NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
12th July 2016

Agenda item 16a

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 31st May 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 noted that opening budgets for 2016/17 are now loaded to the ledger and all budgets are signed off by budget managers. The CCG is awaiting formal notification that it will be allowed to utilise £800k of the non-recurrent drawdown as per the submitted financial plan.

2. QIPP

The Committee noted the QIPP target for 2016/17 is £11.2m of which 80% (£9.0m) has been identified.

3. 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. The Committee noted the new requirement to submit a monthly return to NHS England relating to procurements that have either commenced or are due to commence.

4. PERFORMANCE

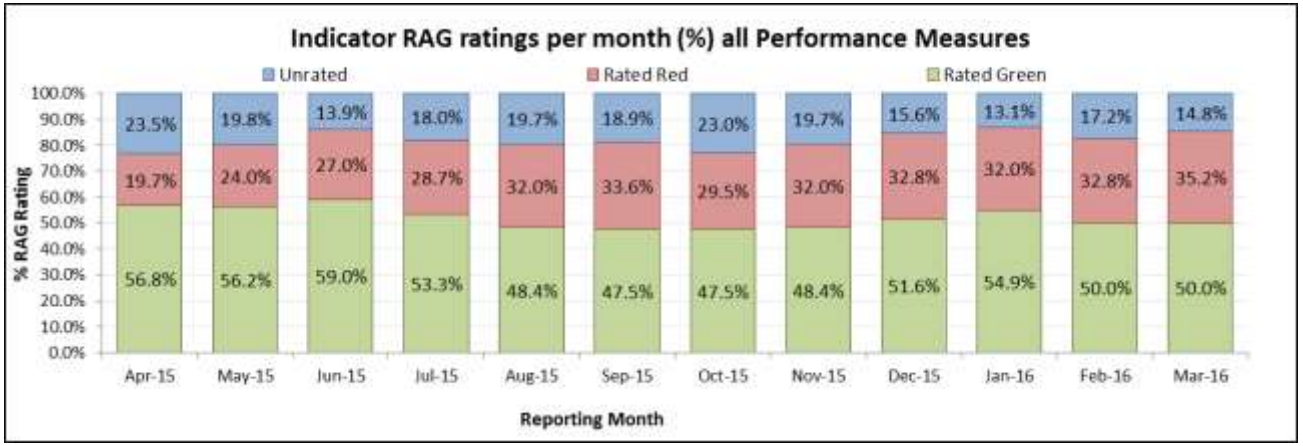
The following tables are a summary of the Month 12 2015/16 performance information presented to the Committee;

Executive Summary - Overview

Mar-16

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	16	16	11	10	1	2	**28**
Outcomes Framework	16	18	11	13	10	6	**37**
Mental Health	29	27	18	20	10	10	**57**
Totals	**61**	**61**	**40**	**43**	**21**	**18**	**122**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	57%	57%	39%	36%	4%	7%
Outcomes Framework	43%	49%	30%	35%	27%	16%
Mental Health	51%	47%	32%	35%	18%	18%
Totals	**50%**	**50%**	**33%**	**35%**	**17%**	**15%**



Exceptions were highlighted as follows;

Executive Summary - Commentary

Key:

See individual exception report

Mar-16

NHS Constitution

16 of the 28 Indicated areas are rated green. There were 2 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 9th consecutive month 79.00% - SQPR report and unconfirmed) against the 90% target. This is a 0.61% 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 March at (92.00%). 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 8th consecutive month 93.95% - SQPR report and unconfirmed) against the 95% target. This is a 0.59% 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 March at (92.00%). 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 the 95% target and has breached both in month (90.32%) and Year End (91.89%). Attendances have continued to increase with an additional 1,742 (14.6% increase) attendances in March compared to 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 (RAP) trajectory for 16/17 has been aligned to the STF (Sustainability and Transformation Fund) improvement trajectories with the 95% target proposed to be met by July 2016. By end of May16 the RAP indicates that the recruitment of an additional 37 Senior Sister posts for 24/7 cover should be completed. Other Actions include: Embedding PWC work programme across acute, local authority and CCG, to impact positively on Delay Transfers of Care and improve flow. Co-located Urgent Care Centre is live from 1st April 2016 including streaming of ED patients to appropriate Primary Care clinicians. Discussions are taking place to share information between the ED and UCC to ensure safe transfer of patients and reporting activity against the 95% target. The Trust failed to achieve both Type I and the All Types target for the month and the predicted fine for this is £95,280.

Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	This indicator has breached the 94% target in month for March (90.63%) and Year End (92.54%) due to previous performance in month breaches (May, August, September, October and March). This indicator is affected by small number variance's with breaches impacting against a small cohort of patients. Validated figures for March have confirmed that there were 3 patient breaches (out of 33) and the Trust have confirmed that all breaches for this indicator in March 16 were due to delays in Urology. Figures have been confirmed and validated as 90.91% for March and remains below target. The CCG position for March for this indicator is 100% (22 patients all seen within standard).

Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	The Trust have responded to the CCGs GC9 initiation discussions and have proposed that taking the full 2% of monthly contract value would be disproportionate and would seek some resolution on the proportion of the permanent retention. The Trust has responded "Given that of the 9 indicators for cancer, three were not met, we would request this is taken into account for any permanent retention and would propose a cap of 0.67%. This would minimise the impact for the Trust which is currently working hard to achieve 62 day targets in very challenging circumstances. You will be aware that nationally, Urology remains a significant challenge and the service is currently putting significant additional activity, where possible, to maximise performance and avoid patient breaches". Majority of actions from the remedial action plan have been completed, however, they are not having the impact expected. A recovery trajectory has been put in place (to hit by June16) although the Trust has advised the current trajectory will be difficult to achieve in the current climate. Further Actions: Additional clinics have been scheduled and changes to pathways e.g. diagnostic tests taken place earlier. Capacity issues continue to be primary concern with Urology still the main concern (national issue) given the lack of consultants and inability to recruit to vacancies. The Trust has continued to offer robotic procedures even though there is a capacity and waiting list issue (patients opting to wait longer, even though they could breach waiting list targets). The intensive support team have visited and a draft report with recommendations is with the Trust. The CCG will be provided with a copy of the report as soon as possible. Initial review suggests there isn't one answer to fix all the issues. The Trust have also received noticed of revised national guidance with regards the 62 day pathways, which primarily relates to a revision of the apportionment of fines - e.g. fair warning on forwarding referrals – current local guidelines stated tertiary referrals had to be passed on within 42 days of the initial referral, however new guidance has been reduced to within 38 days. Guidance states that if a patient breaches the 38 day limit and then subsequently the 62 day target, then the referring organisation will get the full fine, if the patient referral meets the 28 days target, but breaches the 62 day target then the receiving organisation will receive the full fine. It was noted as part of the CQRM meeting that there could be issues with this methodology when dealing with complex care patients. 16/17 is to be performance managed as a shadow year (to embed) and will be monitored and reviewed for 17/18.

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 met the 90% target for March (91.30%) however has failed to met the Year End (87.49%) due to previous poor performance levels over the year (only achieving 4 out of the 12 months). 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. This indicator is affected by small number variances 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 performance for March has increased 19.3% since February. The Trusts validated figures for March have been confirmed as 92.3% and above target, however the CCG position has been confirmed as 88.9% and below target. The CCG breach relates to 1 patient (out of 9).
Rates of Clostridium difficile	The C-Diff performance in Month 12 brings the Year to Date number of breaches to 73 and has breached the full year threshold set for RWT by NHSE of 35. There were 9 positive cases by toxin test, 6 of these were attributable to RWT using the external definition of attribution. Fidaxomicin continues to be in use for recurrences and is encouraged by the Consultant Microbiology Team, there have also been 3 faecal transplants successfully undertaken. 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 Trust has included a C-Diff positive cases major interventions and impact graph as part of the monthly CQRM to highlight the effects of actions. The RWT C-Diff total for March comprises of 4 x Wolverhampton CCG patients, 1 x South East Staffordshire and Seisdon Peninsula CCG and 1 x Stafford and Surrounds CCG. The Wolverhampton CCG view (Acute and Non Acute) for March is 7 (6 x Royal Wolverhampton, 1 x Royal Orthopaedic Hospital). The full year C-Diff position for Wolverhampton CCG is 86 (45 Acute, 41 Non Acute).

All handovers between ambulance and A & E must take place within 30 minutes	Month 12 breached the zero target with 49 breaches (within 30-60 minutes) and this is an improvement in performance from the previous months performance (of 79). March has also seen an improvement in the >60minute with only 2 breaches down from 13 in February. The cumulative position for 15/16 is still ahead of last year's position (76 fewer breaches overall this year). There were no patients who breached the 12 hour target during March. Noted actions (as per Exception report) : - Ambulance crews unload and stay with patient in corridor until patients move from Emergency Department - Embedding PWC work programme across acute, local authority and CCG, to impact positively on Delay Transfers of Care and improve flow. - 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. - Co-located Urgent Care Centre live from 1st April 2016 including streaming of ED patients to appropriate Primary Care clinicians. On-going plans to share information between ED and UCC to ensure safe transfer of patients and reporting activity against the 95% target. The total fine for ambulance handover during March is predicted at £11,800. This fine is calculated on 49 patients between 30-60 minutes @£200 per patient (£9,800) and 2 patients >60 minutes @£1,000 per patient (£2,000).
All handovers between ambulance and A & E must take place within 60 minutes	Month 12 breached the zero target with 2 breaches (>60 minutes), however this is an improvement in performance from the previous months performance (13 in February). March has also seen an improvement in the 30-60minute with 49 breaches down from 79 in February. The cumulative position for 15/16 is still ahead of last years position (23 fewer breaches overall this year). There were no patients who breached the 12 hour target during March. The total fine for ambulance handover during March is predicted at £11,800. This fine is calculated on 49 patients between 30-60 minutes @£200 per patient (£9,800) and 2 patients >60 minutes @£1,000 per patient (£2,000).

Trolley waits in A&E	There were no 12 hour trolley breaches for March, 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. The CCG Quality and Risk Team have confirmed that this breach is no longer on STEIS.

Outcomes Framework

18 of the 37 Indicated areas are rated green. There were 6 unrated indicator(s) - eg. data not received. The 13 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). March data indicates a 0.52% increase in performance to 95.10% for all wards (excluding assessment units) and has met the 95% target in month, however has breached the Year End (94.21%). It should be noted that the assessment units (see LQR2b) saw a 1.66% decrease from the previous month (82.5%) and is below target in month. The performance for both indicators remains below target on the YTD performance. The RWT clinical director has arranged a meeting on the 8th April to discuss issues, training and identify areas of concern. Stringent performance management is in place to identify issues. There is no fine for all wards (excluding Assessment Units) and a predicted £5,000 combined total fine (including Assessment Units)

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). March data indicates a 1.66% decrease in performance to 82.5% (excluding assessment units) and has failed to meet the 95% target in month, and has also breached Year End (80.81%). It should be noted that the assessment units (see LQR2a) saw a 0.52% increase from the previous month (95.1%) and met target in month. The performance for both indicators remains below target on the YTD performance. Feedback from the April CQRM meeting at RWT: A meeting has taken place in Emergency Services, specifically with PAU regarding discharge of patients in evenings to resolve issues. The RWT clinical director arranged a meeting for the 8th April to discuss issues, training and identify areas of concern. Stringent performance management is taking place to identify issues. 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 and not midwives. There is no fine for all wards (excluding Assessment Units) and a predicted £5,000 combined total fine (including Assessment Units)
Serious incidence reporting - Report incidences within 48 hours	This indicator has breached in month (1) and Year End with a total of 5 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, 2016/7868 - Mar16, Pressure Ulcer Grade 4 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 did not breach in March, however has breached Year End with a total of 11 breaches. 2015/13684 Pressure Ulcer (Grade 3), 2015/18918 Sub-optimal care of the deteriorating patient, 2015/20082 Pressure Ulcer (Grade 3), 2015/20700 Pressure Ulcer (Grade 3), 2015/22136 Pressure Ulcer (Grade 3), 2015/25934 Sub-optimal care of the deteriorating patient, 2015/29091 Pressure Ulcer (Grade 3), 2015/34203 related to a Treatment Delay report, 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) 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 (2) and Year End (12) against the zero target for 15/16. The March breach related to : 2016/22368 - Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria 2016/255 - Suboptimal Care of the deteriorating patient Each breach is reviewed at the Contract Review and the Clinical Quality Review Meetings. The fine for this breach is estimated to be £750.
% of patients requiring assistance to eat at mealtimes receive the necessary assistance	This indicator has failed to meet the 90% target for the first time this year (86.00%). The Trust have confirmed that the March 16 reported performance was affected by a corrupted data file, the Trust have confirmed that the data is non recoverable and although the Trust believe the true performance to be within target are unable to confirm this via the data. The issue will be raised at the CQRM meeting as the CCG require assurance that future performance is accurately reflecting the true performance situation.

% 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 to March performance have seen significant improvements and have all achieved 100%, however the Year End performance is below the 98% target (95.24%). 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 failed to achieve the 85% target in month (77.99%) however, has achieved the Year End (85.50%). As per the March CQRM minutes, RWT have confirmed that training will be reviewed and how it is delivered. The predicted fine for this March 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 (97.22%). 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 86.23% for March (a 6.76% increase from previous month). Attendances have continued to increase with an additional 1742 (a 14.6% increase) 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 (RAP) trajectory for 16/17 has been aligned to the STF (Sustainability and Transformation Fund) with the 95% target proposed to be met by July 2016. The March daily performance indicates the highest performance for the month was 95.5% (Sunday 27th March) and the lowest as 62.6% (Sunday 6th March). The Trust failed to achieve both Type I and the All Types target for the month and the predicted fine for this is £95,280.
% of women booked by 12 weeks and 6 days	This indicator has failed to meet the 90% target both in month (87.80%) and Year End (89.23%). It was noted at the April CQRM meeting that maternity figures now include Walsall bookings. The Trust have recurited 8 new midwives and the CCG will montor performance for improvements.
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 March, however, this indicator has already breached the annual target of zero this year due to the 4 previously reported Never Events. These included : 2015/24026 - Retained Swab 2015/30332 - Drain inserted into wrong side 2015/31339 - Lucentis injection in wrong eye 2016/3315 - Wrong Site Surgery (Wrong Tooth Extracted) - note this has since been reviewed and removed from STEIS
Category A calls resulting in an emergency response arriving within 8minutes – Red 2	This indicator failed to meet the 75% target for the first time in February and although has seen an improvement is still failing in March (74.40%). However, performance has met the Year End target reporting at 77.72%.

Mental Health

27 of the 57 Indicated areas are rated green. There were 10 unrated indicator(s) - eg. data not received. The 20 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 achieved the 95% target in month for March reporting 95.00% of CPA follow ups within 7 days, it has however, breached Year End (93.48%). There were 2 breaches (out of 40) that were not followed up 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.
MH Evidence of using HONOS: Proportion of patients with a HONOS score	This indicator has breached the 95% target in month (94.73%), however has achieved the Year End at 95.27%. The Trust have highlighted that the key issues in underperformance are due to clinic cancellations (due to the Junior Doctors Strikes), Staff Sickness and the an increase in demand. Reminders have been communicated to all medics and CPNs regarding the importance of recording the HONOS at all stages (including the reviewing of assessments to ensure HONOS is undertaken at the earliest opportunity). The Trust continue to manage staffing levels to ensure clinics/assessments are maintained.

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 each month since April 15 with March achieving 0% (numerator = 0, denominator = 4). 24 assessments appointments were offered in March and there were 9 DNAs during the month. DNA reasons included : Arrived too late, DNA (no reason offered), DNA (moved out of area), DNA (no fixed abode), DNA (letter arrived on day of appointment. The Team continue to text message and call 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 appointment date. The team aim to offer 100% of referrals an appointment for assessment to meet the 5 day target, however due to mandated Family Intervention training undertaken by the team in March one of the assessment clinics was cancelled to facilitate team attendance thus impacting on availability to be able to offer this. The service is delivering an assessment clinic and 3 initial assessment slots in outpatient clinics this supports the requirement for clients to be seen within 5 days and thus being able to establish a care plan within 2 weeks. The DNA rate is impacting upon the timeframe in which to support compliance regarding the care-plan being in place. There is a designated team member for ensuring prompt allocations of clients following assessment. 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. An agency nurse has now been recruited with suitable clinical skills and experience and is providing clinical resource to cover the Band 6 vacancy and will continue until the recruited staff member commences in post, this will improve availability and capacity for assessments and allocation of care co-ordinator. The job descriptions for new posts created as part of the business plan are progressing through the job matching process and will be advertised once this process is completed.

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 and has been reported at month 12 as a breach with 43 new cases (noted that average is 3.6 cases per month at M12). Performance over the year has been affected by high DNA rates and capacity within the Early Intervention Team (long term sickness, failure to recruit to Deputy Team Leader role, and 3 changes of agency staff). An agency nurse has now been recruited to cover the vacant post as an interim measure until the permanent recruited staff member commences in post. Following unsuccessful attempts to recruit to the Deputy Team Lead role, this post has been reviewed and revised and a decision made to recruit to a clinical band 6 post without the managerial elements, these elements will be supported within the wider team. Funding has been agreed for additional staffing who will increase capacity for assessment and care co-ordination and will be able to promote the service within the City linking in with GPs, schools, colleges and statutory and voluntary agencies. In order to offer increased diversity and skill mix within the team and to reflect practice population, a BME CPN role and Youth Worker role will also be recruited to.

EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed to meet the 50% target both in month (6.67%) and Year End (29.5%). There were 24 assessments offered during March with 9 DNAs. DNA reasons included: Arrived too late, DNA (no reason offered), DNA (moved out of area), DNA (no fixed abode), DNA (letter arrived on day of appointment). The Team continue to send text messages and call new clients to remind them about their appointments (as well as sending out appointment letters). They inform referrers so that they have details of the initial assessments so that they can pass the information to the clients, if they are seeing them again before the appointment date. The team aim to offer 100% of referrals an appointment for assessment to meet the 5 day target, however due to mandated Family Intervention training undertaken by the team in March one of the assessment clinics was cancelled to facilitate team attendance thus impacting on availability to be able to offer this. The service is delivering an assessment clinic and 3 initial assessment slots in outpatient clinics this supports the requirement for clients to be seen within 5 days and thus being able to establish a care plan within 2 weeks. The DNA rate is impacting upon the timeframe in which to support compliance regarding the care-plan being in place. There is a designated team member for ensuring prompt allocations of clients following assessment. 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. An agency nurse has now been recruited with suitable clinical skills and experience and is providing clinical resource to cover the Band 6 vacancy, the agency nurse and will continue until the permanent recruited staff member commences in post and this will improve availability and capacity for assessments and allocation of care co-ordinator. The job descriptions for new posts created as part of the business plan are progressing through the job matching process and will be advertised once this process is completed.

Delayed transfers of care to be maintained at a minimum level	This indicator has breached the 7.5% threshold for March (9.85%) and Year End with an average performance per month of 13.67%. Performance 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 and includes 3 older adult patients who have already been escalated to local authorities but have still been delayed for a considerable time. The full Trust delay figure for March is at 4.7%.
Proportion of patients with a Care Plan when discharged from Older Adults Ward	The Trust has confirmed that an incorrect figure has been reported via the March SQPR, performance was originally reported as 20%, however has since been revised to the correct figure of 80% which remains under target. Performance for this indicator has failed to meet the 95% target in month and Year End (88.81%). 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 (num - 4, denom - 5 = 80%). The March breach relates to a patient who went to the Community Mental Health Team (CMHT) directly from the ward and there was confusion regarding if referred to the Home Treatment Team which then resulted in them not being seen within 7 days. Following this issue a crib sheet has been distributed for staff to follow and the deputy team manager will monitor on a daily basis until the team are confident with the process. Discharge plans will be discussed during the ward review meetings, and plans for HTT or Community follow-up need to be clear to avoid such reoccurrences in future.
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 6th consecutive month this year (57.24%) 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 (48.93%). 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 6 months and performance will continue to be monitored closely. Target has been met for the last 6 months and performance will continue to be monitored closely. Any decline in performance will be discussed via the Contract Review meeting. This local quality requirement was discussed at the April CQRM.

IAPT People who have entered treatment as a proportion of people with anxiety or depression (local prevalence)	This indicator has met the 15% target at M12 (15.40%). The CCG have noted that NHS England may still query the performance of this indicator as it has failed to hit the 3% increase per quarter.
SUIs Provide commissioners with Grade 1 RCA reports within 45 working days where possible, exception report provided where not met	This indicator achieved the 100% target every month with the exception of August. This indicator has therefore breached the Year End target (97.22%).
SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for March 2016, however the YTD has breached the 100% target (97.22%) 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 met the 95% in month (95.14%), however, has breached Year End (90.90%). 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.
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 60.00%. 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. March performance has been reported at 100% (numerator=1, denominator=1). 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% March submission relates to one member of staff that was 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 March has achieved the 85% target for the sixth consecutive month (92.21%). The Year End performance is below target at 83.77% 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 (86.98%) however the Year End performance is below target at 73.54% 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 sixth consecutive month, however the Year End is still below target 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 70.16% for March however, is still below the 85% target. The Year End performance is also below target at 50.38% 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 June15 and has achieved 86.78% for March16 and is above the 85% target. Although this indicator has met target for the fourth consecutive month, the Year End is still below target (55.44%). 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.
PSYCH LIAISON & CHTTs Emergency up to 6 hours. % of assessments relating to referral within period	M12 SQPR submitted 80% in error, has since been revised to 100% and GREEN in month and Year End (99.05%)

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 of the submissions was shared with the Committee and assurance was taken from the demonstration of the robust processes in place.

6. ASSURANCE RE DATA QUALITY

Following a query raised by the Governing Body at the last meeting relating to how it gains assurance that information received is correct. An internal audit report from 2015/16 was shared with the Committee for consideration. The report gave an overview of CCG system and process to ensure quality of data. The Committee took assurance from the substantial opinion and from the systems and processes in place to provide checks and balances.

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.

Further, 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 other forums such as 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: **1st June 2016**