NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
9th February 2016

Agenda item 12

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group(WCCG) Finance and Performance Committee- 26th January 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 M9	Achieved M9	Variance	RAG
Programme Cost £'000*	244,185	246,626	2,441	G
Reserves £'000*	3,383	925	-2,458	G
Running Cost £'000*	4,315	4,097	-218	G
Maximum closing cash balance £'000	283	10	-273	G
Maximum closing cash balance %	1.25%	0.04%	-0.71%	G
BPPC NHS by No. Invoices (cum)	95%	98%	-3%	G
BPPC non NHS by No. Invoices (cum)	95%	97%	-2%	G

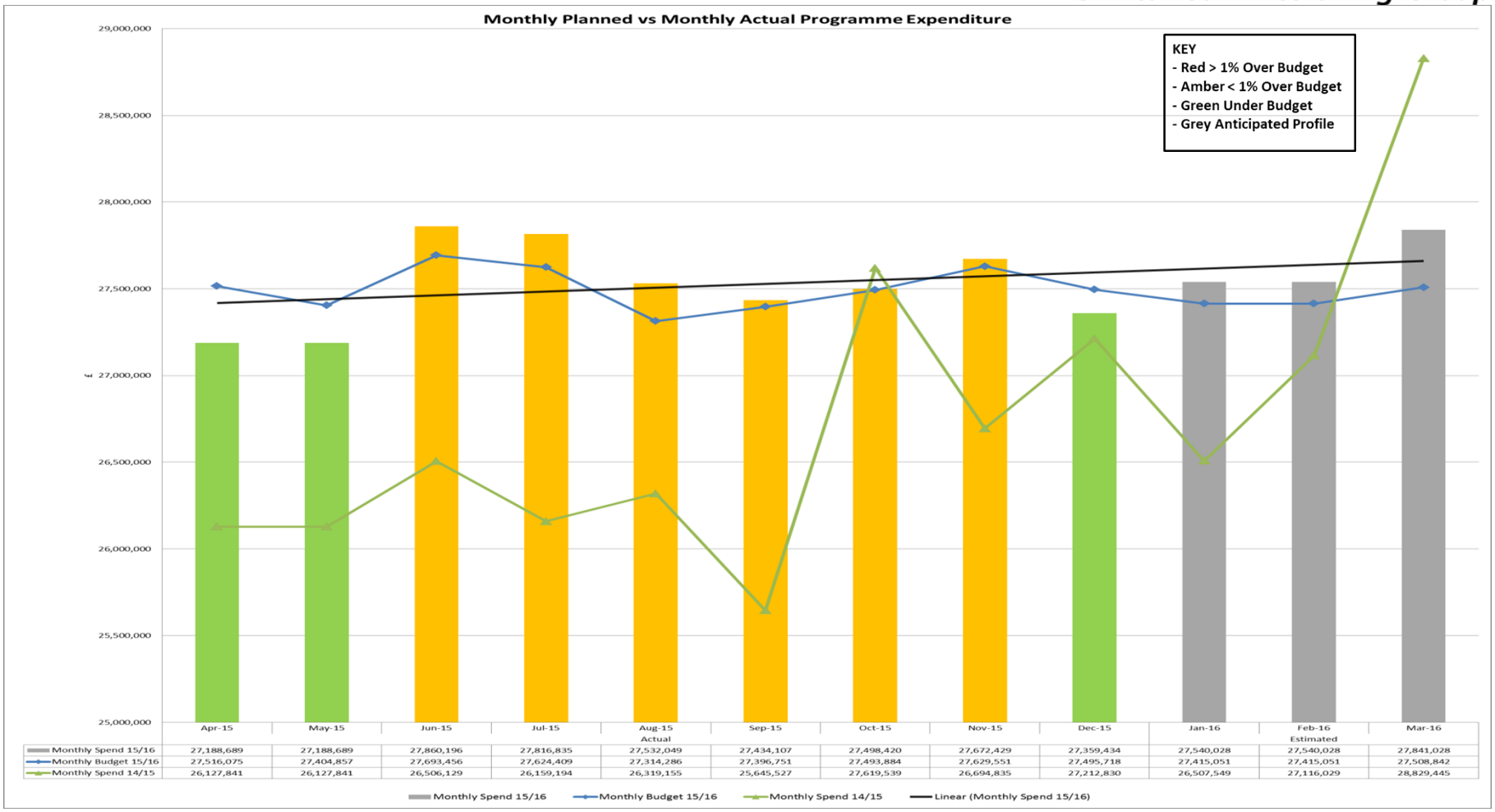
*The net effect of the three identified lines is an under spend of £235k therefore the green rating refers to the overall position.

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

	Annual Plan £'000	YTD Performance M9			
		Plan £'000	Actual £'000	Variance £'000	Var %
Acute Services	174,953	130,667	133,197	2,530	1.94%
Mental Health Services	32,697	24,523	24,816	293	1.20%
Community Services	33,108	24,831	25,016	185	0.75%
Continuing Care/FNC	13,198	10,105	9,103	-1,002	-9.91%
Prescribing & Quality	49,751	37,310	36,297	-1,013	-2.72%
Other Programme	22,328	16,750	18,197	1,447	8.64%
Total Programme	**326,034**	**244,185**	**246,626**	**2,441**	**1.00%**
Running Costs	6,120	4,315	4,097	-218	-5.05%
Reserves	3,874	3,383	925	-2,458	-72.66%
Total Mandate	**336,028**	**251,883**	**251,648**	**-235**	-0.09%
Target Surplus(deficit)	5,905	6,475	-	-6,475	-100.00%
Total	**341,933**	**258,358**	**251,648**	**-6,710**	-2.60%

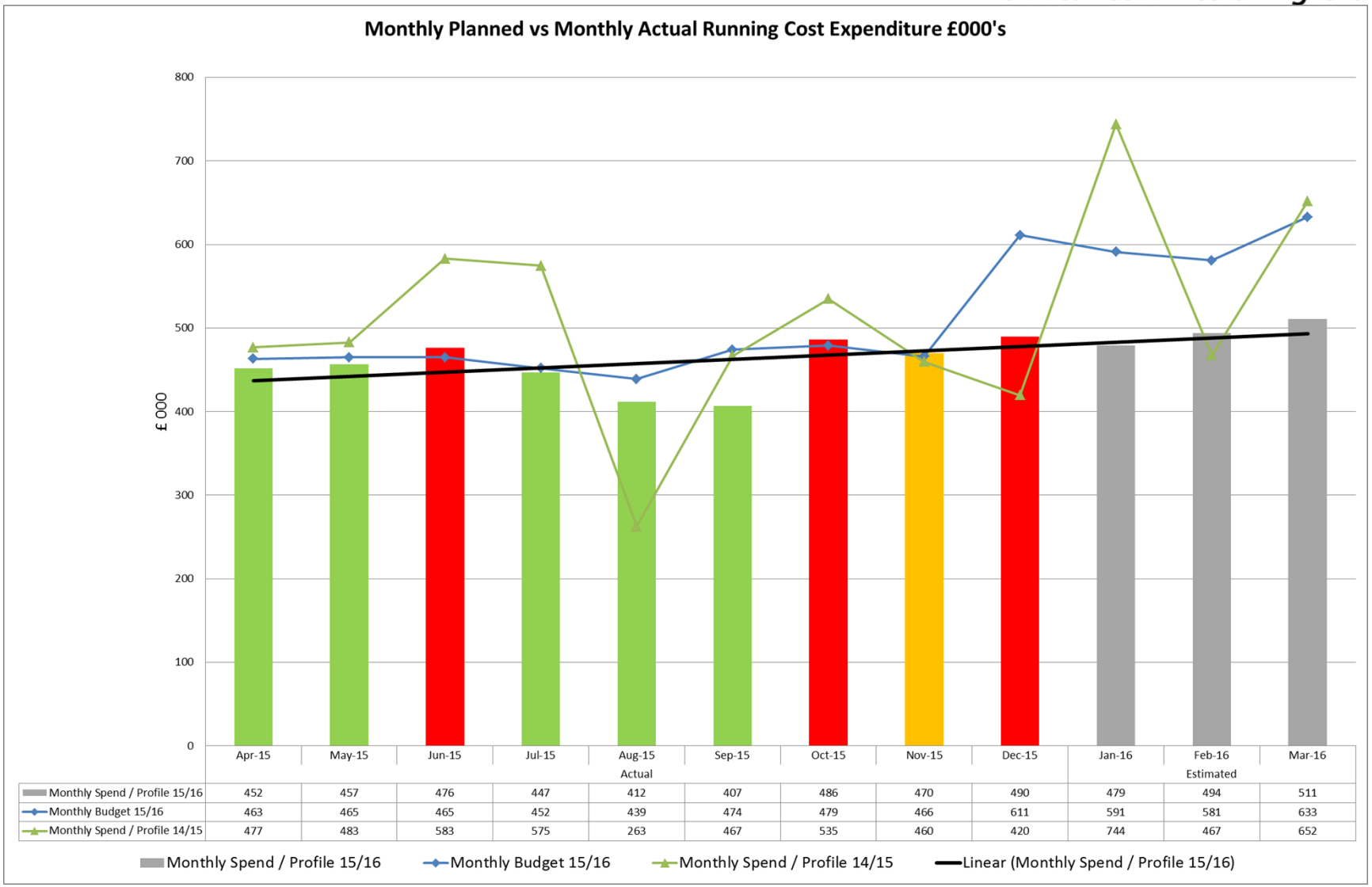
The table below details the forecast out turn by service line.

	Annual Plan £'000	Forecast Outurn at M9		
		Actual £'000	Variance £'000	Var %
Acute Services	174,953	178,163	3,210	1.83%
Mental Health Services	32,697	32,809	112	0.34%
Community Services	33,108	33,348	241	0.73%
Continuing Care/FNC	13,198	12,158	-1,040	-7.88%
Prescribing & Quality	49,751	48,567	-1,069	-2.15%
Other programme	22,328	24,240	1,797	8.05%
Total Programme	**326,034**	329,285	**3,251**	**1.00%**
Running Costs	6,120	5,556	-564	-9.22%
Reserves	3,874	1,187	-2,687	-69.36%
Target Surplus	5,905	5,905	0	0.00%
Total Mandate Spend	**341,933**	**341,933**	**0**	0.00%



	Apr-15	May-15	Jun-15	Jul-15	Aug-15 Actual	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16 Estimated	Mar-16
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	27,540,028	27,540,028	27,841,028
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	27,415,051	27,415,051	27,508,842
Monthly Spend 14/15	26,127,841	26,127,841	26,506,129	26,159,194	26,319,155	25,645,527	27,619,539	26,694,835	27,212,830	26,507,549	27,116,029	28,829,445

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



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
					Actual						Estimated	
Monthly Spend / Profile 15/16	452	457	476	447	412	407	486	470	490	479	494	511
Monthly Budget 15/16	463	465	465	452	439	474	479	466	611	591	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

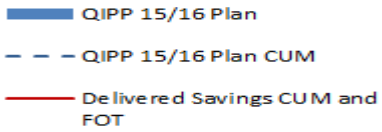
The Committee noted the current position of QIPP Programme performance as at Month 9.

2015- 16 M9

Delivery Board	Current Mth Plan	Current Mth Savings	Variance from Plan	Annual Plan	FOT	FOT Variance from Plan
Modernisation and Medicines Optimisation	2.305	2.423	0.118	3.063	3.050	-0.013
Integrated Care	1.394	2.271	0.876	2.050	3.259	1.209
Primary Care	1.905	1.754	-0.151	2.771	2.455	-0.316
Better Care Fund	1.206	1.055	-0.151	1.914	1.429	-0.485
Unallocated	0.999	0.000	-0.999	2.000	0.000	-2.000
Other	0.000	0.000	0.000	0.000	0.000	0.000
Total	7.809	7.503	-0.307	11.798	10.194	-1.604

The CCG started the financial year with an unallocated QIPP of £2m. As the year has progressed the CCG has identified additional QIPP through either new schemes or over delivery of planned levels which has enabled the unallocated gap to be closed. During the year slippage has been identified in planned QIPP schemes and it is this slippage which is wholly contributing to the shortfall in delivery against the annual plan.

Details of the Savings Plans
Key:

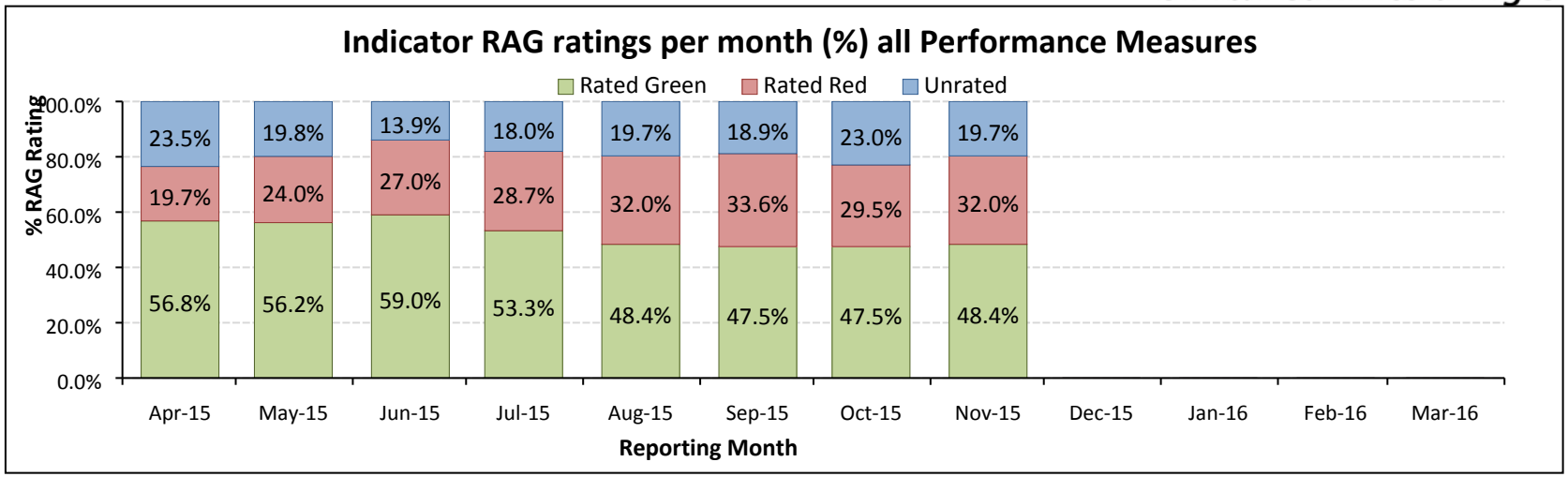


4. PERFORMANCE

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

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	Unrated (blank)	Total
NHS Constitution	17	18	10	10	1	0	**28**
Outcomes Framework	14	13	9	13	14	11	**37**
Mental Health	27	28	17	16	13	13	**57**
Totals	**58**	**59**	**36**	**39**	**28**	**24**	**122**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	Unrated (blank)
NHS Constitution	61%	64%	36%	36%	4%	0%
Outcomes Framework	38%	35%	24%	35%	38%	30%
Mental Health	47%	49%	30%	28%	23%	23%
Totals	**48%**	**48%**	**30%**	**32%**	**23%**	**20%**



Exceptions were highlighted as follows;

Executive Summary - Commentary	
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 5th consecutive month (79.38% - SQPR report and unconfirmed) against the 90% target. This is a 1.97% decrease from the previous month, however, it should be noted that following national guidance RTT performance is primarily measured using the Incomplete Headline Level (92% target) which achieved performance in November but is very close to target (92.04%). 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 4th consecutive month (93.10% - SQPR report and unconfirmed) against the 95% target. This is a 0.07% decrease from the previous month, however, it should be noted that following national guidance RTT performance is primarily measured using the Incomplete Headline Level (92% target) which achieved performance in November but is very close to target (92.04%). 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	November 15 failed to meet the 95% target both in month (92.04%) and YTD (93.64%). Attendances have continued to increase with an additional 857 (8.24%) attendances compared with the same period last year. The Trust failed to achieve both Type I and the All Types target for the month. Following the opening of the Urgent and Emergency Care Centre (UECC) on 25th November and a revised clinical process, the department has experienced significant pressure, increases in volume, cohorting ambulance patients and peaks in attendance. Issues have been intensified by logistical challenges. Provisional data for December performance indicates a significant decline in performance with the lowest single day reported performance to date (56% - 19th December). The Trust have issued a draft Remedial Action Plan (RAP) focussing on the primary drivers for failures e.g. Bed availability, patient flow, delays in patients having first assessment, patients and ambulances arriving in batches and other Emergency Department delays and the CCG are awaiting confirmation of agreement. Following an escalation to a Level 4 , the following actions were put in place : Reviews of staff rotas and increased consultant cover over Christmas period), improved escalation process and a run through of the "ergonomic" issues within the new department. WMAS have received funding for a "Frequent Fliers" project (the GP Practice visit programme targeting A&E "Frequent Fliers" is continuing until the end of March). A new Rapid Response Pilot (RRP) has been commissioned to provide Wolverhampton residents urgent

	access to rapid response assessment, diagnostics and support to safely manage patients in their own home and avoid unnecessary admissions to hospital and alleviate A&E pressure.
Percentage of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	This indicator has failed to meet the 94% target for November (86.96%), however the Year End is still within target (94.27%). Comments from the Trust indicate that validation is ongoing and final cancer data is uploaded nationally 6 weeks after month end.
Percentage of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	The performance for this indicator has failed to meet the 85% target for the 8th month (78.08%), with 29 patient breaches during November. The Trust have provided a breakdown of performance by speciality for information with the high breach areas as follows : Head & Neck (30.77%), Gynaecology (46.67%), Urology (69.23%, Upper GI (72.22%) and Colorectal (78.57%). A draft Remedial Action Plan (RAP) has been developed and includes the following actions : Implementation of the 8 High Impact Actions following tripartite agreement, review of current plan including pathway reviews and optimisation of diagnostic pathway, change in team structure to create a 62 day Pathway Manager role. The CCG are awaiting agreement of the RAP with a phased trajectory (85% and 89% excluding tertiary referrals by March 2016).
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 meet the 90% target for the month (89.5%) and Year End (87.8%). There were 2 patient breaches in November. 2 x locum Cancer Dermatologists have been recruited however difficulties in recruitment to the vacant full time Urologist posts continues due to a national shortage of Urologists. Pathway redesign to reduce Diagnostic Test waits. The Trust has attended a 62 day Cancer national listening event on 10th December in an attempt to help develop a national solution for the late 62 day tertiary referrals issue. The current performance has fluctuated close to the target over the last few months and is to be monitored closely. A Remedial Action Plan (RAP) will be developed if performance deteriorates.

Rates of Clostridium difficile	The C-Diff performance in Month 8 brings the Year to Date number of breaches to 57 and has already breached the full year threshold set for RWT by NHSE of 35. There were 10 positive cases by toxin test, 7 of which 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 attended by CCG action plan in place (Trust Wide) and CCG contributing 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. The HCAI data for November indicates that 2 cases where non Wolverhampton residents (1 x South East Staffs and Peninsula, 1 x Sandwell and West Birmingham).

All handovers between ambulance and A & E must take place within 30 minutes	Month 8 breached the zero target (79) which follows the same trend of increased numbers over winter as in previous reporting years. Although the in month figures are very close, it is important to note that the cumulative performance for 15-16 is still ahead of last year's position. There were no patients who breached the 12 hour target. The following actions were put in place during December : WMAS have received funding for a "Frequent Fliers" project (the GP Practice visit programme targeting A&E "Frequent Fliers" is continuing to end of March) and additional HALO cover funded to assist with handovers at time of pressure. Noted actions: Ambulance crews unload and stay with patient in corridor until patients move from Emergency Department, it 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. This fine for this indicator is £15,800 (79 patients between 30-60 minutes @£200 per patient).

All handovers between ambulance and A & E must take place within 60 minutes	Month 8 breached the zero target for the third consecutive month, reporting 7 breaches. Historically, the number of breaches increase over the winter period and although the in month position is lower than last year (Nov14 = 13 breaches), the current Year End position is higher than last year (Nov 14 Cumulative = 15, Nov 15 Cumulative = 17). The following actions were put in place during December : WMAS have received funding for a "Frequent Fliers" project (the GP Practice visit programme targeting A&E "Frequent Fliers" is continuing to end of March) and additional HALO cover funded to assist with handovers at time of pressure. Noted actions (as per Exception report) : Ambulance crews unload and stay with patient in corridor until patients move from Emergency Department, it 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. The fine for this indicator is £7,000 (7 patients >60 minutes @£1,000 per patient).

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

13 of the 37 Indicated areas are rated green. There were 11 unrated indicator(s) - eg. data not received. The 13 red rated areas are :

Description	Commentary
Falls per 1,000 occupied bed days	The performance for this indicator has achieved target for the 5th consecutive month. The number of falls (by occupied bed days) remain under the 5.6 target. The year to date average has fallen by 0.62 since last month and is now reporting at 4.79. Rapid improvement model undertaken on one of the wards is being reviewed with the intention to roll out. The Strategic group is currently in the process of reviewing its current work streams in line with National and International best practice.

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). November data indicates a 0.01% increase in performance to 95.04% for all wards (excluding assessment units). This is the 2nd month standard has been achieved for this indicator. It should be noted that the assessment units (see LQR2b) saw a 1.42% decrease in the same month and is still below target in month. The performance for both indicators remains below target on the YTD performance. A remedial action plan (RAP) has been developed (Dec15 V2) as performance has failed to achieve the desired standard with base ward areas close to compliant every month but with individual factors contributing to non-compliance. Actions include : Review of pathway for regular attenders into clinics to understand requirements around discharge, possible inclusion of patient return (for further investigation/overnight leave etc.), Trust training package and delivery plan, making e-discharge more accessible by moving link to front page of intranet, continue to target areas of poor compliance and weekly performance reports distributed to Divisional Medical Directors. Improvement and maintenance of performance is largely due as a result of a meeting held between Clinical leads from across the Trust to better understand the reasons for non-compliance with e-discharge and with a number of suggestions proposed with a view to improving performance.

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). November data indicates a 1.42% decrease in performance (83.46%) for all assessment units. It should be noted that the assessment units (see LQR2a) saw a 0.01% increase in the same month and has achieved standard for the 2nd time in the year. The performance for both indicators remains below target on the YTD performance. A remedial action plan (RAP) has been developed (Dec15 V2) as performance has failed to achieve the desired standard with base ward areas close to compliant every month but with individual factors contributing to non-compliance. Performance has seen small improvement over the previous few months, however is still below the 95% standard.
Serious incidence reporting - Report incidences within 48 hours	There were no breaches in November 15, however this indicator has already failed the Year End with 3 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
Serious incidence reporting - Update on immediate actions of incident within 72 hours	This indicator breached the zero target for November 15 and has already breached Year End (8 breaches in total). The Serious Incident ref : 2015/34203 related to a Treatment Delay report which was due on the 2nd November, but was not received until 3rd November. Each breach is reviewed at the Contract Review Meeting and the Clinical Quality Review Meeting. The fine for this breach is estimated to be £250.

Serious incidence reporting - Share investigation report grade 2 within 60 days	This indicator has breached both in month (3) and Year End (7) against the zero target for 15/16. The November breaches consist of : 2015/26166 - Treatment delay 2015/26159 - Confidential Information Leak 2015/28241 - Surgical/invasive procedure incident. Each breach is reviewed at the Contract Review Meeting and the Clinical Quality Review Meeting. The fine for these breaches is estimated to be £750.
Number of cancelled operations - % of electives	The M8 performance breached the 0.80% threshold (0.88%) however Year End is still within tolerance. 68 operations were cancelled during November. The cancellations that fall into the "other" category were : 1 x Cardiac, 3 x Cardiology (Dr off sick), 6 x Gynae (5 problems with heating, 1 MRSA result not back in time), 2 x Ophthalmology (1 x no consent form, 1 x theatre airflow not working), 4 x Orthopaedic (2 x problems in theatre, 1 x consent form not available, 1 x kit damaged). One of these cancellations relate to Cannock Chase Hospital. A root cause analysis (RCA) continues to be undertaken for every cancelled operation for non-medical reasons and continues to be reviewed weekly at the Divisional Managers 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 November performance has seen a significant increase (of 12.74 to 95.24%) but is still below the 98% target. 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 already failed Year End. We are awaiting confirmation that the methodology for this indicator is correct (as it has been 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. A&E saw an increase in attendances in both the previous year (857 attendance increase) and only a slight decrease from the previous month (287 attendance decrease). November 15 failed to meet the 95% target both in month (88.85%) and YTD (91.07%). The Trust failed to achieve both the Type I and All Types target for the month. The Trust have issued a draft Remedial Action Plan (RAP) focussing on the primary drivers for failures e.g. Bed availability, patient flow and first assessment (including Delayed Transfers of Care) and other Emergency Department delays and the CCG are awaiting confirmation of agreement. Following an escalation to a Level 4, the following actions were put in place during December : Reviews of staff rotas and increased consultant cover over Christmas period), improved escalation process and a run through of the "ergonomic" issues within the new department (new telephones, improvements on comms and signage etc). WMAS have received funding for a "Frequent Fliers" project (the GP Practice visit programme targeting A&E "Frequent Fliers" is continuing to end of March). A new Rapid Response Pilot (RRP) has been commissioned to provide Wolverhampton residents urgent access to rapid response assessment, diagnostics and support to safely manage patients in their own home and avoid unnecessary admissions to hospital and elevate A&E pressure. Following the December actions, performance has shown slow improvement and has achieved target only three times over the Christmas period. Performance is being monitored closely. The predicted fine for the November breach is £51,840.

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 95% within 10 days	This indicator met the 95% target for November. The Year End continues to breach due to below target performance during April, May, September and October. Previous actions of an additional member of staff and implementation of a waiting list initiative appear to have improved performance and reductions in the backlog of patients.
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 met the 99% target (99.53%) for November, however the Year End continues to breach due to below target performance in previous months.
The occurrence of a Never Event as defined in the Never Events Policy Framework from time to time	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 Meeting and Clinical Quality Review Meeting.

Mental Health

28 of the 57 Indicated areas are rated green. There were 13 unrated indicator(s) - eg. data not received. The 16 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 November 2015 performance and reported 100% of CPA follow ups within 7 days. However, the indicator is breaching the 95% Year End target (92.68%). 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.
CPA Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	This indicator has met the 90% target for November (100%) however is breaching the Year End (88.52%). It has also been noted that an amendment to the October submission has been received (from 90% to 83.33%) and is breaching target. The Trust have confirmed that changes to figures will be due to data quality checks and updated information. This performance percentage is affected by small number variations and the November figures are based on 12 patients (10 of which achieved plan within 4 weeks).
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 since April 15 with the November reporting at 0% (numerator=0, denominator = 2). The EI service continues to experience high DNA's. 23 initial assessments were offered during November, 8 of those did not attend. Staff availability during the month was affected by annual leave of both medical and clinical staff, statutory training and short term sickness. The Team are continually reviewing the high number of DNAs and exploring ways to reduce them including contacting clients who DNA to establish reasons why. Telephone calls and text reminders are being used with new clients to remind them about their appointments (additional to appointment letters).

EIS Percentage of all routine EIS referrals, receive initial assessment within 5 working days	This indicator has failed both in month (46.67%) and Year End (36.30%) against a target of 95%. All appointments in November were offered within 5 working days of the referral being received however the EI team continues to experience high DNA's. 23 initial assessments were offered during November, 8 of those did not attend. Staff availability during the month was affected by annual leave of both medical and clinical staff, statutory training and short term sickness. The Team are continually reviewing the high number of DNAs and exploring ways to reduce them including contacting clients who DNA to establish reasons why. The standard initial assessment letter has been amended to include the reason for offering early appointments to assist recovery. The deputy team leader post remains vacant and results in a loss of capacity as the post holder would have a 50/50 split of caseload and management responsibilities. It is worth noting that several attempts have been made to recruit to the post and that the candidate pulled out of the interview scheduled for Dec

Delayed transfers of care to be maintained at a minimum level	This indicator has breached the 7.5% threshold for November (21.1%) and performance is at the highest levels seen over the previous 3 years (16% increase on same month last year). This indicator 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. A high number of delays has been reported across the female and Older Adult Wards of Penn Hospital and a weekly report/monitoring has been undertaken and circulated to the senior management team. The current performance highlights that there are 9 patients classified as a delay. Some of the delays are of a complex nature - Cambian have a number of delays that is impacting on the discharge of 1 patient. The Trust has sought advice on one case as the patient has no access to funds, home office are aware of the case and will not be taking any action. Planned discharge dates have also been provided for 2 further patients. A review of the Bed Management Meeting is to be undertaken by the General Manager and will encompass all of BCPFT Mental Health beds. There is also a review/implementation of bed management policy. An invitation to the Bed Management meeting has been extended to housing and P3 colleagues and Conference Call facilities have also been introduced so that delegates do not have to attend the meeting and can dial in. Attendance requests to the Older Adults Local Authority however, it has been reported that it would be difficult for them to commit. A process has been agreed with the Older Adult lead and Ward Manager to ensure that progress is being made against each delay and each individual delay is discussed in detail with 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 target (95%) for November (4/4 clients with a care plan on discharge = 100%), however due to low performance in April and May the Year End is below target (85.71%). As there is only 1 older adult ward, the performance percentage of this indicator is affected greatly by any breach due to the small numbers of patients affected.
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 2nd time this year (54.24%) however, due to previous month's performance the Year End is below target (44.48%). 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.
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 already breached the Year End target (95.83%).
SUIs Provide commissioners with grade 2 RCA reports within 60 days	There were no RCA breaches for November 2015, however the YTD has breached the 100% target (95.83%) 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 meetings 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 for the seventh consecutive month. A remedial action plan (RAP) is in place and further discussions regarding failure to hit trajectory is due to take place on 4th December with the Trust and Sandwell Commissioners. Early indications are that this indicator should hit target by 18th December. The Trust have confirmed that by 18th December they had achieved 95.02%.

SAFEGUARDING CHILDREN % compliance with staff safeguarding training strategy at level 2.	Performance for this indicator has steadily improved over the year and November has achieved the 85% target for the second consecutive month (89.09%). The Year End performance is below target at 77.01% 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.	Performance for this indicator has seen a steady improvement since June but has failed to achieve the 85% target for November (68.42%). The Year End performance is also below target at 60.97% and the remedial action plan is still in place as covers other Safeguarding indicators although early indications are that the performance has met target for December (85.2%).
SAFEGUARDING ADULTS % compliance with safeguarding adults higher level training	This indicator has seen a steady improvement since June and although has achieved the highest performance so far this year has failed to meet the 85% target in November (65.29%). The Year End performance is also below target at 43.94% and this indicator is being monitored against the remedial action plan.
SAFEGUARDING ADULTS % compliance with MCA/DoLS training	This indicator has seen a steady improvement since June and although has achieved the highest performance so far this year has failed to meet the 85% target in November (65.29%). The Year End performance is also below target at 43.94% and this indicator is being monitored against the remedial action plan.

5. MSMG/EXTERNAL PLACEMENTS PANEL(CHILDREN'S) UPDATE

The Committee received an update on the planned financial outturn and was given assurance of the matters in hand to provide appropriate financial and clinical governance.

6. FINANCE AND ACTIVITY PLANS FOR 2016/17

The Committee received an overview of the key requirements of the 2016/17 planning round including timetable and considered the need to develop a 5 year Sustainability and Transformation Plan.

Draft budgets and an updated plan will be shared at the February Committee meeting in readiness for the Governing Body sign off of budgets in March. It was highlighted that due to the uncertainty of the timing of/receipt of finalised tariff figures and the Governing Body meeting schedule, this will either be at the meeting due to be held on 8th March or at an additional meeting which may be required alongside the Development Session planned for 22nd March.

7. QUALITY PREMIUM

The Committee was given an update on the Quality Premium achievements for 2014/15 based on the results received. The spend plans in development were discussed and noted that the spend must occur in the 2015/16 financial year.

The CCG has received £564,000 which reflects achievement in a number of key quality areas and is the highest performing CCG locally (in the Birmingham and Black Country area).

8. RECRUITMENT FOR LAY MEMBER OF THE FINANCE AND PERFORMANCE COMMITTEE

The Committee considered the proposal to appoint an additional (non-Governing Body) Lay Member to support the development of the Committee by adding additional impartial strategy viewpoint to aid challenge and discussion. It was noted that the remuneration for the role had been discussed and agreed by the Remuneration

Committee earlier that day. The Committee agreed to appoint a lay member in line with the role description, noted the recruitment process outlined and agreed to proceed with this.

9. KEY RISKS AND IMPLICATIONS

Financial Risk

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

Risks	Potential Risk Value £m
CCGs	
Acute SLAs	0.50
Community SLAs	0.00
Mental Health SLAs	0.00
Continuing Care SLAs	0.00
QIPP Under-Delivery	0.00
Performance Issues	0.00
Primary Care	0.00
Prescribing	0.00
Running Costs	0.00
Other Risks	0.00
TOTAL RISKS	**0.50**

Mitigations	Expected Mitigation Value £m
Uncommitted Funds (Excl 2% Headroom)	
Contingency Held	0.00
Contract Reserves	0.00
Investments Uncommitted	0.00
Uncommitted Funds Sub-Total	**0.00**
Actions to Implement	
Further QIPP Extensions	0.00
Non-Recurrent Measures	0.00
Delay/ Reduce Investment Plans	0.00
Other Mitigations	0.50
Mitigations relying on potential funding	0.00
Actions to Implement Sub-Total	**0.50**
TOTAL MITIGATION	**0.50**

- M9 shows a reduction in level of risk reported by the CCG following the inclusion of BCF risk at the re assessed level within the overall reported financial position.
- current assessment of risk for the CCG; a gross risk of £0.75 but risk assessed to £0.5m. This has reduced from last month as risks are either factored into the position or reduceas the financial year progresses.
- The CCG has identified potential mitigations to the risks identified. The current assessment of mitigations, £0.5m. The key mitigation relates to other non-recurrent flexibilities which have been identified.
- Although the CCG is able to identify sufficient mitigations to cover its risks the position remains very finely balanced.
- In delivering the financial surplus in M9 the CCG has already committed its Contingency reserve of £1.714m therefore this cannot be considered as mitigation.

Other Risk

- 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
- Breaches in performance and increases in activity will ultimately result in an increase in costs to the CCG. Performance must be monitored and managed effectively to ensure providers are meeting the local and nationally agreed targets.

10. RECOMMENDATIONS

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

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