NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12th April 2016

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Finance and Performance Committee- 29th March 2016**
Report of:	Claire Skidmore – Chief Finance and Operating Officer
Contact:	Claire Skidmore – Chief Finance and Operating Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
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):	

• **Domain2: Performance**	The CCG must meet a number of constitutional, national and locally set performance targets.
• **Domain 3: Financial management**:	The CCG aims to generate financial stability in its position, managing budgets and expenditure to commission high quality, value for money services.
• **Domain 4: Planning**	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 Target	Target M11	Achieved M11	Variance	RAG
Programme Cost £'000*	299,139	300,044	904	G
Reserves £'000*	3,013	910	-2,103	G
Running Cost £'000*	5,487	4,984	-503	G
Maximum closing cash balance £'000	271	123	-148	G
Maximum closing cash balance %	1.25%	0.57%	-0.68%	G
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	96%	-1%	G

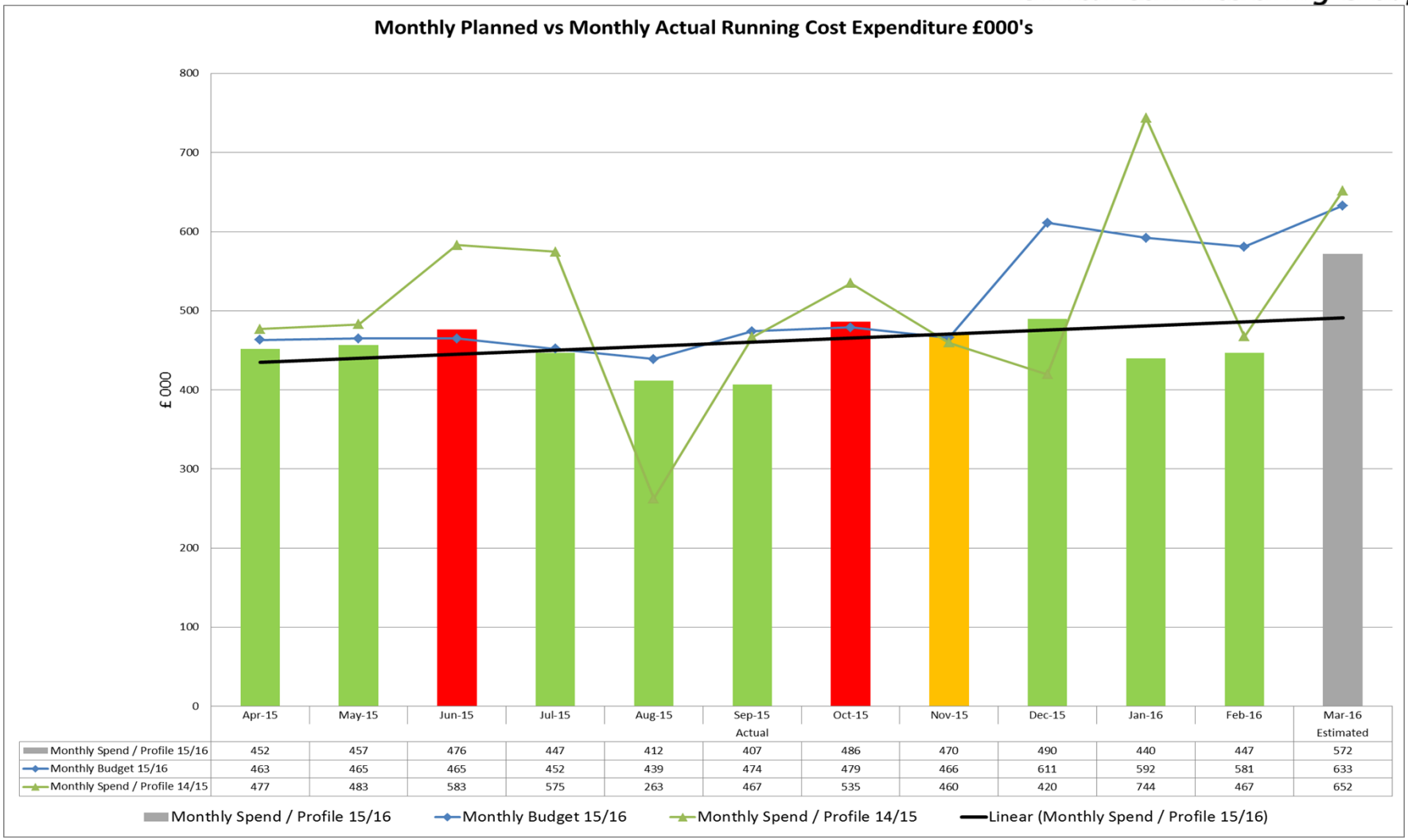
The table below highlights year to date performance as reported to and discussed by the Committee;

	Annual Plan £'000	YTD Performance M11			
		Plan £'000	Actual £'000	Variance £'000	Var %
Acute Services	175,099	160,351	162,040	1,689	1.05%
Mental Health Services	34,060	31,221	31,051	-171	-0.55%
Community Services	33,108	30,349	30,315	-34	-0.11%
Continuing Care/FNC	13,198	12,167	10,845	-1,322	-10.87%
Prescribing & Quality	49,936	45,775	44,456	-1,319	-2.88%
Other Programme	21,028	19,277	21,337	2,060	10.69%
Total Programme	**326,428**	**299,139**	**300,044**	**904**	**0.30%**
Running Costs	6,120	5,487	4,984	-503	-9.17%
Reserves	3,244	3,013	910	-2,103	-69.80%
Total Mandate	**335,792**	**307,640**	**305,937**	**-1,702**	-0.55%
Target Surplus(deficit)	5,905	7,535	-	-7,535	-100.00%
Total	**341,697**	**315,175**	**305,937**	**-9,237**	-2.93%

The table below details the forecast out turn by service line

	Annual Plan £'000	Forecast Outurn at M11		
		Actual £'000	Variance £'000	Var %
Acute Services	175,099	176,945	1,846	1.05%
Mental Health Services	34,060	33,892	-168	-0.49%
Community Services	33,108	33,108	0	0.00%
Continuing Care/FNC	13,198	11,937	-1,261	-9.56%
Prescribing & Quality	49,936	48,578	-924	-1.85%
Other programme	21,028	23,283	1,821	8.66%
Total Programme	**326,428**	327,743	**1,315**	**0.40%**
Running Costs	6,120	5,556	-564	-9.22%
Reserves	3,244	1,493	-1,751	-53.98%
Target Surplus	5,905	5,905	0	0.00%
Total Mandate Spend	**341,697**	**340,697**	**-1,000**	-0.29%

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15 Actual	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16 Estimated
Monthly Spend 15/16	27,188,689	27,188,689	27,860,196	27,816,835	27,532,049	27,434,107	27,498,420	27,672,429	27,359,434	27,258,699	27,213,192	27,213,192
Monthly Budget 15/16	27,516,075	27,404,857	27,693,456	27,624,409	27,314,286	27,396,751	27,493,884	27,629,551	27,495,718	26,975,177	27,608,390	27,519,377



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15 Actual	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16 Estimated
Monthly Spend / Profile 15/16	452	457	476	447	412	407	486	470	490	440	447	572
Monthly Budget 15/16	463	465	465	452	439	474	479	466	611	592	581	633
Monthly Spend / Profile 14/15	477	483	583	575	263	467	535	460	420	744	467	652

2. CONTRACT AND PROCUREMENT REPORT

The Committee received the latest overview of the contract and procurement situation. There were no significant changes to the procurement plan.

3. QIPP

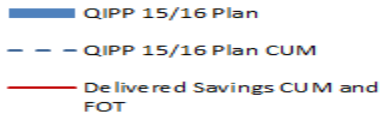
The Committee noted the current position of QIPP Programme performance as at Month 11.

2015- 16 M11

Delivery Board	Current Mth Plan	Current Mth Savings	Variance from Plan	Annual Plan	FOT	FOT Variance from Plan
Modernisation and Medicines Optimisation	2.809	2.867	0.058	3.063	3.070	0.007
Integrated Care	1.830	2.977	1.147	2.050	3.325	1.275
Primary Care	2.482	2.219	-0.263	2.771	2.455	-0.316
Better Care Fund	1.673	1.209	-0.464	1.914	1.429	-0.485
Unallocated	1.665	0.000	-1.665	2.000	0.000	-2.000
Other	0.000	0.000	0.000	0.000	0.000	0.000
Total	10.459	9.273	-1.186	11.798	10.281	-1.517

Details of the Savings Plans

Key:



4. PERFORMANCE

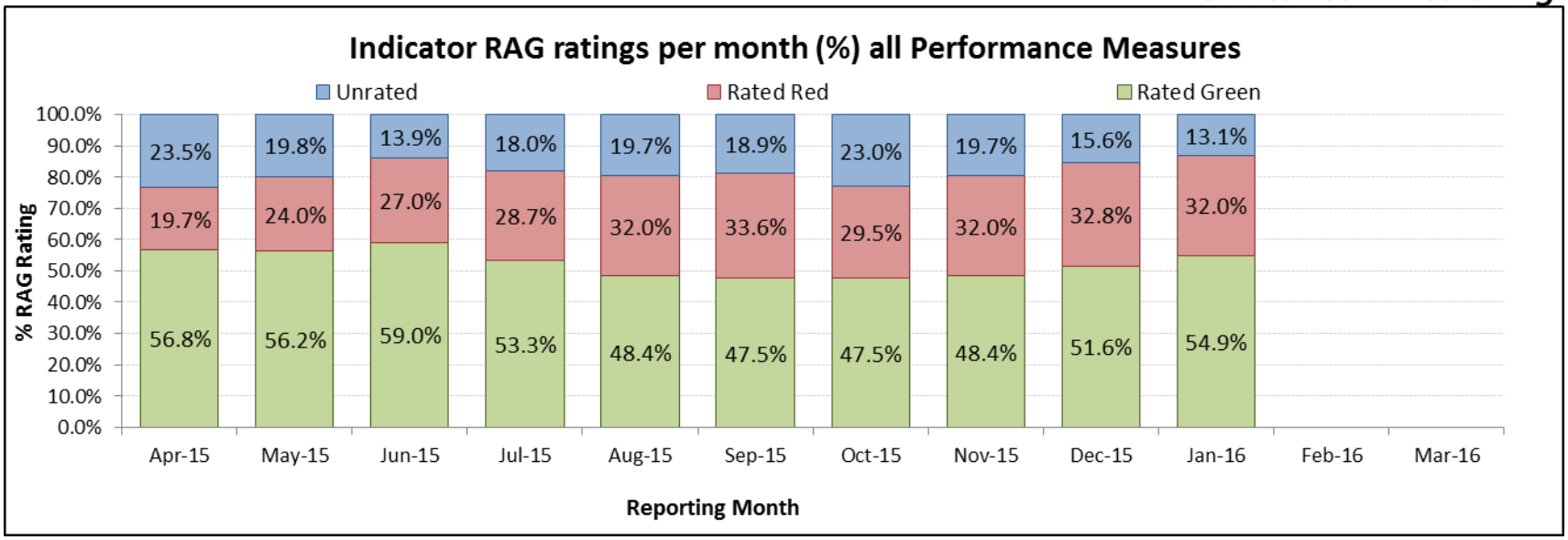
The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Jan-16

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	17	18	11	10	0	0	**28**
Outcomes Framework	17	18	13	11	7	8	**37**
Mental Health	29	30	16	19	12	8	**57**
Totals	**63**	**66**	**40**	**40**	**19**	**16**	**122**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	61%	64%	39%	36%	0%	0%
Outcomes Framework	46%	49%	35%	30%	19%	22%
Mental Health	51%	53%	28%	33%	21%	14%
Totals	**52%**	**54%**	**33%**	**33%**	**16%**	**13%**



Exceptions were highlighted as follows;

Jan-16

NHS Constitution

18 of the 28 Indicated areas are rated green. There were 0 unrated indicator(s) -eg. data not received. The 10 red rated areas are :

Description	Commentary
Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	RTT headline has failed to achieve for the 7th consecutive month (80.21% - SQPR report and unconfirmed) against the 90% target. This is a 1.65% decrease from the previous month, however, it should be noted that the following national guidance RTT performance is primarily measured using the Incomplete Headline Level (92% target) which achieved performance in January at (92.03%). The CCG will continue to monitor Admitted and Non Admitted levels locally.

Percentage of non-admitted patients starting treatment within a maximum of 18 weeks from referral	RTT headline has failed to achieve for the 6th consecutive month (92.70% - SQPR report and unconfirmed) against the 95% target. This is a 0.48% increase from the previous month, however, it should be noted that the following national guidance RTT performance is primarily measured using the Incomplete Headline Level (92% target) which achieved performance in January at (92.03%). The CCG will continue to monitor Admitted and Non Admitted levels locally.
Percentage of A & E attendances where the patient was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	This indicator remains under 90% and has breached both in month (89.31%) and Year End (92.69%). Attendances have continued to increase with an additional 2,050 (17.85%) attendances in January compared with the same period last year. The Trust failed to achieve both Type I and the All Types target for the month. The Remedial Action Plan trajectory has been missed for January and provisional data indicates failure in February. Due to the continued failure of the A&E target and in line with General Conditions (GC9) the Trust were notified that 2% of the Actual Monthly Value of the Trust contract is to be withheld (as of 1st March 2016). Negotiations for an alternative action plan are on-going and will feed into the sustainability and transformation fund plans for 2016/17. The Vocare Urgent Care Centre is due to fully open from 1st April 2016, however in light of the increase in attendances and the decline in recent performance, the Phase One opening has been brought forward to 9th March 2016 (currently a skeleton service) to support A&E.
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	This indicator failed to meet the 94% target for the 3rd consecutive month (82.93%) and YTD (92.34%). There were 7 patient breaches in January 2016, of which 6 were due to Urology capacity issues and 1 patient was a joint operation between Gynaecology and Lower GI surgeons which was not able to be scheduled within the standard. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2, figures have been confirmed locally as 93.33% and under target.

Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Following the previous months in month achievement of the 85% target (85.71%), this indicator has seen a -14.38% decrease to 71.34% and the lowest performance since August 2015 (70.86%). There were 29 patient breaches during January (9 x Tertiary Referrals received between days 30 and 112 of the patients pathway, 8 x Capacity Issues, 6 x Patient Initiated and 6 x Complex Pathways. The Trust have provided a breakdown of performance by specialty for information with the high breaches as follows (% seen within standard): Head & Neck (33.33%), Colorectal (46.67%), Urology (51.16%), Gynaecology (54.55%), Upper GI (66.67%), Breast (91.67%), Lung (94.12%) and with both Haematology and Skin achieving 100% of patients seen within standard. A Remedial Action Plan (RAP) has been agreed and includes the following actions : Improved tracking of Cancer patients and escalation to ensure all cancer pathways are being reviewed and managed appropriately, a review of Cancer Services to ensure staffing levels and skill mix are available across the cancer services team, weekly escalation meetings to Divisional manager to review performance with a view to identify process bottlenecks, Hysteroscopy sessions increased at Cannock to provide additional capacity. The RWT quarterly report on Cancer Services has been presented to Trust Board and highlights an impending peer review which involves an external visit to the Head & Neck team. RWT Trust Management Committee has noted that the Head & Neck team treat almost as many patients as Birmingham's team despite being half the size of it's neighbour. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2, figures have been confirmed locally as 64.52% and under target. As per the January CRM meeting the Trust confirmed that they will not have met the RAP trajectory for January and the CCG has initiated discussion of GC9 initiation with the process to start on the basis of failing January.
Percentage of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	This indicator has failed to achieve the 90% for January (83.78%) and YTD (88.66%). There were 4 patient breaches (1 x Complex Pathway, 2 x Capacity Issues and 1 x Patient Initiated). A Remedial Action Plan (RAP) has been agreed and includes the following actions : Improved tracking of Cancer patients and escalation to ensure all cancer pathways are being reviewed and managed appropriately, a review of Cancer Services to ensure staffing levels and skill mix are available across the cancer services team, weekly escalation meetings to Divisional manager to review performance with a view to identify process bottlenecks, Hysteroscopy sessions increased at Cannock to provide additional capacity. The performance for this indicator is affected by small numbers. Performance had previously seen significant improvement (with December reporting 100%), however performance continues to fluctuate. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2, figures have been confirmed locally as 80.95% and under target.

Rates of Clostridium difficile	The C-Diff performance in Month 10 brings the Year to Date number of breaches to 65 and has already breached the full year threshold set for RWT by NHSE of 35. There were 6 positive cases by toxin test, 3 of these were attributable to RWT using the external definition of attribution. All CDI's are monitored locally at the monthly Clinical Quality and Safety Review Meetings and via the Incident Scrutiny Group. The Trust also provides a regular verbal updates to the CCG Risk and Patient Safety Manager in meetings and during telephone discussions. Outbreak meetings are attended by the CCG and an action plan is in place (Trust Wide) and CCG contribute to Infection Prevention Control Group meetings. The Quality and Risk team are awaiting the 48 hours reports regarding these cases. Contractual sanctions will be imposed at year end based on the number of avoidable attributable cases for RWT. A C-Diff Action Plan is in place (Trust wide) and the CCG contribute to the Infection Prevention Control Group meetings (48 hour reports awaited). It has been noted that data for August 2015 has been amended due to positive toxin test admin issue. Following the advice of the National Mandatory Surveillance Database, this patient has not been attributed against RWT. The SQPR figure for August has been amended to reflect the change (from 11 to 10 cases). The RWT C-Diff total for January comprises of 2 x Wolverhampton CCG patients and 1 x South East Seisdon Peninsula CCG patient.

All handovers between ambulance and A & E must take place within 30 minutes	Month 10 breached the zero target with 50 breaches (within 30-60 minutes) and although this is a significant improvement from the previous months performance of 128, January has seen a deterioration in the >60minute with 10 breaches. The cumulative position for 15/16 is still ahead of last years position (144 fewer breaches overall this year). There were no patients who breached the 12 hour target during January. Noted actions (as per Exception report) : - Ambulance crews unload and stay with patient in corridor until patients move from Emergency DepartmentIt is recognised that ambulances require free cubicles in A&E to able to hand over quickly. Free cubicles are only possible if there is flow within the system. The SRG are focussing on how patients can be discharged more quickly and in a safe manner. The focus is now on reducing delayed transfers of care (Trust to ensure TTO's and discharge summaries are completed as part of ward rounds as soon as possible and the proactive use of discharge lounge), developing a discharge to assess model and improving flow within the hospital system. These should all contribute to freeing up capacity in A&E thus aiding the ambulance handovers. RWT have informed the CCG that batches of ambulances are arriving at A&E which is causing delays in patients being processed.The CCG have commissioned Vocare to commence Phase 1 (ED diverted patients only) of the new co-located Urgent Care Centre, 4 weeks earlier than planned . The aim is to redirect ED patients to a GP based service on 1st floor above ED between 10:00 and 22:00. Phase 2 (ED diverted patients, Walk in Centre facilities and GP OOH provision) will commence as planned on 1 April 2016. The total fine for ambulance handover during January is predicted at £20,000. This fine is calculated on 50 patients between 30-60 minutes @£200 per patient and 10 patients >60 minutes @£1,000 per patient.

All handovers between ambulance and A & E must take place within 60 minutes	Month 10 breached the zero target with 10 breaches (50 within 30-60 minutes, 10 >60 minutes) and although this is a significant improvement from the previous months performance within 30-60 minutes (128), January has seen a deterioration in the >60minute. The cumulative position for 15/16 is still ahead of last years position (34 fewer breaches overall this year). There were no patients who breached the 12 hour target during January. Data has been extracted direct from the WMAS publication website to look at benchmarking conveyance destinations and handover periods. The results for January 2016 activity has been included as part of this report. For January, New Cross ranked 7th (1.1% of conveyances over 60 minutes) and Worcestershire Royal ranking 1st with highest proportion (4% of conveyances over 60 minutes). The total fine for ambulance handover during January is predicted at £20,000. This fine is calculated on 50 patients between 30-60 minutes @£200 per patient and 10 patients >60 minutes @£1,000 per patient.
Trolley waits in A&E	There were no 12 hour trolley breaches for January, however this indicator has breached the annual target (zero) with 1 patient breach in June 2015. Multi agency review has taken place, and cross agency action plan developed. Actions are being reviewed and monitored. The Trust were in discussions regarding the 12 hour breach and the fines associated to the breach. They believed that they did everything they could for the patient, and the issues occurred as Mental Health were unable to accept the patient in time. It was discussed as part of the CQRM meeting and confirmed that RWT would not be fined.

Outcomes Framework

18 of the 37 Indicated areas are rated green. There were 8 unrated indicator(s) - eg. data not received. The 11 red rated areas are :

Description	Commentary
Falls per 1,000 occupied bed days	The performance for this indicator has achieved target for the 7th consecutive month. The number of falls (by occupied bed days) remain under the 5.6 threshold. January performance has seen a slight increase but is still within threshold at 4.44. A rapid improvement model undertaken on one of the wards is being reviewed with the intention to roll out. The RWT Falls Steering group will look at three work streams regards to current policy/process, training and awareness raising in line with National events. Data available has been discussed with governance to identify if there are further trends the Trust can explore from data currently captured. Staff have been identified to attend a regional Citywide falls prevention event and a National best practice event in the forthcoming months.

Electronic Discharge summary to be fully completed and dispatched within 24 hrs. of discharge for all wards excluding assessment units	This indicator has been split for 15/16 into LQR2a (excluding Assessment Units) and LQR2b (all Assessment Units). January data indicates a 0.04% decrease in performance to 95.34% for all wards (excluding assessment units), however this is the 4th month standard has been achieved for this indicator. It should be noted that the assessment units (see LQR2b) saw a 4.76% decrease from the previous month (80.79%) and is still below target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the February CRM meeting at RWT, it has been confirmed that base wards are achieving, although assessment areas are failing. There is a Remedial Action Plan in place with a recovery trajectory; however, the trajectory is not being met. RWT have confirmed that following further investigations, further issues have been identified and Internal Governance is addressing these issues. The Commissioner has informed the Trust of its intention to initiate a GC9 process in relation to the failure to meet the RAP trajectory.
Electronic Discharge summary to be fully completed and dispatched within 24 hrs. of discharge for all assessment units (e.g. PAU, SAU, AMU, AAA, GAU etc.)	This indicator has been split for 15/16 into LQR2a (excluding Assessment Units) and LQR2b (all Assessment Units). January data indicates a 4.76% decrease in performance to 80.79% for assessment units. It should be noted that the all wards (see LQR2a) saw a 0.04% decrease from the previous month (95.34%) and is still above the 95% target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the February CRM meeting at RWT, it has been confirmed that base wards are achieving, although assessment areas are failing. There is a Remedial Action Plan in place with a recovery trajectory; however, the trajectory is not being met. RWT have confirmed that following further investigations, further issues have been identified and Internal Governance is addressing these issues. The Commissioner has informed the trust of its intention to initiate a GC9 process in relation to the failure to meet the RAP trajectory.
Serious incidence reporting - Report incidences within 48 hours	This indicator breached in January with 1 Serious Incident, categorised as a Slip/Trip/Fall (STEIS reference 2016/1830). This brings the YTD Total to 4 breaches. It has been noted that the Trust SQPR January submission included incorrect data - submission utilised decimal places (1.2) rather than full figures (1 breach). Both the Trust and the Quality and Risk Team have verified that January figure as 1 breach. Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings.

Serious incidence reporting - Update on immediate actions of incident within 72 hours	This indicator breached in January with 3 Serious Incidents, categorised as follows : 2016/243 - Pressure Ulcer (Grade 3) 2016/255 - Sub-optimal care of the deteriorating patient 2016/2327 - Pending Review (awaiting formal STEIS category following investigation, currently on Stop Clock with Coroner). This brings the YTD Total to 11 breaches. It has been noted that the Trust SQPR January submission included incorrect data - submission utilised decimal places (3.1) rather than full figures (3 breaches). Both the Trust and the Quality and Risk Team have verified that January figure as 3 breaches. Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings.
Serious incidence reporting - Share investigation report grade 2 within 60 days	This indicator did not breach in month however, the Year End total has breached the zero target (currently reporting at 9 breaches for 15/16). Each breach is reviewed at the Contract Review Meeting and the Clinical Quality Review Meeting.
% emergency admissions seen and have a thorough clinical assessment by a suitable consultant within 14 hours of arrival at hospital	As per the CRM minutes for June, it has been noted that this indicator has become a Quarterly submission. The January performance has seen significant improvements and acheived 100%, however the Year End performance is below the 98% target (94.29%). Feedback from the Trust indicates that the average is 8hrs, however exceptions affect total percentage e.g. late arrival on a Friday night will not be seen until the next ward round over 14hrs later.
% of specialist roles - named professionals to have up to date level 4 Safeguarding Children training.	This indicator has achieved 100% for every month with the exception of July (66.67%), this means that this indicator has failed Year End. We are awaiting confirmation that the methodology for this indicator is correct (as it has noted that Level 3 training methodology has been incorrect and based on 12 months rolling rather than a 3 year period).

% type 1 A&E attendances where the patient was admitted, transferred or discharged within four hours of arrival.	This indicator is for Surveillance Only. This indicator has breached the 95% target since April and has been reported at 84.81% for January (a 0.90% increase from previous month). Attendances have continued to increase with an additional 2,050 (17.85%) attendances compared with the same period last year. The Trust failed to achieve both Type I and the All Types target for the month. The Remedial Action Plan trajectory has been missed for January and provisional data indicates failure in February. Due to the continued failure of the A&E target and in line with General Conditions (GC9) the Trust were notified that 2% of the Actual Monthly Value of the Trust contract is to be withheld (as of 1st March 2016). Negotiations for an alternative action plan are on-going and will feed into the sustainability and transformation plans for 2016/17. The Vocare Urgent Care Centre is due to fully open from 1st April 2016, however in light of the increase in attendances and the decline in recent performance, the Phase One opening has been brought forward to 9th March 2016 (currently a skeleton service) to support A&E. Provisional data for February indicates a continued increase in A&E attendances and has failed to meet the daily 95% target every day since 16th January 2016 (as of 10th March). The Trust are working on actions as detailed within the remedial action plan. The predicted fine for the A&E December breaches is £111,480.
Radiology Reporting (CQ1314_6) - % images reported upon for patients who have had radiological images taken - Results of all direct access imaging diagnostics will be provided to the GP 99% within 20 days after the date of the imaging appointment	This indicator has met the 95% target for January (99.75%), however the Year End continues to breach (98.99%) due to below target performance during April, May, September and October. The indicator for 10 day Radiology reporting indicator (LQR27a - 95% of direct access imaging provided within 10 days) has met both in month (97.67%) and for the first time the Year End (95.25%) has also met the 95% target.
The occurrence of a Never Event as defined in the Never Events Policy Framework from time to time	There were no Never Events reported for January, however, this indicator has already breached the annual target of zero this year due to the 3 previously reported Never Events (retained swab incident in July 2015, wrong side drain and incorrect eye Lucentis injection in September15). Each breach is reviewed at the Contract Review and Clinical Quality Review Meetings. A full RCA will be conducted for each breach with actions and recommendations.

Mental Health

30 of the 57 Indicated areas are rated green. There were 8 unrated indicator(s) - eg. data not received. The 19 red rated areas are :

Description	Commentary
Sleeping Accommodation Breach	The Provider SQPR indicated that there was 1 mixed sex accommodation (MSA) at Edward Street Hospital in May which breaches the full year target of zero. The National Unify return has confirmed that this is attributable to NHS Sandwell and West Birmingham CCG and not Wolverhampton CCG.
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	This indicator has met the January 2016 performance and reported 95.12% of CPA follow ups within 7 days. However, the indicator is breaching the 95% Year End target (93.37%). The use of daily reports that are produced for all community teams highlighting those patients that have been discharged from hospital appears to have had a positive impact on the performance.
EIS More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral	This indicator has failed the 50% target for each month since April with January achieving the highest performance so far at 40% (numerator = 2, denominator = 5). 22 initial assessment appointments were offered in January and there were 13 DNAs during the month. The EI service continue to experience high DNAs and the service continue to explore ways to reduce them. The team offer 100% of referrals an appointment for assessment to meet the 5 day target. The Trust are to meet with the CCG to discuss EIS with a view to put an action plan in place.
EIS Meeting commitment to serve new psychosis cases by early intervention teams. Quarterly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance rounded down. (Monitor definition 11)	This indicator is based on a year end target of 44, current performance is at 35 (if target and performance is split over 10 months this indicator is rated as RED). Performance has been discussed at CQRM, with an action plan in place and monitoring will continue.

EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed both in month (11.11%) and Year End (33.49%) against a target of 95%. The Trust are to meet with the CCG to discuss EIS with a view to put an action plan in place. There were 22 initial assessment appointments offered in January, with 13 DNAs during the month. The team is continually reviewing the high number of DNAs and exploring ways to reduce them, including contacting clients who DNA to establish the reasons why. If the team are able to address the reason for the DNA then alternatives can be offered to meet the need e.g travel cost identified as reason for DNA - client can be offered assessment at GP surgery if room available and closer to clients home. The standard initial assessment letter has been amended to include the reason for offering early appointments to assist recovery as a lack of understanding regarding a quick initial appointment time may have impacted on DNA rates. Team are texting and calling new clients to remind them about their appointments (as well as sending out appointment letters) and letting referrers know the details of initial assessments so that they can pass the information to the clients if they are seeing them again before the Team. The team actively reviews reasons for DNA and will make every attempt to address any new issues with attendance if raised by clients. The team makes every attempt to offer 100% of referrals an appointment for assessment to meet the 5 day target if staff are available.
Delayed transfers of care to be maintained at a minimum level	This indicator has breached the 7.5% threshold for January 2016 (14.17%) and relates to the total number of delay days for the month over the total number of occupied bed days (excluding leave for the month) and is based on the Provider total (All Commissioners) and cannot currently be split by individual commissioner. It has been noted that amendments to previous submissions have been received from the Trust and they have confirmed that these are due to data quality improvements. The Trust continue to promote active management of delays but struggle with moving some "hard to place" patients outside the Trust (due to an arson conviction or awaiting funding) and those patients who have no recourse to public funds (illegal immigrants) who do not get health or housing monies. Buy-in from the Local Authority is not consistent and has been requested. Discussions have taken place at the CQRM meeting regarding escalation of issues to the Local Authority. Each individual delay is discussed in detail and agreed actions signed up to on a weekly basis.

Proportion of patients with a Care Plan when discharged from Older Adults Ward	Performance for this indicator achieved 100% against the 95% target for January (based on 9 patients with a Care Plan on discharge). However due to the under performance in April and May, the Year End is below target (88.57%). As there is only 1 Older Adult ward, and due to the small number of patients the performance percentage is greatly affected by any breach.
IAPT Percentage of people who are moving to recovery of those who have completed treatment in the reporting period	This indicator has achieved the 50% target for the 4th consecutive month this year (56.98%) and is reflective of the changes made to the model of care. Due to the previous months performance the Year End is still below target (47.09%). Discussions have taken place at the CQRM meetings with the Trust regarding the different IAPT model (WCCG commission an IAPT plus service clusters 1 - 7) which impacts on performance levels. Target has been met for the last 4 months and performance will continue to be monitored closely. Any decline in performance will be discussed via the Contract Review meeting.
SUIs Provide commissioners with Grade 1 RCA reports within 45 working days where possible, exception report provided where not met	This indicator failed to meet the 100% target for the first time during August and although have met target every month since, the indicator has breached the Year End target (96.67%).
SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for January 2016, however the YTD has breached the 100% target (96.67%) due to 3 breaches in May. Numbers of serious incidents and RCA's are monitored by the Quality & Risk Team. All breaches are reviewed at the Contract Review and the Quality Review Meetings.
HCAIs IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	This indicator has breached the 95% target since April 15. The Trust have confirmed via the CQRM meeting that the IPC training is meeting target, however, the data on the SQPR includes other mandatory training. This issue should be resolved by M11 submission.

MEDS MGMT Memantine - Trust to give assurance that 95% of patients on Memantine have either moderate Alzheimer's Disease and a record of intolerance/contraindications to Ache or have severe Alzheimer's Disease.	This is a new performance indicator for 15/16. The Provider requested further development time to implement reporting and it was discussed that data should be available by end of Q1, the first performance submission has been received for January 2016 as 77.8% against the 95% target. Meds Management indicators were discussed at CQRM and a further meeting is to be arranged to discuss best way forward. Additional Commentary has been received from the Trust "This is being carried out as a rolling audit and data collection for all inpatient areas. This will reported end Quarter 2 following a data cleansing exercise. EPACT data can be supplied if required however, data will lag behind 3 months".
SAFEGUARDING CHILDREN % compliance with provider protocol for clinical supervision (for frontline staff who work with adults who have responsibility for children and those who work directly with children).	This is a new performance indicator for 15/16. Performance data for October - December was received at M10 and although achieved 100%, due to the null submissions in previous months the Year End performance is calculating at 50%. Comment from Children's Safeguarding Lead - "We only offer supervision to those who are holding children on a plan – this changes from one day to this next. Not all practitioners therefore are in need of CP supervision if they are not holding any cases- it is therefore difficult to give a percentage as we do not have a consistently whole amount to draw one from. CCG to liaise with Quality and Risk Team regarding the reporting of this indicator. The issue of non reporting has been raised at the CQRM as these indicators have been confirmed as required. The Trust have confirmed that they will investigate options".
SAFEGUARDING CHILDREN % compliance with Safeguarding supervision for Named Professionals from Designated Professionals.	This is a new performance indicator for 15/16. The M10 SQPR submission has been queried with the Trust as 100% has been submitted but with zero numerator and denominator. The backing data also indicates a denominator figure of zero submitted for 7 out of the 9 months, this has been queried with the Trust. The Trust have confirmed that the supervision for named professionals by designated professionals only applies to 2 members of staff and they have supervision a set number of times per year so you get some months when they were both due to have a supervision session, and other months neither is due to have a supervision session. The numbers the Trust have been supplying is whether they were due supervision in month, and if so did they have that supervision. The 0% January submission relates to neither were due supervision.
SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 2.	Performance for this indicator has steadily improved over the year and January has achieved the 85% target for the fourth consecutive month (92.78%). The Year End performance is below target at 82.17% and the Remedial Action Plan is still in place as covers other Safeguarding indicators.

SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 3.	This indicator has maintained its improved performance level against the 85% target (85.98%) however the Year End performance is below target at 70.79% and the Remedial Action Plan is still in place as this covers other Safeguarding indicators.
SAFEGUARDING CHILDREN (WCCG Only) % compliance with staff safeguarding training strategy at Level 4 - Named Professionals.	This indicator has achieved the 100% target for the fourth consecutive month; however the Year End is still below target (84.86%) due to previous months below target performance and missing data for April, May and July submissions.
SAFEGUARDING ADULTS % compliance with safeguarding adults higher level training	This indicator has seen a steady improvement since June and has reported 67.75% for January, and although the best performance so far this year, is still below the 85% target. The Year End performance is also below target at 46.77% and the performance is now in line with the Remedial Action Plan trajectory.
SAFEGUARDING ADULTS % compliance with MCA/DoLS training	This indicator has seen a steady improvement since June and has achieved 88.87% for January 2016. Although this is the best performance so far this year, it is still below the 85% target. The Year End performance is also below target at 49.08% and there are on-going discussions with the Trust regarding a Remedial Action Plan to improve performance and the Trust has advised that this indicator is linked to the Adult Safeguarding level 2 training.

5. 16/17 FINANCIAL PLAN AND BUDGET

The Committee received an update on progress with the draft financial plan for 2016/17, noting adherence to the 2016/17 planning rules and discussed risks to the financial position.

A further budget paper is provided alongside this report for consideration and ratification.

6. Better Care Fund Accounting Treatment

The Committee noted the accounting treatment for the Better Care Fund.

7. Finance and Performance Committee Annual Report

The Committee considered and agreed the draft report and took assurance that the Committee has discharged it's duties as set out in its terms of reference.

8. KEY RISKS AND IMPLICATIONS

Financial Risk - 2015/16 Risk

The tables below details the current assessment of financial risk for the CCG.

Risks	Full Risk Value £m	Probability of risk being realised %	Potential Risk Value £m	Proportion of Total %
CCGs				
Acute SLAs	0.50	50.00%	0.25	100.00%
Community SLAs			0.00	0.00%
Mental Health SLAs			0.00	0.00%
Continuing Care SLAs			0.00	0.00%
QIPP Under-Delivery			0.00	0.00%
Performance Issues			0.00	0.00%
Primary Care			0.00	0.00%
Prescribing			0.00	0.00%
Running Costs			0.00	0.00%
Other Risks			0.00	0.00%
TOTAL RISKS	**0.50**		**0.25**	**100.00%**

Mitigations	Full Mitigation Value £m	Probability of success of mitigating action %	Expected Mitigation Value £m	Proportion of Total %
Uncommitted Funds (Excl 2% Headroom)				
Contingency Held			0.00	0.00%
Contract Reserves			0.00	0.00%
Investments Uncommitted			0.00	0.00%
Uncommitted Funds Sub-Total	**0.00**		**0.00**	**0.00%**
Actions to Implement				
Further QIPP Extensions			0.00	0.00%
Non-Recurrent Measures			0.00	0.00%
Delay/ Reduce Investment Plans			0.00	0.00%
Other Mitigations	0.25	100.00%	0.25	100.00%
Mitigations relying on potential funding	0.00		0.00	0.00%
Actions to Implement Sub-Total	**0.25**		**0.25**	**100.00%**
TOTAL MITIGATION	**0.25**		**0.25**	**100.00%**

- M11 shows a steady level of risk reported by the CCG following the inclusion of BCF risk at the re assessed level within the overall reported financial position.
- The mitigations have reduced from last month and the CCG continues to identify sufficient mitigations to cover its risks.
- In delivering the financial surplus in M11 the CCG has already committed its Contingency reserve of £1.714m therefore this cannot be considered as mitigation.

Other Risk

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

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

9. RECOMMENDATIONS

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

Name: **Claire Skidmore**
Job Title: **Chief Finance Officer**
Date: **30th March 2016**