NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
10th May 2016

Agenda item 13

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 26th April 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 position against key financial performance indicators;

Financial Target	Target M12	Achieved M12	Variance	RAG
Programme Cost £'000	326,473	329,267	2,794	R
Reserves £'000	3,244	-	-3244	R
Running Cost £'000	6,120	5,503	-617	G
Cash draw down £'000	325,695	325,695	0	G
Cash draw down %	100%	100%	0%	G
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	97%	-2%	G

Draft accounts for 2015/16 were submitted in April. Audit work commences on 3rd May.

The Governing Body will be required to consider the CCG's audited accounts, annual report and governance statement and sign them off at its meeting on 24th May 2016.

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

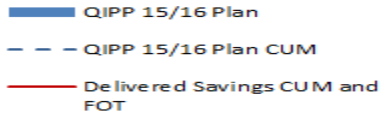
The Committee noted the current position of QIPP Programme performance as at Month 12.

2015-16 M12

Delivery Board	Current Mth Plan	Current Mth Savings	Variance from Plan	Annual Plan	FOT	FOT Variance from Plan
Modernisation and Medicines Optimisation	3.063	3.193	0.130	3.063	3.193	0.130
Integrated Care	2.050	3.325	1.275	2.050	3.325	1.275
Primary Care	2.771	2.455	-0.316	2.771	2.455	-0.316
Better Care Fund	1.914	1.336	-0.578	1.914	1.336	-0.578
Unallocated	2.000	0.000	-2.000	2.000	0.000	-2.000
Other	0.000	0.000	0.000	0.000	0.000	0.000
Total	11.798	10.310	-1.488	11.798	10.310	-1.488

Details of the Savings Plans

Key:



4. PERFORMANCE

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

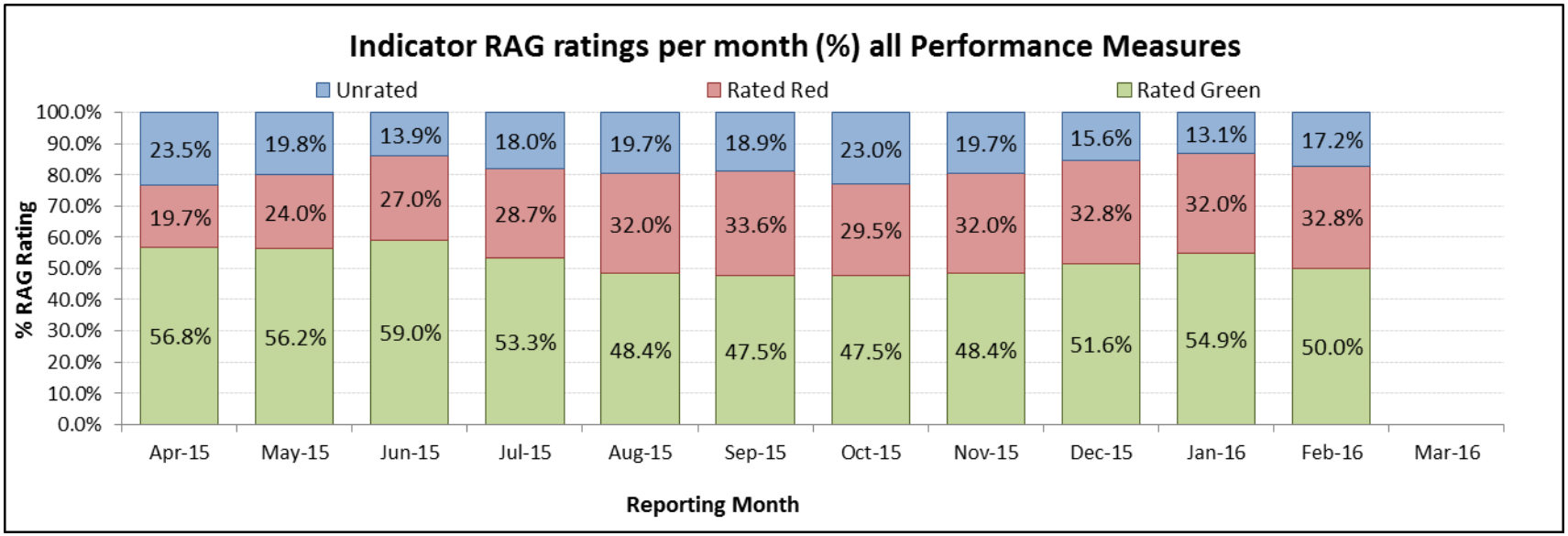
Executive Summary - Overview

Feb-16

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	18	16	10	11	0	1	**28**
Outcomes Framework	18	16	11	11	8	10	**37**
Mental Health	31	29	18	18	8	10	**57**
Totals	**67**	**61**	**39**	**40**	**16**	**21**	**122**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	64%	57%	36%	39%	0%	4%
Outcomes Framework	49%	43%	30%	30%	22%	27%

Mental Health	54%	51%	32%	32%	14%	18%
Totals	**55%**	**50%**	**32%**	**33%**	**13%**	**17%**



Exceptions were highlighted as follows;

Executive Summary - Commentary

Feb-16

NHS Constitution

16 of the 28 Indicated areas are rated green. There were 1 unrated indicator(s) -eg. data not received. The 11 red rated areas

are :

Percentage of admitted patients starting treatment within a maximum of 18 weeks from referral	RTT headline has failed to achieve for the 8th consecutive month (79.61% - SQPR report and unconfirmed) against the 90% target. This is a 0.60% 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 February at (92.11%). 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 7th consecutive month (93.44% - SQPR report and unconfirmed) against the 95% target. This is a 0.74% 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 February at (92.11%). 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 (85.39%) and Year End (92.03%). Attendances have continued to increase with an additional 2,583 (17.85%) attendances in February 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 February and provisional data indicates failure in March. Continued pressure in April has resulted on-going poor performance, reaching only 68.72% on the 4th April. Whilst footfall and NHS111 redirections were average and ambulance activity was as predicted, there may have been some ambulance batching with a bed shortage causing patients to wait in cubicles for in-patient beds with a consequent impact on flow. As this pressure occurred predominately Out of Hours it was difficult to discharge patients in response. A joint teleconference with the CCG, Local Authority and RWT was held to discuss mitigating actions to reduce the risk of further escalation. As a result of the conference call, the Local Authority have escalated actions to discharge patients and the CCG has temporarily relaxed the approval process for Step Down Beds to further speed up discharges. All other actions as part of the agreed RAP are continuing, including the

	regular Executive teleconferences to ensure mitigating action can be taken in response to issues. The predicted fine for breaches is estimated at £181,200.
Percentage of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	This indicator has breached the 96% (95.65%) for the 2nd time this year. The Trust have identified the failure is due to very few numbers of breaches impacting against a small cohort of patients. The validated figures for February confirm that there were above target 96.33% with 8 breaches (218 seen in total) and is therefore GREEN.
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	This indicator has met the 94% target for February (96.43%) however is still breaching YTD (92.71%) due to previous performance in month breaches (May, August, September and October) This indicator is affected by small number variance's with breaches impacting against a small cohort of patients. Figures have been confirmed locally as 96.77% for February and above target. The validated figures for February confirm that there were above target 96.97% with 1 breach (33 seen in total) and is therefore GREEN.
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	This indicator has failed to achieve the 85% for February (77.85%) and has failed 10 out of the 11 months this year (YTD= 75.44%). There were 22 patient breaches during the month of February, (11 x Tertiary referrals received between days 28 and 83 of the patient pathway, 5 x Capacity Issues, 3 x Patient Initiated, 1 x Further Investigations and 2 x Complex Pathways. Of the tertiary referrals, 63.64% were received after day 42 of the pathway and 45.45% of the total tertiary referrals were received after day 62 of the pathway. A Remedial Action Plan has been agreed with the Trust and is aligned with STF Plan Trajectory and constitutional planning submissions for 16/17. Plans remain to deliver against standard by June 2016. It has been noted that the Trust failed to submit the validated January Cancer figures to Unify2. Figures were initially confirmed locally as 78.90% for February, however we have since received the validated figures which confirm that there were below target 79.00% with 16.5 breaches (78.5 seen in total) and therefore remains RED.

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 February (72.00%) and YTD (87.14%). There were 5 patient breaches (3 x Capacity Issues, 1 Patient Initiated and 1 x Patient Not Fit on Day of Surgery). A recovery date is in place and RAP agreed (but 2% of budget line per month for not achieving trajectory will be applied). All specialities apart from Urology are to achieve 92% by April 16. Urology and headline targets to be achieved June 16. This indicator is affected by small number variance's with breaches impacting against a small cohort of patients. Performance had previously seen significant improvement (with December reporting 100%), however performance continues to fluctuate and had decreased 11.78% since last month. February figures were initially confirmed locally as 72.00%. We have since received the validated figures for February which confirm that there were below target 72.00% with 3.5 breaches (12.5 seen in total) and therefore remains RED.
Rates of Clostridium difficile	The C-Diff performance in Month 11 brings the Year to Date number of breaches to 67 and has already breached the full year threshold set for RWT by NHSE of 35. There were 7 positive cases by toxin test, 2 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. 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). The RWT C-Diff total for February comprises of 1 x Wolverhampton CCG patients and 1 x South East Seisdon Peninsula CCG patient. The Wolverhampton CCG view (Acute and Non Acute) for February is 6 - 5 x RWT (1 x Acute, 4 x Non Acute), 1 x UHB (1 x Non Acute).

All handovers between ambulance and A & E must take place within 30 minutes	Month 11 breached the zero target with 79 breaches (within 30-60 minutes) and seen a decrease in performance from the previous months performance (of 50), February has also seen a deterioration in the >60minute with 13 breaches. The cumulative position for 15/16 is still ahead of last years position (76 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 Department - Further work with the voluntary sector to aid: 1) Increased capacity and slightly amended service spec for the supportive discharge service, 2) Intervention specifically targeted to the Refugee and Migrant population to promote better use of GP services as an alternative to A&E. SRG agreed to fund for a further 12 months. 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) commenced as planned on 1 April 2016. The total fine for ambulance handover during February is predicted at £28,800.
All handovers between ambulance and A & E must take place within 60 minutes	Month 11 breached the zero target with 13 breaches (> 60 minutes) and has seen an increase in the number of breaches from the previous months performance (further increase of 3), February has also seen a deterioration in the 30-60 minute performance with 79 breaches. The cumulative position for 15/16 is still ahead of last years position (21 fewer breaches overall this year). There were no patients who breached the 12 hour target during February. New Cross (local provider RWT) ranked 3rd highest number of conveyances, but 7th highest proportion of handovers (0.4%), this is above the WMAS overall performance (0.5%) for February. The maximum handover wait at New Cross during February was 87 minutes (8th February). The total fine for ambulance handover during February is predicted at £28,800. This fine is calculated on 79 patients between 30-60 minutes @£200 per patient and 13 patients >60 minutes @£1,000 per patient.

Trolley waits in A&E	There were no 12 hour trolley breaches for February, 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

16 of the 37 Indicated areas are rated green. There were 10 unrated indicator(s) - e.g. data not received. The 11 red rated areas are :

Description	Commentary
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). February data indicates a 0.76% decrease in performance to 94.59% for all wards (excluding assessment units) and has failed to achieve the 95% target. It should be noted that the assessment units (see LQR2b) saw a 3.37% increase from the previous month (84.17%) and is still below target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the March CQRM meeting at RWT, it has been confirmed that a meeting has taken place to discuss the remedial action plan and there are currently two main areas of concern which are being reviewed: 1) Assessment areas do not have admin support during the evening 2) Gynaecology discharge to GPs not midwives. The fine for not achieving in February is predicted to be £5,000 for all wards excluding Assessment Units (£10,000 combined)

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). February data indicates a 3.37% increase in performance to 84.17% for assessment units and has failed to achieve the 95% target. It should be noted that the assessment units (see LQR2a) saw a 0.76% decrease from the previous month (94.59%) and is still below target in month. The performance for both indicators remains below target on the YTD performance.
Serious incidence reporting - Report incidences within 48 hours	There were no breaches in February 2016; however this indicator has already failed the Year End with 4 breaches. 2015/20802 - June15, Slip/Trip/Fall 2015/22544 - Jul15, Sub-optimal Care 2015/30119 - Sept15, Pressure Ulcer Grade 3 (overturned) 2015/34262 - Oct15, Slip/Trip/Fall 2016/1830 - Jan16, Slip/Trip/Fall
Serious incidence reporting - Update on immediate actions of incident within 72 hours	This indicator did not breach in month however, the Year End total has breached the zero target (currently reporting at 11 breaches for 15/16). 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 has breached both in month (1) and Year End (10) against the zero target for 15/16. The February breach related to: 2016/34684 - Diagnostic incident including delay meeting SI criteria Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. The fine for this breach is estimated to be £250.

% 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 and February performance have seen significant improvements and both achieved 100%, however the Year End performance is below the 98% target (94.81%). 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 clinical staff working in health care settings to have up to date level 3 Safeguarding Children training - all clinical staff who have any contact with children, young people and/or parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns	This indicator has failed the 85% target for the first time since July, achieving 74.94% in month, however, is still achieving the YTD (86.18%). As per the March CQRM minutes, RWT have confirmed that training will be reviewed and how it is delivered. The predicted fine for this February breach is £5,000.
% 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 (96.97%). 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 79.46% for February (a 5.35% decrease from previous month). Attendances have continued to increase with an additional 2,583 (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 February. Whilst footfall and NHS111 redirections were average and ambulance activity was as predicted, there may have been some ambulance batching with a bed shortage causing patients to wait in cubicles for in-patient beds with a consequent impact on flow. As this pressure occurred predominately Out of Hours it was difficult to discharge patients in response. A joint teleconference with the CCG, Local Authority and RWT was held to discuss mitigating actions to reduce the risk of further escalation. The minutes from the March CQRM confirm that a revised remedial action plan will be sent to the CCG and it is anticipated the recovery trajectory will be achieved from July onwards. The February daily performance for Type indicates the highest performance for the month as 93.05% (19th Feb) and the lowest as 64.95% (8th Feb). Provisional data for March indicates a continued increase in A&E attendances (Type 1) has only met the 95% once during the month (27th March = 95.51%), prior to this, the performance has failed to meet the daily 95% target everyday since 16th January 2016 . The Trust is working on actions as detailed within the remedial action plan.
The occurrence of a Never Event as defined in the Never Events Policy Framework from time to time	February breached in month with 1 new Never Event reported (2016/3315 - Wrong Site Surgery - Wrong tooth extracted). Following a review of the patient x-ray, the Clinical Director for Head & Neck has confirmed the correct tooth has been removed. As this will no longer meet the STEIS criteria it will be removed and all contractual figures (and associated sanctions) will be updated. 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.

Category A calls resulting in an emergency response arriving within 8minutes – Red 2	This indicator has failed the 75% target for the first time this year (73.60%). The Year End performance is achieving at 78.02%, March would have to report below 42% in month performance to fail Year End.

Mental Health

29 of the 57 Indicated areas are rated green. There were 10 unrated indicator(s) - e.g. data not received. The 18 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 failed the 95% target for February performance and reported 93.02% of CPA follow ups within 7 days, it is also breaching the Year End target (93.34%). There were 3 breaches (out of 43) that were not followed up within the 7 days; contact with all three patients was initiated, however due to non-response by the individuals the follow up failed within the 7 days. Staff within the inpatient wards have been reminded of the process that should be followed when patients are discharged from, specifically around ensuring that the relevant contact information is obtained from the patient and entered on to CareNotes. Continuous daily monitoring continues to take place throughout the teams. It has also been noted that the proportion of patients discharged from Inpatient Mental Health services on CPA who have a crisis management plan has also failed during February (Ref IR15) achieving 72.2% against the 100% target. This breach relates to 5 individuals of which 4 were due to admin errors which will be resolved when data is re-run at month end.

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 February achieving performance of 25% (numerator = 1, denominator = 4). 23 initial assessment appointments were offered in February and there were 9 DNAs during the month. The EI service continue to experience high DNAs and the service continue to explore ways to reduce them. The team aim to offer 100% of referrals an appointment for assessment to meet the 5 day target. The Trust, SWB CCG and WCCG have met and an action plan is to be agreed and put in place. At the meeting it was also agreed that there should be a task and finish group around EIS and that this group should meet on a regular basis. 4 assessment slots were not available in February due to staff undertaking family intervention training on days that assessment clinics are held. Whilst Clinical Staff will also offer appointments outside of the assessment clinic based on individual need staff training has impacted on availability of staff outside the assessment clinic. The agency nurse who was covering 4 days of the vacant post also left the team in February. The Team continue text messaging 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 ourselves.
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 37 (if target and performance is split over 11 months this indicator is rated as RED), to meet year end this indicator will need to report 7 additional new cases in March (noted that average is 3.4 cases per month as at M11). Performance has been discussed at CQRM, and the Trust have confirmed that they have achieved 43 at Year End and have therefore failed to meet target. The Mental Health Commissioning Manager for the CCG will be discussing this issue with the Trust outside of the CRM meetings.

EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed both in month (12.50%) and Year End (31.58%) against a target of 95%. The Trust, SWB CCG and WCCG have met and an action plan is to be agreed and put in place. At the meeting it was also agreed that there should be a task and finish group around EIS and that this group should meet on a regular basis. There were 23 initial assessment appointments offered in February, with 9 DNAs during the month (6 individuals with multiple DNAs). The team aim to offer 100% of referrals an appointment for assessment to meet the 5 day target, however due to Family Intervention training undertaken by the team in February 3 of the assessment clinics had to be cancelled which impacted on availability. 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 February (20.55%) 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 currently cannot be split by individual commissioner. The Trust have confirmed delays are due to a lack of any alternative provision. This includes individuals who have been assessed and refused by providers, and others whom it has been difficult to identify any suitable placement. There are also examples of placements which are delayed due the funding process, and the lack of LA involvement. These have been escalated to senior management both within the Trust and the Local Authority. This local quality requirement was discussed at the April CQRM.
Proportion of patients with a Care Plan when discharged from Older Adults Ward	Performance for this indicator achieved 100% against the 95% target for February (based on 1 patient with a Care Plan on discharge). However due to the under performance in April and May, the Year End is below target (89.61%). 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 5th consecutive month this year (56.00%) 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 (48.18%). 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 5 months and performance will continue to be monitored closely.
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 (96.97%).

SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for February 2016, however the YTD has breached the 100% target (96.97%) 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 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 for February 2016 (94.98%) and Year End (90.51%). Updated performance figures have been received for December (95.02%) and January (96.08%) which are GREEN. The Trust previously confirmed via the CQRM meeting that the IPC training is meeting target, however, the data on the SQPR included other mandatory training. We are awaiting confirmation if the February breach is a genuine IPC training breach or if there are remaining reporting issues (not discussed at CQRM as reported as a rounded performance of 95% and GREEN, actual performance to 2 decimal places is RED).
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 subsequent months have achieved 100%, due to the null submissions in previous months the Year End performance is calculating at 50.56%. 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. February performance has been reported at 100% (numerator=2, denominator=2). 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 100% February submission relates to both were due (and received) supervision.
SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 2.	Performance for this indicator has steadily improved over the year and February has achieved the 85% target for the fifth consecutive month (91.37%). The Year End performance is below target at 83.00% 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 (87.57%) however the Year End performance is below target at 72.32% 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 fifth consecutive month; however the Year End is still below target (86.76%) 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 66.73% for February however, is still below the 85% target. The Year End performance is also below target at 48.58% and the performance is now in line with the Remedial Action Plan trajectory. The RAP trajectory for Year End is 40%.

SAFEGUARDING ADULTS % compliance with MCA/DoLS training	This indicator has seen a steady improvement since June and has achieved 87.73% for February and is above the 85% target. Although this indicator has met target for the third consecutive month, the Year End is still below target (52.60%). Remedial Action Plan is still in place as this covers other Safeguarding indicators. The Trust has advised that this indicator is linked to the Adult Safeguarding level 2 training.

5. CONSTITUTIONAL TARGET REQUIREMENTS FOR 16/17

The Committee was informed that all the submissions required by NHS England have been submitted in line with the required deadlines. A detailed report will be taken to the May Committee meeting.

6. ASSURANCE RE DATA QUALITY

The Committee consider a query raised by the Governing Body relating to how it gains assurance that information received is correct. Details of audits completed in 2015/16 which were an overview of data quality to provide assurance on performance and clinical quality are to be shared with the Committee for broader discussion.

7. KEY RISKS AND IMPLICATIONS

Financial Risk

The CCG has limited flexibility in its 16/17 budget and, indeed, is reporting potential unmitigated risk of £2m in-year. Strong financial management and programme management of QIPP will be continued in order to mitigate against the risk of spend in excess of plan.

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.

8. RECOMMENDATIONS

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

Name: **Claire Skidmore**
Job Title: **Chief Finance Officer**
Date: **27th April 2016**