Most Likely	£9.986	No risks or mitigations, achieves control total
Best Case	£12.486	Control total and mitigations achieved, risks do not materialise achieves control total
Risk adjusted case	£9.986	Adjusted risks and mitigations occur. CCG achieves control total
Worst Case	£7.486	Adjusted risks and no mitigations occur. CCG misses revised control total

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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: 26th June 2018

18/19 Reference	Description - Indicators with exception reporting highlighted for info	Target	Latest Month Performance	YTD Performance	Variance between Mth	Trend (null submissions will be blank) per Month												
						A	M	J	J	A	S	O	N	D	J	F	M	Yr End
RWT_LQR25	Integrated MSK Service - % of patients on an MSK community pathway, discharged to the community service post elective spell.	95.0%	No Data	No Data														
RWT_LQR26	% of patient with a treatment summary record at the end of the first definitive treatment - DRAFT indicator awaiting CVO	75.0%	No Data	No Data														
RWT_LQR27	Hospital and General Practice Interface for 6 areas as detailed in the Service Conditions Local Access Policies, Discharge Summaries, Clinic Letters, Onward referral of patients, Results and treatments, Feedback/Communications *Note : 18/19 - awaiting confirmation of removal to SDIP	0.0%	No Data	No Data														
RWT_LQR28	All Staff Hand Hygiene Compliance	95.0%	No Data	No Data														
RWT_LQR29	Infection Prevention Training Level 2	95.0%	No Data	No Data														
BCP_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	92.00%	97.91%	97.91%	↑													
BCP_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	0	→													
BCP_DC1	Duty of Candour	YES	YES	0														
BCP_NHS1	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	99.00%	No Data	No Data														
BCP_MHSDS1	Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	90.00%	No Data	No Data														
BCP_IAPT1	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	90.00%	100.00%	100.00%	→													
BCP_EAS4	Zero Tolerance methicillin-resistant Staphylococcus aureus	0	0	0	→													
BCP_EAS5	Minimise rates of Clostridium Difficile	0	0	0	→													
BCP_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	53.00%	33.33%	No Data	↑													No Data
BCP_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	75.00%	88.81%	No Data	↓													No Data
BCP_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	95.00%	99.25%	No Data	↓													No Data
BCP_EH9	The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period	32.00%	No Data	No Data														
BCP_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)	85.00%	No Data	No Data														
BCP_EH11a	Number of CYP with ED (urgent cases) referred with suspected ED that start treatment within 1 week of referral (0-19 year olds)	85.00%	No Data	No Data														
BCP_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)	85.00%	No Data	No Data														
BCP_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)	85.00%	No Data	No Data														
BCP_EBS1	Mixed sex accommodation breach	0	0	0	→													
BCP_EBS3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	95.00%	100.00%	100.00%	→													
BCP_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)	90.00%	No Data	No Data														
BCP_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)	100.00%	93.33%	93.33%	↓													
BCP_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	80.00%	No Data	No Data														

**WOLVERHAMPTON CCG
 GOVERNING BODY
 10 July 2018**

Agenda item 15

TITLE OF REPORT:	Summary – Wolverhampton Clinical Commissioning Group(WCCG) Audit and Governance Committee (AGC) – 22 May 2018
AUTHOR(s) OF REPORT:	Peter Price – 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 Annual Report 2017/2018

The Head of Internal Audit Opinion was confirmed as 'Generally satisfactory with some improvements required'. This was a good performance for the CCG.

1.2 Draft Internal Audit Plan 2018/2019

The Senior Internal Audit Manager reported on the three year plan of Internal Audit work and also the links with the CCGs corporate objectives.

This was approved.

1.3 Report To Those Charged with Governance

There would be no adjustments to the Financial Statement.3

This was accepted.

1.4 Annual Accounts

The Annual Accounts were presented to the Audit and Governance Committee by the Director of Finance and the Head of Financial Resources and were accepted by the Audit and Governance Committee.

These were recommended to GB for approval.

1.5 Management Representation Letter

The Management Representation Letter was presented to the Audit and Governance Committee.

1.6 Annual Report

The Corporate Operations Manger advised that the Annual Report had been aligned to the standard template. The report also discussed the improvements made particularly around Risk Management

The committee recognised the hard work of all staff in delivering financial targets and service improvements in 2017/2018.

1.7 Committee Annual Report

The Committee Annual Report was presented to the Committee with all comments from the last meeting picked up and incorporated into the document.

- 1.8 Local Security Plan 2018/2019
The Local Security Management Specialist presented the Local Security Plan for 2018/2019 which was approved by the committee.

CLINICAL VIEW

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

Governing Body Meeting
10 July 2018

Page 3 of 5

4.5. N/A

Name: Tony Gallagher
Job Title: Chief Finance Officer
Date: 23 May 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
10 JULY 2018
Agenda item 16

TITLE OF REPORT:	Summary – Remuneration Committee – 17 May 2018
AUTHOR(S) OF REPORT:	Peter Price – Remuneration Committee Chairman
MANAGEMENT LEAD:	Peter McKenzie, Corporate Operations Manager
PURPOSE OF REPORT:	To provide an update of key discussions and decisions made at the Remuneration Committee to the Governing Body.
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	<p>The Committee discussed the following points</p> <ul style="list-style-type: none"> • Ratification of Chairman’s Action • The Re-appointment of the Governing Body Practice Manager Representative • Approval of HR Policies
RECOMMENDATION:	That the Governing Body receive and note the contents of this report.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<p><u>Continue to meet our Statutory Duties and responsibilities</u> The Remuneration Committee is responsible for ensuring that the CCG has appropriate Human Resources Policies and Procedures in place to deliver statutory responsibilities as an employer.</p>

1. BACKGROUND AND CURRENT SITUATION

- 1.1 This report gives details of the issues discussed and decisions made at the meeting of the Remuneration Committee on 17 May 2018.

2. ITEMS CONSIDERED BY THE COMMITTEE

2.1. Ratification of Chairman's Action

The Committee agreed to ratify a Chairman's action taken in respect of pay arrangements for CCG staff who had undertaken additional duties during 2017/18.

2.2. Governing Body Practice Manager Representative

The committee agreed that, following the ending of her first term of office, Helen Ryan should be re-appointed as the Governing Body Practice Manager representative in line with the provisions of the CCG's constitution.

2.3 Human Resources Policies

The committee considered and approved updates to the CCG's Dress Code, Smoke Free, Grievance and Whistleblowing policies following them being routinely reviewed.

2.4 Other Items of business

The committee discussed an outline process for Governing Body appraisals and agreed that they would discuss Senior Manager pay arrangements at its next meeting in June. Dates for future meetings were agreed and the committee will determine a forward work plan to include a comparative review of Governing Body pay arrangements later in the year.

3. CLINICAL VIEW

- 3.1. There are clinical members who contribute fully to its deliberations.

4. PATIENT AND PUBLIC VIEW

- 4.1. Not applicable.

5. KEY RISKS AND MITIGATIONS

- 5.1. There are no specific risks associated with this report.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. The costs associated with the issues outlined in this report are being met from within existing pay budgets.

Quality and Safety Implications

6.2. There are no quality and safety implications associated with this report.

Equality Implications

6.3. There are no equality implications associated with this report.

Legal and Policy Implications

6.4. Changes were made to Human Resources Policies as outlined in the paper.

Other Implications

6.5. There are no specific Human Resources implications arising from this report. The Committee receives Human Resources advice when required.

Name Peter Price
Job Title Remuneration Committee Chair
Date: May 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)	Peter Price	29/05/18

WOLVERHAMPTON CCG
GOVERNING BODY MEETING
10 July 2018

Agenda item 17

TITLE OF REPORT:	Summary – Primary Care Commissioning Committee – 22 May 2018 and 5 June 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 22 May 2018 and 5 June 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"> • Financial Position as at Month 12, March 2018 The Chief Finance Officer presented a report to the Committee around the CCG's financial position at month 12 (March 2018). It was reported that the final delegated primary care allocations for 2017/18 is £35.650 million. The outturn is £34.428 million delivering an underspend position of £1.221 million.
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	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 22 May 2018 and 5 June 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 – 22 May 2018

2.1 Financial Position as at Month 12, March 2018

2.1.1 The Chief Finance Officer presented a report to the Committee around the CCG's financial position at month 12 (March 2018). It was reported that the final delegated primary care allocations for 2017/18 is £35.650 million. The outturn is £34.428 million delivering an underspend position of £1.221 million.

2.1.2 The outturn indicates an underspend of £1,221 million across delegated primary care of which £790k is against other GP services which relates to the release of accruals relating to pre-delegation.

2.2 QOF+ Scheme 2018/19

2.2.1 Mr Bourne, Management Consultant, presented the QOF+ Scheme 2018/19 Business Case, Equality Impact Assessment and Quality Impact Assessment to the Committee. The new scheme will be offered to all Wolverhampton Practices and focuses on three priority areas; diabetes (pre-diabetic), alcohol and obesity. The Committee discussed the method of calculating QOF+ points and payments and it was noticed that, with regards to payments, it will be dependent on the number of QOF+ points they accrue, out of a total of 100 available points. The Committee approved the QOF+ scheme proposal and associated documents and noted that the Data Protection Impact Assessment will be to follow.

2.3 Primary Care Quality Report

2.3.1 The Chief Nurse updated the Committee around primary care quality, providing an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen. The following issues were highlighted:

2.3.2 The Friends and Family Test figures for the March 2018 submission show that they are better than regional and national averages. The overall responses remain

positive, 82% would recommend their Practice, however that is still lower than the national average of 89%.

- 2.3.3 The Committee noted that there are currently two serious incidents that are under investigation. With regards to CQC inspections, since April 2017, 18 Practices have received an inspection of which 16 have been rated good and 2 rated as requires improvement.

2.4 Primary Care Counselling Service

- 2.4.1 The Primary Care Transformation Manager updated the Committee on the progress made against the Primary Care Counselling Service which is funded from PMS premium monies and commissioned as a 6 month pilot from June 2017 and has been subsequently extended following a positive evaluation. A 3 year contract with Relate Birmingham has been operational since 1 April 2018.

2.5 Document Management

- 2.5.1 The Primary Care Development Manager presented a business case, service specification and associated documentation around a document management system which is included as part of the GP Forward View around training administrative staff to have the skills to process clinical correspondence effectively. The Committee approved the report and it was noted that the programme of work would be monitored and audited in 6 months' time.

2.6 Improving Access 2018/19

- 2.6.1 The Primary Care Development Manager shared the Improving Access 2018/19 business case and associated documents with the Committee and confirmed that this is a nationally mandated service for extending opening times of primary care on a hub basis. The requirement is to deliver 1.5 hours extra per evening (Monday to Friday after 6.30 pm) and Saturday and Sunday. The deadline to achieve this is 1 September 2018 and delivery plans have been submitted by practice groups to demonstrate how they will achieve this trajectory. The Committee approved the business case and the continuation of this programme of work.

2.7 Out of Area Registration: In Hours Urgent Primary Medical Care (including Home Visits) Enhanced Service

- 2.7.1 The Primary Care Development Manager presented a service specification and associated documents around out of area registration which allows access to local GP practices for patients who are registered with a practice away from home without access to home visits. It was noted that the service should be accessed in periods when urgent care is required and when the patient's medical condition is such that it would be clinically inappropriate for a patient to go to their registered practice. The

Committee approved the Out of Area Registration: In Hours Urgent Primary Medical Care (including home visits) Enhanced Service.

2.5 Other Issues Considered

- 2.5.1 The Committee met in private to receive updates on primary care estate, the Primary Care Commissioning Committee risk register, the Special Allocations Service and an update around primary care contracts.

Primary Care Commissioning Committee – 5 June 2018

- 2.6 The Committee met in private to receive updates on the STP forward view, NHS England half day closing, QOF+, dementia friendly practices, the post-certificate of completion of training (CCT) Fellowship application, feedback from LMC meeting, ERS (Choose and Book) and a primary care contracting update.

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 June 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	19/06/18



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WOLVERHAMPTON CCG
Governing Body
10 July 2018
Agenda item 18

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 May and June 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:	<p>The key points to note from the report are:</p> <p>2.1.1 Extended opening for Pharmacy and GP surgeries – May Bank Holiday</p> <p>2.2.5 Annual Report</p> <p>2.2.7 Annual General Meeting (AGM)</p> <p>2.2.10 Transforming Care Programme (TCP) public engagement – Black Country</p>
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 envelope	<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 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 May and June 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 Extended opening for Pharmacy and GP surgeries May Bank Holiday

Extended bank holiday opening was shown on our website in advance of the two May Bank Holidays. The GP extended hours information was accessed over 1000 times on the website.

2.1.2 Press Releases

Press releases since the last meeting have included:

- Maternal Mental Health Matters
- Measles cases prompt calls for children to get the MMR vaccine
- May Bank Holidays 2018 Pharmacy opening in Wolverhampton
- Get the right treatment over the May Bank Holidays
- Time to get sun smart in Wolverhampton
- Boost for mental health services for new and expectant mums in the Black Country
- Walk this May for health benefits!
- May Bank Holiday 2018 GP opening in Wolverhampton
- Families encouraged to Stay Well this Whitsun holiday
- Have your say and help shape maternity services in region
- Cancer Engagement Event – May 2018
- Fibonacci improvements to boost mental health care in Wolverhampton
- Online digital counselling service for young people aged 11 – 19
- Pregnant women and new mums invited to share their views at the 'Whose Shoes?' maternity services event
- Met Office alert issued for heatwave

2.1.2 Whose Shoes

Pregnant women and new mums have been invited to share their views at the 'Whose Shoes?' maternity services event which will take place in Wolverhampton on Tuesday 17 July. This will be the fourth such event across the Black Country and West Bham STP to gather views and feedback from pregnant women, new mums and their families. More information available here.

<https://wolverhamptonccg.nhs.uk/about-us/news/665-pregnant-women-and-new-mums-invited-to-share-their-views-at-the-whose-shoes-maternity-services-event>



2.1.3 Heatwave advice

Late June saw temperatures across England soar to dangerous levels and a Level 2 warning issued by The Met Office. Communications via press, online, electronically and social media were circulated to public and staff to remind them about how to take care, and shared tips to stay safe in the sun and high temperatures.

2.1.4 NHS70 Wolverhampton city event

Health and social care partners across the city are joining together with Sainsburys to share the NHS70 celebrations on Friday 6 July 2018. We are planning to celebrate 70 years of the NHS at Sainsburys with our own tea party between 10am -12noon.

2.2. Communication & Engagement with members and stakeholders

2.2.1 GP Bulletin

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

2.2.2 Practice Nurse Bulletin

The May/June edition of the Practice Nurse Bulletin included the following topics:

- Nursing Associate and Registered Nurse apprenticeships
- Clinical Academic Internships
- Practice Makes Perfect Forum
- Training and events
- Black Country and West Bham STP stakeholder news
- NHS England CCG Bulletin
- Shaping Maternity Services
- Over-Arching DV Protocol

2.2.3 Members Meeting

The GP Members Meeting took place on 2 May. GP members heard from John Denley, Wolverhampton Director of Public Health about the transformation of Public Health including local changes to Health Checks across the city.

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 completed the Annual Report and submitted to NHSE on time. The Annual Report can also be found on our website <https://wolverhamptonccg.nhs.uk/publications/annual-reports/ccg-annual-reports/2368-wccg-annual-report-17-18>

2.2.6 Annual Report Summary

We are currently compiling the Annual Report Summary which will be available to the public at our Annual General Meeting in July.

2.2.7 Annual General Meeting (AGM)

We are planning for our AGM which will this year be on 25 July at Molineux in the afternoon. More detail about this will be communicated in the coming weeks.



2.2.8 **Mental Health Summit**

We worked in partnership with our communication colleagues in the STP and mental health providers to meet and start to look at how some mental health services can be commissioned and delivered on a Black Country footprint rather than a CCG area. This piece of work will be taken forward as part of the STP Mental Health worksteam.

2.2.9 **Childrens SEND event**

We attended a Wolverhampton SEND event to engage with parents and carers about their experiences of health services across the city. Information gathered at the event will shape future commissioning.

2.2.10 **Transforming Care Programme (TCP) public engagement – Black Country**

We have begun to gather views in Wolverhampton via a survey completed by parents and carers. We want to find out about their experiences of services available (or not) for children, young people and adults with diagnosed learning disabilities (LD) and/or autistic spectrum disorder (ASD) are supported within local communities, within capable environments to avoid unnecessary in-patient mental health admissions. The survey is available here:

<https://www.surveymonkey.co.uk/r/NMFHWDQ>

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 **PPG Chair / Citizen Forum Meeting**

The PPG Chair / Citizen Forum meeting took place in May with an attendance from 11 practices and no Citizens Forum representatives.

The meeting commenced with feedback from each of the practices and it is evident that some are more active than others with a small number of practices reporting that they have not had recent meetings. A couple of practices are very active reporting that they have undertaken surveys and produced newsletters which they had shared with other practices. It was agreed that these could be shared with the larger group.



A general discussion took place from matters arising from the minutes, which included GP charges for patient letters, the imminent GDPR arrangements and the role of patient representatives at CCG meetings.

As agreed at the March meeting, the group were provided with four questions to be reviewed aimed at supporting the CCGs commissioning intentions, a structure diagram and also a brief update on the Care Navigation programme. The four questions were:

- What is good?
- What is ok, but could be improved?
- What is bad?
- How can things be improved?

There was a lively debate on the revised Terms of Reference which some members felt were still too long but that they would be finalised once agreed amendments were incorporated.

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
Clinical Priorities - End of life Strategy
Clinical Priorities - Falls prevention Strategy
Stakeholder event – Care navigation phase 2
Strategic communications
MGS PPG meeting

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: 27 June 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	SEND event Survey	13 June 2018 June 2018
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	27 June 2018



MINUTES OF THE QUALITY & SAFETY COMMITTEE
TUESDAY 10 APRIL 2018 AT 10.30 AM
CCG MAIN MEETING ROOM

PRESENT:

Dr R Rajcholan
Sally Roberts
Sukhdip Parvez

WCCG Board Member (Chair)
Chief Nurse & Director of Quality
Quality & Patient Safety Manager

Independent Member

Peter Price

Patient Reps:

Marlene Lambeth
Alicia Price

Lay Members:

Jim Oatridge

In attendance (part):

Kelly Huckvale
Phil Strickland
Liz Corrigan
Peter McKenzie
Molly Henriques-Dillon

IG Lead
Quality Assurance Co-ordinator
PC Quality Assurance Co-ordinator
Corporate Operations Manager
Quality Nurse Team Leader

APOLOGIES:

Dr Helen Hibbs
Sue McKie

Chief Officer (WCCG)
Patient/Public Involvement Lay Member

QSC051 APOLOGIES & INTRODUCTIONS

Apologies were noted by members and introductions took place.

RESOLVED: That the above is noted.

QSC052 DECLARATIONS OF INTEREST

No declarations were raised.

RESOLVED: That the above is noted.



QSC053 MINUTES & ACTIONS OF THE LAST MEETING

Minutes of the 13th March 2018: The minutes of the meeting held on the 13th March 2018 were approved as a true and accurate record.

RESOLVED: That the above is noted.

Action Log from meeting held on the 13th March 2018: The Action Log was reviewed and updated.

RESOLVED: That the above is noted.

QSC054 MATTERS ARISING: No items were raised.

RESOLVED: That the above is noted.

ASSURANCE REPORTS

QSC055 Quality and Risk Report

MHD presented to the Committee a summary of the key areas of concern. The main points of discussion consisted of the following:

QSC056 Section1: Urgent Care Provider

The key concerns remain the same in terms of the wider performance for Vocare.

QSC057 Section 2: RWT

The following incidents were reported in February 2018:

- 0 Never Events.
- 0 Slips, trips & falls were reported.
- 1 Infection was reported (norovirus on an orthopaedic ward. All appropriate action was taken.)
- 4 diagnostic delays
- 7 pressure injuries
- There were 4 avoidable due to gaps in repositioning.
- The Trust have reviewed their pressure injury policy and this will inform homes on the best practice guidelines for care homes when released.

QSC058 Maternity:

- There have been no maternity incidences this year.
- There are concerns with admissions in February.
- There has been an increase in emergency C sections at 20%.
- SR stated that CCG need more assurance in relation to the emergency c section rates as it is quite an increase and needs to be below 14%, this needs to correlate to the staffing ratio. SR to raise this with the Trust.
- RR stated that she had previously challenged this issue but RWT had responded with reason was due to complexity of patients.



- SR reported that RWT have a 0.3% vacancy rate for midwives.

RESOLUTION: That the above is noted and the following actions were agreed:

- Undertake a review of maternity incidents to include alignment against maternity dashboard.

QSC059 Mortality:

SR reported that the Trust are of the the worst performing nationally with the number of deaths inside and outside of the hospital within 30 days. The Trust has done quite a bit of work around palliative care coding. There is concern that it is not impacting on SHMI. SR added that she has requested that the CCG are involved in their external review. The Trust have reported they are not seeing any learning coming out of SJRs. SR will follow this up at MORAG.

RESOLUTION: That the above is noted and the following actions were agreed:

- Quality Team to undertake further assurance work with regards to MWHT mortality rates, specifically SHMI, this will take place once the Deputy Director is in post at the end of April and will include a review of the SJR process at the Trust and feedback at the July Committee.
- Mortality to be added to Q&S Risk Register.

QSC060 Cancer Waiting times/target compliance:

- SR reported she has escalated the CCG's concern to the Governing Body. The main issue being the 62 days and 104 day waiting times which may potentially be causing patients psychological and actual harm and potentially impacting on patient recovery although the Trust are reporting that patients are not subject to psychological harm. This has been challenged. SR added she has written to GN requesting further documented evidence of the Clinical Harm review process.
- JO requested a comparison of data to Trust's outside of Wolverhampton and requested that this is included in the performance report going forward.

RESOLUTION: The above is noted and the following actions were agreed:

- SR to meet with COO and Cancer Lead Clinician with regards to further assurance and actions of cancer performance, including specific detail relating to the 104 day waits.
- SR to liaise with PHE in relation to breast screening deterioration in performance.
- Cancer wait times/performance comparison data to be included in the performance report going forward.
- Cancer wait times to be added to the Q&S Risk Register.

QSC061 Ambulance Handover: There were 2 breaches of the 12 hour decision to admit. Both of these breaches are clinically justified so the CCG do have a level of assurance.

RESOLUTION: That the above is noted.



BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST**QSC062 Serious incidents:**

- There were 4 Serious Incidents reported by the BCPFT
- SR reported that she had a productive meeting with Joyce Fletcher from the Black Country Partnership Trust.

RESOLUTION: That the above is noted.

QSC063 Vocare:

SR updated the Committee on the following:

- The CCG are monitoring Vocare closely on a weekly reporting basis for a period of 8 weeks.
- An unannounced visit took place on 9th April and improvement was seen specifically with regards to performance. A new Operations Manager has been appointed who seems to have a real handle on issues and is bringing in fundamental changes to rota management and despatch as this currently sits in Stoke.
- Vocare are proactive with the issues they face, staffing is an issue but have introduced nursing incentives and looking at how to manage some of the risks around night visits where patients have to wait longer than expected.
- Vocare have been meeting their performance targets for the last few weeks so the CCG are starting to see improvements but it is still early days.
- RWT have recognised that they need to work more closely with Vocare and they are willing to do so. A process mapping event is planned to review front door activity.
- Further unannounced visits are planned.

RESOLUTION: That the above is noted and the following actions were agreed:

- SR to recommend that Vocare is monitored closely for a further 8 weeks.

QSC064 NEPTS (Non-emergency Patient Transport Services) WMAS

SP updated the Committee on the following:

- CCG previously challenged an incident that happened last year which was escalated to NHSE. CCG are yet to be notified of the outcome. SP will update the Committee at the next meeting.

RESOLUTION: That the above is noted and the following actions were agreed.

- SP to update the committee with the outcome of the challenge.



QSC065 NUFFIELD

The NE reported is awaiting Scrutiny. This will be reported at the next meeting.

RESOLUTION: That the above is noted and the following actions were agreed:

- SP to update the committee with the outcome of the scrutiny of the Never Event.

QSC066 COMPTON HOSPICE

SP reported that a serious incident was reported in February 2018 relating to a confidential information breach. This is being investigated by the Police. The NHSE and CQC were notified. A full RCA is in progress and due to be concluded on 30 April. SP will update the committee at the next meeting on the outcome.

RESOLUTION: That the above is noted and the following actions were agreed:

- SP to update the committee on the outcome of this incident at the next meeting.

QSC067 SAFEGUARDING CHILDREN

SP reported that Level 3 training compliance is continually monitored.

RESOLUTION: that the above is noted.

QSC068 Dr Rajcholan made the following points:

- RR queried whether there was any outcome following the Maternity QRV visit in March. SP confirmed that the CCG was initially part of the review but RWT cancelled the March visit so it did not take place.
- RR queried whether there is a date of when the catheter passport is to be implemented. SR confirmed that this is work in progress and date is yet to be agreed. SR confirmed that this will be a focus.
- RR referred to the Adult Safeguarding section and the 28 deaths to those with learning disabilities. 27 in total across the Black Country and only 8 have been sent to review. RR queried why only 8 have been sent to review. SR stated that A&S should request further assurance with regards progress against Leder programme.

RESOLUTION: That the above is noted and the following actions were agreed:

- A focus is required on the implementation of the catheter passport (MHD).
- A Leder assurance report to be provided to Q&S (AL).



QSC069 Primary Care Report

Liz Corrigan presented the Committee with an overview of activity in Primary Care, the main points of discussion consisted of the following:

Infection Prevention: The poor ratings seems to be down to property rather than poor practice. Just over half of the practices have identified a SEPSIS lead. E-learning has been sent to the practices and Public Health is looking into face to face training.

Influenza Vaccination: the vaccine update is slightly lower than regional and national uptakes. This continues to be monitored by CCG and Public Health are monitoring.

Medicine Alerts: None to review.

Family and Friends Test: Overall the practices with no submission has remained the same at 5%.

Quality Matters: 6 new IG incidents have been reported with the theme being human error. All matters continue to be monitored.

Complaints: Complaints are received on an ad-hoc basis. Themes are refusal to refer and staff attitude. There are currently 16 active complaints which will go through PPIGG.

Serious Incidents: There are currently 2 incidents under investigation. An incident relating to the delayed diagnosis of a child and an incident relating to a strong secondary to rare diagnosis. These have been heard by Scrutiny this week and will then go onto PPIGG. Further investigations are possible.

Escalation to NHS England: An investigation will take place regarding the closing of complaints at a recent PPIGG meeting.

NICE/Clinical Audit: Work is underway to ensure that practices are using the latest guidelines. LC will continue to monitor.

CQC Inspections and Ratings: Practice ratings were reviewed and two practices currently have a RI rating. Both are being monitored by the Primary Care and Contracting Team with input from the Quality Team. Site visits have been undertake/planned and any concerns have been escalated as appropriate.

Risk Register: The current risk register was reviewed, 16 risks were identified. The register continues to be monitored by the Quality Team and the Primary Care Commissioning Committee ensuring risks are being dealt with in a timely manner.

Workforce: The working in Wolverhampton video is nearly complete and will be streamed on facebook and twitter once completed. 500 Nursing Associates will be recruited through the apprenticeship scheme this year. 120 have been identified from this region. Apprenticeships will commence in September and if anyone is interested can contact Liz Corrigan direct. LC is awaiting national guidance on retention.

RESOLUTION: The committee welcomed the report and noted the contents.

QSC070 Information Governance: End of Year Report for 2017/18

KH provided an end of year update to Committee on the Information Governance activity. The main points of discussion consisted of the following:

- KH confirmed that the IG Toolkit has been successfully submitted.
- The CCG submitted a score of 89% where Level 3 status was achieved in some areas.
- IG Mandatory Compliance is 55%.
- There have been no IG risks identified in March 2018.
- One Subject Access Request which is currently in progress.



- There have been no IG incidents this current year.
- In relation to GDPR an action plan is in place which is currently being worked through; key actions being review of policies.
- Spot Checks have been completed for the year and good working practices have been identified although some staff do not to operate a clear desk policy.
- Specific IG spot check findings newsletters will be circulated to enable staff to identify and rectify any potential issues within their environments.

RESOLUTION: The Committee welcomed the report and noted the contents.

QSC071 H&S Performance Report

Phil Strickland provided a quarterly update to the Committee on the continued work undertaken to comply with the CCG's statutory responsibilities with H&S.

PS informed the Committee that he will no longer provide support on Health and Safety matters within the CCG from the 1st April 2018. Options are being explored regarding providing Health and Safety Management and options have been submitted to SMT for approval. Committee will be updated accordingly.

Ensuring the CCG has a new Health & Wellbeing Lead will be discussed at the next JNCC meeting.

ML expressed concern regarding signing in and out of the temporary reception. It was noted that the new reception is not opening until July 2018 at the earliest. The new provider are to look into the Health and Safety Risks if visitors are not signing out. The delayed opening of the new reception will be raised at Governing Body.

RESOLUTION: The Committee noted the contents of the report and agreed the following actions:

- New H&S provider to look into the H&S risks of not signing out of the temporary reception.
- The delayed opening of the new reception to be escalated at Governing Body.

QSC072 Information Governance: End of Year Report for 2017/18

KH provided an end of year update to Committee on the Information Governance activity. The main points of discussion consisted of the following:

- KH confirmed that the IG Toolkit has been successfully submitted.
- The CCG submitted a score of 89% where Level 3 status was achieved in some areas.
- IG Mandatory Compliance is 95%.
- There have been no IG risks identified in March 2018.
- One Subject Access Request which is currently in progress.
- There have been no IG incidents this current year.
- In relation to GDPR an action plan is in place which is currently being worked through; key actions being review of policies.
- Spot Checks have been completed for the year and good working practices have been identified although some staff do not to operate a clear desk policy.



- Specific IG spot check findings newsletters will be circulated to enable staff to identify and rectify any potential issues within their environments.

RESOLUTION: The Committee welcomed the report and noted the contents

RISK REVIEW

QSC073 Quality and Safety Risk Register

PS presented the Risk Register to the Committee. The main points of discussion consisted of the following:

There are 6 Overall Committee Risks;

- 1 Extreme
- 4 High
- 1 Moderate

Safe Working Practices closed down from March's Committee.

Extreme

466: Out of hours – Vocare 16

09/04/18 - Vocare have produced an 8 week recovery plan which is monitored weekly and scrutinised alongside performance outcomes. Governing Body are kept updated with details of progress. A further report to be presented in April 2018. In the meantime, the CCG monitor performance and outcomes via the daily communication, weekly CCG exec review, fortnightly Vocare Exec update, monthly CRM/CQRM and 6 weekly Improvement Board. The CCG is assured that Vocare are focussing their efforts on the right areas and performance against the 95% target has improved (April to date currently 98.67%) and Triage within 15mins has also risen but not yet to the contracted agreed levels.

1/3/2018 - NHSE Quality and Surveillance Group are considering a heightened level of scrutiny. Governing Body updated Feb 2018 detailing progress with a further report to be presented in April 2018. In the meantime, Vocare have produced an 8 week recovery plan which is closely monitored and scrutinised alongside performance outcomes.

High

489: Inappropriate Midwife Arrangements 9

12.03.18 This continues to be progressed by the Head of Safeguarding and Head of Midwifery. Awaiting conclusions. Update to follow in June 2018

11.09.17 Update - no change from July.

The circumstances remain the same. The Head of Safeguarding is in discussion with the Head of Midwifery on how this can be progressed.



312 Mass Causality Planning 8

11/07/17 - 'On call staff including directors have had refresher training on Mass casualty planning' – CCG awaiting handbook from Regional EPRR Lead.
Update chased with TK and overdue.

492 Maternity Capacity and Demand 9

08/01/18 - The number of bookings in November 2017 had gone down from 522 to 500 but the number of deliveries has gone up from 442 to 448.
Midwife sickness rate are an improving picture and midwife vacancy rate is now only 0.3%.

493 PTS Poor Performance 9

27/02/18 - WMAS has submitted a proposal to revise a number of KPIs and reporting requirements. This is being considered by both CCGs. Current performance remains a concern, however additional vehicles/ crews have been put in place. Therefore we expect performance to improve.

Further update to follow in June 18.

Moderate

502 LAC CAMHS 6

9.04.18 Update received from Group Director for CYP (BCPFT) informing the average 40 week wait is misleading as the data included patients who had been given appointments but DNA'd (until they are seen they remain on the waiting list). As a result he has instructed a thorough data cleanse and will also ensure that information that is presented at CQRM is checked and correct prior to submission.

Additional KPI's (including 18 week waiting time) for LAC have been agreed with BCPFT and will enable closer, more detailed monitoring. Exceptions will be reported to CQRM.

The change in working practise within the service has commenced. This will ensure that all CAMHS workers can now support our LAC as opposed to the small dedicated team who did so previously, improving waiting times.

08/1/17 CAMHS transformational plan will address service delivery

Revised WCCG service spec for CAMHS to include LAC

Children's commissioner and DNLAC have agreed KPI's for LAC to be included in 17/18 contracts with exceptions reported to CQRM. Sandwell CCG have agreed amendments. Meeting arranged with BCPFT for approval.

Update was due the 8th April 2018 chased with FB 9/4/18.



General Update:

- The TCP will be looked at from a quality perspective. The developing of a new model for delivery of Community Learning Disability services across the Black Country has the potential to create financial pressures for the CCG which is captured at F&P committee.
- New reporting format including trajectories. Datix will no longer be used to present at Committees.
- Risk updates should also be about what discussions have been raised at committee today that have highlighted a potential risk that requires assessment and where the ownership of that risk sits.

QSC0074 RESOLUTION: The Committee noted the report and the following actions were agreed:

- Cancer Performance Risk – Clinical Harm Review (SR/RR).
- Mortality SHMI Risk (SR/RR).
- SR to hold a TCP discussion outside of the meeting to analyse the changes from a Quality perspective (SR).
- Update Quality Master Register (PS).

ITEMS FOR CONSIDERATION

QSC075 Terms of Reference

SR reported that a draft ToR was circulated with the papers for review/approval. SR proposed that Steven Marshall (Director of Strategy & Transformation) and Mike Hastings (Director of Operations) be added to the group as it would assist with monitoring performance along with a representative from Public Health.

RESOLUTION: The ToR will be reissued to include both Directors along with a representative from Public Health and request any comments for validation at the next meeting.

FEEDBACK FROM ASSOCIATED FORUMS

- QSC076 CCG Draft Governing Body minutes:** noted and no comments received.
- QSC077 Quality Surveillance Group minutes:** noted and RR pointed out page 4 of the minutes that it was noted that there is a zero tolerance for new 104 day breaches where they are not clinically justified. Themes and trends will be identified in readiness for the next meeting and a discussion will take place on pathways. It was agreed there will be a Clinical Harm Review if zero harm continues to be reported.
- QSC078 Draft Commissioning Committee minutes:** Noted and no comments received.
- QSC079 Mortality Assurance Review Group minutes:** Noted and no comments received.
- QSC080 NICE Group minutes:** Noted and no comments received.
- QSC081 Area Prescribing Committee minutes:** Noted and no comments received.



ITEMS FOR ESCALATION / FEEDBACK TO CCG GOVERNING BODY

- QSC082 Mortality to be escalated to Governing Body via the Risk Register: SR will be arranging for a deep dive on mortality and get a CCG analysis when Yvonne Higgins arrives in post which can correlate with the SJR data.
- QSC083 Cancer wait times/performance via the Risk Register: SR is requesting further detail regarding the 104 day breaches.
- QSC084 Opening of the new reception via the risk register: concern was raised regarding the delayed opening of the new reception which is scheduled for July 2018.

QSC085 ANY OTHER BUSINESS

None.

RESOLVED: That the above is noted.

DATE OF NEXT MEETING:

Tuesday 8th May 2018 at 10.30am to 12.30pm in the CCG Main Meeting Room



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**MINUTES OF THE QUALITY & SAFETY COMMITTEE
TUESDAY 8 MAY 2018 AT 10.30 AM
CCG MAIN MEETING ROOM**

PRESENT:

Sally Roberts Chief Nurse & Director of Quality
Sukhdip Parvez Quality & Patient Safety Manager

Independent Member

Peter Price

Patient Reps:

Marlene Lambeth

Lay Members:

Jim Oatridge Interim Chair
Sue McKie Patient/Public Involvement Lay Member

In attendance (part):

Phil Strickland Quality Assurance Co-ordinator
Liz Corrigan PC Quality Assurance Co-ordinator
Peter McKenzie Corporate Operations Manager
Tracie Wilson Quality Improvement Nurse and SPACE Programme
Facilitator
Lorraine Millard Designated Nurse Safeguarding Children
Fiona Brennan Designated Nurse for Looked After Children

APOLOGIES:

Dr Helen Hibbs Chief Officer (WCCG)
Dr R Rajcholan WCCG Board Member (Chair)
Alicia Price Patient Rep

APOLOGIES & INTRODUCTIONS

Apologies were noted by members and introductions took place.

RESOLVED: That the above is noted.

DECLARATIONS OF INTEREST

No declarations were raised.

RESOLVED: That the above is noted.



MINUTES & ACTIONS OF THE LAST MEETING

Minutes of the 10 April 2018: The minutes of the meeting held on the 10th April 2018 were approved as a true and accurate record subject to a slight amendment to item number QSC058 Maternity: There were no incidents reported in February rather than for the year.

RESOLVED: That the above is noted.

Action Log from meeting held on the 10th April 2018: The Action Log was reviewed and updated.

RESOLVED: That the above is noted.

MATTERS ARISING:

JO requested that the comments section is completed for all actions within the action log.

RESOLVED: That the above is actioned.

ASSURANCE REPORTS

5.1 Transforming Care (Confidential)

The above report was tabled at the meeting in order for the committee to be sighted on this national agenda for the committee to seek full assurance of having a positive impact and keeping people safe, with regards CCG actions.

The main points of discussion consisted of the following;

- The purpose of the report is to provide assurance about the care and support of citizens in the TCP cohort.
- Wolverhampton CCG do not currently have any delayed discharges.
- Wolverhampton CCG has a good range of specialist health services to prevent admission to hospital, including Intensive Support.
- Wolverhampton CCG has strong integrated working with the Local Authority, Joint Commissioning as a valued function and a strong local authority dedicated forensic social work team.
- Wolverhampton CCG has highlighted the need to develop improved forensic social care services (currently being procured).
- Wolverhampton CCG has highlighted the need for greater community specialist health forensic services, and greater coverage in terms of hours of the Intensive Support Team – this has been commissioned through BCPFT, for full implementation by September 2018
- Wolverhampton CCG is not expecting to meet the required national trajectory by March 2019, which places the CCG on escalation with NHSE, as part of the wider Black Country escalation.



WE added that this piece of work is involving a cohort of individuals that could be at risk to themselves and others and involves complex decisions to be made with regards placement and as such should be considered as part of the CCG Q&S agenda.

The national programme was designed to support and deliver care for patients with learning disabilities, hospitals should be used as minimal as possible and care delivered close to home. Wolverhampton has got a large cohort of offenders with complex learning difficulties. 90% of in patient population are offenders with offences such as murder; rape; aggregated rape; and arson. When convicted they receive hospital orders rather than sending them to prison, the prison system then transfers offenders to hospital as ministry of justice deem alternative provision not appropriate.

The numbers have been set for the Black Country through national forums Focus for the Committee is to ensure we understand the patient pathways and ensure we have got it right.

SR led a panel across the Black Country which scrutinised each individual patient to ensure their care and treatment is correct therefore reducing risks as much as possible. Both SR and WE are in agreement of results of the scrutiny based on risk. SR flagged the reputational risk with regards current performance.

JO requested distinction of Wolverhampton's performance compared to rest of Black Country.

Action: WE to include citizen stories in the quarterly reporting going forwards.

5.2 Quality & Risk Report

A copy of the Q&S Risk Report was previously circulated and noted by the group. SP reported by exception on the following;

Vocare:

- There has been previous concerns regarding the leadership; triage; productivity and staffing and an 8 week improvement plan was implemented as well as weekly CCG review meetings. SP added that following this intervention Vocare are improving with triage response rates for 13-18 April at 78.7%. Four hour performance rate was reported at 98% for April.
- There is a joint front door process mapping session arranged for 11 May.
- In terms of staffing, 4 GPs have been recruited; 2 team leaders and a Rota Coordinator. Since October there have been no SI breaches when previously there has been 7-8.
- The operational lead has made a significant impact since commencing post and is doing good work.
- The plan is to visit again in 6 weeks to sense check. SP added that he can sense that the relationships between Vocare and RWT are slowly developing.
- The CQC inspected Vocare in February which the preliminary report suggests it has been rated as Requires Improvement, which is progression since the last report.



JO queried if there are clear quarterly milestones on what is required?

SR confirmed that this is in hand as there are discussions being held around milestones and work is in progress on refreshing the action plans into themes.

Cancer performance:

- SP reported that this remains an area of risk relating to performance in particular to the 62 and 104 day waits and further assurance has been requested. There has been a decrease in the 104 day waits, however the Trust has informed the CCG that the 62 day waits are going to get worse before gets better.
- Through CQRM SR has requested a review of the harm process and to ensure that robust processes are in place.
- CCG attends the weekly PTL review meetings for further assurance.
- CCG has requested a revised trajectory in terms of improvement around the tumour pathway. These discussions are on-going with the trust.
- NHSE/I are sighted on current performance.
- Jacqueline Barnes has set a 0 trajectory against 104 day cancer waits although this is unachievable at the moment.

JO queried the 104 day wait and asked what clarified the wait process.

SR clarified it is from the start of the referral through to treatment, including diagnostics.

JO expressed concern regarding the delay in improvement against performance trajectories, specifically when the aspiration is to have a 0 target.

SR confirmed that the remedial action plan put forward by the trust has been challenged, as has the harm review of individual patients. SR advised that discussions are ongoing with the trust.

SR added the PTL group are trying to reduce the waiting days and the challenge is more rigorous and added that robotics are going to be a real challenge.

Maternity:

- The current midwife birth ratio is 1:30; previously it was 1:31 with the national standard rate of 1:28.
- Vacancy rate is 1.3%
- 14 SIs have been reported
- 1 Never Event has been reported in April, this was in relation to a neo natal incident involving intervention to the wrong baby, no prolonged harm has occurred as a result of this incident. SR has sought immediate assurance following the never event via the Deputy Chief Nurse at the trust. The RCA is awaited.
- C sections are high which has been challenged at CQRM. The Trust are carrying out their own review and are going to bring back the outcome to a future CQRM.



Mortality:

- WCCG continue to attend the trust MORAG meeting, the CCG will be undertaking a deep dive review of mortality performance by the trust during June and will report back in August.
- **Never Events**
- There have been 6 Never events reported during 2017/18.
- SR advised that WCCG chair and Chief Nurse had met with the Chair of RWT and exec board representation, including CNO and MD to seek further assurance on board oversight and understanding of the Never Events at RWHT.
- Trust advised that AFPP have been asked to come back into the trust to undertake further activity in theatres with regards cultural understanding around surgery and checking and application of WHO checklist. SR stated she is picking up a theme on checking and that checking seems to be reoccurring theme.
- The Trust's New Chief Nurse is keen to do some system wide theme of just checking and will look at the broader perspective, which is positive.
- SR advised she has requested additional support from NHS England for a wider sharing of Never Events and learning from other trusts across the system to provide an understanding how others have done. NHS England are going to provide that around July.

Never Event: The committee was briefed about another Never Event that had occurred in theatres where a wrong tooth was extracted in error.

Diagnostic and treatment delay:

There has been an increase in the number of diagnostic delays. SR has requested a CCG deep dive retrospective review of incidents and SP has carried out a deep dive. There have been 13 incidences, during the reporting period, 6 in ED and 7 in radiology and specialities, SP considered the incidents in ED. The latest incidents occurred mainly during weekdays patient age demonstrated more incidents occurred at 50-80years old and not speciality related, one key theme was around review by junior doctors or locums. This has been flagged by WCCG to the trust at CQRM and the trust will review the data

Cytology Incident: This relates to a look back of cytology reporting and has identified that 39 women have been affected, The Trust are working with Public Health England and patients are going to be spoken to individually by consultants. There is thought to be no major harm having taken place with regards individual patients but work is ongoing. SR requested this is reported as an SI by the trust, this is awaited and she will continue to liaise with PHE. SR will update at next committee meeting.



5.3 Care Home Report inc SPACE presentation

The above report was circulated and noted by the Committee. TW reported by exception on the following;

- There have been 6 serious incidents in care homes concluded and closed by scrutiny committee in Q4. There is a reduction in stage 3 and 4 pressure injuries from the previous quarter ,however there is an increase in the reporting of stage 2 pressure injuries which may be reflective of early recognition and improved reporting however this will enable the focus of targeted training within care homes.
- Slips trips and falls SIs reduced with zero reported Q4- Effective manual handling was identified as a contributory factor in a previous investigation and assurance has been received from the home that this has been addressed
- Participation in survey monkey has been inconsistent through 2017/18. This will be a focus for the team in order for accurate data to be obtained and enable consistent data comparison being reported.
- There were 99 A&E attendances reported by the participating homes during Q4 due to insufficient admission detail being recorded i.e. "other" the QNA Team are unable to adequately analyse data and identify areas for improvement.
- As well as working with red bag and assisting with the reduction of hospital admissions, the QNA team have supported 5 care homes that have progressed from CQC rating of RI to Good.
- There have been reported closures of care homes during 2017/2018 predominantly due to influenza A and D&V with some confirmed cases of norovirus. The Infection Prevention Team continue to support the sector with outbreak management..
- SR thanks TW for the fantastic work being undertaken by the QNA team and requested that dashboard data is used going forwards to highlight the number of care homes within Wolverhampton, the number who are taking part in the Space programme and how many with contracts.
- JO requested that the data includes the total number of Serious Incidents.

ACTION: MHD to include dashboard data and the total number of Serious Incidents going forwards.

Space Presentation;

TW presented to the Committee an update on the Space Programme. The main points consisted of the following;

- Continuing development of a safety culture and harm reduction by targeted training in care homes
- Identification of themes and trends has identified areas of improvement.
- Targeted work and focus on national programmes is improving nutrition and hydration



- 5 care homes advanced from RI to Good over last quarter, all reports cited engagement in SPACE and Quality Improvement programmes
- Focus on sustainability with QI training undertaken with Local authority compliance officers and commissioning team as well as developing access to resources i.e. quality improvement tools and best practice

JO praised the positive outcomes of the programme.

5.4 Primary Care Report

The above report was circulated and noted by the Committee. LC reported by exception on the following;

- In relation to the flu vaccines, ordering is low with 75% showing at 65% still not sure if still an issue with data from NHS England. An email is going out this morning. Some practices have got some concerns being picked up.
- Flu vaccine is slightly lower
- Medicine alerts 0
- Friends and family tests – PPGs? Identify good practice where there has been some good uptake
- There are no quality matters reporting for April. Planning a review on quality matters, use something more systematic
- Complaints to NHS England– 1 in May, 0 in April
- SI – 2 awaiting sign off and will go to PIGG
- Clinical audit, working on ways of assuring put in to place.
- CQC inspections – 2 RI working with those practices, mainly around safety and leadership and how that is managed.
- Risk Register – PS to pick up
- Extreme risk, confidential risk unable to share due to nature, pick up at Primary Care Commissioning
- Workforce – no exceptions to report

5.5 Q&S Committee Annual Report 2017/18

The above report was previously circulated and noted by the Committee. PM added that the report sets out the work undertaken by the Committee during the 2017/18 financial year and how the committee has met the responsibilities set out by the Governing Body.

It was noted that the Committee has effectively discharged its responsibilities and will review the ToR to ensure managing the work remains effective.

Any queries regarding the report can be directed to Peter McKenzie.

ACTION: ToR to be reviewed and validated at the next meeting.



5.6 Freedom of Information report

PM reported that from 1 January to 29 March the CCG received 62 FOI requests. The CCG responded to 98% within the statutory 20 working days. PM added that there was 1 request that was not responded to within statutory timeframe. Most requests are submitted by students and media with the overall performance for the year at 257 requests with 250 responded to and 7 withdrawn.

It was noted that since the FOI requests have been picked up internally the response rates has improved since looked after by CSU.

There have been no IOC referrals.

5.7 Safeguarding Adults, Children & Looked After Children Quarterly Report

The above report was previously circulated and noted by the Committee. The main points of discussion consisted of the following;

- There are a number of Multi agency learning reviews and table top reviews on going for cases that do not meet the criteria for a SCR in order to identify lessons to be learned and dissemination across the partnership.
- Raising awareness on the Joint Targeted Area Inspection (JTAI), jointly carried out by a number of inspectorates including Ofsted and CQC. It is believed that an inspection is imminent in Wolverhampton. WCCG are working with the local authority to ensure WCCG and provider organisations are prepared.
- The NHSE Funded Safeguarding Project is progressing really well, uptake of training target was exceeded and feedback is positive. AL will use the poster again later this year.
- Significant progress has been made with the GP Domestic Violence Project with plans to extend to include the Urgent Care Centre.

The Designated Adult Safeguarding Lead and the Designated Nurse Safeguarding Children have completed the LeDeR Reviewer training along with other members of the Quality & CHC Teams. Further members of the safeguarding and LAC are due to attend the training. There is a significant back log across Black Country which will be addressed as part of themed table top review. It has been identified that the Black Country Partnership Foundation Trust are not currently engaging with the project. Following discussion with the safeguarding leads both RWT and BCPFT have identified more staff to be reviewers. SR was due to have an update on how many of the backlog relate to Wolverhampton.



Looked After Children (LAC):

FB reported on the main points as follows;

- Numbers of LAC remain relatively static over the last 12 months.
- new working arrangements now in place with RWT extending coverage of health care to LAC placed within 50 miles of Wolverhampton. This will include the quality assurance (QA) of statutory health assessments. The Designated Nurse within the CCG will ensure that a sound QA process continues for those 8% of children placed outside of the 50 mile radius.
- Provider assurances have been added to RWT dashboard in order to capture more in depth activity around initial and review statutory health assessments. This will commence in Q4.
- Concerns around CAMHS waiting times for our LAC are being addressed through the service redesign and transformational plan. Data contained within their annual report presented to the Corporate Parenting was misleading, and following an in depth data cleanse a more reassuring (but not acceptable) picture was formed.
- Their internal processes have already been addressed to ensure waiting times for LAC mirror those of their peers. The CAMHS dashboard has been reviewed to capture LAC specific data with exceptions presented within quarterly reports.
- There have been 3 Quality Assurance visits to The Oaks; Priory Rugeley Horizon School; and Merridale Street West.
- The Children and Social Work Act 2017 now support care leavers up to 25 as opposed to 18.
- JO queried the QA visit to Merridale Street West (MSW) where a medication error had occurred, and whether there was any harm caused to the young person in question.
- FB confirmed no there was no harm caused, and the Home in question had already undertaken significant learning as a result. Re MSW, concerns were around management of complex and challenging behaviours in young people, and the interventions provided by staff. The home has been decommissioned, and staff have been moved to another LA provider. Recommendations following the QA visit were around staff undertaking training before they work with other similar cohort of children.
- SR informed the Committee that the SEND agenda has moved to the Safeguarding Team and added complex children theme going to discuss governance arrangements for children and commissioning in terms of CCG, to enable to feed into a Children's Board.



5.8 Medicines Optimisation Report

The above report was previously circulated and noted by the group. HP presented the the main points as follows;

- A number of safety Alerts have been factored into the work plan.
- A few specific alerts were discussed, including one regarding Valproate in women of a child bearing age as there is a potential risk to infants. There are now recommendations that healthcare professionals prescribing valproate for women of childbearing age must make sure they are enrolled in the pregnancy prevention programme, this includes the completion of a signed risk acknowledgement form when their treatment is reviewed by a specialist, at least annually.
- SR expressed concern regarding the alerts.
- PCMT had supported practices implement the required work for the National diabetes prevention programme, by raising awareness as well as helping to identify suitable patients.
- Antibiotic stewardship programme: the CCGs and Primary Care Medicines Team's contribution to this programme has been recognised in the national AMR Impact Report. There is national scrutiny in this area and the work undertaken builds on the excellent work by local prescribers with all antibiotic prescribing targets having been met. The work is based on highlighting antibiotics resistance, targeted to children and teachers.
- An audit conducted had been completed to understand the safety of prescribing of morphine liquid. Although only 8% of all prescriptions were considered to be unsafe as they didn't provide sufficient clarity of dose. All potential unsafe prescriptions were identified immediately to prescribers for action to ensure prescribing is made safer.
- The Quality Prescribing Scheme had continued to be an effective method of improving prescribing indicators such as reducing the level of hypnotics and NSAID prescribed.
- The PCMT and Medicines Optimisation Team continues to work with dieticians in order to reduce levels of malnutrition and optimise the use of oral supplements ensuring those prescribed supplements receive regular reviews.

RISK REVIEW

6.1 Q&S Risk Register

PS reported to the Committee on the new format for the Risk Register. The main key risks being;

- Cancer performance
- Mortality
- TCP there is a split risk need a discussion from quality perspective. SR confirmed that there is a quality strand to it but the major risk is financial and should



therefore sit the risk at F&P this will be discussed for agreement at Governing Body.

All agreed with new format of the Risk Register.

ACTION: PS to update the Risk Register accordingly.

7 ITEMS FOR CONSIDERATION

There were no items raised.

8 FEEDBACK FROM ASSOCIATED FORUMS (Exceptions and Queries)

There were no items raised.

9 ITEMS FOR ESCALATION/FEEDBACK FROM CCG GOVERNING BODY

There were no items raised for escalation.

10 ANY OTHER BUSINESS

There were no items raised.

11. DATE OF NEXT MEETING

Tuesday 12 June 2018 at 10.30am in the main meeting room, Wolverhampton Clinical Commissioning Group.



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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP

Finance and Performance Committee

**Minutes of the meeting held on 24th April 2018
Science Park, Wolverhampton**

Present:

Mr L Trigg	Independent Committee Member (Chair)
Mr T Gallagher	Chief Finance Officer
Mr S Marshall	Director of Strategy and Transformation (part meeting)
Mr M Hastings	Director of Operations
Dr D Bush	Governing Body GP, Finance and Performance Lead
Dr M Asghar	Governing Body GP, Deputy Finance and Performance Lead

In regular attendance:

Mrs L Sawrey	Deputy Chief Finance Officer
Mr V Middlemiss	Head of Contracting and Performance
Mr P McKenzie	Corporate Operations Manager (part meeting)

In attendance

Mrs H Pidoux	Administrative Team Manager
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1. Apologies

There were no apologies to be submitted.

2. Declarations of Interest

FP.257 There were no declarations of interest.

3. Minutes of the last meetings held on 27th March 2018

FP.258 The minutes of the last meeting were agreed as a correct record.

4. Resolution Log

FP.259 Item 120 (FP.243) - Recommendation to Governing Body to sign off the budget for 2018/19 – Mrs Sawrey to pick up with Mr Gallagher – sign off had been agreed by the Governing Body – action closed.

Item 121 (FP.251) - Analysis of HRG coding to be shared at a future date – to be discussed under the finance section of this meeting – action closed.

Item 122 (FP.254) – Corporate Risk CR07 to be closed for 2017/18 and reopened for 2018/19 (to be considered if this should be 2 risks, current and future) – completed action closed.

Item 123 (FP.254) - Committee Level Risks – FP03 and FP12 to be closed and FP04 risk level to be reduced - completed action closed.

5. Matters Arising from the minutes of the meeting held on 27th March 2018

FP.260 There were no matters arising to discuss from the last meeting.

6. Contract and Procurement Report

FP.261 Mr Middlemiss presented the key points of the report as follows;

Royal Wolverhampton NHS Trust

CRM Presentation – it was noted that this had been on the agenda for a while, however it had not worked well for a number of reasons including a lack of ownership by the Provider. A joint meeting had been held and a new format agreed going forward and the principles of this will be jointly owned. The aim is to generate dialogue rather than have retrospective consideration.

The Staffordshire element of the RWT contract for 2018/19 was close to being signed. Clarification is required regarding the risk share arrangements.

Audit programmes will each have a jointly agreed terms of reference, clinical input will depend on who is carrying out the audit. Delays had been experienced due to a number of issues including winter pressures. This will be discussed with the Trust at the next CRM meeting to agree commencement dates.

Emergency Care Data Set CQUIN – this is part of a new CQUIN which all providers are required to implement. The CCG had raised concerns with regards to the financial implication of the new system, however, RWT had confirmed that the financial impact of these amendments will ‘financially neutralise’ up to March 19 (agreed timescales as per the National Contract). This is not perceived to be a risk to the CCG.

Black Country Partnership Foundation Trust (BCPFT)

Contract Performance Notice – Infection Prevention Training – performance had improved since the Remedial Action Plan was implemented. Verbal

assurance had been received that March is also above target and should achieve Quarter 4 target.

2018/19 Contract Review

Finance – Over performance (inpatients) – there is an over-performance issue on Adults/Older Adults inpatient beds. An agreement had been reached for a cap and collar (cost and volume) contract. It was felt that the risks of this agreement were mitigated against. It is a one year only agreement and there will be robust contract monitoring. If there is deviation from plan this will be challenged. It was noted that the timings of the pre-meetings had been changed to enable Andrea Hadley, Head of Financial Management – Contracts, to attend.

Mr McKenzie joined the meeting

Price Activity Matrix (PAM) refresh – relatively minor changes had been made and there was nothing significant to report to the Committee.

Mr Hastings raised a query in regards to the availability of data for IAPT access at the end of year as early information would allow for better planning. Mr Middlemiss responded that Data Quality was regularly on the agenda of the CRM and assurance required through the year.

Improving Access to Psychological Therapies (IAPT) PbR is on the CCG's internal risk register as NHSE have requested all CCGs and providers to have an agreed plan in place by April on how they are going to implement IAPT PbR locally. No further advice or guidance had been received from NHSE since January and an updated position had not been requested.

Urgent Care/Ambulance/Patient Transport

Urgent Care Centre – noticeable improvement in quality and performance had been seen. Further improvement is required, however, the feedback from the recent contract review meeting was that the provider was moving in the right direction. New staff had been employed which is having a positive effect. Activity for 2018/19 is still being agreed, the default is the higher level of activity.

Other Contracts

Accord Housing Association – Victoria Court – Contractual and financial terms had been agreed between the CCG and Accord for a new contract arrangement for Victoria Court. This centres on 9 inpatient beds for specialist rehabilitation and 3 beds for step down. The Local Authority had agreed to pay an increased top up amount for the 8 beds, based on actual usage, whilst the step down beds are fully funded by the CCG.

Accord had put forward a proposal to the CCG for void losses incurred during the 2017/18 year; the claim was for around £95k. The CCG had agreed to pay £75k.

It was considered that Accord had requested for the CCG to cover all redundancy costs should they not be awarded the contract beyond March 2019. The CCG had agreed to cover only statutory redundancy costs under this scenario, however, if Accord advise that they will no longer offer the service and wish to terminate the contract the CCG will not be liable for any redundancy costs.

Resolved – The Committee

- noted the contents of the report
- actions being taken

Performance Report

FP.262 Mr Hastings highlighted the key points of the Executive Summary relating to Month 11 performance. The following was considered;

- RTT – the 92% target had been missed. A contract performance notice to be issued and will be picked up through the Clinical Quality Review and Contract Review meetings. It was noted that this is a small co-hort of patients.

Mr Gallagher queried which year this related to as the new guidance related to PTL performance rather than achieved 92% target. Mr Middlemiss confirmed that it is retrospective and it was agreed that the new guidance for 2018/19 needs to be reviewed for changes.

- A&E – the target had been missed although an increase in performance had been seen in February. Performance is highest across the Black Country and above average for the wider local area. The current focus is on working with Vocare to ensure pathways are being used correctly.
- Cancer 62 day waits – failed to achieved both the national and revised STF trajectory. Weekly calls continue and the CCG leads for this are Mr Hastings as the Chief Operating Officer and the clinical lead is Sally Roberts, Chief Nurse. Plans are being reviewed and a meeting is to be held with the Trust to agree a realistic recovery trajectory.
- DTOC – targets are being met however performance has deteriorated. This is to be discussed in a planned Better Care Fund meeting.
- E-referrals ASI rates – the deadline for the end of paper referrals and ensuring there is capacity in clinics for GPs to

book on is October 2018. The CCG is part of a working group to achieve this.

- Electronic discharges – Assessment areas had identified a series of issues impacting on compliance including regular attender and clerking of patients onto the computerised systems. Operational/winter pressures resulted in reduced number of completed discharges and training gaps. Actions have been identified to address these issues. Performance on wards continues to be high.
- Ambulance Handover times – missing target due to high volumes

Resolved: The Committee;

- noted the contents of the report.
- new guidance for RTT to be reviewed by MH/VM

7. Finance Report

FP. 263 Mr Gallagher and Mrs Sawrey introduced the report relating to Month 11, February 2018

The following key points were highlighted and discussed;

- All targets had been delivered which was consistent with recent reports to the Committee
- Final accounts for 2017/18 were submitted on 24th April 2018
- A concern was raised regarding the variance in Mental Health and Learning Disability budgets. It was clarified that this is mainly due to the costs of out of area placements particularly where provision is not available in Wolverhampton. Joint work is ongoing to address this issue.

Mrs Sawrey shared an analysis of HRG coding as requested at the last meeting. This was discussed and it was agreed that consideration was to be given to the need to audit coding and how to do this. An update to be given at the July Committee meeting.

Resolved: The Committee

- noted the contents of the report including the submission of the final accounts
- agreed that an update on HRG coding be given at the July meeting

Mr Marshall left the meeting

9. Risk Report

FP.264 Mr McKenzie presented the latest risks relevant to Corporate organisational and Committee level risks relevant to this meeting.

Changes to Corporate Risks

These had been discussed by the Governing Body and no changes were noted.

Committee level risks;

There were no new risks to be considered. The existing risks were noted and discussed as follows;

- FP13 – 62 Day Cancer Waits – it was agreed that this risk relates to quality rather than performance and assurance was given that this is being managed through the Quality and Safety Committee. It was agreed that this risk should be closed for this Committee.
- FP09 – Fraud – Pay and Expenses – to close this risk and for it to be picked up through the Fraud Risk Group.

It was discussed that there is a need to have an overview of team risks to be able to highlight financial risks in the control environment. Mr McKenzie clarified that work is ongoing with the team to review risks and embed the new process. A plan of how to manage a rolling risk register is to be developed by the end of Quarter 1.

Resolved: The Committee;

- Noted that there were no changes to the Corporate Committee Risk Registers
- The following actions to be undertaken to the Committee Level Risk Register;
 - FP13 – 62 Day Cancer Waits – to be closed as picked up through Quality and Safety Committee
 - FP09 – Fraud – Pay and Expenses – to be closed as picked up through Fraud Risk Group

10. Draft Annual Report

FP. 265 Mr McKenzie reminded the Committee that an Annual Report is produced to provide details of how the Committee has discharged its duties in the year. It was noted that there have not been any concerns raised and all the aims set out in the terms of reference have been met.

It was asked that any comments were directed to Peter McKenzie, Corporate Operations Manager, who is compiling the report to feed into the Governance Statement

The Committee;

- Agreed to feedback any comments to Peter McKenzie.
- Noted that the Committee has discharged its duties as set out in its terms of reference.

11. Any other Business

FP.266 There were no items to discuss under any other business.

11. Date and time of next meeting

FP.267 Tuesday 29th May 2018 at 3.30pm

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**WOLVERHAMPTON CLINICAL COMMISSIONING
GROUP COMMISSIONING COMMITTEE**

Minutes of the Commissioning Committee Meeting held on Thursday 26th April 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	Yes
Sally Roberts	Chief Nurse & Director of Quality	Yes
Sarah Smith	Head of Commissioning - WCC	Yes

In Attendance ~

Liz Hull	Administrative Officer	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Jeff Love	Development Manager	Yes (Part)
Maxine Danks	Head of Individual Care Team	Yes (Part)

Apologies for absence

Apologies were submitted on behalf of Peter McKenzie.

Declarations of Interest

CCM683 None.

RESOLVED: That the above is noted.

Minutes

CCM684 The minutes of the last Committee meeting, which took place on 29th Marchy 2018 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM685 Urgent Care Centre – Sally Roberts gave an update and advised the Committee that improvements are being seen in performance, triage, capacity and leadership. Assurance was given that the contract is being monitored very closely.

RESOLVED: That the above is noted.

Committee Action Points

CCM686 None to review.

RESOLVED: That the above is noted.

Review of Risks

CCM687 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 close the risk.

RESOLUTION: That the above is noted and the Risk Register is updated to reflect CC08 being closed.

Community Falls Service Redesign

CCM688 The Committee was provided with an assurance report and an update regarding the redesign of the Community Falls Prevention Service. No issues were identified.

RESOLVED: That the above is noted.

Night Repositioning Service Pilot

CCM689 The Committee was presented with a business case for the commissioning of a 6 month pilot of a service to provide night-time interventions for patients living at home affected by pressure injuries.

The Committee approved the business case and requested that the pilot should be for a period of 12 months to allow a more robust evaluation process.

RESOLVED: That the above is noted.

Contracting Update

CCM690 Contract Performance (activity and finance)

Month 10 finance and activity data was presented at the March 18 Contract Review Meeting (CRM).

The main issues with RWT activity discussed at the CRM were as follows:

Over-performance – the contract is over performing by £2.1m at Month 10; this is a significant movement from Month 9 which was £674k over for all commissioners.

The Wolverhampton CCG element of the Month 10 over-performance equates to £1.17m.

Contract Performance (key performance indicators/quality)

Referral to Treatment – For February 18 this was reported at 90.38% which is below the agreed trajectory (91.81%). The Trust has failed to meet the operational standard relating to the percentage of service users on an incomplete RTT pathway waiting no more than 18 weeks from referral since April 2016. Discussions are being undertaken with clinical staff to increase capacity and reduce backlog to support the achievement of the recovery trajectory

Cancer 62 Days - Cancer 62 days has not achieved throughout the financial year and is presently being reported at 64.12% in February 18 which is the lowest it has been in all the financial year. Further details regarding this are referenced in the Performance report.

Ambulance Handovers – The Trust reported an unprecedented increase in delayed Ambulance handovers during January 18 (199 reported 15 minutes delays in January 18; the highest of the contract year). The February 18 position remains in contractual breach, but is an improvement from the previous month i.e. 102 reported 15 minute delays.

Performance Sanctions

Sanctions have been agreed for Month 10 (January 18) at £113,800, this was predominately due to Ambulance Handovers (as above).

Black Country Partnership Foundation Trust (BCPFT)

Service Development Improvement Plan (SDIP)

The STP is working on reviewing specifications and some (particularly CAMHS specs) are in the final review stage. There is a timetable for review as part of this work and it was agreed to align local SDIP meetings with the STP timetable.

Sandwell and West Birmingham (SWB) CCG have shared a plan for reviewing the mental health specs in line with the STP but more locally for both CCGs. This has been shared with all commissioners from both CCGs to update on their current status with specific specifications. Once this has been reviewed a further meeting will be required to discuss the further development of those specs that remain out of date.

Data Quality Improvement Plan (DQIP)

Work with the DQIP is progressing well and the CCG have been informed (verbally) that the Trust have achieved 16.8% of their IAPT access rate target (against a target of 16.5%) This is a massive achievement as the Trust has attended a number of community events over the past few weeks to approach as many people as possible. This has required extra hours to be put in from staff during evenings and weekends and the service has worked hard to achieve this at the last minute. Formal figures will be available on the 15th working day of this month (23rd April 2018).

The Trust has agreed to implement advice and guidance for GPs and clinicians and has opened dialogue with primary care regarding this and e-referrals. SWBCCG have advised that they have additional investment that they would like to give to BCPFT to fund DOCMAN for all CCGs across the STP. The Trust has welcomed this and will work with SWBCCG to implement this by October 2018. WCCG has also welcomed this as the system can be used for e-referrals, e-discharge and sharing documents, for example clinical letters.

Contract Performance Notice - Infection Prevention Training

There is a joint Remedial Action Plan for Infection Prevention training. The indicator has failed for Q3. Performance for January was 87% against a target of 85% and 90% in February. We have received verbal assurance that March is also above target, therefore the Trust should achieve Q4 target.

Finance - Over performance (inpatients)

There is an over performance issue on Adults/ Older Adults inpatient beds. A number of meetings have been held to reach an agreement that is cost effective for both organisations but the issue is still outstanding. The Trust put forward a proposal that included a tolerance, cap and marginal rate. The CCG has agreed to apply a 2% tolerance and 5% cap with any under/ over-performance to be processed at a marginal rate of 60% to the Acute inpatient and Older adult inpatients. The maximum exposure for both organisations under this arrangement would be £143k.

The CCG has sent a counter offer to BCPFT to include beds at the MacArther Unit and agreed to apply the above principles to the MacArthur Ward with the caveat that we remove one bed from the plan. This is on the basis that we have not fully utilised the beds on this ward and therefore wish to commission based on current activity. BCPFT are yet to respond to this and a further meeting has been scheduled.

Nuffield

2018/19 Contract changes

Focus continues to be on agreeing the 2018/19 contract. The draft contract has been shared with the Provider and the CCG is currently awaiting comment/agreement. The main basis of the CCG's offer is a rebased activity plan which reflects 17/18 outturn (increased plan value is £3.277m). This year's contract massively over-performed and a more accurate plan will therefore enable more robust activity monitoring.

Urgent Care/ Ambulance/ Patient Transport

Urgent Care Centre

The Provider has been given a revised two month timeframe which ceases in April 18 by which certain improvements are expected. As part of the two month improvement plan weekly updates are provided by Vocare. This covers areas such as:

- Relocation of Home visit despatchers
- Home visit breach audit
- Review of Demand Capacity

A meeting has taken place between RWT, Vocare and CCG representatives to discuss how more patients can be triaged from ED to the UCC. Subsequent to this a further process mapping meeting has been arranged with all stakeholder to commence a pathway review.

WMAS Emergency & Urgent Ambulance Service

At the Commissioners Meeting held on 1st March 2018, it was noted that performance has been maintained despite the contract being 11% over plan. Performance for category 2 is exceptional and categories 3 and 4 are also being achieved well within the required response standards.

It was further noted that the Ambulance Improvement Group are conducting a national Spring review into ARP and this will be fed back into the Commissioners Meeting in order to gauge a national viewpoint as well as a local one.

For Wolverhampton CCG, month 11 YTD over performance is £325,000.

WMAS – Non-Emergency Patient Transport Service (NEPTS)

In December 2017 West Midlands Ambulance Service raised concern regarding the contract and performance management process with Wolverhampton and Dudley CCGs for the Non-Emergency Patient Transport Service. In response to this, the CCGs welcomed a proposal by WMAS, received in February 2018, suggesting a number of changes; financial payment process (no funding change), data processing, quality reporting, contract review meeting terms of reference, exception reporting and key performance indicators. Both Dudley and Wolverhampton CCG teams considered the proposals in detail and were in the main supportive.

Further correspondence and discussion has since taken place including a letter from the CCG to WMAS acknowledging their latest letter and outlining agreed items to be provided, closure of the Information Breach Notice, and the CCG's intention to draft a Contract Variation Agreement to reflect the changes that have been agreed.

Other Contracts

Staffordshire and Stoke on Trent Partnership Trust (SSoTP)

There is still significant over performance with the SSoTP contract in particular within the district nursing service. This has been raised with the provider at their CQRM in March and the CCG are awaiting a response from the host CCG as the provider requested time to investigate.

Accord Housing Association – Victoria Court

Contractual and financial terms have been agreed between the CCG and Accord for a new contract arrangement for Victoria Court. This agreement centres on 8 inpatient beds for specialist rehabilitation and 3 beds for step down (following admission in Penn Hospital). The Local Authority has agreed to pay an increased top up amount for the 8 beds, based on actual usage, whilst the step down beds are fully funded by the CCG. A contract has been drafted and we are on track to have this finalised by the end of March.

In parallel with this, Accord has put forward a proposal to the CCG for void losses incurred during the 2017/18 year; the claim is for circa £95k. The CCG has agreed to pay £75,000 of these void losses as Victoria Court confirmed that in order to provide a 24 hour service they must remain fully staffed regardless of the number of patients that they have in the unit. Their current staff mix includes a manager and deputy and 4 nurses, 3 of which are backfilled by agency staff. There is only 1 current vacancy for support staff.

Accord also requested for the CCG to cover all redundancy costs should they not be awarded the contract beyond March 2019. The CCG has agreed to cover only statutory redundancy costs under this scenario, however if Accord advise that they will no longer offer the service and wish to terminate the contract the CCG will not be liable for any redundancy costs. Accord is yet to respond to this proposal.

Cygnet Health Care

It has recently come to light that BCC CCG does not have any agreement in place for us to be associates to their contract and we have not been included on any of their contracts in previous years.

The approximate spend with Cygnet is £2 million and arrangements from 1st April 2018 will need to be discussed and considered as we do not have any contractual agreements in place currently. A meeting has been arranged with the provider to discuss and agree next steps. This is anticipated to take place before the end of April.

RESOLVED: That the above is noted.

Any Other Business

Annual Report – Commissioning Committee 2017/18

CCM691 A copy of the annual report was circulated with a request to send any comments to Peter McKenzie by 10th May 2018.

RESOLVED: That the above is noted.

Date, Time and Venue of Next Meeting

CCM692 Thursday 31st May 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 31st May 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	No

Patient Representatives ~

Malcolm Reynolds	Patient Representative	Yes
Cyril Randles	Patient Representative	Yes

Management ~

Steven Marshall	Director of Strategy & Transformation	Yes
Tony Gallagher	Chief Finance Officer	Yes
Sally Roberts	Chief Nurse & Director of Quality	Yes
Sarah Smith	Head of Commissioning - WCC	No

In Attendance ~

Helen Pidoux	Administrative Team Manager	Yes
Vic Middlemiss	Head of Contracting & Procurement	Yes
Karen Evans	Solutions and Development Manager	Yes (Part)
Mags Court	Children's Commissioning Manager	Yes (Part)
Clare Barratt	Solutions and Development Manager	Yes (Part)

Apologies for absence

Apologies were submitted on behalf of Dr Gulati, Peter McKenzie and Phil Strickland

Declarations of Interest

CCM693 None.

RESOLVED: That the above is noted.

Minutes

CCM6894 The minutes of the last Committee meeting, which took place on 26th April 2018 were agreed as a true and accurate record.

RESOLVED: That the above is noted.

Matters Arising

CCM695 None to review

RESOLVED: That the above is noted.

Committee Action Points

CCM696 None to review.

RESOLVED: That the above is noted.

Sickle Cell & Thalassaemia Support Project

CCM697 The Committee was presented with the final specification for the revised service and the Key Performance Indicators (KPIs) and Information Requirements further developed following recommendations made by the Committee in January.

It was highlighted that the proposed provider had agreed to provide the services as specified and agreed the KPIs and information required as part of the contract. Clarification was given that there are several pathways into the service and that the KPIs and information collected will help to gather information relating to the number of patients accessing the service.

Confirmation was given that there is not a fundamental change to how the service is delivered, however, there would be more robust monitoring and performance measures. Performance would be reviewed in 12 months' time.

It was queried if there were a manageable amount of indicators for the value of the contract. It was felt that it was appropriate to the volume of the contract.

RESOLUTION: The Committee agreed to extend the current contract based on the revised specification from 1st July 2018 to 31st March 2020

Anti-Coag Specification

CCM698 The Committee was informed that the specification was developed in partnership with the Group Manager and Clinical Manager at RWT, the current provider. A service specification had never been agreed and, therefore, was not in the current

contract. The specification will form a baseline to inform discussions and redesign Anti Coag services.

A query was raised regarding the primary care option to delivery this service as part of Enhanced Services. Clarification was given that 15 practices provided this services and it was requested that a line was included in the specification to reflect this service option. It was noted that this service formed part of the ongoing AF/Stroke work.

Dr Kainth queried red flag patients and the difficulties in getting the results reliably back to the GP. It was agreed that a clear pathway to the appropriate clinician needs to be included.

- RESOLVED: That Committee noted the development of the service. Agreed to the specification being CV'd into the current contract with RWT with the following caveats;
- line to reflect the primary care service option to be added and
 - an identified clear pathway to the appropriate clinician.

Karen Evans left the meeting

Contracting Update Report

CCM699 Royal Wolverhampton NHS Trust

2018/19 Contract Negotiations

A revised contracting arrangement (which is being termed as an Aligned Incentives Contract) had been negotiated and agreed between the South Staffordshire CCGs and RWT. This is a risk/gain agreement and presented some element of risk to the CCG has host commissioner. Tony Gallagher clarified that this approach had been suggested by Wolverhampton CCG and the same framework, Bolton Model, had been adopted. This means that all CCGs are operating within this framework, however, the same agreement does not have to be reached. Discussions are currently on going.

Mags Courts joined the meeting

It was noted that this is a new type of agreement and will need to be kept under reviews including monitoring.

Black Country Partnership Foundation Trust (BCPFT)

Service Development Improvement Plan (SDIP)

The Joint Efficiency Review Group (ERG) for Adult Mental Health Services had been re-established and will the current SDIP with a view to updating milestones and work streams as part of the new mental health strategy and STP plan for the Five Year Forward View. The current milestones in the SDIP had not been met and therefore a full review is required for this to be refreshed.

Finance Activity

Following the agreement of a new contracting approach the adult/older adult inpatients, a revised set of contract principles had been agreed with the Trust and a revised Price Activity Matrix. It had also been agreed to closely monitor the use of leave beds via the Price Activity Matrix and raise any concerns at the Contract Review Meeting (CRM). This will include commissioners being notified if leave beds are used.

Urgent Care Centre

There had been demonstrable improvement in KPI performance in the last quarter with measures being achieved. There are currently no live contract notices. It was confirmed that activity levels are available and these are not as high as they should be and are relatively static. It is anticipated that levels will increase following work around joint triage with RWT and signposting appropriate cases to the UCC. An increase in activity would be closely monitored to ensure it is managed.

It was reported that there is work ongoing to map pathways into the UCC. It was felt that the provider, Vocare, was on an improvement journey, that it was early days and that sustainability was important.

Thrive into Work – Independent Placement Support

The Committee was reminded that the CCG is hosting this programme of work on behalf of the West Midlands Combined Authority, NHS England and the Work and Health Unit, to trial a new model of integrated health and employment support.

Delays had occurred due to initial issues during mobilisation relating to staff DBS/safeguarding checks for the providers, marketing etc. which delayed the start date of the trial and this was pushed back to April 2018. The Programme has gone 'live' with revised timeframes and guidance on this is awaited.

The CCG will be writing to all providers detailing the event of the force majeure, its likely impact, the mitigating action being taken and an estimated timescale for services to be delivered

RESOLVED: That the above is noted.

Service Specification for Acorns

CCM700 The Committee was presented with the revised service specification for Short breaks/respite care and the new service specification for Hospice at Home for Children and Young People (CYP).

It was explained that Acorns had been providing this provision for CYP with palliative care needs for some time; however, there was no service specification in place. This specification, revised and developed in conjunction with clinical staff at Acorns, provides the CCG with assurance regarding the service that is being provided.

Access to Acorns had been altered to ensure appropriate CYP are being seen at the correct place and by the right time. Work had been undertaken with Social Care to ensure awareness of the change in provision to ensure it meets the needs of those children who should be accessing it. Social Care had commissioned a new service, opened in May 18, where CYP who do not meet the criteria for access to Acorns will be able to receive a service.

An equality impact assessment outcome was considered. The CCG will monitor those CYP and family and carers who are referred and accepted but who do not take up the services, to ensure they are not denied access to the services as a result of their own disabilities or, if they are part of other disadvantaged groups.

A data privacy impact assessment had been undertaken which had suggested that there are some issues Acorns need to address. Changes are to be requested to the referral system to encourage the use of encrypted emails or via NHS.net emails.

It was noted that the service specifications were embedded in the report and not available to in the meeting papers.

RESOLVED: The above was noted and the service specification approved 'in principle' with the caveat that the service specifications were circulated and any comments feedback to Mags Courts directly.

Special Educational Needs and/or Disabilities (SEND)

CCM701 The Committee was given an update on the progress in respect of implementing the CCG's key duties and responsibilities arising from the Children and Families Act 2014 SEND Code of Practice. To provide information and assurance about the unannounced local OFSTED/CQC SEND inspection and the SEND Tribunal National Trial – Single Route of Redress. (The inspection can take place at any time over the next four years).

A SEND Action Plan supports this area of work based on the self-assessment diagnostic checklist and 6 key domains against which the CCG will be measured as part of the inspection process by CQC and Ofsted relating to leadership and governance, joint arrangements, commissioning, EHC plans, engagement, monitoring and redress. The CCG has this Action Plan to ensure associated actions are considered.

Clare Barratt joined the meeting

This brings together educational and health needs and the CCG has been working in partnership with the local authority on all joint areas of the SEND reforms and to support the delivery of Educational, Health and Care plans being issued within statutory timescales.

It was reported that the CCG is aiming to meet compliance with the SEND Reforms, prepare for the inspection and the new SEND Tribunal National Trial – Single route of Redress by actively engaging in a number of areas of joint work, membership of the SEND Partnership Board and associated work streams as well

as various decision panels. The CCG also routinely contributes to the SEND Self-Evaluation Framework and Joint Assurance Tools. It was noted that there is a tribunal process and a designated Medical Officer to sign off plans.

RESOLVED: The above was noted for assurance

Mags Courts left the meeting

Smoking Cessation in Pregnancy Investment Report

CCM702 The Committee was asked to consider investing in services that support the Infant Mortality agenda and Action Plan re smoking cessation. An investment is proposed in a system wide approach to tackling smoking in pregnancy; the support is to provide additional assistance to women who smoke during pregnancy, for the period April 2018 to March 2020.

Evidence shows that the percentage of women in Wolverhampton smoking at the time of delivery remains consistently high. The pilot project seeks to increase the identification of pregnant women who smoke during pregnancy and implement evidence based programmes to support them to stop smoking. The aim is for the implementation of a dedicated maternity smoking cessation provision to improve both the quality of life for women and their babies who could both be at risk of poor health outcomes. It will improve access to preventative ill health measures, self-help; evidence based support/programmes and improve access to support within local communities to deliver care closer to home.

It was considered whether this would be cost effective and whether it had the support of the midwives. Clarification was given that there was support by the Trust to train midwifery champions and to take the opportunity to use the relationship between the midwife and pregnant woman and was seen as a positive. It was felt that it would give value for money as it would be the wider workforce supporting the initiative and that Public Health had ended its Smoking Cessation Services. Acknowledgment was made that comprehensive evaluation is required and that early evaluation should be brought back to this Committee.

RESOLVED: That the above was noted and the Committee approved the recommendations contained in the report.

Review of Risks

CCM703 Corporate Organisational Risks

CR14 – Developing Local Accountable Care Models – should remain red as ongoing work to test and challenge

Committee Level Risks

CC04 – Community Equipment Procurement – on private agenda

CC10 – Community Neighbourhood Teams – action to be closed

RESOLUTION: That the above is noted

Any Other Business

Black Country STP Individual Placement and Support (IPS) Services

CCM704 The Committee was informed that the doubling of access to IPS for 2020/21, helping those with serious mental illness (SMI) to find and retain employment, is one of the objectives set out in the Five Year Forward View for Mental Health and associated Implementation Plan.

Bid funding had been agreed by NHS England for an STP based service. There are no financial consequences for the CCG in years 1 and 2 and the service consideration had been flagged to finance for the Long Term Financial Model for 2020/21 and beyond. The money was confirmed in June's baseline.

The current provision in Wolverhampton and what the service is designed to deliver was considered. The impact on the workload of the CCG was felt not to be onerous as the reporting is quarterly and the information systems are in place as for THRIVE into Work.

The launch is planned for August 2018 and needs to be approved by both the Commissioning Committee and Governing Body prior to commencement.

The Service provider is Dudley, who will in part sub-contract to BCPFT. DWMHPT already provide a service in Dudley and Walsall. Funding will enable to the provider to increase the capacity and resources within the established IPS teams in all areas of the Black Country to ensure that there is a wide reach with equitable and standardised service across the Black Country.

The provider will carry out Quality, Equality Impact and Privacy Impact assessments which, given that the bid preparation and submission were undertaken by the Trust, the CCG is advised that the assurance therefor will ensure we are compliant. This had been discussed with CSU colleagues, however, . These impact assessments will however need to come back to the CCG for assurance..

RESOLVED: That the above is noted and the Committee agreed the Service Specification.

Any Other Business

CCM705 Advertisement in local press re bank holiday opening times in primary care – comments to be shared with the Communication Team

Date, Time and Venue of Next Meeting

CCM706 Thursday 28th June 2018 at 1pm in the CCG Main Meeting Room

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Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 10th May 2018

Members:

Dr Anand Rischie – Chairman, Walsall CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Andy Williams – Accountable Officer, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Dr David Hegarty – Chairman, Dudley CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC
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
Peter Price – Lay Member, Wolverhampton CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Mike Abel – Lay Member, Walsall CCG

In Attendance:

Charlotte Harris – Note Taker, NHS England
Helen Cook – Communications and Engagement, Wolverhampton CCG
John Deffenbaugh – Director of Frontline (coach to Chair)

Apologies:

Prof. Nick Harding – Chair, Sandwell & West Birmingham CCG
Dr Ruth Tapparo – GP/Board Member, Dudley CCG
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. INTRODUCTION

- 1.1 Welcome and introductions as above.
- 1.2 Apologies noted as above.
- 1.3 Dr Anand Rischie 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 28th March were agreed as an accurate record of the meeting.
- 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 Action 072, Jim Oatridge confirmed that this is still in progress.
- 1.7 Actions 076/88, Angela Poulton stated that data was included in the papers but not sourced from NCDR. Simon Collings was unable to attend the meeting.

- 1.8 Action 084, Paul Maubach confirmed that it had been agreed that capacity was needed to progress GPFV workforce plan, and that a revised proposal requiring £26,000 investment per CCG was being considered. This item to be discussed further under agenda item 3.1.
- 1.9 Action 091, for discussion at the next Clinical Leadership Group Meeting scheduled for the 24th May.
- 1.10 Action 093, all CCGs shared their place-based journeys and aspirations at the JCC Executive Visioning Session on 1st May so this standing agenda item will commence from June.
- 1.11 It was agreed to merge actions 095, 096 and 097 into one action as it involves the work around Clinical Strategy.

2. CORE BUSINESS

2.1 The Place Based Commissioning update was deferred to the June JCC meeting.

2.2 Clinical Leadership Group Update

2.2.1 Dr Anand Rischie referred members to the paper *Addressing Clinical Priorities across the Black Country System*, setting out the approach to developing the Black Country Clinical Strategy that was approved by CLG when it met on 26th April 2018. The CLG also received a comprehensive presentation on Frailty that highlighted good practice across the system and generated discussion about the opportunities to transfer learning to improve care and reduce variation across organisations. It was agreed to establish a Frailty Working Group for this purpose, supported by the Right Care team. There are other working groups for Hypertension and Respiratory already established. The need for finance representatives to be involved in the working groups at the right time was agreed.

Action: Angela Poulton to connect the CLG working group leads with Matt Hartland/James Green.

2.2.2 Paula Furnival discussed the gaps to be addressed, including the three main interfaces Learning Disabilities, Mental Health and Frailty, and identified the opportunity to bring local authorities into discussions about commissioning intentions and delivery this is currently only the case for the Transforming Care Programme.

Action: Local Authority representatives to be invited to the Clinical Leadership Group meetings.

2.2.3 Paul Maubach asked how the acute sustainability review work will feed into the development of the clinical strategy and how the collaborative Mental Health commissioning will be reflected. Provider processes to review the sustainability of their services may identify a few areas which need more dialogue across the system. There is a need for a review of what the Trusts are doing and the timetables they are working towards. For Mental Health, there is a workshop for the two Trusts on 16th May 2018 and it was questioned how this would work into the priorities and Clinical Strategy. Angela Poulton noted that the work will confirm what is already in the system and identify gaps. Dr Helen Hibbs stated that Richard Beeken is leading the Acute Sustainability Review across the four trusts which must be completed by 31st August 2018. The clinical strategy needs to be agreed by 30th September 2018. The clinical strategy and sustainability review are equally important and will work together.

Action: Angela Poulton to ensure the findings of the acute sustainability review are fed into the final clinical strategy.

2.2.4 Dr Anand Rischie noted the attendance at the CLG is good but acute Trust representation remains low. Dr David Hegarty suggested this was the link through to sustainability reviews, and raised the importance of gaining better clarity regarding NHSE expectations of the Clinical Strategy. It was suggested that this might be discussed at the next CLG. There needs to be networking across all clinical strategy development across the West Midlands to ensure they are all aligned regarding their approach and structure, and involving NHS England on route. There is recognition for a need to include a children and young person strategy with Mental Health and interaction with Social Care and the Third Sector.

Action: Dr David Hegarty to review whether there is a forum where the Chairs of the Clinical Leadership Groups meet.

2.2.6 Matthew Hartland noted that the list was long and suggested this needed to be a smaller to ensure focus and delivery. Regarding the working groups There is a need to understand the Terms of Reference for the groups and making sure they are aligned to other items of work. The Estate Strategy and Capitals Bid are both being worked on and these need to be aligned with the Clinical Strategy.

2.2.7 It was confirmed the wider determinants of health, such as housing, will be on the place based agenda. Dr David Hegarty confirmed there was a paper on the wider determinants of health which reviewed the health and financial opportunities. This has already been to some health and well-being boards. There was a real recognition at the CLG that this was important.

Actions:

- **Prof. Nick Harding as Chair of the Clinical Leadership Group to write to all Trusts requesting representation at meetings.**
- **Dr Anand Rischie to discuss with Prof Nick Harding how to engage Local Authority colleagues in the work of the Clinical Leadership Group, including the working groups, before the next JCC meeting.**

2.3 Collective Responsibilities

2.3.1 Dr Anand Rischie discussed the importance of the Committee needing to identify services and activities for which the 4 CCGs have collective responsibility. The work being undertaken via the CLG will help to inform this. Dr Helen Hibbs referred members to the work that is just starting to provide NHSE with the Black Country roadmap to strategic commissioning which is required by 21st May. An Executive lead from each CCG will be identified to work on developing the roadmap.

2.3.2 It was noted that Prof. Nick Harding had mentioned at the CLG and JCC that by having representation of the four systems they will need to sign up to have collective responsibility. Each system will work on place based care and with their local authority. There needs to be collective responsibility on the system and system plus levels. There are similarities in how the systems are working but they are commissioning differently, and opportunities to commission together need to be identified. It was suggested there needs to be a statement of commitment to have collective responsibility. Mike Abel noted that it is an important aspect but can be difficult to put into practice. There are examples of collective working not being done or not working well. There is a need to come together to accept collective responsibility and working.

2.3.3 Andy Williams referred members to the need for relationships between NHSE and the STP leadership to establish, the place-based work that is progressing and suggested the need for the nature of strategic commissioning to be more clearly defined. There are some cases

where provider and commissioner intentions are slightly out of phase. There needs to be a review of what the nature of strategic commissioning is and there is uncertainty on how to embrace it. If strategic commissioning is about working the traditional way but at a larger footprint this may not work, and there may be the need to start commissioning in a different way. The outcomes and resource for each programme need to be defined. Dr Helen Hibbs agreed this will not make things better the health economy or change the health for patients if a change is not made. The ICS Development has Strategic Commissioning as an important element. This should be agreed in a multitude of forums until it is sorted. The suggestion was made to ask whether the roadmap to strategic commissioning should be a CLG agenda item.

Actions:

**Angela Poulton to speak to Prof. Nick Harding regarding adding Strategic Commissioning as a CLG agenda item.
The AO's to discuss and agree a clearer definition of strategic commissioning**

2.4 Programme Performance

- 2.4.1 Angela Poulton presented the STP reports on performance of the priority areas produced by the NHSE STP programme office. There are areas where all STPs within the West Midlands that are not performing, namely A&E. The Black Country is doing better for many of the performance standards than other STPs. It was confirmed the Accountable Officers regularly see this information. It was agreed it was a pragmatic way of having performance information at the JCC at this time. Dr Helen Hibbs noted that the Performance Leads across the STP were currently meeting and discussing ways to get information to the JCC and across the patch. They are aware of the information but there needs to be a discussion on what is being done to address it. An automated way of getting the information would be beneficial. The performance of Cancer is an issue for Royal Wolverhampton Trust. They recently met with NHS England and NHS Improvement and are working to be on a recovery trajectory by 2019.
- 2.4.2 Andy Williams noted that the STP is being judged in two ways; performance, which we are doing well overall, and how the system works collectively. There are opportunities to work together to improve this perception and make an impact on some areas that are not performing well. It was questioned whether the performance reports can reflect on style and way the STP is working collectively.
- 2.4.3 Dr Helen Hibbs gave an update on the Transforming Care Programme. They have failed their trajectory as previously reported. There has been a revision of the governance structure as NHS England requested. Dr Helen Hibbs will chair the TCP Board and NHS England has put a temporary Programme Manager and small team in to support the Programme. The Black Country has a lot of long stay in-patients which will not be discharged in time which means they are likely to fail next year. Discussions with Ray James and upwards communications did no lead to Simon Stevens agreeing to revise the trajectories or life of the Programme. The recovery plan has been submitted, included in the papers. There has been internal scrutiny of the cases outstanding and external scrutiny reviews are being undertaken by national professionals from NHS England next week. The Clinical Pathway Group is meeting more often. There is ongoing work with Black Country Provider Foundation Trust.
- 2.4.4 Matthew Hartland gave an update on the financial implications. The budget for CCGs is £21.7 million. This is for the cost of the beds and the community model. There has been risk identified following the implementation of the revised FTA process. There will also be a risk around the new model for the NHS and the local councils. The risk that has been identified in

total is £4.4 million. This is half for the NHS and half for the councils, the NHS element currently not budgeted for. The costing for the beds model is nearly complete with the pricing being agreed. Budgets have been identified for the community model. The Black Country delivery model has not concluded. The FTA process states the funding does not follow the patient but the net increase or reduction will go down to the Black Country so there is a net position. The Finance Group are working to see the best way to proportion the risk down for each CCG.

2.4.5 Paul Maubach suggested an external group doing a risk assessment with confirmation of the potential of moving patients and the time it will take can be reflected to NHS England, and may be helpful. Dr Helen Hibbs agreed, and shared that there is potentially more that can be done, for example with forensic patients being in the community. It needs to be crystal clear that everything that can be done has been attempted.

2.4.6 Paula Furnival informed members that there has been no change in situation for local authorities; TCP nationally and regionally has been based on the funding following the patient. The National Funding Agreement has not been published yet but it is expected that this will affirm this. Ray James is seeking to have the funding follow the patients appropriately. Angela Poulton raised that she had been contacted by Rita Symons to discuss the governance arrangements around TCP. The only thing that has been delegated to the JCC is the transitional funding and the oversight, with every other aspect including the community model requiring approval by each of the four CCG Governing Bodies. Dr Helen Hibbs noted that to be fully delegated to the JCC, TCP requires sign off from governing bodies. NHS England is requesting one commissioner for this programme, and the Accountable Officers will discuss this further outside the meeting. TCP will remain a standing agenda item.

Action: The Accountable Officers to discuss governance arrangements for TCP.

2.5 Specialised Services

2.5.1 Angela Poulton informed she was unable to get the information from the National Commissioning Data Repository and that work is ongoing with Midlands and Lancashire CSU and Arden and GEM CSU to access the database. The information included in the papers has been sourced from Secondary Uses Data, and is unlikely to be accurate as it has not been subject to the level of validation Specialised Services commissioners undertake for their reporting. Paul Maubach remarked that the information will be understated and noted that the information as presented does give spend to budget details, comparison of activity/spend to other STPs or highlight any contract performance issues. It is important to make progress on the specialised commissioning element due to the flows of patients and the development of services within the Black Country. This should sit alongside the future of strategic commissioning.

2.5.2 Matthew Hartland noted that there is uncertainty on the budget, what the contract spending is and if there is overspending or under. Paul Maubach informed Toby Lewis has raised concerns over lack of progress over specialised commissioning. NHS England has replied with a request for what the Black Country would like. This will need to be a formal request back to NHS England. James Green noted in proportion terms it is showing a lot less than half.

Action: Dr Helen Hibbs to arrange a meeting with Rachel O'Connor to discuss Specialised Services.

2.6 STP and ICS Update

- 2.6.1 Thanks were given to Andy Williams for all his work leading the Black Country STP, recognised to have been a challenging task. Dr Helen Hibbs has agreed to take over as the STP Lead. There are interviews for the Independent Chair occurring next week. There has been discussion regarding an interim Portfolio Director that may not be full time. The letter from the STP Stocktake meeting noted there are key areas for focus including a plan to develop a Strategic Commissioning Structure and Roadmap by the 31st May 2018, a draft Clinical Strategy by the 28th June 2018 with full completion by 30th September 2018, completion of the Acute Sustainability Reviews finalised by the 31st August 2018, engagement with regards to Specialised Commissioning, the JCC Commissioning Intentions for 2019/20 by the 30th September 2018, non-executive collaborative engagement and NHS leaders continuing their joint working. There is a Mental Health Summit occurring next week which will help with the commissioning intentions. Julie Jasper enquired about the penal regime for non-delivery to which Dr Helen Hibbs confirmed her confidence that the requirements would be met.
- 2.6.2 Dr David Hegarty noted that there are systems being held up as examples but are also described as not functioning well. Dr Helen Hibbs informed there have been a lot of changes happening in NHS England and NHS Improvement leading to a lot of reorganisation. Dr David Hegarty noted how the STP works together is something that needs work on. Jim Oatridge noted there has been a focus on failure. There needs to be a focus on achievements. Dr Anand Rischie referred to previous conversations around sorting the acute agenda to help the image of collaboration. Dr Helen Hibbs suggested that hard commissioning works for a while but there needs to be work done on relationships too.
- 2.6.3 Dr Helen Hibbs referred to the ICS Development presentation and how strategic commissioning is important. This had been discussed at the Visioning Session on 1st May 2018. The presentation was adapted from the Coventry and Warwickshire STP. It is an overview of the current thoughts around strategic commissioning. It was suggested that the Black Country STP would need to review the areas shown regarding aligning commissioning functions and what would fall under tactical and strategic commissioning for the Black Country. There was a discussion on place based commissioning and if it was agreed that it will sit within the ICS system but this is for each local system to decide. Dr Helen Hibbs informed that Wolverhampton has not agreed whether CCG functions will sit with the acute trusts or within the local authority. There is a clear direction of travel that some tactical functions will need to sit in the place based.
- 2.7 The **Risk Register** was deferred to the June JCC meeting.

3. DECISIONS REQUIRED

3.1 Strategic Commissioning Roadmap and Proposal Project Support Arrangements for Joint Commissioning

- 3.1.1 This is an NHSE requirement, identified in the stocktake letter. The three Accountable Officers will nominate an Executive from within the 4 teams to be part of the Task and Finish Group to do the work, reviewing both strategic and tactical functions. There was a discussion about the need for more resources to support the STP and JCC. This includes the proposed Project Support Office (PSO) and extends to staff to deliver the GPFV workforce plan. Matthew Hartland advised that CCGs are all at running cost thresholds and there will need to be some internal review to identify funding for any additional posts. Paul Maubach noted this is a necessary requirement to keep on top of things as areas of work with stall. Funding for the Portfolio Director will come from the STP but this is non-recurrent. There will need to be work on future strategic commissioning and how this will be resources.

3.1.2 The combined cost to each CCG for the PSO and GPFV will be £57,000. Wolverhampton will be the host for the PMO. The Task and Finish Group will be reporting back at the end of June. Andy Williams noted there are fundamental questions that need addressing by the Accountable Officers regarding Strategic Commissioning. He questioned how far the remit of Strategic Commissioning goes and what the correct scale is. There needs to be a look at what the open conversation with partners is to look like. There needs to be wider conversations with local government and NHS partners. Dr Helen Hibbs suggested there was no blueprint on how to do this and so they are doing this in stages. They will need to hold the provider alliance to account in regards to quality. There is a new Regional structure which includes the West and East Midlands. It was agreed that this would be a way forward and it was approved.

Action: The AO's to discuss and agree a clearer definition of strategic commissioning.

3.1.3 Paula Furnival informed that local authorities would welcome being part of the discussion. The Mental Health commission involves a prevention and community model, the focus being to minimise clinical intervention requirements through building community assets and resilience to enable quick recovery.

3.1.4 It was confirmed that Mike Hastings, Stephanie Cartwright and Paul Tulley have been nominated for the Task and Finish Group. Andy Williams will appoint the representative from Sandwell and West Birmingham.

3.2 Personalised Care Demonstrator Site Bid

3.2.1 Angela Poulton reported that since the last JCC she had been involved in discussion between Joe Fraser and Personal Health Budget (PHB) leads to agree the revised targets, and it has become apparent that there are more PHBs than are currently reported. Owing to the later start date, the funding has been reduced by £50,000 to £250,000 and the spending plan revised accordingly.

3.2.2 There was a discussion about the need for a Black Country Personalised Care lead to be identified as Laura Broster is Director of Communications and will not have capacity moving forward to deliver this remit. Angela Poulton reported that despite requests to all four CCGs, a lead has not been found. Matt Hartland added that backfill was available for the Personalised Care lead. The assumption is that the work will be handed to the STP Portfolio Director should a lead not be identified who can interface with NHS England, which was not supported.

Action: The Accountable Officers to identify a Black Country commissioning lead for Personalised Care.

3.2.3 The JCC were asked whether there should be a continuation of the bid in light of the revised PHB targets and spending plan. Signatures are required from Dr Helen Hibbs (STP), Paul Maubach (CCG) and Paula Furnival (Local Authority). Paula Furnival stated that she requires the support of the other Local Authority Directors of Adult Social Care to enable her to act as signatory. Paula Furnival shared that there are existing cohorts of individuals who have combined health and social care funding that meet the requirements for PHBs, and there needs to be a conversation on who is to leads from the local authorities. Angela Poulton to follow up outside the meeting.

Action: Angela Poulton to discuss Local Authority lead sign off for the Personalised Care Demonstrator Site with Paula Furnival.

3.2.3 Paul Maubach noted there is a risk of not receiving all the funding should targets not be met but the spending profiled holding it back which reduces the risk. Angela Poulton noted that there is a better understanding of PHBs and the Committee agreed to continue with the bid submission. James Green noted there needs to be a joint approach for PHBs and it was agreed there needs to be PHB lead to oversee. It was suggested there needs to be review of the financial risk of the change in activity. Paula Furnival informed there could be shared learning gained from local authorities regarding managing risks and budgets.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 CCG Collaboration – BC Decommissioning Policy

4.1.1 Angela Poulton presented the *Decommissioning and Disinvestment Policy*. There is a later version. It is a work in progress. Mike Abel requested that when the final policy is presented to this Committee it needs to be accompanied by a document that sets out the differences between the joint policy and the existing approved CCG policies and confirmation that each CCG has agreed the content proposed. Angela Poulton confirmed the process being followed and the CCG representatives working with her on the policy development, and agreed to these requirements. The joint policy will be overarching and allow for each CCG's local processes to be applied. The ambition is to achieve sign off by end of July, ensuring due approval process.

4.1.2 There were no other sub-group reports. Angela Poulton noted that some groups were suspended, such as the Systems Design and Contractual Frameworks group that will be re-commence in July. The joint Finance work largely occurs via the STP and operational joint forums and it was agreed that updates will be provided as needed.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 ICS Development Programme – 12/07/2018

5.1.1 There was request from Helen Black for the JCC meeting in July to be used for the ICS Development Programme. Dr Helen Hibbs noted that the JCC meeting should not be used but there may be the option to allow the ICS Development Programme session to take place immediately before/after the meeting. This will be worked out at the meeting with PWC taking place tomorrow.

5.2 It was agreed that due to many members not being available for the 14th June scheduled meeting, the JCC meeting for June would be moved to the same date as the JCC Executive Away Day on 21st June.

6. DATE OF NEXT MEETING

Thursday 21st June, 09:30-11:00, Venue to be confirmed.

**Wolverhampton Clinical Commissioning Group
Audit and Governance Committee**

Minutes of the meeting held on 17 April 2018 commencing at 10.00am
In Armstrong Room, Science Park, Wolverhampton

Attendees:

Members:

Mr P Price	Chairman/Governing Body Member
Mr D Cullis	Independent Lay Member
Mr L Trigg	Lay Member/Governing Body Member

In Regular Attendance:

Mr P McKenzie	Corporate Operations Manager, WCCG
Miss M Patel	Administrative Support Officer, WCCG (minute taker)

In Attendance:

Ms A Breedan	Partner – Head of Internal Audit, PwC (Partial Meeting)
Mr T Gallagher	Chief Finance Officer, WCCG and Walsall CCG
Mr N Mohan	Senior Manager, LCFS, PwC (Partial Meeting)
Mr M Stocks	Partner, External Audit, Grant Thornton
Ms M Tongue	Head of Financial Resources, WCCG
Ms J Watson	Senior Internal Audit Manager, PwC (Partial Meeting)

Apologies for attendance:

AGC/18/26 Apologies for absence were submitted by Mr McLarnon and Mr Grayson.

Declarations of Interest

AGC/18/27 There were no declarations of interest.

Counter Fraud Annual Report

AGC/18/28 Mr Mohan presented the Counter Fraud Annual Report to the Audit and Governance Committee. Also included was the self-review tool for information. The report had been agreed with Mr Gallagher.

RESOLUTION: The Committee:

- Approved the Counter Fraud Annual Report.

Internal Audit Progress Report – Arrangements with the CSU in relation to procurement

AGC/18/29 A review was conducted around the services provided by Arden and Greater East Midlands Commissioning Support Unit (the CSU) to the CCG. Areas of improvement were identified and also areas where the CSU was adding value.

There were two medium risk and 2 low risk findings identified. Mr Price asked what the issue was around the finding around duplicated process was. Ms Watson explained that it was around the production of reports from both the CSU and the CCG during the contracts reward stage and that this process could, on occasion be streamlined. Mr McKenzie felt that, particularly when decisions were taken at the Governing Body, it was useful to have a covering report from the CCG officer leading the process added to the procurement report and supported decision making.

RESOLUTION: The Committee:

- Accepted the report.

Internal Audit Progress Report – Follow-Up

AGC/18/30 The report gave details of internal audit recommendations from the 2016/17 Internal Audit programme. As of the 31 March 2017, 25 recommendations outstanding. Of the 25 there were 7 outstanding and progress was being looked at.

The lay members asked when the Audit and Governance Committee would become involved in looking at timescales slippage and the reasoning behind it. After discussion the Committee felt that it would be a good idea for them to receive an overview report when deadlines had slipped and the reasoning behind it in order to assess if this would be deemed as a risk.

RESOLUTION: The Committee:

- Accepted the report.
- Ms Watson to produce a report with outstanding recommendations and reasons for slippage by owners.

Internal Audit – Information Governance

AGC/18/31 The Information Governance (IG) Toolkit would be replaced by the new Data Security and Protection Toolkit from the 1 April 2018. It was the CCG's responsibility to ensure that the outgoing IG Toolkit was populated by this date.

One low risk had been identified regarding Operating Effectiveness which was being looked at.

RESOLUTION: The Committee:

- Accepted the report.

Internal Audit Progress Report – Conflicts of Interest

AGC/18/32 The report had shown that there had been significant improvement in this area. One low risk had been identified which the Corporate Operations Manager was looking to close by the end of the month.

RESOLUTION: The Committee:

- Accepted the report.

Internal Audit Progress Report – Risk Management

AGC/18/33 The report showed a significant change with work around Risk Management in the CCG.

There had been a change in Executive responsibility, new Board Assurance Framework and also more challenge at both Governing Body and Meetings around Risk. Overall, the level of assurance had moved from High Risk to Low risk. Whilst one low/medium risk had been identified overall the work around risk management was more efficient.

RESOLUTION: The Committee:

- Accepted the report.

Draft Internal Audit Annual Report

AGC/18/34 The Draft Annual Report showed the work for the year. It also included the draft opinion for the year and the audit work that had been completed for the year. There were two medium and two low risk findings.

The draft opinion given was 'Generally satisfactory with some improvements required'.

RESOLUTION: The Committee:

- Accepted the report.

Internal Audit Plan 2018/2019

AGC/18/35 The Internal Audit Plan for 2018/2019 set out the programme of work that would be undertaken by the Internal Audit Team. Ms Watson advised that she had also met with the Executive Team and that it had been a positive meeting.

Guidance had not been received around Information Governance but the committee asked that General Data Protection Regulation (GDPR) was factored into this.

Mr Trigg asked why the report was heavily focused on Quarter 3. Ms Watson advised that this was when the majority of the information was available. Mr Price thought it might be more beneficial to look at this so that the timing of reports could be more spaced out through the committee dates.

RESOLUTION: The Committee:

- Update at next meeting with a view to sign off.

Minutes of the last meeting held on 20 February 2018

AGC/18/36 The minutes of the last meeting were agreed as a correct record with the below changes:

- On the attendee list that the word 'Independent' was taken out from Mr Trigg's title.
- Item AGC18/07 the bullet point around Dashboards and Deep Dives to read "Dashboards and Deep Dives to be used more effectively"
- AGC18/07 – Mrs Watson advised that the terms of reference and approach to the fieldwork on the Better Care Fund had meant that it had not been necessary to go to the City of Wolverhampton City as anticipated.

Matters arising (not on resolution log)

AGC/18/37 There were no matters arising to discuss.

Resolution Log

AGC/18/38 The resolution log was discussed as follows;

- Item 109 (AGC/18/06a) - Internal Audit Plan 2018/2019 – Report to be brought to the next meeting – On agenda. Closed.
- Item 110 (AGC/18/06b) - Internal Audit Plan 2018/2019 – Report to be circulated to members prior to the next meeting – Closed.
- Item 111 (AGC/18/07a) - Internal Audit Progress Report – IG Report to be circulated before the next meeting – Closed.
- Item 112 (AGC/18/07b) - Internal Audit Progress Report – Management comments to be added to report - Closed
- Item 113 (AGC/18/09a) - Draft Counter Fraud Plan – Ms Patel to circulate Counter Fraud Progress Report to committee members with comments to be sent back to Mr Mohan by Friday 9 March 2018 – Closed.
- Item 114 – (AGC/18/09b) - Draft Counter Fraud Plan – Mr Price to raise with Mr Gallagher around feedback to Managers when staff leave the organisation that protocol has been followed – Closed.
- Item 115 (AGC/18/13) - Governance Statement – Comments from Committee Members to be incorporated into the Governance Statement – Closed.

- Item 116 (AGC/18/14) - Draft Committee Annual Report – Outcome of the Audit and Governance Committee Effectiveness Questionnaire to be feedback to the Governing Body – Update at next meeting.
- Item 117 (AGC/18/16) - Draft Review of Effectiveness including Audit Committee Questionnaire – Effectiveness questionnaire to be circulated in advance of next meeting and feedback to be discussed at meeting – On agenda. Closed.

Ms Breadon, Ms Watson and Mr Mohan left the meeting.

External Audit Progress Report

AGC/18/39 Mr Stocks gave an update around the circulated External Audit Progress Report. The early testing on the accounts was highlighted in the reports and work was taking place around Value for Money on the STP.

The report highlighted work that had been done and the External Audit team had liaised with the Internal Audit team.

RESOLUTION: The Committee:

- Accepted the report.

Informing the Audit Risk Assessment

AGC/18/40 The Informing the Audit Risk Assessment Report was part of the risk assessment procedures required to obtain an understanding of Management processes and the Audit & Governance Committee's oversight of the following areas:

- Fraud
- Laws and Regulations
- Going Concern
- Related Parties
- Accounting Estimates

Mr Price asked if evidence was sought to back up management comments. Mr Stocks advised that it was checked through testing and other measures.

Mr Cullis asked who was responsible for the compliance around legislation. Mr McKenzie advised that a piece of work had been done around statutory duties and looking to align to the relevant Director of the Executive Team. Dr Helen Hibbs as the Chief Officer had overall responsibility for this in the sign off of the Annual Governance Statement. Mr Gallagher said that much of this was embedded in the National Standard Contracts and suggested for additional assurance that the results of the mapping exercise were brought to the Audit and Governance Committee Meeting.

RESOLUTION: The Committee:

- Noted the report.
- Results from the mapping exercise around the National Standard Contracts to be brought to the next meeting.

Risk Register Reporting/Board Assurance Framework

AGC/18/41 Mr McKenzie circulated a tabled working document which looked at the Governing Body Assurance Framework and Corporate Organisational Risks. This would then be taken to the Governing Body in May. Each risk to each objective had been assessed. New risks had also been identified. There had been no strategic risks identified and individual Committees were taking ownership of risks. Mr McKenzie felt at this point that there shouldn't be a change in the risk profile but this could change after the May Governing Body Meeting.

Mr Trigg as the Chair of the Finance and Performance Committee observed that some risks such a Finance were high risk at the beginning of the year and then low at the end of the year. He told the committee that Mr McKenzie was looking at a different way of reporting this.

Mr McKenzie said that work was still going on to ensure that ownership for risks were allocated correctly to Committees and the Governing Body and that levels or risk were looked at.

High level risks identified were around New Ways of Working across the STP and Safeguarding Compliance around RWT and a new risk around TCP.

Mr McKenzie also informed the Audit and Governance Committee about ongoing work such as staff training and the replacing of Datix with a new system.

RESOLUTION: The Committee:

- Noted the Plan.

Draft Governance Statement

AGC/18/42 Mr McKenzie presented the draft Governance Statement. This did not include the Head of Internal Audit opinion as it had not been received at the time of production. Comments had been taken on board from the last meeting and the draft statement had been reviewed by the Chief Officer.

RESOLUTION: The Committee:

- Noted the governance statement

Draft Committee Annual Report

AGC/18/43 The Draft Committee Annual Report had followed the same format as the previous year. It gave assurance to the Governing Body. The only gap was around Committee Effectiveness which would be added.

RESOLUTION: The Committee:

- Noted the report and its recommendations.

Final Review of Effectiveness

AGC/18/44 The Effectiveness Questionnaire had been circulated to the Committee members before the meeting.

Mr Trigg queried around:

- Question 3 – ‘Is there a clear balance between items for the Audit Committee versus the Governing Body?’ – the statement ‘The Chair of the Committee and the Board chair discuss the balance of items periodically. Mr Price advised that he had asked Miss Patel to arrange these meetings with Dr S Reehana the Chair of the Governing Body.
- Question 10 – ‘Do all members received an annual appraisal and have the opportunity to develop their skills as appropriate?’ – Mr Price asked for appraisals to be set up with the lay members.
- Question 15 – ‘Does the Committee feel that it undertakes a robust review of draft Annual Report and Accounts?’ – Felt that it would be useful that there was time to review the accounts in advance of the meeting but did acknowledge that there were limitations due to workloads and getting information.

Mr McKenzie asked if the Effectiveness Questionnaire could be completed and sent back to him as soon as possible.

RESOLUTION: The Committee:

- Noted the report.
- Miss Patel to arrange meetings with the Chair of the Audit and Governance Committee and the Chair of the Governing Body.
- Responses to the Effectiveness Questionnaire to be sent back to Mr McKenzie as soon as possible.
- Miss Patel to arrange appraisals.

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

AGC/18/45 Mr Price informed the Committee that feedback from the last Governing Body Meeting centred largely on quality issues around Vocare although

this was improving slowly.

The Financial position was positive for this year but there were risks on a recurring basis.

Mr Cullis asked if Vocare were issued with service penalty deductions to which Mr Gallagher advised that they were.

The meeting of the Black Country Joint Governance Forum had not taken place to report back from.

Draft Final Accounts

AGC/18/52 Mr Gallagher and Ms Tonge presented tabled draft annual accounts to committee members. The date of submission was on 24 April 2018.

The report showed a comparison between this year (2017/018) and last year (2016/2017). There were some significant differences including the CCG taking on delegated Primary Care. Ms Tongue had conducted an analytical review and the briefing note would be circulated to the Committee members.

All key performance indicators had been met.

The Committee were asked to send back any comments around the draft annual accounts as soon as possible.

RESOLUTION: The Committee:

- Noted the report

Losses and Compensation Payments – Quarter 1 - 4 2017/18

AGC/18/53 Mr Gallagher presented this report and advised the Committee that there was 2 low value losses of £332.19 during quarters 1 - 4 of 2017/2018 which had been reported to members in previous reports. There was 1 special payments during 2017/18 relating to a verbal settlement with a private mental health provider to the value of £109.500. This had been made following legal advice received by the CCG.

RESOLUTION: The Committee:

- Noted the report

Suspension, Waiver and Breaches of SO/PFPS

AGC/18/54 Mr Gallagher noted the below in quarter 4 of 2017/18:

- During quarter 4 of 2017/18 there were 15 invoices in breach of PFPs (3.56% of all invoices paid);

- 15 waivers were raised during quarter 4;
- 4 non-healthcare invoices were paid without a purchase order being raised during quarters 4.

Mr Pride asked Ms Tongue for more detail behind requisition numbers 4990 & 4991.

RESOLUTION: The Committee:

- Noted the report
- Ms Tongue to send more detail behind requisition numbers 4990 & 4991 to the Chair and other Audit and Governance Committee members.

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

- AGC/18/55 The Committee noted that as at 31 December 2017 there were:
- No sales invoice greater than 10k and over 6 months old.
 - 11 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.

RESOLUTION: The Committee:

- Noted the above.

Any Other Business

AGC/18/56 There were no items to discuss.

Date and time of next meeting

AGC/18/57 Tuesday 22 May 2018 at 11am in the CCG Main Meeting Room at Wolverhampton Science Park

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Health and Wellbeing Board

Minutes - 11 April 2018

Attendance

Members of the Health and Wellbeing Board

Councillor Roger Lawrence	Leader of the Council
Councillor Sandra Samuels OBE	Cabinet Member for Adults
Councillor Paul Sweet	Cabinet Member for Children and Young People
Brendan Clifford	Service Director - City Health
John Denley	Director of Public Health
Steven Marshall	Director of Strategy & Information, Wolverhampton CCG
Chief Supt Jayne Meir	West Midlands Police
Mark Taylor	Strategic Director - People
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Craig Alford	Third Sector Partnership
Sheila Gill	Healthwatch Wolverhampton
Dr Ranjit Khutan	University of Wolverhampton

Employees

Neeraj Malhotra	Consultant for Public Health
Helen Tambini	Democratic Services Officer
Shelley Humphries	Democratic Services Officer

Part 1 – items open to the press and public

Item No. *Title*

- 1 **Apologies for absence**
Apologies for absence were received from Councillor Val Gibson, Councillor Paul Singh, Jo-Anne Alner, David Baker, Emma Bennett, Helen Child, Dr Helen Hibbs, Dr Alexandra Hopkins, Elizabeth Learoyd, David Loughton CBE, Linda Sanders, Sarah Smith, David Watts and Lesley Writtle.

- 2 **Notification of substitute members**
Dr Ranjit Khutan attended on behalf of Dr Alexandra Hopkins, Sheila Gill attended on behalf of Elizabeth Learoyd, Steven Marshall Attended on behalf of Dr Helen Hibbs and Craig Alford attended on behalf of Helen Child.

- 3 **Declarations of interest**
There were no declarations of interest made.

4 **Minutes of the previous meeting - 10 January 2018**

Resolved:

That the minutes of the meeting held on 10 January 2018 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**

There were no matters arising from the minutes of the previous meeting.

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

The key points from the Forward Plan were identified as:

- Overview of Primary Care
- Estates Strategy Update
- West Park
- BC Fund Update

With regards to the Estates Strategy Update item, the Chair noted that it was important that significant savings be made and that close working with other bodies, such as West Midlands Police, be encouraged going forward.

Before proceeding, it was noted by Councillor Samuels OBE that the Mental Health Strategy report had been deferred. The report was driven by other services which were specialist in nature and further work was required. All CCGs would need to modify the original strategies which had caused a delay.

Resolved:

1. That the Mental Health Strategy be presented at the July meeting.
2. That it be noted that a review of work would be held on 17 April 2018.

7 **City of Wolverhampton Vision for Public Health 2030**

It was agreed to consider agenda item 8 first. John Denley, Director of Public Health, presented the City of Wolverhampton Vision for Public Health 2030. The key element of the public health vision was to identify what was unique in Wolverhampton, what made a difference in people's lives and what would make people aspire to stay and invest in the City. The aim of the document was to improve public health at a population level and the principle behind the document was that various areas made a difference in healthcare, such as education, home environment, job stability and a thriving community.

John Denley explained that the vision was to shift the focus from simply improving life expectancy to improving quality of life, as well as enabling people to improve themselves by making better choices.

Councillor Paul Sweet noted that the project had been brought forward despite recent financial challenges. The Chair added that it was necessary to influence better life choices; it had been identified that 80% of people were willing to improve things for themselves, they required the correct tools.

Sheila Gill supported the idea in that the introduction of 'self-service' simplified things, however there was a danger in people doing things for themselves as

services would no longer be available at GP level. More work needed to be carried out to educate people further.

John Denley referred to the Wolverhampton Lifestyle Survey which identified that people preferred self-service. Using the Stop Smoking Service as an example, findings showed that out of 20,000 service users 8% of people quit smoking longer term using self-service. This illustrated that people preferred to make the decision themselves but needed the resources to help them achieve their goal. Tools suggested included social media content, contact with GP or Associated Trust for service users to gain information for themselves.

Resolved:

That the City of Wolverhampton Vision for Public Health 2030 be endorsed.

- 8 **City of Wolverhampton Public Health Annual Report 2017-2018**
John Denley, Director of Public Health presented the City of Wolverhampton Public Health Annual Report 2017 – 2018. The report fulfilled the statutory obligation and the intention was to open a debate by concentrating on numbers and providing comparisons with priority areas and key themes.

Much of the document consisted of a ward-by-ward breakdown of statistics. For example, with regard to population, a 'pyramid' shaped table represented a young, mobile population whereas a table with a 'bulge' indicated a more stable population that may have other health requirements. The aim going forward was to improve on current statistics and to ensure that Wolverhampton's deliverable services were amongst the top quartile in the country.

At the recommendation of Councillor Samuels OBE, it was agreed that all figures were to be checked for errors. In response to a question, John Denley confirmed that the goal would be to reach the top quartile within 18 months.

In answer to a question on how the widening gap in health equalities would be addressed, John Denley advised that the Black Report focused mainly on one issue and one service whereas the intention going forward would be to involve other issues. A partnership with various other services, such as the NHS Trust Partnership and CCG, would provide a cradle-to-grave service.

In response to a question regarding the current performance levels, Steven Marshall from the CCG informed the Board that the Variable Distribution Update for Wolverhampton identified that some small practices had found that there was an imbalance in staff and service users with an anticipated use of 110% but an actual uptake of 90%, which may have been a contributing factor.

John Denley confirmed that the report would need to be signed off by the Board and would then be promoted with the aim of initiating a conversation about public health. A copy would be sent out to each ward and partnerships and, once available to local residents, any technical information would be explained.

Following comments, John Denley agreed that one of the aims of the report would be to help support or stabilise the Third Sector and to determine the possibility of an outreach team to support communities in isolation.

Jeremy Vanes expressed concerns about the achievability of the goals following recent years of austerity and on-going service cuts. He confirmed that the Royal

Wolverhampton NHS Trust would support the work and that the strategy would be to bridge the gap.

John Denley stated that he would aim to make more use of the Joint Strategic Needs Assessment (JSNA) and that it would be important for the Board to look at population mobility. The Health and Wellbeing Board could be used as a platform for more in-depth work on whether Wolverhampton had fared better or worse across the City.

Jayne Meir expressed concern that violence and its impact were not included. John Denley agreed that joint working with West Midlands Police going forward could help to create a safe environment.

Jayne Meir stated that the issue was not only place-based violence, but domestic crimes and drugs / alcohol misuse were also increasing issues. The Chair agreed that this be discussed at a separate occasion and that the Public Health Annual Report needed to be integrated with the Partnership Programme.

Councillor Samuels OBE stated that there had been a reduction in infant mortality and smoking in pregnancy over the last 10 years. A seven - year life expectancy age gap existed between wards and there was an opportunity for strategies to address how that could be reduced.

Resolved:

1. That the report on City of Wolverhampton Public Health Annual Report 2017 – 2018 be noted.
2. That the report on City of Wolverhampton Public Health Annual Report 2017 – 2018 be published subject to the figures and statistics being checked.

9

Health and Wellbeing Board Development Event - Issues Update

Brendan Clifford, Service Director – City Health, presented the Health & Wellbeing Board Development Event – Issues Update report.

Workforce supply had been identified as an at-risk area within the Royal Wolverhampton Trust (RWT). Jeremy Vanes stated that the RWT was running 8 – 10% short on nurses. The system in place was a bank of nurses working on internal overtime and this was becoming unsustainable. The hope would be to employ people properly and recruit, however the overseas top-up immigration quotas had impaired this. The current plan was to persist and lobby the Government to raise awareness to improve the situation; some improvements had been achieved, but the winter of 2017 had had a huge impact on retention and a solution had not yet been found.

Regarding Estates, Brendan Clifford confirmed that Julia Nock had provided an update of flows of people to services. The West Midlands Combined Authority [WMCA] were to summarise current trends and work with the Chair and Councillor Sweet.

Councillor Sweet agreed that this work should be continued as there would be additional benefits to the public. Councillor Samuels OBE expressed an interest in the retention of 'growing our own' staff by utilising reserves of local people before looking elsewhere. Jeremy Vanes agreed that it was important to take on qualified staff and that all local staff were utilised before looking elsewhere. In addition, the

length of training for medical staff and lack of bursaries available were identified as potential issues for those wanting to train.

Resolved:

That a summary of issues raised at Strategy Day be presented at the next meeting.

10

City of Wolverhampton Partnership Response to People with No Recourse to Public Funds (NRPF)

Neeraj Malhotra, Public Health Consultant, presented the City of Wolverhampton Partnership response to People with No Recourse to Public Funds (NRPF). The aim of the work was to bring four main areas together:

1. The City of Wolverhampton Council's Policy on NRPF set out both the rates that the Council would pay the roles and responsibilities of the Council. The policy would be presented to the Cabinet in April 2018 for approval.
2. The NRPF Pilot was intended to expedite the resolution of people's immigration status, reducing the number of people left in 'limbo' awaiting the outcome of their case. The funding available would be brought to the Board as part of an update at the October meeting.
3. The multi-agency NRPF Forum had a wide range of members. Previous meetings of the Forum had provided the chance to gain a perspective from a service point of view and input from the West Midlands Police to open an ongoing dialogue. There was no confirmation in terms of volume and scale of issues faced and the strategy would enable agencies to gain a further understanding of challenges.
4. The multi-agency protocol had been put in place to work with Council policy in order to avoid working in isolation but without simply duplicating the content of it. The intent was to achieve a consistent and co-ordinated way of working across the City. This had been created following a serious case review involving the death of a child from a NRPF family. In that instance, the family had been moved from a London borough and no inter-council dialogue had been addressed therefore illustrating the need to strengthen communication.

The Chair advised that the London boroughs had been contacted following this incident to request that a checklist of various items be actioned when moving people from one borough to another. This had been agreed between around 50% of councils but the importance of strong communication was still necessary. The Chair stated that the Partnership scheme was an excellent piece of work in progress and the report following the pilot would prove useful. It was agreed that the findings of the pilot be reported to the Board in October.

Resolved:

That an update on the NRPF Pilot be provided at October meeting.

11

Strengthening Governance and System Leadership

Brendan Clifford, Service Director - City Health, presented the City of Wolverhampton Health and Wellbeing Board Internal Review. The review outlined the purpose and responsibilities of the Board and the intentions for the future. Several 'Key Shifts' in the Board's operation were identified and the outlined proposal included a rebranding of the Board itself to highlight changes. The board was invited to provide comments on the review by the end of May, which would then be collated and presented to the Board at the July meeting.

Councillor Samuels OBE stated the importance of ensuring full involvement in meetings to openly discuss how to move forward. Councillor Sweet praised how inclusive the Board was and how its link to the public set it apart. He encouraged the group to provide feedback.

The Chair emphasised the need to improve outcomes and to continue to be anchored with other services in the City. A strategy needed to be approved and understood by the Board and consultations would include all groups. There was a need to confirm how the Voluntary Sector worked with the Board and it was agreed that a Peer Review would be beneficial for the Board going forward.

Resolved:

That Members of the Board provide any comments in writing by the end of May and that these be collated to be presented to the Board for the July meeting.