# BOARD MEETING OF THE GOVERNING BODY

**TO BE HELD ON TUESDAY, 10 MARCH 2015**  
**BOARDROOM, WHITE ROSE HOUSE**  
**AT 1.00 PM**  
**AGENDA**

## PART 1

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14. Finance Report Month 10 2014/15  
   Andrew Pepper

15. Process for sign off of CCG Final Accounts 2014/15  
   Andrew Pepper / Jo Webster

16. Governing Body Terms of Office and appointment procedures  
   Dr Phil Earnshaw

17. Service Level Agreement negotiations with Yorkshire and Humber Commissioning Support  
   Andrew Pepper

18. NHS Wakefield CCG Assurance Framework  
   Andrew Pepper

19. NHS Wakefield CCG Risk Register  
   Andrew Pepper

20. Receipt of minutes and items for approval
   a Audit Committee  
      Sandra Cheseldine
      (i) Minutes of meeting held on 16 December 2014
   b Integrated Governance Committee  
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      (i) Minutes of meeting held on 18 December 2014  
      (ii) Minutes of meeting held on 20 January 2015
   c Clinical Cabinet  
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   e Health and Well Being Board  
      Jo Webster / Dr Philip Earnshaw
      (i) Minutes of meeting held on
   f Decisions of the Chief Officer – verbal update  
      Jo Webster

21. Any other business

22. The Board is recommended to make the following resolution:
   “That representatives of the press and other members of the public
   be excluded from the remainder of this meeting having regard to the
   confidential nature of the business to be transacted, publicity on
   which would be prejudicial to the public interest” (Section 1 (2) Public
   Bodies (Admission to Meetings) Act 1970”).

23. Date and time of next Public meeting:
   Tuesday, 12 May 2015, 1pm in the Boardroom, White Rose House
NHS Wakefield Clinical Commissioning Group
GOVERNING BODY
BOARD MEETING

Minutes of the meeting held on 13 January 2015
Boardroom, White Rose House

Present
Andrew Balchin Corporate Director, Adults, Health & Communities - Wakefield Council
Dr Avijit Biswas GP, Pinfold Lane Surgery
Dr David Brown GP, Kings Medical Centre
Stephen Bryan Practice Manager, Stuart Road Surgery
Dr Ann Carroll GP, Outwood Park Medical Centre
Sandra Cheseldine Lay Member - Audit
Dr Paul Dewhirst GP Queen Street Surgery
Dr Phil Earnshaw Chair and Clinical Leader
Sharon Fox Independent Nurse Member
Stephen Hardy Lay Member - PPI
Dr Clive Harries GP, Chapelthorpe Surgery
Mr Hany Lotfallah Secondary Care Consultant
Andrew Pepper Chief Financial Officer
Jo Pollard Chief of Service Delivery and Quality
Dr Adam Sheppard GP, Lupset Health Centre & Assistant Clinical Leader

In attendance
Esther Ashman Head of Strategic Planning (minutes 15/14)
Melanie Brown Programme Commissioning Director Integrated Care (minutes 15/18)
Katherine Bryant Governance & Board Secretary (minute taker)
Fred Chambers Interim Project Accountant (minutes 15/18)
Matt England Head of Contracting and Commercial Strategy (minutes 15/11)
Laura Elliott Head of Quality and Engagement (minutes 15/11)
Michele Ezro Associate Director Service Delivery and Quality
Sarah Fatchett Strategic Lead, West Wakefield Health & Well Being (minutes 15/13)
Edwina Harrison Chair of Safeguarding Children Board (minutes 15/09)
Liz Howarth Interim Primary Care Lead (minutes 15/14)
Dr Chris Jones Programme Director, West Wakefield Health & Well Being (minutes 15/13)
Pat Keane Interim Director, Strategic Projects (minutes 15/14)
Chris Makin Senior Commissioning Manager (minutes 15/10)
Karen Parkin Associate Director Finance, Governance & Contracting
Mandy Sheffield Head of Safeguarding (minutes 15/09)
Duncan Smith Service Manager, Transformation and Integration (minutes 15/19)

15/01 Welcome and Chair’s Opening Remarks

Dr Earnshaw welcomed everyone to the meeting. The NHS has been in the spotlight during the Christmas period. This is a result of increased demand for services, and also increased scrutiny in the run-up to the general election. The CCG will remain focused on
doing the best possible for the population of Wakefield.

Dr Earnshaw commented on the publication of the NHS England ‘Five Year Forward View’ and the different models of provider organisation the report proposed. The pace of change within the NHS is very quick and the pace will continue to increase.

15/02 Apologies for Absence

Apologies for absence were received from:

Dr Andrew Furber  Director of Public Health – Wakefield Council
Rhod Mitchell      Lay Member and Vice Chair
Jo Webster         Chief Officer

15/03 Public Questions and Answers

There was one written question from a member of the public requesting details of the items to be discussed within the private section of the meeting. In response a further query was raised about which contracts the CCG has with Mid Yorkshire Hospitals Trust (MYHT) and when these will be reviewed, it was agreed that a full answer will be answered in writing following the meeting.

15/04 Declarations of Interest

Dr Phil Earnshaw reminded members of the Governing Body that any conflicts of interest identified should be declared during the meeting.

Dr Sheppard and Dr Harries declared an interest in relation to agenda item 12 (Prime Minister Challenge Fund Update). They are both partners within GP practices included within Wakefield West. It was agreed that they can remain in attendance and will be permitted to participate in discussion during the presentation.

Andrew Balchin declared an interest in relation to agenda item 18 (social care funding). It was agreed that he can remain in attendance but will not be permitted to participate in discussion nor take part in any vote on the decision.

15/05 Minutes of the meeting held on 11 November 2014

It was RESOLVED that:

i) The minutes of the meeting of the NHS Wakefield Clinical Commissioning Group Governing Body Meeting held on 11 November 2014 were agreed as a correct record subject to one amendment - both Stephen Hardy and Dr Adam Sheppard were in attendance, but are not recorded in the minutes.

15/06 Action sheet from the meeting held on 11 November 2014

Katherine Bryant confirmed that all actions were complete with the exception of:

14/212 – People Strategy: the amendments requested by the Governing Body will be completed by the end of January 2015.

15/07 Matters arising
There were no matters arising.

15/08 Chief Officer Update

It was noted that Jo Webster was not in attendance because she is unwell. In her absence Andrew Pepper presented the Chief Officer report.

The CCG will publish information about its equality objectives by 31 January 2015. The final report has been considered by the Public involvement and Patient Experience Committee (PIPEC) and will be presented to the Integrated Governance Committee on 20 January 2015 for approval prior to publication by 31 January 2015.

Following the success of the Prime Minister Challenge Fund wave one, GPs within Wakefield plan to submit an application to wave two of the fund. The bid will promote faster innovation in primary care. Dr Earnshaw noted the conflict of interest for all GPs and the Practice Manager representative in relation to this update item. The Governing Body agreed that it was critical learning from the Wakefield West wave one project was identified and reflected in the wave two Prime Minister Challenge Fund bid.

Andrew provided a brief update on the PMS (Personal Medical Services) Equitable Funding Review. The CCG has taken a co-ordinating role in this review of funding to general practice, bringing together the Local Medical Committee (LMC) (on behalf of all Wakefield practices), NHS England area team (the current contract holders) and Wakefield Council Public Health Department. Dr Earnshaw noted the conflict of interest for all GPs and the Practice Manager representative in relation to this update item.

An application has been submitted to NHS England to make amendments to the CCG’s Constitution. The final version of the Constitution was approved at a meeting of the CCG’s members on 6 January 2015.

Andrew reported that on 2 December 2014 the CCG received a petition including 3635 signatures. The petition has been shared with NHS England. It states:

“I am totally opposed to the Government slashing £3.8 million from GPs budgets in our area which could see small practices closing; 38 full time doctors or 95 full time nurses being lost; and patients waiting longer to be seen by a GP”

Dr Earnshaw explained that NHS England has changed their position on this matter. It has been indicated that all the PMS Premium funding will be invested back into general practice and all of it will be retained within the CCG area in which the practice operates.

NHS England has an assurance process which is applied to all CCGs. The Area Team is moving to a risk based process and as such have adopted a light touch approach to NHS Wakefield. This consisted of a meeting between Jo Webster and the Area Team Director Moira Dumma. A copy of the letter confirming the outcome of this meeting is included within the report. Dr Earnshaw welcomed this development and the positive assurance this provides to the Governing Body.

It was RESOLVED that the Governing Body:

(i) Note the contents for information and support on-going developments outlined in the content of the report.
Edwina Harrison introduced herself and explained that she has been chair of the Wakefield and District Safeguarding Children Board for five years.

It was noted that the Safeguarding Children Board annual report was considered by the Governing Body in November 2014.

The Safeguarding Children Board is a statutory requirement. Although the Board has had increased flexibility in recent years there are still national priorities including forced marriage, female genital mutilation and domestic violence which the Board must focus on. In addition Edwina explained that the Board looks to the Joint Strategic Needs Assessment (JSNA) for guidance on the areas which should be considered.

There are strong partnerships which support the Safeguarding Children Board. Following a number of Serious Case Reviews a series of challenge events were held. Edwina said that these events were at some points uncomfortable for all involved. The events enabled further exploration of the issues and provided more assurance than written action plans. Edwina explained that following these events a number of enduring and complex issues have been identified. These issues present a challenge in safeguarding children and young people in Wakefield. They include information sharing between GPs and the hospital, the hospital and community services, midwives and social workers. In addition, the ways in which the Multi Agency Safeguarding Hub (MASH), Joint Investigation Team (JIT) and other ‘front door’ services (with the public) join up and share information. Finally Edwina noted that ‘change is constant’; there are many initiatives which can detract resources from the front line.

Looking forward to the future Edwina explained that she has received a letter from the Minister (Edward Timpson - Parliamentary Under Secretary of State for Children and Families). The letter invites Safeguarding Children Boards to consider how they can do things differently. Edwina highlighted activity undertaken by the Safeguarding Children Board sometimes overlaps with other organisations such as the CCG’s Governing Body. In light of this there may be opportunities to simplify and streamline what each body does in relation to safeguarding.

Dr Harries thanked Edwina and expressed his regard for the work undertaken by the Board to support and encourage information sharing. Dr Harries asked what more can be done to further improve information sharing. Edwina noted that the recommendations from many of the Serious Case Reviews pointed to the optimisation of SystmOne and work undertaken in response has demonstrated tangible improvements. Moreover there has been an evident change in culture within the district. However there is further work to do and there are other systems between which information sharing has not yet been optimised.

Dr Carroll drew attention to early intervention hubs which will be rolled out during 2015. In order to avoid mixed messages further information will be circulated to people once the hubs have launched (but not before).

The ‘Signs of Safety’ an integrated framework for every agency involved in child intervention work was launched in December 2014. Dr Carroll explained that this will mean all professionals will use a standard risk assessment format whichever organisation they work for. Edwina also welcomed this initiative and noted that it will support a shift in thinking and culture.
Edwina highlighted the success of the Multi-Agency Safeguarding Hub (MASH). There are challenges to secure long-term funding for the MASH. In addition as the project ages it will be important to keep the MASH ‘live’ and maintain the energy levels.

Edwina said that the CCG representatives involved with the Safeguarding Children Board and other support provided by the CCG has been exemplary. There are no issues or concerns that she needs to raise with the Governing Body. Moreover should Edwina identify issues at a future date she is assured that the necessary mechanisms are in place to resolve them.

Finally Edwina commented on the publication of the Jay Report (regarding Child Sexual Exploitation in Rotherham) and the situation in Wakefield and district. It was recognised a few years ago that this was an issue for West Yorkshire. In response a West Yorkshire wide Safeguarding Children group was established. This group enables localities to benchmark and also share best practice. In addition Edwina said that Mandy Sheffield was instrumental in establishing a task and finish group in 2010 which recommended the establishment of the multi-agency Action on Child Sexual Exploitation (MAACSE) panel in 2012. In December a challenge day (including 100 people) considered whether children are safe from child sexual exploitation in Wakefield. Edwina reported that while it is probable child sexual exploitation does take place in Wakefield; the necessary procedures are in place to identify issues and put necessary actions in place to protect children. Nothing of concern was identified during this challenge day and as a result there was a consensus that a deeper dive is not required at this time.

It was RESOLVED that the Governing Body:

(i) Note the contents of the presentation by the Chair of the Wakefield and District Safeguarding Children Board.

15/10 Update: Winterbourne View – Time for Change

Jo Pollard explained that the report focuses on four key areas. Firstly an update on the cohort of patients (i.e. a person with learning disabilities in an acute mental health hospital bed) identified following the Winterbourne View report. Secondly, a summary of guidance issued in November 2014 and the impact of the CCG. Thirdly, the proposed implementation plan. Finally, a summary of the Winterbourne Report.

Chris Makin reported that of the 15 patients identified within the Winterbourne cohort (Wakefield patients with learning disabilities in an acute mental health hospital bed), five have been discharged, two have a discharge date and eight remain in hospital. The CCG is working with NHS England and the independent living team to progress this work. Chris said he expects that within six months all these patients will be discharged or have a discharge date. It was agreed that a further update will be provided to the Governing Body once this work has been completed.

The Winterbourne View, Time for Change (November 2014) report makes recommendations about transforming the commissioning of services for people with learning disabilities and/or autism. Chris highlighted five key recommendations:

1) Strengthening rights of people with learning disabilities and/or autism.
2) Forcing the pace on commissioning through increased requirements on Clinical Commissioning Groups.
3) Increased registration requirements, inspection and potential closures of inappropriate hospital settings.
4) Building capacity in the community to enable support to be provided at the lowest
level of restriction appropriate to an individual’s safety.
5) Holding people to account including commissioners and providers about their respective performance and practice.

The CCG makes weekly returns to NHS England reporting on progress. A key focus will be developing the market in Wakefield, so that out of area placements will not be required.

Sharon Fox asked whether there are facilities within the area to support patients with complex needs. Chris confirmed that South West Yorkshire Partnership Foundation Trust undertake initial assessment and treatment in the area. However there is a need for ongoing market development.

Andrew Balchin said the report provides food for thought. There are a number of areas which can be improved including striving for long term and joined up planning (e.g. jointly with children and young people’s services).

The Governing Body acknowledged the significant progress made since Chris joined the CCG.

It was RESOLVED that the Governing Body:

(i) Note receipt of the report on progress regarding the Winterbourne View cohort of patients;
(ii) Note new guidance received —’Winterbourne View, Time for Change’ published in November 2014; and
(iii) Note the potential implications for Wakefield Clinical Commissioning Group.

15/11 Integrated Quality and Performance Summary Report

Andrew Pepper introduced the report and explained that the report was considered by the Integrated Governance Committee in December 2014. The report includes data to October 2014, however additional verbal updates will be provided on the current situation. Andrew confirmed that as reported in the media the health system is very busy at the current time.

It was reported that Accident and Emergency (A&E) performance at Mid Yorkshire Hospitals Trust (MYHT) has met the standard for the year to date, although not in the current month.

Matt England confirmed that MYHT and Yorkshire Ambulance Service (YAS) failed to meet ambulance turnaround targets to the required standard. In addition YAS failed to meet Cat A (Red1) and Cat A (Red2) 8 minute response times for the year to date.

The Governing Body noted that both the CCG and MYHT have met the monthly Referral to Treatment incomplete pathway performance for the second consecutive month. However both the CCG and Trust have failed to meet the required standards for RTT indicators in non-admitted and admitted pathways.

Dr Sheppard reported that MYHT A&E service is under significant pressure. Both YAS and MYHT are operating at REAP (Resource Escalation Action Plan) level 5, which means that non-urgent surgery has been cancelled. However it is important to benchmark the Trust’s performance against other hospitals. MYHT are performing 33rd out of 140 hospitals. This demonstrates the resilience of the system and the success of investment across the health system. Dr Sheppard confirmed that the CCG is doing all it can to question and
seek assurance that services are safe.

Dr Harries asked whether YAS are struggling to cope with the increased pressure. Dr Sheppard confirmed that as reported in the media increased demand has impacted on the service provided by YAS; especially Cat A (Red1) and Cat A (Red2) 8 minute response times.

The Governing Body thanked everyone across the NHS working hard to keep the health system running safely.

Laura Elliot noted that the report has been redesigned and invited members of the Governing Body to provide feedback on the new format.

One MRSA case was assigned to Wakefield CCG in September 2014. This is the first case reported during 2014/15. A review has deemed this as an unavoidable case of MRSA. Laura highlighted the progress made since last financial year.

SWYPFT has been placed in the lowest risk banding in the CQC’s intelligent monitoring report.

The CQC have published inspection reports from their visits to GPs in Wakefield during July 2014. Laura noted that some practices that were inspected have been incorrectly recorded in the CQC’s intelligent monitoring banding.

The Governing Body were invited to ask questions.

Sharon Fox expressed concern that on two occasions when the CQC have inspected Care Homes they have identified failings in relation to the ‘are they caring’ standard. She asked whether this was a one-off or an indication of culture within the district. Laura confirmed that this is not being picked up elsewhere, and therefore assumed to be a one-off. Andrew Balchin added that from the local authority’s perspective this is not a trend, but it is something to keep a close eye on. Andrew noted the council’s changing role moving from provider of social care services to an oversight role. The council will look at new ways of encouraging providers to invest in good quality provision.

In relation to the CQC inspection report about Stuart Road Surgery Sharon Fox asked whether the CCG is providing support to ensure clinical supervision is used for nursing staff. Laura confirmed that the CCG is in ongoing dialogue with the practice to provide appropriate support.

Dr Brown asked whether penalties will be applied to providers who fail to meet RTT targets. Andrew Pepper confirmed that the CCG will levy penalties in accordance with national guidance.

Stephen Hardy sought further information about the performance of YAS in relation to stroke. Laura Elliot confirmed representatives from YAS attended the Mid Yorkshire stroke improvement group and provided further information about next steps. A discussion followed about stroke services. Dr Earnshaw noted proposed changes to stroke services in London and suggested that this may be a model for change across the NHS.

It was RESOLVED that the Governing Body:

(i) Note the content of the report
15/12  Update: MYHT Care Quality Commission Improvement Plan

Jo Pollard explained that this report summarises MYHT response to the CQC inspection in July 2014, the final CQC report was published in November 2014.

It was noted that Jo Webster is a member of the MYHT implementation group mentioned within the report. In addition the CCG receives monthly updates and assurance at the Quality Board.

Dr Carroll asked whether leadership at the Trust has improved following the report. Jo Pollard confirmed that she is as assured as she can be. She noted a number of recent personnel changes and appointments at MYHT.

It was RESOLVED that the Governing Body:

(i) Note the contents of paper and the Mid Yorkshire Hospitals NHS Trust (MYHT) CQC Improvement Plan for information.

15/13  Wakefield West : Prime Ministers Challenge Fund Update - Presentation

Dr Chris Jones and Sarah Fatchett joined the meeting to present an update on the Wakefield West Prime Ministers Challenge Fund projects.

Wakefield West is made up of six GP practices which have a total population of 64,000. Wakefield West is one of 20 areas awarded monies from the wave one Prime Ministers Challenge Fund. The scope of the project is to modernise the access to general practice and look at new ways of delivering general practice services. Dr Jones explained that a key component of the project is extended practice hours (8am - 8pm, seven days per week) from an independent hub staffed by practice GPs. The project is six months into a 12 month programme. Feedback to date has been very positive and early indications are that A&E attendances are being avoided.

Dr Jones explained that the model is “GP Led but not GP first”. It includes other health professionals (e.g. physiotherapy, pharmacy, mental health workers, community nursing and heath/wellbeing workers), social workers and community consultants.

The Health-Pod (a vehicle with an inflatable building extension) has recently started to operate. The Pod will visit locations across the district and offer a menu of services. Sarah Fatchett expressed thanks for the local authority for all their help and support, including engagement work and logistics support.

Dr Jones explained that the next step will be for a digital platform which will allow video consultations. The system has been tested and initial results are very positive. Sarah noted positive patient feedback from people of all ages.

A service directory has been developed, it will support patients to navigate service options. It is available on the Wakefield West website and will also be available from kiosks at GP practice receptions.

Dr Earnshaw thanked Dr Jones and Sarah Fatchett for attending the meeting. He welcomed this innovative and exciting work. In turn Sarah thanked everyone at the CCG for all their help and support.
It was RESOLVED that the Governing Body:

(i) Note the contents of the presentation.

15/14 Planning Guidance 2015/16

Esther Ashman explained that following publication of the Five Year Forward (vision for the future of the NHS) planning guidance was published in late 2014. The guidance was prepared jointly between six national bodies.

Esther commented that NHS Wakefield is very well placed because the guidance points to areas the CCG is already progressing. In addition the guidance focuses on seeking IT solutions to support integration and identifying ways to retrain and retain the NHS workforce. Esther noted that three new funds have been launched by NHS England, these funds focus on:
1) support for a small number of geographical areas to introduce new care models.
2) a fund to invest in primary care – further details are awaited.
3) a new national programme to support the development of a national evidence based diabetes prevention programme linked to the NHS Healthcheck.

Work will continue to develop the CCG’s plan for 2015/16. This will be reviewed by the Planning and Delivery Group before presentation to Clinical Cabinet. Input from Networks will be also be sought and included.

Dr Carroll highlighted the significant challenges faced by the CCG in achieving parity on mental health; in particular the introduction of new and important access standards for mental health. Dr Harries agreed but reassured the Governing Body that the team are reviewing the planning guidance and working to ensure that the CCG enables genuine parity of esteem.

Andrew Balchin welcomed the renewed focus on partnership working. He noted the important role of the voluntary and community sector in delivering health and social care services in Wakefield.

Esther Ashman circulated further information about the NHS England scheme to fund vanguard sites for new models of care. It was noted that those areas which are already working on new models of care (such as Wakefield) will be well placed to apply for funding. Following discussion the Governing Body agreed that the CCG should continue to explore the potential of submitting a bid to the fund. Further details will be provided to Clinical Cabinet. It was agreed that a group will be established on the CCG’s intranet to facilitate further discussions about a bid to the fund.

It was RESOLVED that the Governing Body:

(i) Note the content of the planning guidance for 2015 – 2016.
(ii) Note the actions required of the CCG and the process through which they will be carried out.
(iii) Agreed that subject to further consideration at Clinical Cabinet NHS Wakefield CCG would like to express an interest in the new funds established by NHS England.

15/15 Primary Care Co-commissioning

It was noted that all GPs have a conflict of interest in relation to this item. It was agreed
that they can remain in attendance and will be permitted to participate in discussion.

Liz Howarth explained that the CCG has submitted an application to assume full delegated authority from NHS England to co-commissioning primary care. It was noted that the Governing Body discussed and agreed to this proposal in July 2014 and November 2014. A meeting of the CCG’s members was held on 6 January 2015, they reconﬁrmed support for the CCG to apply for full delegation to commissioning general practice. It is expected that NHS England will conﬁrm in early February 2015 whether the application has been successful.

Liz reminded the Governing Body that primary care commissioning will enable local control and inﬂuence. In addition it will bring local experience and understanding to oversight of quality in primary care.

The CCG is working closely with NHS England to resolve a number of questions. This includes queries about ﬁnancial allocations and the management of property / premises.

Dr Brown asked for further information about the implications of delegated commissioning for the CCG. Katherine Bryant explained that there will be changes to the organisation’s governance structure; this includes the establishment of a new committee (the Conﬂicts of Interest Management Committee). This committee will have delegated authority to make decisions about commissioning primary care. The terms of reference for this committee will be presented to the Governing Body for approval in March 2015. In addition Katherine highlighted the revised conﬂicts of interest policy which complies with new NHS England guidance.

It was RESOLVED that the Governing Body:

(i) Support the transfer of the defined functions and responsibilities for general practice commissioning responsibility in line with the CCG ambition to develop people-centred primary care and integrated services for the beneﬁt of patients.

15/16 Conﬂicts of Interest Policy

Andrew Pepper explained that NHS England recently published new statutory guidance for CCGs about the management of conﬂicts of interest. The policy presented for approval has been amended to reﬂect the requirements of this guidance.

Katherine Bryant outlined the main changes made to the policy. The NHS England guidance requires that the CCG’s member practices declare interests. It was not initially clear how this should be implemented; whether all GPs in Wakeﬁeld would need to declare conﬂicts of interest. Following discussions with NHS England it has been agreed that this will only be applied to GPs and other general practice staff who are involved in CCG decision making, for example those who sit on a GP network committees or take part in any ad-hoc task groups.

In addition the frequency with which the register must be updated has increased. The CCG must satisfy itself on a quarterly basis that all the CCG’s registers of interests are accurate and up to date.

Finally Katherine noted that procurement decisions relating to the commissioning of primary medical services will be made by the CCG’s new Conﬂicts of Interest Management Committee (currently referred to as the Executive Approvals Group). In accordance with the NHS England guidance this Committee will meet in public. A standing invitation will be
made to Wakefield Healthwatch and Wakefield Health and Wellbeing Board to appoint representatives to attend meetings of the Committee.

As part of the co-commissioning application the Chair of the Audit Committee and the Chief Officer provided formal attestation to NHS England that NHS Wakefield CCG has complied with the NHS England guidance. They will be required to provide similar assurance to NHS England on an annual basis.

Dr Earnshaw noted that as far as possible efforts have been made to ensure that the CCG approach the management of conflicts of interest in a transparent, yet proportionate and pragmatic way.

Dr Sheppard and Dr Harries noted the importance of an appropriate culture to support the management of conflicts of interest. It was proposed a Memorandum of Understanding is developed with members to explain the statutory requirement to declare interests.

Sandra Cheseldine thanked Katherine Bryant for all her hard work to revise the policy.

Dr Dewhirst left the meeting.

It was RESOLVED that the Governing Body:

(i) Approve the revised NHS Wakefield CCG Conflicts of Interest Policy.

15/17 Update: System Resilience

Jo Pollard introduced this paper and explained that the paper provides an update on monies invested ensure the health system is resilient. Andrew Pepper noted that the paper also includes further details about the investment of monies to support achievement of Referral to Treatment (RTT) targets. He reported that an additional £3.9m has been made available, but not yet received by the CCG.

Dr Carroll asked whether flex-data is yet available for attendances at A&E. Dr Sheppard said that although up to date information is available it cannot be reported because it has not been validated. Dr Earnshaw added that Wakefield attendance is only 1% above plan, however neighbouring CCG areas are up to 10% above plan. Overall MYHT A&E attendances are 5% above plan. Dr Sheppard confirmed that the CCG is working with MYHT to support their response and consider how capacity can be increased at Dewsbury hospital.

It was noted that general practice is also very busy with a significant increase in activity. A discussion followed regarding the feasibility of collecting activity data from general practice. It was agreed that this would be considered further.

It was RESOLVED that the Governing Body:

(i) Note the allocation of resources and the detail of how it is being deployed across System Resilience Group partners to assist with managing seasonal pressure

15/18 Integration Governance Review: Signal of Intent

Melanie Brown provided an overview of the paper and explained that on behalf of the Health and Wellbeing Board she has led a governance review to ensure that the right
arrangements are in place for oversight of the Better Care Fund.

Melanie reported that the Wakefield Better Care Fund application has been approved, on the condition that appropriate management arrangements are put in place. The Governing Body expressed their thanks to everyone who worked on the bid.

The report sets out the current Health and Wellbeing Board governance arrangements which are quite complex. It is proposed that these arrangements are streamlined to ensure swift decisions. The structure will include a joint committee between the CCG and the local authority to oversee the Better Care Fund.

Following the Health and Wellbeing Board on 22 January 2015 there will be a four week consultation about the proposals. Melanie noted that one amendment to the paper presented will be the creation of a Connecting Care Executive. This group will bring together the Integration Executive and the Joint Strategic Commissioning Board.

It was agreed that a further update will be presented to the Governing Body in March 2015. This will include information about the section 75 agreement which will underpin the Better Care Fund.

It was RESOLVED that the Governing Body:

(i) Adopt the principles outlined in the ‘proposed governance arrangements moving forwards’ section of the report;
(ii) Approve the timetable outlined in the ‘proposed governance arrangements moving forwards’ of the report - to have the Better Care Fund pooled budget arrangements agreed and signed by both Wakefield Council and Wakefield Clinical Commissioning Group, through a section 75 agreement by 1st April, 2015; and
(iii) Consider receiving further updates about this governance review through the Chief Officer update at future Governing Body meetings.

15/19  S256 agreements re Social Care Funding (by NHS England) and Reablement Services (by CCG)

The Governing Body noted that Andrew Balchin has declared an interest in relation to this agenda item. It was agreed that he can remain in attendance, but will not be permitted to participate in discussions nor take part in any vote.

Duncan Smith explained the Council receives two payments for S256 agreements. The first is paid from NHS England in relation to Social Care funding and the second for reablement funding that is allocated to the CCG and is transferred to the Council.

The proposal has been scrutinised by both Clinical Cabinet and the Joint Strategic Commissioning Board. Due to the financial value, approval from the Governing Body is also required.

Duncan provided further information about the development of reablement provision in Wakefield district. The funding is intended to support people living independently. Part of the funding is used for short-term support to help people maintain or regain maximum independence at home. In addition residential reablement beds have been funded. It was noted that during 2015/16 the funding will be included within the Better Care Fund.

Mr Lotfollah asked whether it will be possible to monitor whether the funding has contributed to a reduction in re-admissions. Andrew Pepper noted that the Better Care
Fund will include performance metrics related to emergency admissions and could possibly be extended to include re-admissions.

A discussion followed about the manner in which the funds have been split between different reablement provisions. Andrew Pepper reminded the Governing Body that the proposals have already been scrutinised by Clinical Cabinet.

It was RESOLVED that the Governing Body:

i) Note and agree the S256 agreement prior to progress to Health and Wellbeing Board.

15/20 Finance Report Month 8 2014/15

Karen Parkin introduced the report which provides an update to the end of November 2014. The CCG is on track to achieve a £6.5m surplus for the financial year. There have been no allocation changes during the period, although in October the CCG received additional funding from NHS England to support system resilience and RTT (tranche one).

Karen confirmed that the majority of indicators are green. The exceptions are achievement against the Quality, Innovation, Productivity and Prevention (QIPP) target and a projected activity over-trade with Leeds Teaching Hospitals Trust. A cost pressure has emerged in relation to excluded rheumatology drugs. The prescribing budget is underspent but there is a national cost pressure on Category M drugs.

Section nine of the report highlights current risks and opportunities. These have not been played into the financial figures included within the report. Andrew Pepper said that this is a challenging position for the CCG, with a number of significant potential risks which need to be handled carefully.

Karen drew attention to an opportunity for the CCG following a potential restatement of the Continuing Healthcare risk pool. It was noted that following a national reassessment funds from the pool funding will be returned to the CCG. These funds will be available for the CCG to draw down in future financial years.

It was RESOLVED that the Governing Body:

i) Notes the contents of the month eight 2014/15 finance report.

15/21 Minutes of the Audit Committee

Sandra Cheseldine presented minutes of the Audit Committee meeting held on 25 September 2014. She highlighted the shortened timetable for preparation of the CCG’s annual report and accounts. It was noted that the committee has considered the financial treatment of GP pension contributions. Sandra commented that this may present complications during the preparation of the CCG’s annual report and accounts. As a result of changes at the Audit Commission the CCG will appoint the external auditors from the financial year 2017/18.

It was RESOLVED that the Governing Body:

i) Note the minutes of the Audit Committee held on 25 September 2014
15/22 Minutes of the Integrated Governance Committee

Dr Phil Earnshaw presented minutes of the Integrated Governance Committee meetings held on 16 October and 20 November 2014 and invited the Governing Body to consider the headline discussions.

It was RESOLVED that the Governing Body:

i) Note the minutes of the Integrated Governance Committee held on 16 October and 20 November 2014

15/23 Minutes of the Clinical Cabinet held on 30 October and 27 November 2014

Dr Adam Sheppard presented minutes of the Clinical Cabinet meeting held on 30 October and 27 November 2014 and invited the Governing Body to consider the headline discussions.

It was RESOLVED that the Governing Body:

i) Note the minutes of the Clinical Cabinet held on 30 October and 27 November 2014.

15/24 Minutes of the Health and Well Being Board held on 18 September 2014

Dr Phil Earnshaw presented the minutes from the Health and Well Being Board meeting held on 18 September 2014.

It was RESOLVED that the Governing Body:

i) Note minutes of the Health and Well Being Board held on 18 September 2014.

15/25 Decisions of the Chief Officer

Katherine Bryant confirmed that the Chief Officer has not made any decisions under the emergency powers delegated to her by the CCGs operating scheme of delegation.

15/26 Any other business

There were no other items of additional business.

It was RESOLVED that:

(i) representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” (Section 1 (2) Public Bodies (Admission to Meetings) Act 1970).

15/27 Date and time of next meeting

Tuesday, 10 March 2015, 1pm in the Boardroom, White Rose House.
**NHS Wakefield Clinical Commissioning Group**  
**GOVERNING BODY**  
**BOARD MEETING**  

Action Points from the Meetings held on Tuesday 13 January 2015

<table>
<thead>
<tr>
<th>Minute No</th>
<th>Topic</th>
<th>Action Required</th>
<th>Who</th>
<th>Date for Completion</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/164</td>
<td>Health of Looked After Children – annual report</td>
<td>• In November it was reported that the ‘tough books’ have been purchased, however following connection difficulties, Mid Yorkshire Hospitals Trust (MYHT) are working with BT to ensure a SIM card which provides the optimum signal across Wakefield district. Once this has been resolved ‘toughbooks’ will be provided to the Looked After Children team.</td>
<td>Jo Pollard / Mandy Sheffield</td>
<td>January 2015</td>
<td>Complete</td>
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| 14/212    | People Strategy | • Amend the People Strategy as follows:  
  a) further strengthen reference to the CCG’s values within the strategy;  
  b) re-consider whether the ‘People Strategy’ is the correct title for the document. | Dawn Clissett / Jayne Beecham | February 2015 | Complete |
|           |       |                 |     |                      |          |
| 15/10     | Winterbourne View Update | • Update to the Governing Body to confirm that the cohort of Winterbourne View patients have been reviewed, and everyone inappropriately placed in hospital to move to community based support.  
patients refers to Wakefield patients with learning disabilities in an acute mental health hospital bed.

| 15/14 | Planning Guidance | • Further consideration by Clinical Cabinet of a bid by the CCG to become a vanguard site for new models of care.  
• Establish an intranet group to facilitate further discussion about the CCG submitting a bid to become a vanguard site for new models of care. | Esther Ashman | February 2015 | Following discussion several submissions were made by the CCG. Two submissions have been shortlisted and national workshops were held on 3 & 4 March. A decision is awaited.  
All submissions will complement each other and work together to improve outcomes for patients across the district.  
Information about Vanguard site bids included on Skyline. |
<p>| 15/16 | Conflict of Interest Policy | • Disseminate new policy. Consider how best to communicate to member practices, including the possibility of a Memorandum of Understanding. | Katherine Bryant | February 2015 | Further information will be provided at the member meeting in March 2015 |
| 15/17 | System Resilience | • Explore the feasibility of collecting activity data from general practice. | Dr Greg Connor | March 2015 | Work ongoing with the Network Development Unit to see what anonymised data can be extracted from practice systems. |</p>
<table>
<thead>
<tr>
<th>15/18</th>
<th>S256 agreements</th>
<th>• Consider whether it would be possible to include Better Care Fund performance metrics related to emergency re-admissions.</th>
<th>Melanie Brown</th>
<th>March 2015</th>
<th>Agenda item 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/18</td>
<td>Better Care Fund</td>
<td>• Update for the Governing Body about the section 75 agreement which will underpin the Better Care Fund.</td>
<td>Melanie Brown</td>
<td>March 2015</td>
<td>Agenda item 13</td>
</tr>
</tbody>
</table>
Title of meeting: Governing Body

Date of Meeting: 10 March 2015

Paper Title: Chief Officer Briefing

Purpose (this paper is for): Decision ✓ Discussion Assurance Information

Report Author and Job Title: Jo Webster, Chief Officer

Responsible Clinical Lead: Dr Phillip Earnshaw, Chair

Responsible Governing Board Executive Lead: Jo Webster, Chief Officer

Recommendation:

To note the content for information and support on-going developments outlined in the content of the report.

Executive Summary:

To provide a brief update to members of the Governing Body on areas not covered on the main agenda.

Link to overarching principles from the strategic plan:

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<td>Organising ourselves to deliver for our patients</td>
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Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA): Not applicable

Outline public engagement – clinical, stakeholder and public/patient: Not applicable

Assurance departments/organisations who will be affected have been consulted: CCG Leadership Team

Previously presented at committee / governing body: Not applicable

Reference document(s) / enclosures: None

Risk Assessment: Not applicable

Finance/ resource implications: Not applicable
Care Homes and Social Care

Introduction

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

Across the Wakefield and MYHT footprint we submitted four expression of interests to be vanguards into the Models of Care and these are outlined below:

MYHT submitted an EOI for Additional approaches to creating smaller viable hospitals

This submission outlined that MYHT wanted to achieve the following:

- Implement full range of service changes.
- Centralise specialist care & expand local access (Dewsbury).
- Developed high quality midwifery unit
- Centralised neonatal services in specialist centre (Pinderfields).
- Developed sub-acute rehabilitation & elective services (Dewsbury).
- Developed integrated emergency care network across 3 hospitals.
- Emergency care unit, ED & walk in minor (Dewsbury).
- Developed integrated model for elderly care/rapid assessment 24/7 response

Primary care networks and colleagues in the Provider Alliance worked collectively on submitting this EOI together.

Our Model of Care will break the mould and will provide a comprehensive tool for proactive assessment, care planning and social interaction for people in care homes designed to optimise the health and life experience of residents. This will include assessment of people’s social care needs, using tested listening tools to take account of people’s life experience and aspirations, as well as identification of health needs to feed into a holistic care plan. The aim is to increase the potential for people to move back to independent living where safe and appropriate and to reduce the likelihood of health deterioration resulting in urgent demand for primary and secondary care.

An exciting feature of our Model of Care will be a pilot to test the potential to apply this proactive approach to people in supported living with the aim of reducing the number of people who progress to residential care (In 2013/14, 1:23 residents in Wakefield District Housing supported living schemes moved to residential or nursing home care.)
The Model of Care will bring together a range of initiatives which are already being piloted across the district and will deliver a coordinated approach to wellbeing for people in care settings. Key features of the model will be:

- Maintaining wellbeing through assessment and care planning that focuses on the wider determinants of health: ‘somewhere to live, someone to love and something to do’
- Enabling people to live in the most independent setting for as long as possible
- Proactive and systematic multi-disciplinary assessment, care planning and delivery involving GPs, primary and secondary care clinicians, pharmacists, experts in social care, including voluntary sector workers, working with care home staff to provide holistic care and so reduce the risk of deterioration and dependence
- Engagement of residents, families and staff in the design of new models of care and in their own support package
- Enhanced skills for care home staff to build capability and confidence in managing people with complex needs – raising the threshold for – and thus reducing the frequency of emergency call

Nationally over 260 expressions of interest were received for the programme these submissions went through a robust national and regional assessment process, which has seen every submission receiving review by medical, nursing, local government and patient/user colleagues at both a national and regional level, as well as assessment by NHS England, Monitor and NHS Trust Development Authority as the partners sponsoring the programme. Wakefield were invited to the second stage of the assessment for the Care Homes submission and the Multi speciality Community Provider for West Wakefield. Furthermore MYHT were invited to the second stage of the assessment for their submission in additional approaches to creating smaller viable hospitals for Dewsbury site. We are awaiting further feedback from the national programme about the success of all of these submissions but as approximately 50 submissions in total got through to this second wave Wakefield needs to celebrate that we had three invitations included in this second stage.

**MSCP - West Wakefield**

This submission builds on the successful wave one Prime Minister Challenge Fund bid in West Wakefield and focuses on delivering the following key objectives:

- Community Integration
- Care Home project
- The Connected Home
- Person Centred digital Health and Well-being
- Working with Consultants

**MSCP - Ferrybridge Medical Centre group of practices, Elizabeth Court Surgery and Kings Medical Practice**

This is a new partnership between the Ferrybridge Medical Centre group of practices, Elizabeth Court Surgery and Kings Medical Practice. Currently this involves 3 practices working under the Ferrybridge Medical Centre umbrella, the Elizabeth Court Surgery and
King’s Medical Practice. Overall this partnership covers 43,000 patients and operates from 8 sites.

This partnership aims to modernise and broaden the offering in Primary care whilst also building on its current strengths. We will become far more proactive in helping the whole community become much more aware and engaged in the prevention agenda. Certain subgroups of the population find the current format of GP difficult to access and we will consolidate our current work into a simple to access 7 day a week offering. One of our practices used to be a national beacon for integrated nursing teams. We would wish to recreate this in a modern environment. We will then use the whole nursing team to coordinate with the Connecting Care Hubs that have been developed to provide specialised community services and social care. We will have care coordinators based in practice. We recognise that in order to increase capacity in primary care we need to develop a non-registered workforce to undertake some work traditionally performed by doctors and nurses. We would wish to use tools like the Calderdale Framework to develop a sustainable model for the non-registered workforce.

**Specialised Services Commissioning Update**

In January 2015 Board members were informed a national consultation was underway regarding the future commissioning arrangements for specialist renal and morbid obesity surgery services.

The consultation period ended on the 9 January 2015 and NHSE reported that it has listened to patients, clinicians and CCG’s and would continue national commissioning of specialist renal and morbid obesity surgery services in 2015/16. It has confirmed it will keep under review whether to transfer responsibility to clinical commissioning groups, but any changes would not happen before April 2016.

From April 2015 the CCG will therefore be responsible for commissioning the following services which will need to be reflected in local contracts:

- Specialised wheelchair services;
- Outpatient neurology referrals made by GPs to Adult Neurosciences Centres; and
- Outpatient neurology referrals made by GPs to Adult Neurology Centres.

Board members are asked to note that NHSE has also launched a new consultation about how it will prioritise which specialised services and treatments to invest in. The consultation will last for 90 days from 27 January 2015. NHSE is also undertaking an engagement exercise to seek views on which specialised services should be prioritised for ‘service reviews’ as part of a rolling programme of reviewing how each specialised service is delivered.

Board members are asked to note that although there have been many positive achievements within the specialised service commissioning sector, nationally levels of growth in spending on specialised services are at variance with resource allocations. The challenge for commissioners and providers in the coming year is to achieve the best outcomes possible for patients within the constrained resources available set in the context of Quality Innovation Productivity and Prevention (QIPP) agenda. For commissioners, it will mean...
prioritising carefully and working in collaboration with partners where preventive action in upstream services can reduce pressure on complex care. The detailed arrangements for co-commissioning and revised governance structures to support this approach are being developed and will be shared with the Board at the earliest opportunity.

From a finance perspective significant work will need to take place during 2015/16 to map specialised services expenditure to CCG’s. In addition to this NHS Wakefield CCG is also in discussion within NHSE Specialised Commissioning Team (SCT) to agree an approach to addressing legacy issues associated with allocation transfers for the following services:

- Paediatric Insulin pumps;
- Vascular services; and
- HIV outpatient services.

The financial implications of any legacy issues and future transition arrangements will be reported to Board via the Chief Finance Officers reports.

**Connecting for Health NHS National Network Application Form**

Wakefield Council are seeking to procure a N3 connection which would be used to assist in the integration and data sharing agenda. The Council have requested support from the CCG with their application. This matter was discussed at Clinical Cabinet.

On the basis that the N3 connection represents both a much needed development to assist in the integration of services and that it does not give rise to any contractual or financial liabilities to the CCG, the CCG have supported the Council’s application.

Wakefield Council have an action plan in place to complete the information governance toolkit and the CCG have offered their help or expertise to enable the Council to ensure their information governance toolkit compliance.

**Age related macular degeneration (AMD)**

The Governing Body are advised that NHS Wakefield CCG has agreed to be a co-signatory on the collective letters that NHS Clinical Commissioners are to send to the Secretary of State, General Medical Council (GMC) and the Chief Executive of NHS England in relation to unlicensed medication for AMD. The following outlines the content of the letters:

**Secretary of State** letter includes the following:

- Given the necessary time that it will take to conduct this Multiple Technology Appraisal we request that you:
  - Support Clinical Commissioners who wish in the meantime to make local commissioning decisions to prescribe Avastin in place of the NICE mandated products Lucentis and Eylea, on the grounds that this is a safe and cost effective alternative treatment that can save the NHS hundreds of millions of pounds, which can be reinvested in patient care.
- Provide assurance to Clinical Commissioners that the Department of Health will underwrite the costs of any legal action that may result from the implementation of local commissioning decisions relating to the use of Avastin in NHS pathways

- Authorise NICE to undertake a Multiple Technology Appraisal review looking at the comparative cost effectiveness of Avastin, Lucentis and Eylea; and

GMC is asked to produce a statement to provide a specific exception from the standard guidance regarding the use of off-license medicines in the case of Avastin, and to issue an unambiguous statement of support to doctors who seek to prescribe this cost effective treatment in line with paragraph 18 of Good Medical Practice.

The Chief Executive of NHS England is asked to support a case for change with both the Secretary of State for Health and the GMC; provide support to Clinical Commissioners who wish to make local commissioning decisions to prescribe Avastin in place of the NICE mandated products Lucentis and Eylea, on the grounds that this is a safe and cost effective alternative treatment that can save the NHS hundreds of millions of pounds which can be reinvested in patient care.

The letters have approximately 115 signatories for CCG members of NHSCC.

Commissioning Working Together Programme Update

The programme is now embarking on phase two and a full report on the progress of each workstream for phase one will be reported on to Chief Officers across the Commissioning Working Together footprint before the end of March 2015. Phase two will be underpinned by a strategic review of health and care in the context of 5 year forward view, Dalton and planning guidance for 2015/16. The output of the review will inform local planning, the development of a Working Together Strategy and provider’s response to working collectively.

The Urgent Care workstream is now live and initially it coordinate the establishment of an Urgent and Emergency Care Network with membership drawn from local Chairs and leads of System Resilience Groups. The Network will bring together and share information, best practice and to will also be develop thinking to effect transformational system change.

Work is continuing within the Children’s worksteam as the project moves into its second phase. This next phase will focus on consolidating the case for change, seeking input and view form key stakeholders, and developing a regional service specification for the commissioning of safe and sustainable Children’s Surgery and Anaesthesia.

Following successful workshops through October, November and December negotiations are taking place to reach an agreement to support a rota sharing system which would to ensure 24/7 consultant cover for Acute Cardiology and a final meeting of cardiologists and managerial leads from participating Trusts will take place over the coming months to finalise detail.

A Project Lead has now been appointed to take establish a Yorkshire and the Humber approach to a review of HASU services.
Clinical options for new service models within the smaller specialities workstream have been developed and reviewed by the Clinical Senate which will inform the case for change.

We have established Patient and Public Advisory Forum, which will meet every six weeks. A Terms of Reference for the forum has been drafted, in partnership with local Healthwatch officers, to enable it to advise on the appropriate level of patient and public engagement/consultation across the Commissioners Working Together Programme.

Organisational Development Strategy

At the Governing Body meeting in November A People Strategy was presented and approved subject to two amendments:

- the strategy has been retitled as the Organisational Development (OD) Strategy
- it now includes overt reference to the CCG’s values and how the strategy is informed by, and supports, these values

The strategy has been introduced via the Staff Briefing, and will now appear on Skyline alongside the accompanying action plan.

Public Sector Equality Duty Report

As reported to the Governing Body in January 2015, the CCG is required under the Equality Act 2010, to demonstrate that we are meeting our legal duties with regards to equality and diversity. This means that we have to publish information annually, and agree and publish equality objectives.

Our second Public Sector Equality Duty (PSED) report was published on 31 January 2015 following presentation at Public involvement and Patient Experience Committee (PIPEC) in December 2014, and the Integrated Governance Committee in January 2015. The report is an update of activity undertaken during 2014/15 to embed equality within the CCG, and refreshes the content of the first report published in 2014. It includes a number of case studies reflecting relevant work the CCG has undertaken over the past year to plan and commission services for all our patients and communities, such as the Our Street, Your Street event in October 2014; Improving primary care access for patients with sensory impairment; and Reducing stigma and creating an inclusive culture as part of the mental health transformation programme.

The Integrated Governance Committee will continue to receive quarterly updates on progress against our four Equality Objectives, and meeting the requirements of the national Equality Delivery System (EDS) in line with NHS England guidance.

Crisis Care Concordat

Work has been underway since December to develop and finalise a local action plan for how we will deliver the Crisis Care Concordat. The concordat declaration was signed up to by all
partners across health, social care, third sector, police and housing in November 2014 and the action plan sets out how we will work towards the achievement of the 5 key aims:

- **Commissioning to all earlier intervention and responsive crisis services**
- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

The final draft will be presented to the Health & Wellbeing Board for approval on Thursday 19th March before we upload our plan to [www.crisiscareconcordat.org.uk](http://www.crisiscareconcordat.org.uk) by 31st March 2015.
Recommendations:

It is recommended that the Governing Body:

i. note the current performance against the CCG strategic objectives and Quality Premium; and

ii. approve the actions being taken to address areas of underperformance.

Executive Summary:

The Integrated Quality & Performance report is a key tool to provide assurance to the CCG that strategic objectives are being delivered and to direct attention to significant risk, issues, exceptions and areas for improvement. The report is aligned to the CCG’s six strategic priorities outlined in our Strategic Plan (NHS Wakefield – the next 5 years).

The report is a summary of the January and February Integrated Quality & Performance reports which have been presented to the two previous Integrated Governance Committee meetings. It reflects indicators that are currently underperforming against target up to December 2014, with summary exception reports to highlight the key issues and actions being taken to improve performance, as well as flagging key quality issues including recently published CQC reports.

Key Success Stories

- YAS Cat A (Red1 and Red2) 19 minute response times have met the operational standard in December for both CCG and provider position.
- There continues to be no reported 12 hour Trolley waits for the year to date.
- The Trust have met all the required standards for cancer indicators for 2ww waits both month and YTD position,
- The Trust have met all the required standards for cancer indicators for 31 days waits both month and YTD position,
- The CCG and MYHT have met the monthly Referral to Treatment – Incomplete pathway performance for the fourth consecutive month.
- 6 Week Diagnostic test waiting times have met the required standard during the period and the YTD for both the CCG and MYHT
- NHS Wakefield is now meeting the Dementia Diagnosis Rate Challenge.
- MYHT and NHS Wakefield are on track to meet Clostridium difficile targets for 2014/15, with MYHT having one of the best infection rates in the region.
- MYHT achieved encouraging results in the National A&E Patient Survey.
- MYHT continues to have one of the best SHMI scores in the region.
- Wakefield Hospice receives a ‘good’ rating overall from the CQC with an ‘excellent’ rating for caring.

Key areas for improvement

- YAS Cat A (Red1) and Cat A (Red2) 8 minute response times have failed to meet the operational standard for
YTD.
- A&E performance at MYHT has not met the required standard for December and the YTD Position.
- The CCG and trust have not met the required standards for cancer indicators for 62 day waits for referrals from NHS screening programme for the month,
- The CCG has not met the required standards for cancer indicators for 62 day waits from GP referrals for the month and YTD Position,
- The Acute Trust and Ambulance turnaround targets continue to fail to meet the required standard.
- IAPT performance has improved compared to the Q1 position, but continues to be below the required standard.
- The Trust has failed to meet the monthly position for 62 day cancer wait linked from NHS screening programme.
- The trust have reported 2 occasions in month where patients who have had cancelled operations have not been offered a new date within 28 days.
- The CCG has reported one over 52 Week Wait for Incomplete pathways during the current period,
- Stroke: MYHT haven’t made any significant improvement in the latest SSNAP data.
- NHS 111 performance is deteriorating in 2014/15.

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<td>Assurance on areas of underperformance or risks to safety and quality are discussed with providers through respective contractual and quality governance arrangements.</td>
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<td>Previously presented at committee / governing body:</td>
<td>Integrated Governance Committee – 20 January and 19 February 2015</td>
</tr>
<tr>
<td>Reference document(s) / enclosures:</td>
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<td>Risk Assessment:</td>
<td>Mitigating actions have been included within the report and risks are captured as appropriate in the Board Assurance Framework and Corporate Risk Register.</td>
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<tr>
<td>Finance/ resource implications:</td>
<td>Mitigating actions required to improve performance or quality are assessed on an individual basis for any finance or resource implications</td>
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Integrated Quality and Performance Report
March 2015
Governing Body Summary
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<td>36</td>
</tr>
</tbody>
</table>

### Arrow Key

<table>
<thead>
<tr>
<th>Arrow</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>↑</td>
<td>Target met, trend increased</td>
</tr>
<tr>
<td>↑</td>
<td>Target not met, trend improving</td>
</tr>
<tr>
<td>↔</td>
<td>No change</td>
</tr>
<tr>
<td>↓</td>
<td>Target met, trend deteriorated</td>
</tr>
<tr>
<td>↓</td>
<td>Target not met, trend deteriorated</td>
</tr>
<tr>
<td>↑</td>
<td>No target, trend increasing</td>
</tr>
<tr>
<td>↓</td>
<td>No target, trend decreasing</td>
</tr>
</tbody>
</table>
Executive Summary

Recommendations
It is recommended to:

1. Note the current performance against the CCG’s strategic objectives and Quality Premium
2. Approve the actions being taken to address performance areas

All data relates to December 2014 unless otherwise stated

<table>
<thead>
<tr>
<th>Key Success Stories</th>
<th>Area’s for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• YAS Cat A (Red1 and Red2) 19 minute response times have met the operational standard in December for both CCG and provider position.</td>
<td>• YAS Cat A (Red1) and Cat A (Red2) 8 minute response times have failed to meet the operational standard for YTD.</td>
</tr>
<tr>
<td>• There continues to be no reported 12 hour Trolley waits for the year to date.</td>
<td>• A&amp;E performance at MYHT has not met the required standard for December and the YTD Position.</td>
</tr>
<tr>
<td>• The Trust have met all the required standards for cancer indicators for 2ww waits both month and YTD position,</td>
<td>• The CCG and trust have not met the required standards for cancer indicators for 62 day waits for referrals from NHS screening programme for the month,</td>
</tr>
<tr>
<td>• The Trust have met all the required standards for cancer indicators for 31 days waits both month and YTD position,</td>
<td>• The CCG has not met the required standards for cancer indicators for 62 day waits from GP referrals for the month and YTD Position,</td>
</tr>
<tr>
<td>• The CCG and MYHT have met the monthly Referral to Treatment – Incomplete pathway performance for the fourth consecutive month.</td>
<td>• The Acute Trust and Ambulance turnaround targets continue to fail to meet the required standard.</td>
</tr>
<tr>
<td>• 6 Week Diagnostic test waiting times have met the required standard during the period and the YTD for both the CCG and MYHT</td>
<td>• IAPT performance has improved compared to the Q1 position, but continues to be below the required standard.</td>
</tr>
<tr>
<td>• NHS Wakefield is now meeting the Dementia Diagnosis Rate Challenge.</td>
<td>• The Trust has failed to meet the monthly position for 62 day cancer wait linked from NHS screening programme.</td>
</tr>
<tr>
<td>• MYHT and NHS Wakefield are on track to meet Clostridium difficile targets for 2014/15, with MYHT having one of the best infection rates in the region.</td>
<td>• The trust have reported 2 occasions in month where patients who have had cancelled operations have not been offered a new date within 28 days.</td>
</tr>
<tr>
<td>• MYHT achieved encouraging results in the National A&amp;E Patient Survey.</td>
<td>• The CCG has reported one over 52 Week Wait for Incomplete pathways during the current period,</td>
</tr>
<tr>
<td>• MYHT continues to have one of the best SHMI scores in the region.</td>
<td>• Stroke: MYHT haven’t made any significant improvement in the latest SSNAP data.</td>
</tr>
<tr>
<td>• Wakefield Hospice receives a ‘good’ rating overall from the CQC with an ‘excellent’ rating for caring.</td>
<td>• NHS 111 performance is deteriorating in 2014/15.</td>
</tr>
</tbody>
</table>

Current Intelligence

• YAS performance against the Cat A Red 1 and 2 operational standards remains below the required standard, and the proposed remedial action plan has not been agreed by the Commissioners, it is unlikely the year end position will deliver the required operational performance standard.
• The 2014/15 Quality Premium continues to be at risk due to the performance of RTT Incomplete pathways at MYHT and YAS Ambulance response times.
• A&E performance has not met the target for the month of December, as previous intelligence anticipated, This is largely due to unprecedented demand.
Executive Summary

Wakefield CCG Strategic Objectives Balanced Scorecard - (YTD - Position)

- A Step Change in the Productivity of Elective Care
- Mental Health Service Transformation
- Access to the Highest Quality Urgent and Emergency Care
- Maternity, Children and Young People Transformation
- Patient Experience Measures
- Internal Operational and Improvement

Cancer - Max 2 week wait from urgent GP referral to first course of treatment for all cancer
Cancer - Max 31 days wait from diagnosis to first definitive treatment for all cancer
Cancer - Max 31 days for subsequent treatment where that treatment is an anticancer drug regime
Cancer - Max 31 days for treatment where that treatment is a course of radiotherapy

Improving Access to Psychological Therapies
Care Programme Approach

Ambulance R1 8 min response
Ambulance R2 8 min response
Ambulance 19 min transportation
Ambulance to A&E handover
Crew clear delays
A&E waits no more than 4 hrs
Trolley waits - no more than 12 hrs

Smoking in pregnancy

Healthcare Acquired Infections - MRSA
Healthcare Acquired Infections - CDI
Mixed Sex Accommodation (MSA) Breaches

FIT - A&E
FIT - Inpatient
FIT - Maternity
### Executive Summary

#### Quality Premium 2014/15

<table>
<thead>
<tr>
<th>Population</th>
<th>£1,775,000</th>
</tr>
</thead>
</table>

**Financial Gateway**
- A CCG will not receive a quality premium if:
  - In the view of NHS England, during 2014/15 the CCG has not operated in a manner that is consistent with the obligations and principles set out in the Managing Public Money; or
  - During 2014/15 it incurs an unplanned deficit, or requires unplanned financial support to avoid being in this position; or
  - It receives a qualified audit report in respect of 2014/15

**NHS Constitution measures**
A CCG will have its quality premium reduced if the providers from whom it commissions services do not meet the NHS constitution requirements for the following patient rights or pledges (25% reduction per measure):
- Maximum 18 week waits from referral to treatment (incomplete pathways)
- Maximum 4hr waits in A&E departments
- Maximum 14 day wait from an urgent GP referral for suspected cancer

#### Quality Premium Measure Table

<table>
<thead>
<tr>
<th>Domain</th>
<th>Quality Premium Measure</th>
<th>Percentage of quality premium</th>
<th>Potential value for CCG</th>
<th>Current YTD Performance</th>
<th>Current eligible QP Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>Potential years of life lost (PYLL)</td>
<td>15%</td>
<td>£266,250</td>
<td><strong>£266,250</strong></td>
<td>£266,250</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long term conditions</td>
<td>Improving Access to psychological therapies</td>
<td>15%</td>
<td>£266,250</td>
<td><strong>£266,250</strong></td>
<td>£266,250</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long term conditions</td>
<td>Avoidable emergency admissions</td>
<td>25%</td>
<td>£443,750</td>
<td><strong>£443,750</strong></td>
<td>£443,750</td>
</tr>
<tr>
<td>Ensuring people have a positive experience of care</td>
<td>Friends and family test and patient experience</td>
<td>15%</td>
<td>£266,250</td>
<td><strong>£266,250</strong></td>
<td>£266,250</td>
</tr>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from</td>
<td>Improved reporting of medication and safety</td>
<td>15%</td>
<td>£266,250</td>
<td><strong>£266,250</strong></td>
<td>£266,250</td>
</tr>
<tr>
<td>Further local measure</td>
<td>Smoking in pregnancy</td>
<td>15%</td>
<td>£266,250</td>
<td><strong>£266,250</strong></td>
<td>£266,250</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>£1,775,000</td>
<td><strong>£1,775,000</strong></td>
<td>£1,775,000</td>
</tr>
</tbody>
</table>

#### NHS Constitution Rights and Pledges

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Current YTD Performance</th>
<th>Adjustment to Funding</th>
<th>Quality Premium Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Treatment (18 Weeks Incomplete)</td>
<td><strong>Red</strong></td>
<td>-25% -£</td>
<td>443,750</td>
</tr>
<tr>
<td>A&amp;E Waits</td>
<td><strong>Green</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Waits - max 14 days urgent GP Referral</td>
<td><strong>Green</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category A Red 1 Ambulance Calls</td>
<td><strong>Red</strong></td>
<td>-25% -£</td>
<td>443,750</td>
</tr>
</tbody>
</table>

**Total Adjustment**
-£ 887,500

**NET Total Payable**
£ 621,250

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Wakefield
Clinical Commissioning Group
### Strategic Performance Monitoring

#### Summary

- There are a total of 28 strategic performance measures from the NHS Constitution used by the CCG to measure strategic performance. The measures have been aligned to the thematic characteristics within the 5 Year strategic plan.
- A number of additional supporting measures also been aligned to the strategic planning themes, with a view to identifying wider system performance and effectiveness.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>National Average</th>
<th>Actual</th>
<th>YTD</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MYHT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test - A&amp;E</td>
<td>Nov</td>
<td>87%</td>
<td>93.0%</td>
<td>94.0%</td>
<td>↓</td>
</tr>
<tr>
<td>Friends and Family Test - Inpatient</td>
<td>Nov</td>
<td>94%</td>
<td>97.0%</td>
<td>95.6%</td>
<td>↑</td>
</tr>
<tr>
<td>Friends and Family Test - Maternity</td>
<td>Nov</td>
<td>95%</td>
<td>94.0%</td>
<td>97.5%</td>
<td>↓</td>
</tr>
<tr>
<td>Labour Ward % of patients recommending the service</td>
<td>Nov</td>
<td>92%</td>
<td>97.0%</td>
<td>96.9%</td>
<td>↑</td>
</tr>
<tr>
<td>Post Natal Ward % of patients recommending the service</td>
<td>Nov</td>
<td>77%</td>
<td>69.0%</td>
<td>54.6%</td>
<td>↑</td>
</tr>
<tr>
<td>% of staff recommending Trust as place to receive treatment</td>
<td>Q2</td>
<td>-</td>
<td>28.0%</td>
<td>0.4%</td>
<td>↓</td>
</tr>
<tr>
<td>% of patients recommending the service</td>
<td>Dec</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>National Average</th>
<th>Actual</th>
<th>YTD</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test - Calderdale, Kirklees and Wakefield</td>
<td>Nov</td>
<td>75 (Trust target)</td>
<td>100</td>
<td>79.79</td>
<td>↑</td>
</tr>
<tr>
<td>% of staff recommending Trust as place to receive treatment</td>
<td>Q2</td>
<td>77%</td>
<td>79%</td>
<td>74%</td>
<td>New indicator</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>NHS Wakefield</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Wakefield PALS</td>
<td>Jan</td>
<td>31</td>
</tr>
<tr>
<td>NHS Wakefield Complaints</td>
<td>Jan</td>
<td>11</td>
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## Strategic Performance Monitoring

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Wakefield CCG</th>
<th>Trend Information</th>
<th>Provider</th>
<th>Trend from previous Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E 4 hour waiting time standard</td>
<td>Dec</td>
<td>95%</td>
<td>96.8%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>88.3%</td>
<td>94.8% 94.8% 94.8%</td>
</tr>
<tr>
<td>Trolley Waits in A&amp;E</td>
<td>Dec</td>
<td>0</td>
<td>0</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>0 0 0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Acute Trust - Turnaround Time</td>
<td>Dec</td>
<td>100%</td>
<td>74.5%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>73.1%</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Ambulance - Turnaround Time</td>
<td>Dec</td>
<td>100%</td>
<td>73.4%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>85.1%</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td>Cat A (Red 1) 8 min response time</td>
<td>Dec</td>
<td>75%</td>
<td>85.5%</td>
<td>65.6% 72.1% 72.1%</td>
<td>Not reported at CCG Level</td>
<td>- - - - -</td>
<td>63.4% 69.3% 69.3%</td>
</tr>
<tr>
<td>Cat A (Red 2) 8 min response time</td>
<td>Dec</td>
<td>75%</td>
<td>76.4%</td>
<td>59.7% 69.4% 69.4%</td>
<td>Not reported at CCG Level</td>
<td>- - - - -</td>
<td>60.4% 69.2% 69.2%</td>
</tr>
<tr>
<td>Cat A (Red 1 and 2) 19 min response time</td>
<td>Dec</td>
<td>75%</td>
<td>99.6%</td>
<td>98.8% 96.8% 96.8%</td>
<td>Not reported at CCG Level</td>
<td>- - - - -</td>
<td>92.5% 95.6% 95.6%</td>
</tr>
<tr>
<td>Care Programme Approach (CPA)</td>
<td>Q3</td>
<td>N/A</td>
<td>97.4%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>n/a</td>
<td>97.2% 96.7% 96.7%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies</td>
<td>Q2</td>
<td>3.75 in Q4</td>
<td>10.8%</td>
<td>Not at Provider Level</td>
<td>Not at Provider Level</td>
<td>n/a</td>
<td>Not at Provider Level</td>
</tr>
</tbody>
</table>

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**MYHT**

**YAS**

---

**Wakefield CCG**

**Trend Information**

---

**Provider**

**Trend from previous Quarter**

---

**Dr AS**

**Dr JF**

---

**Dr CH**

**MEz**

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**Exception Report**

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## Strategic Performance Monitoring

### A step change in the productivity of elective care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Wakefield CCG</th>
<th>Trend Information</th>
<th>Provider</th>
<th>Trend from previous Month</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Date Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Waits - 2 Weeks</td>
<td>Dec</td>
<td>93%</td>
<td>96.2%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>98.6% 94.7% 94.7%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 2 week waits from GP referral to first outpatient appointment - all cancer</td>
<td>Dec</td>
<td>98%</td>
<td>98.6%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>98.3% 97.3% 97.3%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 2 week wait for patients referred with breast symptoms - cancer not suspected</td>
<td>Dec</td>
<td>96%</td>
<td>98.0%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>98.0% 98.0% 98.0%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Waits - 31 Days</td>
<td>Dec</td>
<td>96%</td>
<td>98.0%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>98.7% 98.7% 98.7%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait from diagnosis to first definitive treatment - all cancers</td>
<td>Dec</td>
<td>94%</td>
<td>97.8%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>100.0% 96.3% 96.3%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait for subsequent treatment where treatment is an anti-cancer drug regime</td>
<td>Dec</td>
<td>98%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>100.0% 100.0% 100.0%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 31 day wait for subsequent treatment where treatment is a course of radiotherapy</td>
<td>Dec</td>
<td>94%</td>
<td>97.9%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>100.0% 99.0% 99.0%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 60 day wait for first definitive treatment following a consultant decision to upgrade priority of patient</td>
<td>Dec</td>
<td>90%</td>
<td>63.6%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>80.0% 87.2% 87.2%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Waits - 62 Days</td>
<td>Dec</td>
<td>90%</td>
<td>93.7%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>89.9% 94.3% 94.3%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 62 day waits from referral linked to the NHS Screening Program to start 1st treatment for all cancers</td>
<td>Dec</td>
<td>90%</td>
<td>93.7%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>88.9% 94.3% 94.3%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Max 62 day wait from urgent GP referral to first definitive treatment for cancer</td>
<td>Dec</td>
<td>85%</td>
<td>84.8%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>84.0% 83.8% 83.5%</td>
<td>Dr AM</td>
<td>MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>Dec</td>
<td>90.0%</td>
<td>91.0%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>89.9% 87.3% 87.3%</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTT Admitted pathways</td>
<td>Dec</td>
<td>95.0%</td>
<td>95.4%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>91.1% 90.8% 90.8%</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTT Non-admitted pathways</td>
<td>Dec</td>
<td>95.0%</td>
<td>95.4%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>91.1% 90.8% 90.8%</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RTT - Incomplete pathways</td>
<td>Dec</td>
<td>92.0%</td>
<td>92.4%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>92.5% 91.5% 91.5%</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of 52 week referral to treatment pathways over 52 weeks</td>
<td>Nov</td>
<td>1</td>
<td>16</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>15 15 21</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>Dec</td>
<td>99%</td>
<td>99.1%</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>99.1% 99.2% 99.2%</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients who have operations cancelled on/after admission, should be offered a date for re-admission within 28 Days</td>
<td>Q3</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>MYHT</td>
<td>0 0 0</td>
<td>Dr AM</td>
<td>LD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Strategic Performance Monitoring

### Wakefield CCG

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend Information</th>
<th>Previous months score card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>Dec</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>••••••</td>
</tr>
<tr>
<td>Heathcare Associated Infections</td>
<td>Dec</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>↔</td>
<td>••••••</td>
</tr>
<tr>
<td>Clostridium Difficile</td>
<td>Dec</td>
<td>7/92</td>
<td>101</td>
<td>1</td>
<td>46</td>
<td>61</td>
<td>↑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td>↔ 0 0 0 ↔</td>
</tr>
<tr>
<td></td>
<td>→ Dr PW LD</td>
</tr>
<tr>
<td></td>
<td>→ Dr AF JYD</td>
</tr>
</tbody>
</table>

## Maternity, Children and Young People Transformation

### Wakefield CCG

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Trend Information</th>
<th>Previous quarters score card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking in pregnancy</td>
<td>Q2</td>
<td>23%</td>
<td>21.9</td>
<td>18.3</td>
<td>19.3</td>
<td>19.1</td>
<td>↑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider</th>
<th>Trend from previous Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYHT</td>
<td>↑ 18.5% 19.4% 19.4% ↑</td>
</tr>
<tr>
<td></td>
<td>→ Dr AF MEl</td>
</tr>
</tbody>
</table>

---

**Wakefield CCG**

Clinical Commissioning Group
Contents

• Quality Intelligence Group – December 2014 and January 2015
**Quality Intelligence Group**: The Group represents every team within the CCG, plus colleagues from Public Health, the Local Authority, Healthwatch and the Commissioning Support Unit working in relevant functions, such as complaints, PALS, engagement and communications. At each meeting a template captures and triangulates ‘soft’ intelligence from sources such as Patient Opinion, feedback from member practices, PALS enquiries, media reports, staff observations (including patient safety walkabouts) and staff/family experiences. From this key themes are identified and any actions agreed dependent on the strength of evidence, link with ‘hard’ data sources, and judgement on the level of concern. Quality Intelligence Group documents are now available on Skyline along with an interactive board for the sharing of intelligence.

72 items of intelligence gathered

<table>
<thead>
<tr>
<th>Key theme</th>
<th>Source of evidence</th>
<th>Strength of evidence</th>
<th>Hard evidence link</th>
<th>Service provider</th>
<th>Level of concern</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Assessment Unit - Pinderfields</td>
<td>Staff feedback, NDU / GP</td>
<td></td>
<td></td>
<td>MYHT CQC Report</td>
<td>High</td>
<td>1. Reality checks in January by Healthwatch</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MYHT Safe Staffing Report</td>
<td></td>
<td>2. List for PSW: follow up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MYHT</td>
<td></td>
<td>3. Check nurse staffing levels for this ward</td>
</tr>
<tr>
<td>Inadequate discharge</td>
<td>Engagement Staff feedback Healthwatch</td>
<td></td>
<td></td>
<td>MYHT SWYPFT</td>
<td>High</td>
<td>1. CCG/LA established Integrated Discharge Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Highlight issues through Integrated Discharge Team.</td>
</tr>
<tr>
<td>Medicines</td>
<td>Staff feedback Healthwatch</td>
<td></td>
<td></td>
<td>MYHT CQC Report</td>
<td>Medium</td>
<td>1. Indicators to improve medicines reconciliation are being developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MYHT</td>
<td></td>
<td>as part of 2015/16 CQUINs for MYHT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CQC action plan</td>
<td></td>
<td>2. CQC action plan contains a number of measures to address medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>management issues.</td>
</tr>
<tr>
<td>Transfer of patients / Patient flow</td>
<td>PALS / Complaints Staff feedback NDU GP feedback</td>
<td></td>
<td></td>
<td>GP</td>
<td>Medium</td>
<td>1. Check transfer policy – audit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MYHT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CQC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MYHT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gate 42/43 (elderly)</td>
<td>Incidents Staff feedback Healthwatch</td>
<td></td>
<td></td>
<td>MYHT CQC Report</td>
<td>High</td>
<td>1. CQC action plan contains a number of measures to address quality of</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MYHT</td>
<td></td>
<td>care on these wards</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Safe Staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward A2 (stroke neurology) –</td>
<td>Healthwatch PALS / Complaints Staff feedback</td>
<td></td>
<td></td>
<td>MYHT CQC Report</td>
<td>High</td>
<td>1. Patient Safety Walkabout will be undertaken. This ward was</td>
</tr>
<tr>
<td>Pinderfields</td>
<td></td>
<td></td>
<td></td>
<td>MYHT</td>
<td></td>
<td>intended to be visited on December’s walkabout which was postponed due</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Safe Staffing</td>
<td></td>
<td>to capacity issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Report</td>
<td></td>
<td>2. Stroke is discussed quarterly at MYHT Executive Quality Board.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Moved AAU to Gate 43 at 1.00am, staff quote from nurses on Gate 43 – ‘not sure where we are going to put her’
- A2 – Lack of compassionate Care, patients helping other patients & staff attitude
- Discharged without restart of carers
- Given an alternative to his medication which was out of date by 3 years
**Quality Intelligence Group:** The Group represents every team within the CCG, plus colleagues from Public Health, the Local Authority, Healthwatch and the Commissioning Support Unit working in relevant functions, such as complaints, PALS, engagement and communications. At each meeting a template captures and triangulates ‘soft’ intelligence from sources such as Patient Opinion, feedback from member practices, PALS enquiries, media reports, staff observations (including patient safety walkabouts) and staff/family experiences. From this key themes are identified and any actions agreed dependent on the strength of evidence, link with ‘hard’ data sources, and judgement on the level of concern. Quality Intelligence Group documents are now available on [Skyline](#) along with an interactive board for the sharing of intelligence.

47 items of intelligence gathered

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<th>Service provider</th>
<th>Level of concern</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>PALS / Complaints</td>
<td>✔ ✔ ✔ ✔ ✔</td>
<td>111 Performance Report</td>
<td>YAS</td>
<td>High</td>
<td>1. Discuss with contract lead. 2. Raise at 111 West Yorkshire Quality Group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Staff attitude (various locations)</td>
<td>Staff, PALS / Complaints</td>
<td>✔ ✔</td>
<td>-</td>
<td>MYHT, Marie Stopes</td>
<td>High</td>
<td>1. Ask about local measures re staff attitude - MYHT and Marie Stopes.</td>
</tr>
<tr>
<td>Care of the elderly</td>
<td>Healthwatch, Incidents, Media, Engagement</td>
<td>✔ ✔ ✔ ✔ ✔</td>
<td>MYHT Safe Staffing Report</td>
<td>MYHT General Practice</td>
<td>High</td>
<td>1. Undertake Patient Safety Walkabouts on G31a, G43 and at Queen Elizabeth House 2. Discuss issue of Advance Care Directives for this GP practice with NDU, CCG Clinical Advisor and Commissioning Manager.</td>
</tr>
<tr>
<td>Appointments</td>
<td>Staff, PALS / Complaints</td>
<td>✔ ✔ ✔ ✔ ✔</td>
<td>Referral to treatment data GP patient survey</td>
<td>MYHT General Practice</td>
<td>High</td>
<td>1. Summarise specialities with problem.</td>
</tr>
<tr>
<td>Autism appointment</td>
<td>PALS / Complaints</td>
<td>✔ ✔</td>
<td>-</td>
<td>SWYPFT</td>
<td>High</td>
<td>1. Share intelligence with relevant Commissioning Manager.</td>
</tr>
</tbody>
</table>

Care of elderly patient at Gate 31A and QEH.  
NHS 111 - Delay in call back from 111.  
Delay in Autism assessment for child  
Knee operation at MYHT rescheduled 4 times
Access to the highest quality urgent and emergency care

Contents

- Additional Support Measures
- Exception Report - A&E 4 hour wait
- Exception Report – Acute Trust Turnaround Times
- Exception Report – Ambulance Turnaround Times
- Exception Report – Ambulance Response Times
- A&E National Patient Survey
- Young Healthwatch – A&E visit summary
## Access to the highest quality urgent and emergency care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Wakefield CCG</th>
<th>Trend Information</th>
<th>Provider</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Re-Admissions</td>
<td>Nov</td>
<td>&lt;3.5%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>3.3%</td>
<td>3.6%</td>
<td>3.6%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td>Emergency Re-Admissions</td>
<td>Nov</td>
<td>&lt;12.6%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>12.5%</td>
<td>12.6%</td>
<td>12.6%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td>% Patients scanned within 1 hour of arrival</td>
<td>Jul Sep 14</td>
<td>50%</td>
<td>-</td>
<td>24.1%</td>
<td>24.2</td>
<td>↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Patients admitted to stroke ward within 4 hours of arrival</td>
<td>Jul Sep 15</td>
<td>60% nat av</td>
<td>-</td>
<td>53.0%</td>
<td>52.0%</td>
<td>55.0%</td>
<td>↑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YAS 111 Performance</td>
<td>Dec</td>
<td>98%</td>
<td>35.7%</td>
<td>17.0%</td>
<td>26.3%</td>
<td>26.3%</td>
<td>↓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Calls answered within 60 seconds</td>
<td>Dec</td>
<td>95%</td>
<td>-</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>77.9%</td>
<td>91.6%</td>
<td>91.6%</td>
<td>↓</td>
<td>Dr CJ</td>
</tr>
<tr>
<td>% of warm transfers</td>
<td>Dec</td>
<td>95%</td>
<td>31.0%</td>
<td>21.1%</td>
<td>30.5%</td>
<td>30.5%</td>
<td></td>
<td></td>
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<tr>
<td>% Definitive Clinical Assessments in time</td>
<td>Dec</td>
<td>95%</td>
<td>87.2%</td>
<td>97.6%</td>
<td>99.0%</td>
<td>99.0%</td>
<td>↓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Emergency within 1 hour</td>
<td>Dec</td>
<td>95%</td>
<td>58.6%</td>
<td>55.9%</td>
<td>60.5%</td>
<td>60.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Urgent within 2 hours</td>
<td>Dec</td>
<td>95%</td>
<td>76.9%</td>
<td>66.8%</td>
<td>75.0%</td>
<td>75.0%</td>
<td>↑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Less Urgent within 6 hours</td>
<td>Dec</td>
<td>95%</td>
<td>92.4%</td>
<td>90.3%</td>
<td>95.7%</td>
<td>95.7%</td>
<td>↑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stemi</td>
<td>Aug</td>
<td>80.5%</td>
<td>82.8%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>82.3%</td>
<td>83.2%</td>
<td>83.2%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td>% of patients receiving primary angioplasty within 150 minutes.</td>
<td>Aug</td>
<td>88.0%</td>
<td>85.0%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>87.2%</td>
<td>86.2%</td>
<td>86.2%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td>Cardiac Arrest</td>
<td>Aug</td>
<td>8.2%</td>
<td>10.3%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>10.9%</td>
<td>10.0%</td>
<td>10.0%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td>Stroke</td>
<td>Aug</td>
<td>62.0%</td>
<td>64.5%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>57.3%</td>
<td>57.4%</td>
<td>57.4%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
<tr>
<td>Staff Absence (YAS)</td>
<td>Nov</td>
<td>&lt;5%</td>
<td>5.9%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>7.2%</td>
<td>6.5%</td>
<td>6.5%</td>
<td>↓</td>
<td>Dr AS</td>
</tr>
</tbody>
</table>
Access to the highest quality urgent and emergency care: Exception Report

**Description of underperformance identified:** The Trust achieved performance of 88.3% against the 95% target for patients waiting less than 4 hours in A&E. Of the 17,770 patients that accessed A&E services, 2065 waited over 4 hours,

**Reason for Underperformance**
The main reason for delays in A&E is bed waits which results in pressure within the A&E Department.

The main contributing factor is staffing levels across the Trust resulting in restricted bed availability and patient flow:

- Annual leave during period
- Short term sickness
- Reorganisation of capacity to determine nurse to patient ratios.

Another related issue is the Delayed Transfers of Care, which impacts on patient flow and is reported through the MYHT Trust Board.

**Actions taken**
- Weekly SRG Executive meetings to discuss performance and ensure patient flow maintained across the health and social care system
- SRG winter schemes for all partners started at the beginning of December and are being monitored by the SRG
- Weekly winter calls with SRG partners commenced in December and have been increased to daily since the beginning of January to review performance and agree daily actions to improve performance
- Weekly meeting across West Yorkshire to learn from other health and social care economies and benchmark performance
- During this period the Resource Escalation Action Plan (REAP) has been revised
- A number of operational SRG plans are in place to support the strategic winter plan to include: The Cold Weather Plan for adverse weather, seasonal flu plan, a Christmas Holiday Plan
- There has been a focused work stream between all SRG partners on Discharge Planning and Process development to identify discharge and an improvement plan to rectify. This has focuses on the interdependency between urgent/emergency care and the Care Closer to Home agenda.
- On-going work with the Local Authority to re-invigorate the patient choice policy for patients entering long term care facilities.
- Monthly SRG meetings continue
Access to the highest quality urgent and emergency care: Exception Report

**NHS Constitution Indicator**

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust - Turnaround Time</td>
<td>Dec</td>
<td>100%</td>
<td>74.5%</td>
<td>Not reported at CCG Level</td>
<td>Not reported at CCG Level</td>
<td>MYHT</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** There were a total of 4371 handovers across the three MYHT A&E locations, of these 3038 took place within 15 minutes, 835 took place between 15 and 30 mins, 239 between 30 and 60 mins, and 44 over 60 mins. The overall performance for the Trust was 73.1% of handovers took place within 15 mins.

**Reason for Underperformance**

The individual site performance within MYHT identifies Pinderfields as a significant contributor to the Trust level performance not being achieved: Dewsbury – 87.6% Pinderfields – 66.2% Pontefract - 98.6%

The three main reasons for the majority of breaches are as follows:
- **Clinical staff availability for handovers**
- **No available cubicles (Specifically in Pinderfields)**
- A comparison of handover performance with the A&E 4hrs performance standards does identify a correlation between the two targets and demonstrates the correlation to the Trusts challenges in maintaining patient flow.

**Actions taken**

MYHT, in particular PGH, has been identified by lead commissioners and YAS as one of 4 sites across Y&H where the provider will work more directly with YAS colleagues to improve turnaround performance. The lead consultant for emergency medicine has met with the chief paramedic and reviewed 60 cases attending PGH. This has identified a number of actions including:
- YAS to improve the use of self-handover based on the current protocol
- Identification of cases which could be handover in a wheelchair to nurses – therefore not limited by waiting a cubicle
- YAS to work with paramedics on education around alternative pathways e.g. falls pathways, to increase their utilisation and avoid transfer to ED altogether
- YAS and ED to reinforce with staff the need to complete the handover screen as soon as handover complete as appears to be some delays of up to 8 minutes

There remains at MYHT:
- Named triage nurses to who are given responsibility for policing and achieving target for turnaround on every shift
- Promotion self-check in

As performance on turnaround and handover strongly correlates to the level of crowding within the emergency department and issues with the flow of patients through the hospital, System resilience has focussed on reducing pressure in these areas. This has been done through funding GP’s in the emergency department, extra bed capacity and assisting MYHT with discharges.

**Wakefield CCG - Acute TRT- 15 mins between ambulance and**

- **Action Plan in Place:** Yes
- **Risk Register ID:** 427
- **Clinical Lead:** Dr Adam Sheppard
- **Commissioning Lead:** Jenny Feeley
- **CCG Assurance:** MYHT Executive Contract Board
Access to the highest quality urgent and emergency care: Exception Report

**NHS Constitution Indicator**

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<th>Risk Register ID</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance - Turnaround Time</td>
<td>Dec</td>
<td>100%</td>
<td>75.4%</td>
<td>Not reported at CCG Level</td>
<td>MYHT</td>
<td>427</td>
<td>Dr AS</td>
<td>JF</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** There were a total of 4156 post handovers completed across the three MYHT A&E locations. Of these 3536 took place within 15 mins, 583 between 15 and 30 mins, 33 between 30 and 60 mins, and 4 over 60 mins. The overall performance for the Trust was 85.1%

**Reason for Underperformance**

- The individual site performance can be seen below:
  - Dewsbury – 79.6%
  - Pinderfields – 87.5%
  - Pontefract - 83.3%

**Actions taken**

- Same actions apply as listed in Acute Trust Turnaround Times
- Improving the governance and processes supporting 'self handover' of patients, and promoting its use with paramedics
- Notices regarding handover processes and contacts have been displayed in or close to notify and handover screens to remind staff.
- YAS continue to work with crews on identifying individual staff who experience longer “Ready” times

**Wakefield CCG - Ambulance TRT - Crew clear within 15 mins**

<table>
<thead>
<tr>
<th>Action Plan in Place</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Register ID</td>
<td>427</td>
</tr>
<tr>
<td>Clinical Lead</td>
<td>Dr Adam Sheppard</td>
</tr>
<tr>
<td>Commissioning Lead</td>
<td>Jenny Feeley</td>
</tr>
<tr>
<td>CCG Assurance</td>
<td>YAS Contract Management Group</td>
</tr>
</tbody>
</table>
Description of underperformance identified: YTD Position Dec 2014, the CCG achieved a performance of 72.1% and 69.4% against a target of 75% for Cat A Red 1 and Red 2 (8 Minute) response times respectively, and YAS achieved 69.3% and 69.2% against the same targets.

Reason for Underperformance

The Trust have been unable to deliver YTD the operational performance standard, at the contract or at an individual WCCG level. There are 3 main factors the Trust are citing as contributing to the underperformance:

- An employee resource gap
- The impact of rota changes
- Increased in demand Red 1 & 2.

The proposed Remedial Action Plan and trajectories presented by YAS to commissioners is still to be finalised in light of the Good Governance Institute Report.

Actions taken

YAS has already implemented a range of improvement measures:

- Increase in clinical staff/ Limited use of independent sector crews / Use of Emergency Care Assistants/
- Extension of meal break window/ Additional modelling by external organisation to optimise rotas and resource deployment/ Recruitment to 70 vacancies.

December was a particularly challenging month for YAS causing them to implement Reap level 5 and their demand management plan. YAS have now employed a company to review the action plan for performance improvement and trajectory in line with the recommendations from the good governance report that was completed on behalf commissioners and in collaboration with YAS.

A capacity review has been developed with YAS to review the demand levels and there increase, this commenced in February.

Wakefield CCG - Ambulance Response Times Cat A - Red 1 and 2 - 8 mins

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance response times</td>
<td>Dec</td>
<td>75%</td>
<td>80.5%</td>
<td></td>
</tr>
<tr>
<td>Cat A (Red 1) 8 min response time</td>
<td>Dec</td>
<td>75%</td>
<td>76.6%</td>
<td></td>
</tr>
</tbody>
</table>

Wakefield CCG

Provider                  | YTD | Actual | FOT | Previous Month | Trend Information |
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS CCG</td>
<td>65.4%</td>
<td>65.4%</td>
<td>69.3%</td>
<td>69.3%</td>
<td>Down</td>
</tr>
<tr>
<td>Wakefield CCG</td>
<td>60.4%</td>
<td>60.4%</td>
<td>69.2%</td>
<td>69.2%</td>
<td>Down</td>
</tr>
</tbody>
</table>

Wakefield CCG - Ambulance Response Times Cat A - Red 1

[Graph showing data]

Wakefield CCG - Ambulance Response Times Cat A - Red 2

[Graph showing data]

Action Plan in Place | Yes
Risk Register ID     | 426
Clinical Lead        | Dr Adam Sheppard
Commissioning Lead   | Jenny Feeley
CCG Assurance         | YAS Contract Management Group
The CQC has published the results of the national A&E survey. During 2014, a questionnaire was sent to 850 people who had attended a MYHT A&E department during January, February or March 2014. Responses were received from 289 patients.

### Year-wise Response Rate

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Rate</td>
<td>36%</td>
<td>33%</td>
<td>34%</td>
</tr>
</tbody>
</table>

### Number of Responses

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of questions in which MYHT performs better than most other trusts</td>
<td>9</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Number of questions in MYHT is performing about the same as other trusts</td>
<td>22</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td>Number of questions in which MYHT performance is worse than most other trusts</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

### Questions in MYHT performs better than most other trusts

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being examined: for not having to wait too long before being examined by a doctor or nurse</td>
<td>7.2/10</td>
</tr>
<tr>
<td>Explaining test results: for feeling staff explained their test results in a way they could understand, where these were given before they left A&amp;E</td>
<td>9.1/10</td>
</tr>
</tbody>
</table>

### Questions in MYHT performs worse than most other trusts

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about waiting for an examination: for being told how long they would wait to be examined</td>
<td>2.6/10</td>
</tr>
</tbody>
</table>

### Questions in which MYHT performance about the same as other trusts and MYHT received a score>9

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handover from ambulance to A&amp;E: for not having to wait long with the ambulance crew before care was handed to A&amp;E</td>
<td>9.2/10</td>
</tr>
<tr>
<td>Acknowledging patients: for doctors and nurses not talking in front of them, as if they weren't there</td>
<td>9.0/10</td>
</tr>
<tr>
<td>Privacy: for being given enough privacy during examinations and treatment</td>
<td>9.3/10</td>
</tr>
<tr>
<td>Explaining test results: for feeling staff explained their test results in a way they could understand, where these were given before they left A&amp;E</td>
<td>9.1/10</td>
</tr>
<tr>
<td>Not feeling threatened: for not feeling threatened by other patients or visitors</td>
<td>9.7/10</td>
</tr>
<tr>
<td>Purpose of medications: for having the purpose of new medications explained before they left A&amp;E</td>
<td>9.5/10</td>
</tr>
</tbody>
</table>

### Questions in which MYHT performance about the same as other trusts and MYHT received a score≤6

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to receive pain relief: for not having a long wait to receive pain relief if requested</td>
<td>5.5/10</td>
</tr>
<tr>
<td>Medication side effects: for being told about possible side effects of medication, for those prescribed new medication while in A&amp;E</td>
<td>4.7/10</td>
</tr>
<tr>
<td>Resuming usual activities: for having had staff explain when they could resume their usual activities</td>
<td>5.5/10</td>
</tr>
<tr>
<td>Assessment of living and support arrangements: for feeling staff considered their family and home situation before they left A&amp;E</td>
<td>4.6/10</td>
</tr>
<tr>
<td>Danger signals: for being told about any danger signals to watch for after going home</td>
<td>5.6/10</td>
</tr>
</tbody>
</table>

The results will be presented to the MYHT Executive Quality Board in the Trust’s next Integrated Patient Experience Report.
On 24 July 2014 four Young Healthwatchers undertook an announced visit to the Emergency Department (paediatrics and adults) at Pinderfields Hospital following concerns received by Young Healthwatch about long waits, prioritising of patients, and dealing with patients with mental health conditions or Attention Deficit Hyperactivity Disorder (ADHD). The main objectives for the visiting team were:

- Quality of care/care and dignity of patients;
- Admission and discharge plans;
- Quality of information around the patients’ plan for their treatment/discharge;
- Waiting times;
- Waiting room facilities and access.

The visiting team observed the department, interviewed patients in the waiting areas and received information from the ED team about the treatment areas; managing patients with ADHD, mental health condition or from a care home; safeguarding procedures in place; the environment and waiting room; activities for children; meals; and car parking. Patients – children and adults - interviewed stated the care they received was good, and that the staff were friendly and caring. A number of recommendations were made by the Young Healthwatch team and the Trust had submitted a response to these as part of the report. The full report is available at http://www.healthwatchwakefield.co.uk/news/young-healthwatch-enter-view-pinderfields-emergency-department

A young girl in children’s ED had been asked if she wanted a drink.

One gentleman asked if there was anything he would change said “waiting for the plastic surgeon and a bed.”

A 17 year old male said the care and facilities in ED were all fine. He had been sent from the Walk in centre, where he had waited 45 minutes, and he was now waiting for the doctor following assessment by a nurse.
A step change in the productivity of elective care

Contents

• Exception Report – Max 62 day wait from referral linked to the NHS Screening Program to start 1st treatment for all cancers
• Exception Report – Cancer 62 day wait from urgent GP referral to first definitive treatment
• Exception Report – 18 Week RTT – Completed Admitted Pathways
• Exception Report – 18 Week RTT – Completed Non Admitted Pathways
• Exception Report – 18 Week RTT – Incomplete Pathways
• Exception Report – RTT Waits over 52 Weeks for Incomplete Pathways
A step change in the productivity of elective care

NHS Constitution Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Wakefield CCG</th>
<th>Trend Information</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max 62 day wait from urgent GP referral to first definitive treatment for cancer</td>
<td>Dec</td>
<td>85%</td>
<td>81.4%</td>
<td>84.9%</td>
<td>83.8%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** The latest available data for December reports month and YTD CCG under performance levels of 84.9% monthly against the 85% target, and 83.8% for YTD position against the 85% target.

**Reason for Underperformance**

The under performance in WCCG Monthly position is due to 13 breaches of the standard; in total there have been 86 patients treated in the month.

A review of the >62 day pathways completed by the Trust has identified the following sites having the breaches YTD position:

- Head & Neck – 2 breached December
- Lower Gastrointestinal – 2 breached December
- Lung – 1 breached December
- Other – 1 breached December
- Skin – 2 breached December
- Upper Gastrointestinal – 2 breached December
- Urological – 3 breached December

**Actions taken**

A local action plan is already in place with the Trusts Cancer management team.

Other actions to address performance are:

- Ensure under-performing tumour site specific services achieve 7 day first seen from referral to achieve tertiary referral by day 38.

The CCG has:

- Through the Wakefield and North Kirklees Cancer Locality Group commissioned a 62 day pathway performance review, with particular focus on the Lung and Upper GI Tumour Site.
- Requested a scoping paper for the commissioning of an external audit/review of cancer pathways within MYHT which is under review.

### MYHT - Cancer 62 day wait from urgent GP referral to first definitive treatment

<table>
<thead>
<tr>
<th>Indicator Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Wakefield CCG</th>
<th>Trend Information</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max 62 day wait from urgent GP referral to first definitive treatment for cancer</td>
<td>Dec</td>
<td>85%</td>
<td>84.9%</td>
<td>83.8%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>

**Action Plan in Place**

Yes

**Risk Register ID**

492

**Clinical Lead**

Dr Abdul Mustafa

**Commissioning Lead**

Michelle Ashbridge

**CCG Assurance**

MYHT Executive Contract Board
A step change in the productivity of elective care

**NHS Constitution Indicator**

Max 62 day wait from referral linked to the NHS Screening Program to start 1st treatment for all cancers

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Trend Information</th>
<th>Provider</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Waits - 62 Days</td>
<td>Dec</td>
<td>90%</td>
<td>93.7%</td>
<td>88.9% 94.3% 94.3%</td>
<td>MYHT</td>
<td>81.8% 94.1% 94.1%</td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** The latest available data for December reports monthly CCG under performance levels of 88.9% monthly against the 90% target, and 81.8% for Trust monthly position against the 90% target.

**Reason for Underperformance**

The under performance in WCCG Monthly position is due to 1 breach of the standard; In total there have been 9 patients treated in the month.

A review of the >62 day pathways completed by the Trust has identified the following sites having the breaches YTD position:

- Gynaecological – 1 breached December

**Actions taken**

See previous slide

**MYHT - Max 62 day wait from referral linked to the NHS Screening Program to start 1st treatment for all cancers**

**Action Plan in Place**

Yes

**Risk Register ID**

492

**Clinical Lead**

Dr Abdul Mustafa

**Commissioning Lead**

Michelle Ashbridge

**CCG Assurance**

MYHT Executive Contract Board
A step change in the productivity of elective care

**NHS Constitution Indicator**

**18 Week RTT Waiting times - Completed Admitted pathways**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2015/16 CCG Performance</th>
<th>Total Information</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>Dec</td>
<td>90%</td>
<td>Actual: 88.9% YTD: 87.3% FOT: 87.3%</td>
<td>From previous month: Previous months score card:</td>
<td>MYHT: 86.3% YTD: 86.5% FOT: 86.5%</td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** In Dec - 2014, The CCG achieved 88.9% for Completed Admitted pathways (across all providers), MYHT achieved 86.3% for Completed Admitted pathways within 18 weeks against the ≥90% target.

**Reason for Underperformance**

- Of the 2,942 admitted pathways completed in the month, 398 were completed over 18 weeks.

- There are 8 specialties in total that have failed.
  - ENT – 70.1%
  - Cardiology – 88.9%
  - General Surgery – 89.1%
  - Gynaecology – 83.6%
  - Ophthalmology – 74.5%
  - Oral surgery – 87.8%
  - Plastic surgery – 85.9%
  - Trauma and orthopaedics – 70.8%

**Actions taken**

- The next stage audit for January using December data was agreed and commenced 26th January, with a final stage scheduled for May from April data to assess full year effect of the changes MYHT have been making over recent months.

- The validated December position for MYHT shows achievement in the incomplete pathway and non-achievement in the Admitted and NonAdmitted. The CCG are reviewing and in consultation with MYHT regarding remedial action plans.

- MYHT have been working on and developing a sustainability plan that has been shared with WCCG and IST. The purpose and aims of the sustainability plan are to deliver a sustainable model and a series of practices that will deliver the required performance levels for RTT across all three pathways. How this will be achieved is to drive the incomplete pathway to a level that will automatically deliver the Admitted and NonAdmitted to required levels of performance.

- NHS England have initiated the match and move process from MYHT to IS providers for TR/Q and ENT between Dec-14 to Mar-15.

- An RTT summit was held with MYHT, WCCG, NKCCG and NHSE on 26th February 2015 to examine current performance and planned performance.

**Action Plan in Place**

<table>
<thead>
<tr>
<th>Risk Register ID</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>CCG Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Dr Patrick Wynn</td>
<td>Linda Driver</td>
<td>MYHT Executive Contract Board</td>
</tr>
</tbody>
</table>
A step change in the productivity of elective care

18 Week RTT Waiting times - Completed Non Admitted pathways

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Trend Information</th>
<th>Provider</th>
<th>Trend from previous Month</th>
<th>D.A.</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>Exception Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>Dec</td>
<td>95.0%</td>
<td>95.4% 91.1% 90.8% 90.8%</td>
<td>90.9% 90.7% 90.7%</td>
<td>MYHT</td>
<td>90.9%</td>
<td>Dr PW</td>
<td>Linda</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

Description of underperformance identified: In Dec - 2014, The CCG achieved 91.1% for Completed NON Admitted pathways (across all providers), MYHT achieved 90.9% for Completed NON Admitted pathways were within 18 weeks against the ≥95% target

Reason for Underperformance: Of the 7,808 non admitted pathways completed in the month, 723 were completed over 18 weeks. There are 15 specialties in total that have failed.
- Dermatology – 84.8%
- ENT – 91.7%
- Gastroenterology – 90.0%
- General Medicine – 90.3%
- General surgery – 90.2%
- Gynaecology – 92.5%
- Neurology – 87.7%
- Ophthalmology – 93.4%
- Oral surgery – 94.5%
- Plastic surgery – 85.3%
- Respiratory Medicine – 90.6%
- Rheumatology – 94.5%
- Trauma and orthopaedics – 90.2%
- Urology – 92.1%
- Other – 90.9%

Actions taken:
See actions in Admitted Pathway

Wakefield CCG - 18 weeks RTT Waiting Times - Completed Non Admitted

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>94.0%</td>
<td>94.0%</td>
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<td>94.0%</td>
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</tbody>
</table>

Action Plan in Place: Yes
- Risk Register ID: 450
- Clinical Lead: Dr Patrick Wynn
- Commissioning Lead: Linda Driver
- CCG Assurance: MYHT Executive Contract Board
A step change in the productivity of elective care

### NHS Constitution Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 CCG Performance</th>
<th>Trend Information</th>
<th>Provider</th>
<th>Trend from previous Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Week RTT Waiting Time Standard</td>
<td>Dec</td>
<td>92.0%</td>
<td>92.6%</td>
<td>92.5% 91.5% 91.5%</td>
<td>MYHT</td>
<td>92.1% 92.0% 92.0%</td>
</tr>
</tbody>
</table>

#### Description of underperformance identified:
In Dec 2014, 92.5% of patients on Incomplete pathways for the CCG (across all providers) and 92.1% of the pathways for MYHT were within 18 weeks against the ≥92% target.

#### Reason for Underperformance
There were a total of 378 breaches in excess of the tolerance threshold identified.

- There are 4 specialties in total that have failed.
  - Dermatology – 85.8%
  - ENT – 90.2%
  - Trauma and Orthopaedics – 85.3%
  - General Surgery – 91.5%

#### Actions taken
See actions in Admitted Pathway

#### Wakefield CCG - 18 weeks RTT Waiting Times - Incomplete Pathways

<table>
<thead>
<tr>
<th>Action Plan in Place</th>
<th>Risk Register ID</th>
<th>Clinical Lead</th>
<th>Commissioning Lead</th>
<th>CCG Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>450</td>
<td>Dr Patrick Wynn</td>
<td>Linda Driver</td>
<td>MYHT Executive Contract Board</td>
</tr>
</tbody>
</table>
A step change in the productivity of elective care

Zero tolerance RTT Waits over 52 weeks for incomplete pathways

<table>
<thead>
<tr>
<th>NHS Constitution Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
<tr>
<td>Number of 52 week Referral to treatment pathways</td>
</tr>
<tr>
<td>number of patients on incomplete pathways over 52 weeks</td>
</tr>
</tbody>
</table>

Description of underperformance identified: The Trust identified one patient on incomplete pathways at the end of December that had been waiting over 52 weeks. This patient has been identified as a Wakefield CCG responsibility.

Reason for Underperformance
The breach at MYHT have been identified in:
• 1 in General Surgery (Wakefield CCG)

A full breach analysis for the occurrence has been provided by the Trust which identifies the root cause to be:
• Incorrect clock stops

The patient has subsequently completed treatment in January 2015. This case has been identified through the process of waiting list validation undertaken as part of the Trust’s programme to improve data quality.

Actions taken
The Trust has identified the following ongoing actions to ensure these types of breaches do not occur again:
• Re-education awareness and knowledge of 18 weeks across various teams
• Validation and tracking of patients at 10 weeks as part of the Trust wide validation programme currently taking place.
• Design of a new outcomes form.
• Review of workload of key administration staff to ensure patient tracking occurs robustly.

The Trust believes the identification of these breaches has been as a result of a better data quality strategy.

Wakefield CCG - Zero tolerance over 52 week waits - incomplete pathways

<table>
<thead>
<tr>
<th>Action Plan in Place</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Register ID</td>
<td>450</td>
</tr>
<tr>
<td>Clinical Lead</td>
<td>Dr Patrick Wynn</td>
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<td>Commissioning Lead</td>
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</tr>
<tr>
<td>CCG Assurance</td>
<td>MYHT Executive Contract Board</td>
</tr>
</tbody>
</table>
Mental Health service transformation

Contents

• Additional Support Measures
• Exception report – Service users on CPA in employment
• Exception report – SWYPFT sickness absence rate
• SWYPFT 15 Steps Challenge
SWYPFT started participating in the Mental Safety Thermometer in May 2014 during a testing phase so results should be treated with caution. The survey officially launched in November 2014. This is a point of care survey carried out on a single day each month on all appropriate patients.
Mental Health service transformation: Exception Report

**Exception Report**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>YTD</th>
<th>Previous performance</th>
<th>Trend – previous month</th>
<th>Forecast 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of service users on Care Programme Approach in employment</td>
<td>Nov 14</td>
<td>10%</td>
<td>7.5%</td>
<td>7.4%</td>
<td>📉</td>
<td>↑</td>
<td></td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** The percentage of service user on a CPA in employment is consistently below the 10% target.

<table>
<thead>
<tr>
<th>Reason for Underperformance</th>
<th>Actions to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWYPFT do not provide any rationale in their monthly Integrated Performance Report.</td>
<td>SWYPFT are undertaking benchmarking between the BDUs to compare performance. SWYPFT are reviewing how many service users are involved in activities which will increase the chance of service users gaining employment e.g. volunteering. This will be discussed at the SWYPFT Quality Board on 23 February 2015.</td>
</tr>
</tbody>
</table>

**% service users on CPA in employment**

- **Employment:**
  - Apr: 8.5%
  - May: 8.0%
  - Jun: 7.5%
  - Jul: 8.0%
  - Aug: 7.5%
  - Sep: 8.0%
  - Oct: 7.5%
  - Nov: 8.0%

- **Target:**
  - November 2014: 10%

**Action Plan in Place:** Yes
**Clinical Lead:** Dr Clive Harries
**Commissioning Lead:** Michelle Ezro
**Executive Lead:** Jo Pollard
**CCG Assurance:** SWYPFT Quality Board
Mental Health service transformation: Exception Report

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>YTD</th>
<th>Previous performance</th>
<th>Trend – previous month</th>
<th>Forecast 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWYPFT sickness absence rate</td>
<td>Nov 14</td>
<td>&lt;4%</td>
<td>4.6%</td>
<td>4.6%</td>
<td>••••••••••</td>
<td>↓</td>
<td></td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** Sickness absence is November was 4.6%. The 4% target has been missed every month in 2014/15.

**Reason for Underperformance**
Sickness absence in Wakefield is 4.4% (YTD). The divisions with the highest absence rates are the Forensic division with 7% and Special 5.3% YTD.

Analysis of absence rates between April – August 2014 of other mental health providers in Yorkshire shows that SWYPFT has the joint lowest staff absence rates alongside Leeds and York Partnership NHS Foundation Trust.

**Actions to be taken**
This will be discussed at the SWYPFT Quality Board on 23 February 2015.

**Yorkshire Mental Health Trusts Staff Absence April - August 2014**

<table>
<thead>
<tr>
<th>%</th>
<th>Leeds &amp; York</th>
<th>SWYPFT</th>
<th>Humber</th>
<th>RDASH</th>
<th>Bradford</th>
<th>Sheffield</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4.5</td>
<td>5.5</td>
<td>6</td>
</tr>
<tr>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
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<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

**SWYPFT sickness rate**
- Absence rate
- Target

**Action Plan in Place** Yes

| Clinical Lead   | Dr Clive Harries |
| Commissioning Lead | Michelle Ezro  |
| Executive Lead   | Jo Pollard      |
| CCG Assurance    | SWYPFT Quality Board |
NHS Wakefield CCG participated in the inaugural 15 Steps Challenge Visit at Fieldhead on 20 October 2014. Visits took place at SWYPFT inpatient areas in Barnsley, Calderdale, Kirklees in addition to Fieldhead in the same week. The 15 Steps Mental Health toolkit contains a series of prompts about the first impressions of the care setting. Those participating in the visits spoke with service users and staff to get their views about the wards visited. 15 steps originated from a quote from a woman who said that within 15 steps of walking onto a ward they could tell what kind of care their daughter would receive.

SWYPFT analysed the findings of all the visits and identified the following themes:

**Good practice:**
- The majority of the inpatient wards across the Trust were calm and well organised, welcoming and homely.
- Staff and service users felt safe and the ward areas were clean and well maintained.
- Staff were welcoming, friendly and caring
- Positive interaction between service users and staff was observed in most areas

**Areas for improvement:**
- Some inpatient areas had information about activities available with evidence of service user involvement in art and sports displayed although this is an area that needs more development
- There were areas of good practice regarding notice boards and information for service users but in other areas information was either not available or out of date.
- There was a lack of information in alternative formats and languages
- Some areas required general maintenance including the replacement of some signs, redecoration or refurbishment.

A programme of further walkabouts will be discussed at the next SWYPFT Quality Board on 23 February 2015.
Maternity, children and young people transformation

Contents

• Additional Support Measures
• Exception report: Breastfeeding
MYHT started participating in the Maternity Safety Thermometer in February 2014 during a testing phase so results should be treated with caution. The survey officially launched in November 2014. This is a point of care survey carried out on a single day each month on all postnatal mothers and babies. Data is collected from postnatal wards, women’s homes and community postnatal clinics.
Exception Report

Initiation of breast feeding and % infants totally or partially breast fed at 6 weeks

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>YTD</th>
<th>Previous performance</th>
<th>Trend – previous month</th>
<th>Forecast 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of breast feeding (WCCG)</td>
<td>Q2</td>
<td>60%</td>
<td>67.1%</td>
<td>62.4%</td>
<td>●●</td>
<td>↑</td>
<td>●</td>
</tr>
<tr>
<td>% infants totally or partially breast fed at 6 weeks (WCCG)</td>
<td>Q2</td>
<td>36%</td>
<td>32%</td>
<td>31.9%</td>
<td>●●</td>
<td>↑</td>
<td>●</td>
</tr>
</tbody>
</table>

Description of underperformance identified: NHS Wakefield CCG met the 60% initiation of breast feeding target in Q2. The totally or partially breast fed target is being missed consistently. The % of infants totally or partially breast fed at 6 weeks in West Yorkshire is currently 42%.

Reason for Underperformance

Breastfeeding rates at 6-8 weeks have remained relatively stagnant for a number of years despite numerous work plans to improve rates including MYHT achieving UNICEF baby friendly level 3 status.

The rates at 6-8 weeks are, nevertheless, a slight drop on previous years. It is possible that this has been exacerbated in the last year due to a number of factors including uncertainty over the future of the peer supporter service (Local Authority have now agreed to extend this for a future year) and staffing shortages in the midwifery service.

It is felt that this partly is a cultural issue which will take some time to change.

Breast feeding initiation figures have improved markedly in the second quarter of the year. This is thought to be partly due to an improvement in coding at MYHT but is also part of a steady upward trend.

Actions to be taken

An infant feeding whole systems development event is scheduled for 10th February in order to identify best practice, local challenges and priorities for a way forward.

Each midwifery community team now has identified breastfeeding champions and additional midwife support assistants are being recruited; their role will include supporting breastfeeding. Mid Yorkshire are re-designing their antenatal classes to better meet need. This will include a session on baby bonding & infant feeding.

% infants totally or partially breast fed at 6 weeks

<table>
<thead>
<tr>
<th>% infants totally or partially breast fed at 6 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCCG 6 week</td>
</tr>
<tr>
<td>Target</td>
</tr>
</tbody>
</table>

Action Plan in Place

<table>
<thead>
<tr>
<th>Action Plan in Place</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Lead</td>
<td>Dr Ann Carroll</td>
</tr>
<tr>
<td>Commissioning Lead</td>
<td>Morna Cooke</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Jo Pollard</td>
</tr>
<tr>
<td>CCG Assurance</td>
<td>MYHT Executive Quality Board</td>
</tr>
</tbody>
</table>
System Wide Quality Measures (Organising ourselves)

Contents

• Additional Support Measures
• Exception Report: MYHT Safety Thermometer
• Wakefield Hospice CQC Report
• Croft House CQC Report
• Atlee Court CQC Report
• Earls Lodge CQC Report
• HMP Wakefield CQC Report
### Additional Support Measures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting Period</th>
<th>Target</th>
<th>2013/14 Performance</th>
<th>MYHT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Actual</td>
<td>YTD</td>
<td>FOT</td>
</tr>
<tr>
<td>Venous Thromboembolism % patients risk assessed</td>
<td>Nov</td>
<td>95%</td>
<td>95.30%</td>
<td>95.50%</td>
<td>96.10%</td>
</tr>
<tr>
<td>Harm free care % patients receiving harm free care</td>
<td>Dec</td>
<td>95%</td>
<td>90.40%</td>
<td>93.71%</td>
<td>93.01%</td>
</tr>
<tr>
<td>Never Events Number of never events</td>
<td>Jan</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Serious Incidents Number of open serious incidents</td>
<td>Jan</td>
<td>-</td>
<td>-</td>
<td>170</td>
<td>-</td>
</tr>
<tr>
<td>Serious Incidents Number of new serious incidents for month</td>
<td>Jan</td>
<td>-</td>
<td>39</td>
<td>30</td>
<td>218</td>
</tr>
<tr>
<td>Patient Safety Incidents Proportion of patient safety incidents that are harmful</td>
<td>Dec</td>
<td>&lt;29%</td>
<td>34.10%</td>
<td>45.30%</td>
<td>45.30%</td>
</tr>
<tr>
<td>Summary Hospital Mortality Indicator SHMI score</td>
<td>Jan 14-Mar 14</td>
<td>&lt;100</td>
<td>-</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>Hospital Standard Mortality Rate HSMR remodelled</td>
<td>Sep 13-Aug 14</td>
<td>&lt;100</td>
<td>-</td>
<td>93.6</td>
<td></td>
</tr>
<tr>
<td>Hospital Standard Mortality Rate HSMR - weekend</td>
<td>Aug</td>
<td>&lt;100</td>
<td>92.45</td>
<td>93.13</td>
<td>101.28</td>
</tr>
<tr>
<td>Absence Staff absence rate</td>
<td>Dec</td>
<td>&lt;4%</td>
<td>4.49%</td>
<td>5.42%</td>
<td>4.67%</td>
</tr>
<tr>
<td>CQC Rating</td>
<td>Dec</td>
<td>95%</td>
<td>-</td>
<td>Requires improvement</td>
<td></td>
</tr>
</tbody>
</table>
**System Wide Quality Measures (Organising ourselves): Exception Report**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Target</th>
<th>Actual</th>
<th>YTD</th>
<th>Previous performance</th>
<th>Trend – previous month</th>
<th>Forecast 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients receiving harm free care (falls, VTE, pressure ulcers or catheter related urinary tract infections)</td>
<td>Dec 14</td>
<td>95%</td>
<td>93.71</td>
<td>93.01</td>
<td>⬇️</td>
<td>⬇️</td>
<td>⬇️</td>
</tr>
</tbody>
</table>

**Description of underperformance identified:** The Patient Safety Thermometer defines harm free care as the proportion of patients surveyed not experiencing harm from a fall within the previous 72 hours, VTE, pressure ulcers or catheter related urinary tract infections. Participating organisations submit data for every patient in their care on a single day each month. Patients who are admitted with an existing pressure ulcer or catheter and a urinary tract infection are classed as suffering harm. Performance dipped to 93.71% in December from 94.20% in November 2014. The percentage of patients suffering harm in 2014/15 has reduced compared to 2013/14.

**Reason for Underperformance**

| Pressure ulcers | MYHT reported 90 pressure ulcers in December, 43 fewer than December 2013. 27 (30%) were new pressure ulcers. Highest number of new pressure ulcers Sep – Dec 14 DDH W2 (elderly) 16 PGH G43 (elderly) 12 PGH G41 (elderly) 10 Total number reported - 130 Incidences of new pressure ulcers are spread across the acute and community settings. |
| Falls | For the 2nd consecutive month MYHT reported that 2 patients suffered harm from a fall. This is the lowest number ever reported. |
| VTE | Highest number of new VTEs reported Sep – Dec 14 DDH Medical Assessment Unit - 7 PGH G20 (respiratory) - 6 PGH Acute Assessment Unit – 5 DDH W2 (elderly) – 4 Total number reported - 29 |
| UTI and catheter | Highest number of UTIs reported Sep – Dec 2014 PGH G43 (elderly) , DDH W2 (elderly) and DDH W4 (stroke rehab) all 5 Total number reported - 54 |

**Actions to be taken**

| Pressure ulcer | Progress against the Pressure Ulcer Action Plan has been impacted by operational pressures. AAU receives ‘intensive support’ with the TVN providing 1:1 education and training with staff. A Pressure Ulcer Audit tool has been developed which will assess nursing practice. This intensive support package will be evaluated and, if positive, will be spread to other identified wards. The MYHT Pressure Ulcer Improvement Group continues to meet fortnightly and reports progress to the Executive Team. Exception Reports are submitted to MYHT Trust Board. |
| W2 and G43 | These wards will be visited on Patient Safety Walkabouts. |

Safety Thermometer performance will be discussed at MYHT Executive Quality Board on 12 February 2015.

**Harm free care**

![Graph showing trend of harm free care](image)

<table>
<thead>
<tr>
<th>Harm</th>
<th>13/14</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>1.50</td>
<td>0.59</td>
<td>1.09</td>
<td>0.11</td>
<td>0.12</td>
<td>0.60</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>6.82</td>
<td>5.12</td>
<td>5.79</td>
<td>4.54</td>
<td>5.34</td>
<td>5.42</td>
</tr>
<tr>
<td>VTE</td>
<td>0.64</td>
<td>0.27</td>
<td>0.86</td>
<td>0.22</td>
<td>0.30</td>
<td>0.38</td>
</tr>
<tr>
<td>UTI</td>
<td>9.41</td>
<td>3.21</td>
<td>1.03</td>
<td>0.99</td>
<td>0.65</td>
<td>0.79</td>
</tr>
</tbody>
</table>

**Action Plan in Place**

| Yes |
| Clinical Lead | Dr Patrick Wynn |
| Commissioning Lead | Laura Elliott |
| Executive Lead | Jo Pollard |
| CCG Assurance | MYHT Executive Quality Board |
## System Wide Quality Measures (Organising ourselves): CQC Reports

<table>
<thead>
<tr>
<th>Provider</th>
<th>Wakefield Hospice</th>
<th>Outcomes</th>
<th>Previous</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>29 October 2014</td>
<td>Safe</td>
<td>N/A</td>
<td>Good</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced</td>
<td>Effective</td>
<td>N/A</td>
<td>Good</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Hospice</td>
<td>Caring</td>
<td>N/A</td>
<td>Outstanding</td>
</tr>
<tr>
<td>CQC history: 19 September 2013- routine inspection</td>
<td>Responsive</td>
<td>N/A</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well-led</td>
<td>N/A</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall rating</td>
<td></td>
<td>Good</td>
</tr>
</tbody>
</table>

### What residents, relatives and staff said:

- "(The staff) are skilled and very patient"  
- "They are angels, they care, they are absolutely brilliant and they have all the time in the world for us."
- "I cannot believe how good they are. They want to do it (the job). They treat me with dignity – they draw the curtains round."
# System Wide Quality Measures (Organising ourselves): CQC Care Home Report

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Previous</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croft House</td>
<td>Care and welfare of people who use services</td>
<td>Action needed, moderate impact</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

**Date of Inspection**: 19 February 2014

**Review Type**: Follow up inspection

**Link to Report**: Croft

**CQC history**: 10 April 2013 - routine inspection

---

**What residents, relatives and staff said:**

- "They are good to me and will come when I call".
- "I am very happy here. I love my room and the staff are kind".
- Staff had "done wonders".

This is the first care home in the Wakefield district to be given a new style rating by their CQC.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
<th>Previous</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlee Court</td>
<td>Safe</td>
<td>N/A</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Date of Inspection</td>
<td>12, 13 August 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced</td>
<td>N/A</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Atlee</td>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>CQC history: 19 February 2014 - follow up inspection</td>
<td>Responsive, Well-led</td>
<td>N/A</td>
<td>Good</td>
</tr>
</tbody>
</table>

**Overall rating**: Requires improvement

**What residents, relatives and staff said:**

- "Staff on the whole are fairly prompt but if they doing something you might have to wait but they say will come back."
- "Meals nice and tasty."
- "I am well looked after and well cared for"
What residents, relatives and staff said:

- "I'm not sure why they're making me stay in bed. They've told me that I'm poorly".
- "No, I don't think they [staff] cared".
- "I'm alright, can't grumble"

There is a Large Scale Investigation underway and there is a voluntary embargo in place. The majority of the concerns relate to the nursing unit which currently has less than 50% occupancy. All residents have been reviewed and are not considered to be at significant risk and therefore there are no plans in place to move any residents. Contract monitoring is being undertaken and the home has an action plan in place for the outstanding training (all other actions have been completed).
Spectrum Healthcare provide primary healthcare services and non-clinical substance misuse services at HMP Wakefield. This includes GP clinics and nurse led services as well as pharmacy services. The other services such as inpatient care and primary mental health services are provided by alternative providers.

<table>
<thead>
<tr>
<th>Provider</th>
<th>HMP Wakefield</th>
<th>Outcomes</th>
<th>Previous</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>7,8 July 2014</td>
<td>Care and welfare of people who use services</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced inspection</td>
<td>Cooperating with other providers</td>
<td>Compliant</td>
<td>Action needed, minor impact</td>
</tr>
<tr>
<td>Link to Report</td>
<td>HMP</td>
<td>Management of medicines</td>
<td>Not assessed</td>
<td>Compliant</td>
</tr>
<tr>
<td>CQC history: 15 May 2012- routine inspection</td>
<td></td>
<td>Safety and suitability of premises</td>
<td>Not assessed</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supporting workers</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessing and monitoring the quality of service provision</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

What residents, relatives and staff said:

“The staff are dedicated and very respectful”

“The healthcare here is the best I have ever encountered in a prison”

“It can feel like there is different treatment for different people”.

When undertaking the inspection the CQC asked the 5 key questions. The CQC identified concerns in the following areas:
**Title of meeting:** Governing Body  
**Date of Meeting:** 10 March 2015  
**Paper Title:** 2015/16 Operational Plan

<table>
<thead>
<tr>
<th>Purpose (this paper is for):</th>
<th>Decision ✓</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Information</th>
</tr>
</thead>
</table>

**Report Author and Job Title:** Esther Ashman, Head of Strategic Planning  
**Responsible Clinical Lead:** Dr Phillip Earnshaw, Chair & Clinical Leader  
**Responsible Governing Board Executive Lead:** Pat Keane, Interim Director, Strategic Projects

**Recommendations:**  
It is recommended that the Governing Body:

- approves the current iteration of the 2015/16 financial plan, noting the risks and outstanding matters and that the financial planning arrangements are overseen by the Integrated Governance Committee.

- notes the presentation outlines the proposed detail of the draft of NHS Wakefield Clinical Commissioning Groups 2015/16 operation plan, which is brought to members for noting and comment prior to development of the final plan.

**Executive Summary:**  
This report will be accompanied by a presentation at the meeting of the Governing Body.

- Provide Governing Body with details of progress to date in the development of the 2015/16 operational plan to improve services for the people of Wakefield and the proposed content outlined in the associated presentation.

- Provide Governing Body with the timescales for completion of the operational plan and development of the related delivery plans.

**Link to overarching principles from the strategic plan:**

- Citizen Participation and Engagement ✓
- Wider Primary Care at Scale including Network development ✓
- A Modern Model of Integrated Care ✓
- Access to the Highest Quality Urgent and Emergency Care ✓
- A Step Change in the Productivity of Elective Care ✓
- Specialised Commissioning ✓
- Mental Health Service Transformation ✓
- Maternity, Children and Young People Transformation ✓
- Organising ourselves to deliver for our patients ✓

**Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA):**  
The Impact assessments are being carried out to include the delivery plans currently in development.

**Outline public engagement – clinical, stakeholder and public/patient:**  
Engagement has taken place as part of the five year strategy. In addition since September 2014 engagement has taken place through Governing Body development sessions, Board, Clinical Cabinet, membership meetings and with other CCG’s and providers in the footprint.
<table>
<thead>
<tr>
<th>Assurance departments/organisations who will be affected have been consulted:</th>
<th>Engagement with providers developing their operational plans has been part of the triangulation process across the footprint.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously presented at committee / governing body:</td>
<td>Previous presentations have been carried out at a number of Clinical Cabinets both formal and informal. Updates on the planning process have also taken place at Governing Body in November 2014 and January 2015. Financial information presented to Integrated Governance Committee in February 2015.</td>
</tr>
<tr>
<td>Risk Assessment:</td>
<td>Risk is an integral part of the whole system approach to planning and as such has been done as part of the development of the Operational Plan</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>Finance and Resource implications are an integral part of the operational plan.</td>
</tr>
</tbody>
</table>
1.0 Purpose of the Report
1.1 The purpose of this report is to:

- Provide Governing Body with details of progress to date in the development of the 2015/16 operational plan to improve services for the people of Wakefield and the proposed content outlined in the associated presentation.
- To provide Governing Body with the timescales for completion of the operational plan and development of the related delivery plans.

2.0 Background
2.1 This paper builds on previous presentations which have been brought to the Governing Body in November 2014 and January 2015 which outlined the detail of the Five Year Forward View and the 2015/16 Planning Guidance.

CCG’s were asked by NHS England to refresh their operational plans for 2015/16 as described in “The Forward View into Action: Planning for 2015/16” document. Our plan articulates our key strategic priorities, to develop and progress our emerging vision for the future of health and care for the people of the Wakefield District.

3.0 Engagement
3.1 Building on existing clinical engagement and leadership, the Governing Body members as part of their board development sessions have reinforced the need to focus on the five key areas which also has a strong focus in the Five year forward view:

- Prevention;
- Integration;
- Planned Care;
- Urgent Care and
- Primary Care.

3.2 The Local Clinical Networks have been briefed on the 2015/16 Planning Guidance through the monthly corporate leads update and the Planning and Delivery group have provided updates to Clinical Cabinet and the Executive Team on a regular basis over the last few months. We have also worked with colleagues across the provider landscape, West Yorkshire CCG footprint and the Local Authority to ensure our plans not only triangulate and complement each other but to also ensure that we are co-ordinating our capacity and capability to tackle transformation together.

4.0 CCG key dates for submissions
4.1 A full timetable is outlined by NHS England in the planning guidance; however key dates for the operation plan submission are as follows:

- 27 February - Submission of full draft plans to Area Team
- 17 March - Assurance and detailed feedback from the Area Team
5.0 Securing financial resilience

The purpose of this section is to update the Governing Body on the financial planning assumptions, risks and opportunities for 2015/16 and onwards in the context of revised planning guidance. The Integrated Governance Committee received an interim update on 19 February 2015 ahead of the draft financial planning deadline of 27 February 2015.

Tariff Update

5.1 On 18 February 2015, NHS England published the interim tariff arrangements seeking provider responses to two options - Enhanced Tariff Offer (ETO) and Default Tariff Rollover (DTR) by 4 March 2015. The draft revised contracts timetable indicates a revised contract agreement date of 31 March 2015.

5.2 The ETO option uses 15/16 draft prices with a reduced level of efficiency (reducing by 0.3%) and increases Marginal Rate Threshold for Emergency Admissions from 30% to 70%; as well as changes to elements of specialist commissioning. The financial impact of this on the CCG is estimated at £2m. This gross cost may be defrayed through an allocation increase from the £150m central fund, however, the allocation principles have not yet been agreed nationally and – therefore – cannot be assumed in the plan to date. Mid Yorkshire Hospitals NHS Trust have agreed this as their preferred option.

5.3 The DTR option uses 14/15 prices and reduces access to CQUIN payments.

2015/16 CCG Financial Planning

5.4 By way of context, the NHS has received an increased financial settlement for 2015/16 of £1.98bn. However, the previous Fundamental Review of Allocations placed Wakefield CCG current funding above target against the revised national formula; and under the design of the allocation system this means that Wakefield CCG received a minimum growth of 1.4% plus a fair share of system resilience monies – leading to an overall increase of 1.94%.

5.5 NHSE business rules remain unchanged, with CCGs required to deliver a minimum 1% surplus, retain a minimum 0.5% contingency and ensure that a minimum of 1% is invested non-recurrently.

5.6 The CCG programme allocation in 2015/16 is £466,885k – which includes minor amendments to take account of agreed allocation changes. In addition, an allocation of £7,557k will transfer to the CCG in relation to the Better Care Fund.

5.7 The CCG non-recurrent brought forward surplus has been amended to reflect the increased in-year planned surplus after taking account of the CHC risk-pool return. This has been increased to £7,610k.
5.8 Following a successful business case to increase overall drawdown and mitigate risk, the CCGs indicative draw-down level has been notified as £1,750k.

5.9 The CCGs in-year surplus for 2015/16 is therefore a product of the above. Our planned surplus is therefore £5,860k (1.2%) and although this is above the minimum surplus agreed by Governing Body, it reflects the increased brought forward surplus and the outcome of the national exercise to allocate drawdown limits.

5.10 Other key headlines include:

- Retention of a 1% contingency to manage risks and opportunities
- An efficiency target of £13.7m
- A detailed non-recurrent investment plan to support national and local priorities – which has been shared with Clinical Cabinet
- A revised schedule of risks and opportunities; which includes known or possible risks. It should be noted that risks exceed opportunities by £2m in relation to the interim tariff regime and a further £2.2m in relation to other net risks. Each risk has a mitigation plan and owner and a key component of mitigating risk will be the successful delivery of QIPP targets.
- A detailed analysis and budget book is currently being finalised and will be subject to the outcome of contract negotiation with providers.

5.11 In relation to Primary Care, the net delegated budget of £54.2m, is not reflected in CCG plans to date. The pro-rata share of co-commissioning QIPP of £1m is subject to a separate QIPP plan to deliver efficiencies.

5.12 The CCG running costs allocation remains as per original planning assumptions at £7,695k.

5.13 This is a 10% reduction on 14/15 running costs in cash terms. In real terms the reduction is greater (assessed as 12%-13%) as the CCG has cost pressures associated with inflation and pension increases. The key components to deliver a balanced plan are:

- A reduction in recharges from NHS Property Services
- A budget review of variable costs lines
- Review of programme / running cost to ensure appropriate classification.
- The planned staged reduction associated with Commissioning Support Unit (CSU) costs is secured in part by the former 2-year arrangement but the planned broader review of CSU services to gain better value for money (e.g. in-housing) forms part of the Transition Board business case process which may delay some elements of implementation. This introduces some uncertainty in timing and scope.

5.14 The CCG is required to prepare a credible and coherent plan which meets the business rules and links activity, service and finance. The current iteration of the financial plan is one which delivers the above but with residual risk which needs to be carefully managed; through ensuring that QIPP is delivered sustainably and that non-recurrent investment delivers transformational benefits.

5.15 Looking ahead into 2016/17 and beyond, the CCG has previously identified that the net efficiency requirement will be c2.5%. This level of financial challenge over the medium term will require a transformational approach to managing demand and a partnership approach to managing
6.0 Governance and Accountability

6.1 Work will continue in the CCG via the Planning & Delivery Group to ensure that progress continues to be made to deliver the local plans, in line with the assurance processes and frameworks set out by NHS England and the Area Team during 2015/16.

6.2 The Planning and Delivery Group is in the process of evolving to facilitate the organisation in continuing to commit to a whole system approach to planning, not just for 2015/16 but for the life of the five year strategy and beyond. The added value from the group meeting has been widely recognised and the opportunities to structure its role include:

- Ensuring quality is at the centre of all planning and delivery;
- Ensuring there is a focus on transactional delivery. Doing this through having the right people in the room focusing on a one year timeline, with a clear work plan with priorities and resources agreed for delivery;
- Streamlining communication processes;
- Enabling effective working through clear leadership, accountability and decision making;
- Ensuring a focus on transformational horizon scanning with a 3 – 5 year focus enabling longevity and sustainability across the whole system.

The process for looking at transformation horizon scanning has already begun, with mechanisms having been developed to enable this to happen not just in the CCG but across the health and social care system and with North Kirklees CCG.

6.3 The work of this group will continue to be accountable to Clinical Cabinet, to continue to assure them that not only are we meeting the agreed transactional plans for the year, but that our plans for beyond that will meet the future needs of the organisation and our patients.

7.0 Recommendations

- It is recommended that the Governing Body approves the current iteration of the 2015/16 financial plan, noting the risks and outstanding matters and that the financial planning arrangements are overseen by the Integrated Governance Committee.

- It is recommended that the Governing Body note the presentation outlines the proposed detail of the draft of NHS Wakefield Clinical Commissioning Groups 2015/16 operation plan, which is brought to members for noting and comment prior to development of the final plan.

Pat Keane, Esther Ashman
Interim Director Strategic Projects Head of Strategic Planning
Paper 10

Mid Yorkshire Hospitals NHS Trust
Meeting the Challenge and
Outcome of the Gateway Review

Presentation
Title of meeting: CCG Governing Body
Date of Meeting: 10 March 2015
Public/Private Section: Public

Paper Title: Co-commissioning – Update and assurance

Purpose (this paper is for):
- Decision
- Discussion
- Assurance
- Information

Report Author and Job Title:
Martin Smith – Programme Manager, Commissioning and Integrated Care
Katherine Bryant – Governance & Board Secretary

Responsible Clinical Lead:
Dr Greg Connor – Executive Clinical Advisor

Responsible Governing Board Executive Lead:
Pat Keane – Interim Director- Strategic Projects

Recommendation:

It is recommended that the Governing Body:

i. delegate authority to the Chief Officer and Chair of the Audit Committee to approve and sign the NHS England and Wakefield CCG delegation agreement for primary care co-commissioning.

ii. approve the Probity Committee terms of reference (appendix 2), and agree the terms of reference will be reviewed in six months.

iii. note the approach outlined in the paper for how the CCG and NHS England progress co commission of primary care.

iv. note that internally and externally the CCG has undertaken a process to provide assurance that the CCG is ready to take on the new primary care commissioning arrangements.

Executive Summary:

On 17 February 2015 Wakefield Clinical Commissioning Group (CCG) was given level 3 approval to take forward delegated general practice commissioning responsibility. The scope of primary care co-commissioning in 2015/16 is general practice services only.

Wakefield CCG is currently undertaking an internal audit to assess its readiness for general practice co-commissioning. Additionally Wakefield CCG has also commissioned the West Yorkshire Audit Consortium to externally audit its readiness for co-commissioning on the 10th March 2015.

Wakefield CCG and NHS England local regional team are committed to working together to ensure that the transfer of functions will be as seamless as possible with no gap in service for patients.

Primary care co-commissioning will present a greater risk of conflicts of interest, both real and perceived. To help Wakefield CCG manage these conflicts of interest a new committee of the Governing Body will be formed; the Probity Committee.

Link to overarching principles from the strategic plan:
- Citizen Participation and Engagement
- Wider Primary Care at Scale including Network development
- A Modern Model of Integrated Care
- Access to the Highest Quality Urgent and Emergency Care
- A Step Change in the Productivity of Elective Care
- Specialised Commissioning
- Mental Health Service Transformation
- Maternity, Children and Young People Transformation
- Organising ourselves to deliver for our patients
<table>
<thead>
<tr>
<th><strong>Outcome of Impact</strong>&lt;br&gt;Assessments completed (e.g. Quality IA or Equality IA)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outline public engagement – clinical, stakeholder and public/patient:</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Assurance departments/organisations who will be affected have been consulted:</strong></td>
<td>Finance (Chief Finance Officer)&lt;br&gt;Quality (Head of Quality and Engagement)&lt;br&gt;Governance (Governance &amp; Board Secretary)&lt;br&gt;Contracting (Head of contracting)</td>
</tr>
<tr>
<td><strong>Previously presented at committee / governing body:</strong></td>
<td>Primary Care Co-Commissioning Update presented in January 2015</td>
</tr>
<tr>
<td><strong>Reference document(s) / enclosures:</strong></td>
<td>Appendix 1 – Letter from NHS England, Primary Care Co-commissioning: Approval for Delegated Arrangements&lt;br&gt;Appendix 2 – Probity Committee: Terms of Reference&lt;br&gt;Appendix 3 – Primary care co-commissioning governance structure</td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
<td>The internal audit report will consider any risks presented by general practice co-commissioning.</td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
<td>Allocations for GP primary care service have been confirmed at £54.2m under the application for full delegation. Actual contractual amounts are currently being reconciled to the allocation however West Yorkshire Area Team have indicated that there is a deficit which will resulting in a QIPP saving of £1m.&lt;br&gt;&lt;br&gt;In addition internal resources will be required within the CCG to manage the workload of primary care commissioning and contracting. This is still being worked through and until then NHS England will continue to provide the service.</td>
</tr>
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</table>
Co commissioning: Update and assurance paper

1 Introduction

On 17 February 2015 it was announced that Wakefield Clinical Commissioning Group (CCG) were one of 64 CCGs given full delegation (level 3) approval to take forward delegated general practice commissioning responsibility (letter attached at appendix 1). This means that c.£54m of budgets will be delegated to Wakefield CCG in April 2015 to take this forward.

Nationally NHS England has recognised that CCGs may face challenges related to the transfer of related commissioning responsibilities and have provided assurance that CCGs will be supported through this transition.

2 Background Information

Wakefield CCG believes that primary care co-commissioning could accelerate the progress of its five year strategic plan for delivering wider primary care at scale, enabling a people centred approach to the commissioning and delivery of primary care. The opportunities, through co-commissioning, support the local plans for integration and the development of different models in primary care in line with the Five Year Forward View.

The scope of primary care co-commissioning in 2015/16 is general practice services only. Through delegated arrangement Wakefield CCG may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. However any changes by the CCG must comply with public procurement regulations and with statutory guidance on conflicts of interest.

3 Governance Arrangements

Primary care co-commissioning will present a greater risk of conflicts of interest, both real and perceived. To help Wakefield CCG manage these conflicts of interest the Governing Body approved a new Conflicts of Interest Policy in January 2015. The policy was developed in line with NHS England statutory guidance issued in December 2015.

A new committee of the Governing Body will be formed; the Probity Committee. Please note this committee has previously been referred to as the ‘Executive Approvals Group’ and also the ‘Conflicts of Interest Management Committee’. The terms of reference for this committee are included at appendix 2 and are presented for approval. It is recommended that the Probity Committee terms of reference will be reviewed in six months. Further information is included at appendix 3; this diagram outlines the governance structure which will support co-commissioning.

In accordance with guidance from NHS England meetings of the Probity Committee will be held in public. Furthermore a standing invitation will be made to Wakefield Healthwatch and Wakefield Health and Wellbeing Board to appoint representatives to attend meetings of the committee.

On 17 March NHS Wakefield’s three Lay Members will attend training commissioned by NHS England. The training will build understanding about what conflicts of interest mean and how lay members can support the organisation to address conflicts of interest.
Assurance

Wakefield CCG and NHS England local regional team are committed to working together to ensure that the transfer of functions will be as seamless as possible with no gap in service for patients. Following a meeting held with the regional team it was agreed that NHS England will develop a memorandum of understanding to assure Wakefield CCG that they will continue to deliver the services after 1st April and until a transfer date is agreed for each service area.

Wakefield CCG is currently undertaking an internal audit to assess its readiness for general practice co-commissioning. The audit is focused on reviewing the current capacity and capability of taking on these new functions alongside identifying the key risks to delivery.

Additionally Wakefield CCG has also commissioned the West Yorkshire Audit Consortium to audit its readiness for co-commissioning. This audit will focus on the measures in place as well as the overall strategic fit of the additional role.

As a condition of the delegated arrangements NHS England have requested that a delegation agreement will need to be signed by the CCG and returned on 12th March however NHS England has not yet issued this agreement to the CCG.

It is recommended that the Governing Body delegates the approval and signature of the delegation agreement to the following Governing Body members; Chief Officer, and Chair of the Audit Committee.

Timeline

Wakefield CCG and the NHS England local regional team will develop a transition timeline, the key deliverables are:

- **March 2015**: NHS England and Wakefield CCG agreed and sign delegation agreement.
- **March 2015 – April 2015**: Wakefield CCG conduct internal and external audit of readiness to take on Co commissioning.
- **April 2015 – October 2015**: Wakefield CCG and NHS England local regional team work together to develop transition plan and memorandum of understanding.

Finances

The agreed allocation for GP primary care services for WCCG is £54.2m. This includes a £1m QIPP. As detail within the GP contracts emerges for 15/16, this is being reconciled to the allocation. Uncertainty remains on premises costs, doctors review body inflation, list size growth, and other extra-contractual payments such as seniority, dispensing fees, interpreting
and expenses. QIPP plans also need confirming but are expected to include rates rebates, surplus against DDRB assumptions, list size validations and use of contingency.

7 Recommendations

The Governing Body of Wakefield Clinical Commissioning Group is invited:

1. To delegate authority to the Chief Officer and Chair of the Audit Committee to approve and sign the NHS England and Wakefield CCG delegation agreement for primary care co-commissioning.

2. To approve the Probity Committee terms of reference (appendix 2), and agree the terms of reference will be reviewed in six months.

3. To note the approach outlined in the paper for how the CCG and NHS England progress co commission of primary care.

4. To note that internally and externally the CCG has undertaken a process to provide assurance that the CCG is ready to take on the new primary care commissioning arrangements.

Enclosures

Appendix 1 Letter from NHS England, Primary Care Co-commissioning: Approval for Delegated Arrangements

Appendix 2 Probity Committee: Terms of Reference

Appendix 3 Primary care co-commissioning governance structure
Dear Andrew,

**Primary Care Co-commissioning: Approval for Delegated Arrangements**

Further to your submission to take forward new arrangements for primary care co-commissioning, I am delighted to inform you that NHS Wakefield CCG has been approved to take on delegated responsibility for NHS England specified general medical care commissioning functions from 1 April 2015, as per the functions set out in the forthcoming delegation agreement.

Delegated commissioning gives CCGs an opportunity to develop a more holistic and integrated approach to improving healthcare for local populations. It gives CCGs an opportunity to further improve out-of-hospital services provision and deliver the new models of care set out in the NHS Five Year Forward View. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.

Delegated commissioning is a step on the journey towards a more place based approach to commissioning and the primary care team in the local office of the North Region are committed to supporting you in your new arrangements. The joint primary care co-commissioning programme oversight group, co-chaired by Ian Dodge and Dr Amanda Doyle (Chief Clinical Officer, NHS Blackpool CCG and Co-chair, NHS Clinical Commissioners), will also provide further support at a national level, in conjunction with a co-commissioning operational group to ensure any issues requiring escalation are dealt with promptly.

We will be issuing a copy of the delegation agreement shortly which we ask that you kindly sign and return by 5pm on 12 March 2015. The signed agreement should be sent to england.co-commissioning@nhs.net. All outstanding governance matters (such as constitution amendments and ratification of revised conflicts of interest policies) must be resolved by the time the agreement is signed.

Once you have returned the signed agreement, we will then issue the final delegation and signed agreement that will formalise the delegation. In the meantime, the NHS England North Region will be in touch shortly to finalise the arrangements for implementation of the delegation arrangement.

**High quality care for all, now and for future generations**
We look forward to working with you.

Yours sincerely,

Ian Dodge  
National Director  
Commissioning Strategy

Dame Barbara Hakin  
National Director:  
Commissioning Operations

Paul Baumann  
Chief Financial Officer

High quality care for all, now and for future generations
| Accountability arrangements and authority | The Governing Body for NHS Wakefield Clinical Commissioning Group (CCG) hereby resolves to establish a committee of the Governing Body to be known as the Probity Committee in line with NHS Wakefield CCG’s constitution.

The Probity Committee will operate within the legal framework for NHS Wakefield CCG. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions to NHS Wakefield CCG. The Governing Body has determined that the Probity Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers. Consequently decisions of the Committee related to these delegated functions and delegated powers cannot be overruled by the Governing Body.

The membership, remit, responsibilities and reporting arrangements of the Probity Committee are set out in these terms of reference and shall have effect as if incorporated into the CCG Constitution and Standing Orders.

The Probity Committee has no executive powers, other than those specifically delegated in these terms of reference or otherwise agreed by the Governing Body.

The Probity Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee within its remit as described in these terms of reference. The Committee has full authority to commission any reports or surveys it deems necessary to help fulfil its obligations, including legal or other independent professional advice. |
| Relationship and reporting | The Probity Committee is a sub-committee of the Governing Body for NHS Wakefield CCG. Minutes of meetings will be presented to the Governing Body. Reports on specific issues will also be prepared when necessary for consideration by the Governing Body.

Other committees of the Governing Body for NHS Wakefield CCG will refer items to the Probity Committee if they identify that the issue presents a conflict of interest for all or the majority of GP members of the Governing Body.

The Probity Committee may establish groups to support it in its role (on an ongoing or short term basis). The scope and membership of those groups will be determined by the Probity Committee. |
| Role and function | The role of the Committee is to facilitate decision making about items which present conflicts of interest for all or the majority of GP members of the Governing Body.

Specifically, the role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of |
the NHS Act but may be extended (subject to approval from the Governing Body) to other areas which present a conflict of interest.

Specific duties of the Probity Committee are categorised in the “Responsibilities” section below.

In performing its role the Committee will exercise the functions in accordance with the agreement the CCG has entered into with NHS England.

The work of the Committee will be flexible to new and emerging priorities and risks.

The Committee will ensure that appropriate clinical engagement (including from primary care) is sought before reaching decisions.

<table>
<thead>
<tr>
<th>Responsibilities</th>
<th>Conflicts of Interest for GPs</th>
</tr>
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<tbody>
<tr>
<td>• make decisions on behalf of the Governing Body about items which present conflicts of interest for all or the majority of GP members of the Governing Body.</td>
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<tr>
<td><strong>Commissioning of primary medical services</strong></td>
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<tr>
<td>• seek to increase quality, efficiency, productivity and value for money and to remove administrative barriers in primary medical services in Wakefield district.</td>
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<tr>
<td>• make decisions on the review, planning and procurement of primary medical services in Wakefield district, under delegated authority from NHS England. This includes the following:</td>
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<tr>
<td>• GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract);</td>
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<tr>
<td>• newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);</td>
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<td>• design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);</td>
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<td>• decision making on whether to establish new GP practices in an area;</td>
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<td>• approving practice mergers; and</td>
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<tr>
<td>• make decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).</td>
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<tr>
<td>• as appropriate, make decisions about the following activities which will be carried out by the CCG:</td>
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<tr>
<td>• to plan, including needs assessment, primary medical services in Wakefield District;</td>
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<tr>
<td>• undertake reviews of primary medical care services in Wakefield District;</td>
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<tr>
<td>• co‐ordinate a common approach to the commissioning of primary care services generally;</td>
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<tr>
<td>• manage the budget for commissioning of primary medical services in Wakefield District.</td>
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<tr>
<td>• support the development of high quality primary medical services in</td>
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</table>
Wakefield district.

**Network Development Framework (or any successor schemes)**

- approve the Network Development Framework (NDF), any subsequent amendments proposed and/or any successor schemes to the NDF;
- consider proposals made by the Network Development Framework Scrutiny Panel and approve payments made to Member practices in accordance with the Network Development Framework;
- seek assurance that the Network Development Framework delivers intended benefits and thus represents value for public money. This includes ensuring that the scheme:
  - fulfils the requirement in Everyone Counts to invest around £5 per patient in primary care;
  - builds on the lessons learned relating to innovation and performance management;
  - maintains improved patient access to primary care services;
  - enhances patient engagement and support self-care;
  - supports the implementation of integrated care by underpinning the care closer to home programme;
  - assists the networks to identify and meet the health needs of their local populations in partnership with the local authority and deliver the national outcomes required of the Better Care Fund.

**Other Duties**

The Committee will agree an annual work plan to ensure that it covers all the duties above and undertake an annual self-assessment.

The Committee may agree other areas of responsibility as appropriate with the Governing Body.

**Membership**

The Committee appointments will be approved by the Governing Body on an annual basis. The membership of the Committee is given below:

- Chair of the Committee (the nominated lay member who is also the Deputy Chair of the Governing Body);
- Lay Member – Audit
- Lay Member – Patient and Patient Involvement;
- Chief Officer;
- Chief Financial Officer;
- Chief of Service Delivery & Quality;
- Registered Nurse;
- Secondary Care Specialist;
- Executive Clinical Advisor (a GP).

All members of the Committee have one vote. In the event of a tied vote the Chair will hold a second and casting vote.
Nominated appropriate equivalent deputies can attend in extenuating circumstances. Nominated deputies will only be in attendance and cannot vote.

Any director or senior managers may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. Other officers may be requested to attend in an advisory capacity.

<table>
<thead>
<tr>
<th>In Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A representative from Healthwatch Wakefield;</td>
</tr>
<tr>
<td>• A representative from the Wakefield Health and Wellbeing Board;</td>
</tr>
<tr>
<td>• A representative from NHS England;</td>
</tr>
<tr>
<td>• Associate Directors, as appropriate;</td>
</tr>
<tr>
<td>• Heads of Service, as appropriate;</td>
</tr>
<tr>
<td>• Director of Public Health;</td>
</tr>
<tr>
<td>• Governance &amp; Board Secretary.</td>
</tr>
</tbody>
</table>

Those in attendance do not qualify to vote.

For those attending, named deputies should attend in exceptional cases only and this should be communicated to the Chair and secretary of the meeting in advance.

**Members of the public and representatives of the press**

Meetings of the Committee will be held in public, and members of the public and representatives of the press will be permitted to attend and observe the meeting.

In accordance with the CCG’s Standing Orders the public and representatives of the press shall be required to withdraw upon a resolution of members of the Committee as follows:

> ‘that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest’, Section 1 (2), Public Bodies (Admission to Meetings) Act 1960.

**Chair**

The Chair of the Committee will be the Lay Member - Deputy Chair of the Governing Body.

The Vice Chair of the Committee will be the Lay Member – Patient & Public Involvement.

**Quoracy**

The Committee shall be quorate if at least three members shall be present. This must include a Lay Member and either the Chief Officer, Chief Finance Officer or the Chief of Service Delivery and Quality.

**Frequency of meetings**

There shall be appropriate flexibility as the frequency of meetings of the Committee, but these shall normally be held quarterly.
<table>
<thead>
<tr>
<th><strong>Frequency of attendance</strong></th>
<th>Members are expected to attend all meetings; however a nominated appropriate equivalent deputy can attend in extenuating circumstances. Deputies will only be in attendance.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conduct</strong></td>
<td>Members of the Committee and those in attendance at meetings will abide by the ‘Principles of Public Life’ and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Citizen’s Charter and Code of Practice on Access to Government Information. All members will have due regard to, and operate within, the prime financial policies, standing orders, the constitution and other policies and procedures of NHS Wakefield CCG.</td>
</tr>
<tr>
<td><strong>Declaration of interests</strong></td>
<td>All potential conflicts of interest will be declared and dealt with in line with the CCG’s policies / procedures for handling conflicts of interest. Declarations of interest will be an agenda item at each meeting. Everyone at a meeting will be required to declare any interest they have in any agenda items as soon as it becomes apparent. The Chair will determine whether the individual will be excluded from relevant parts of meetings, or be able to join in the discussion, but not participate in the decision making itself or vote. All declarations of interest will be recorded in the minutes.</td>
</tr>
</tbody>
</table>
| **Administration**        | Secretariat support for the Committee will be provided by the administration function within the CCG. They will ensure that minutes of the meeting are taken and provide appropriate support to the Chair and Committee members. Duties will include:  
  - agreement of agenda with Chair and attendees and collation of papers;  
  - ensuring that minutes are taken and keeping a record of matters arising and issues to be carried forward;  
  - timely distribution of papers, no later than 5 working days before a meeting for agenda and papers and no later than 5 working days after a meeting for distribution of minutes;  
  - record of matters arising, issues to be carried forward. |
| **Urgent matters arising between meetings** | The Chair of the Committee, the Chief Officer and Chief Financial Officer, in consultation, may also act together on urgent matters arising between meetings of the Committee.  
In the absence of the Chair, the Chief Officer and Chief Financial Officer and a Lay Member, in consultation, may act together.  
These matters will be ratified at the next meeting of the Committee. |
| **Monitoring of compliance** | The Governing Body will monitor the effectiveness of the Committee through receipt of the minutes and the Committee’s Annual Report to the Governing |
| **Date agreed** | TBC – will be presented to the Governing Body in March 2015. |
| **Review date and monitoring** | Annually, or as and when legislation or best practice guidance is updated. Any amended terms of reference will be agreed by the Committee for recommendation to a subsequent meeting of the Governing Body. |
Governance Structure - Primary Care Co-Commissioning
Operating within the CCG’s governance framework as outlined in the Constitution

Governing Body

- Approval of GMS, PMS and APMS contracts
- Including design, taking contractual actions and removing a contract.
- Approve enhanced services
- Approve local incentive schemes
- Approve new GP practices, practice mergers
- Agree ‘discretionary’ payment
- Monitor NDF performance & approve payments
- Consider items which present conflict of interest for GPs

Probity Committee

- Refer items which present conflict of interest for GPs to the Probity Committee

Clinical Cabinet

- Strategic vision and direction for commissioning
- Refer items which present conflict of interest for GPs to the Probity Committee

Integrated Governance Committee

- Primary Care quality monitoring
- Primary care contract monitoring including performance and procurements issued (not contractual actions)

Items which present a conflict of interest for the GP members of the Governing Body
Paper 12

Working in partnership to improve the Health of Wakefield

Presentation
<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>CCG Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>10 March 2015</td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Better Care Fund- Update and approval process for the Section 75 Partnership Framework Agreement</td>
</tr>
<tr>
<td>Agenda Item:</td>
<td>13</td>
</tr>
<tr>
<td>Public/Private Section:</td>
<td>Public</td>
</tr>
</tbody>
</table>

**Purpose (this paper is for):**
- Decision
- Discussion
- Assurance
- Information

**Report Author and Job Title:** Melanie Brown
Programme Commissioning Director Integrated Care

**Responsible Clinical Lead:** Dr Avijit Biswas, Dr Adam Sheppard, Dr Ann Carroll

**Responsible Governing Board Executive Lead:** Jo Webster, Chief Officer

**Recommendation:**

It is recommended that the Governing Body:

(i) agree Wakefield Clinical Commissioning Group will enter into a section 75 agreement with Wakefield Council in relation to the governance and management of the Better Care Fund.

(ii) delegate approval for the final Section 75 Agreement to the Chief Officer and Clinical Leader within the approved sum of £42 million.

(iii) note the decision made by the Governing Body in January 2015 to delegate authority to the Chief Officer, Clinical Leader, Assistant Clinical Leader and Chair of Audit Committee to finalise arrangements for the Better Care Fund.

(iv) agree Wakefield Clinical Commissioning Group will host the Better Care Fund pool in 2015/2016, with the exception of the Integrated Community Equipment Service and the Disabled Facilities Grant which will be hosted and managed by Wakefield Council.

**Executive Summary:**

- The Better Care Fund delivery needs to commence in April 2015.
- There has been a joint process in place between the Wakefield Clinical Commissioning Group (CCG) and the Wakefield Council (WC) to develop the overarching Partnership Framework Section 75 Agreement, which needs to be in place by 1st April 2015.
- The current draft of the Section 75 Agreement is subject to review by CCG and Council officers and legal teams and therefore the Governing Body is asked to delegate approval of the final Section 75 Agreement to the Chief Officer and Clinical Leader.

**Link to overarching principles from the strategic plan:**

- Citizen Participation and Engagement
- Wider Primary Care at Scale including Network development
- A Modern Model of Integrated Care
- Access to the Highest Quality Urgent and Emergency Care
- A Step Change in the Productivity of Elective Care
- Specialised Commissioning
- Mental Health Service Transformation
- Maternity, Children and Young People Transformation
- Organising ourselves to deliver for our patients

---

**Title of meeting: CCG Governing Body**

**Date of Meeting:** 10 March 2015

**Paper Title:** Better Care Fund- Update and approval process for the Section 75 Partnership Framework Agreement

**Purpose (this paper is for):**

- Decision
- Discussion
- Assurance
- Information

**Report Author and Job Title:** Melanie Brown
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- Organising ourselves to deliver for our patients
<table>
<thead>
<tr>
<th><strong>Outcome of Impact</strong>&lt;br&gt;Assessments completed (e.g. Quality IA or Equality IA)</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outline public engagement – clinical, stakeholder and public/patient:</strong></td>
<td>CCG Governing Body members who are also members of the Health and Well-being Board have considered these proposals&lt;br&gt;Public engagement - ‘not applicable’</td>
</tr>
<tr>
<td><strong>Assurance departments/ organisations who will be affected have been consulted:</strong></td>
<td>Finance (Chief Finance Officer)&lt;br&gt;Commissioning (Associate Director - Service Delivery and Quality)&lt;br&gt;Clinical leads (Chair of Clinical Cabinet, Care Outside Hospital Lead, GP Children’s Lead &amp; GP Safeguarding Lead)&lt;br&gt;Public Health (Director Public Health &amp; Public Health Consultant)</td>
</tr>
<tr>
<td><strong>Previously presented at committee / governing body:</strong></td>
<td>13 January 2015</td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
<td>Not applicable for this stage</td>
</tr>
</tbody>
</table>
Better Care Fund: Update

1 Introduction

Governing Body members received a briefing at their meeting on 13 January 2015 in which they discussed the monitoring arrangements that would need to be in place to oversee and manage the Better Care £42 million pooled fund and discussed if Wakefield Clinical Commissioning Group should consider hosting the Better Care Fund pooled budget.

The Governing Body indicated a preference to host the Better Care Fund and agreed to enter discussions with local authority colleagues to progress the hosting arrangements for Wakefield District.

Following that meeting this paper asks the Governing Body of Wakefield Clinical Commissioning Group to delegate the final sign off of the Better Care Fund partnership agreement (known as a section 75 agreement) to the Chief Officer and Clinical Leader.

2 Background Information

The Care Act 2014 (Part 4, section 121, (3)) sets out the legislative framework that the resources identified as part of the Better Care Fund are required to be placed into pooled budgets under a legal framework referred to as a section 75 joint governance arrangements between CCGs and Councils. Technical guidance published to support the development of Better Care Fund (BCF) planning has made it clear that the Health and Wellbeing Board has a responsibility to have oversight of these pooled resources. This will require the Health and Wellbeing Board to have a more active role in the joint commissioning of health and social care interventions as outlined through Wakefield’s local BCF plan. All Health and Wellbeing Boards have already been asked to sign off local Better Care Fund plans before submission to NHS England and Wakefield undertook this in their September Board meeting. The Wakefield Health and Wellbeing Board supported a proposal for a pooled budget of £42 million and a planned 3.2% reduction in emergency admissions by 2016/17. This proposal was approved by NHS England on 31st December 2014.

Clinical Commissioning Groups were licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006. Section 75 of the NHS Act 2006 provides for CCGs and local authorities to pool budgets.

The CCG’s governance framework is described by the constitution and appendices. The Clinical Commissioning Group recently updated these documents to permit the CCG to establish joint committees with local authorities in an agreement under section 75 of the National Health Service Act 2006. The Clinical Commissioning Group submitted its revised constitution to NHS England for approval in January 2015. The process for approval of the amendment of the constitution takes approximately two months to complete, it is anticipate that Wakefield Clinical Commissioning Group will have this approved mid-March 2015.

The pooled budget for the Better Care Fund and its section 75 arrangements need to be adopted and in place for April 2015 to meet the requirements of the Care Act 2014.
3 Governance

The governance arrangements must be in place from April 2015 and will include reporting arrangements into Wakefield District Health and Wellbeing Board (who have oversight of the BCF). The management arrangements for the Better Care pooled fund will need to include the following statutory functions for the Better Care Fund which are outlined in the Care Act 2014 (Part 4, section 121, (3)):

- to agree the strategic planning;
- manage the pooled budget; and
- oversee and performance manage the planning as well as the practical and financial implementation of the fund.

Following the January 2015 Board meeting colleagues in the CCG and the Council have worked together to agree the hosting arrangements for the Better Care Fund pool. It has been agreed that Wakefield Clinical Commissioning Group will host the Better Care Fund pool in 2015/2016. A partnership agreement is under development to formalise this arrangement and it has been agreed with the Council that this will be a one year agreement in the first instance.

The integrated community equipment service already has a pooled fund in place between the CCG and the Council. The local authority leads the commissioning arrangements for this joint service and it is proposed that for service continuity these arrangements remain the same for 2015/2016. A review of the service is also underway led by the Public Health team and this will be reported into the governance arrangements for the Better Care Fund. The integrated community equipment service and Disabled Facilities Grant will remain part of the Better Care Fund partnership agreement but the host for this scheme will be identified as Wakefield Council.

4 Monitor the management of the BCF pooled budget

As host for the Better Care Fund, Wakefield Clinical Commissioning Group will have the responsibility and will need to ensure that the following monitoring processes will be in place for April 2015:

- In-year financial monthly monitoring and reporting arrangements to the HWB / Connecting Care Executive;
- Non-financial performance metrics;
- Performance data to be reported;
- Appointment of a Pool Manager – this would add both capacity & running costs to either organisation;
- Separate accounting within the fund of ring-fenced budgets; and
- Dispute resolution – this will need to be addressed in the s75.

5 Legal

Officers in the CCG and the Council are still working through some of the detail for the Better Care Fund partnership agreement. There are some gaps currently that are being worked through such as the detail on the risk share agreement and some other areas. However, an
evolving Better Care Fund Section 75 partnership agreement is currently with the CCG legal team (DAC Beachcroft) for advice. The Council legal team are also considering this draft partnership agreement too.

6 Timetable for developing the BCF Section 75 agreement

The timetable colleagues in the CCG and the Council are working towards is outlined below and aims to have the pooled budget arrangements agreed and signed by both parties, through a section 75 agreement by, 1st April, 2015.

<table>
<thead>
<tr>
<th>Key Deliverable</th>
<th>Milestone Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance Review – signal of intent Principles approved</td>
<td>November 2014- Completed</td>
</tr>
<tr>
<td>BCF pooled budget section 75 agreement drafted</td>
<td>End January 2015- Completed</td>
</tr>
<tr>
<td>Value of initial Better Care Fund pooled budget agreed</td>
<td>End February 2015- Completed</td>
</tr>
<tr>
<td>Section 75 agreement signed</td>
<td>End March 2015</td>
</tr>
<tr>
<td>Implementation date -Better Care Fund pooled budget</td>
<td>1st April 2015</td>
</tr>
</tbody>
</table>

8 Governance Arrangements

Revised governance arrangements for the Health and Wellbeing Board and joint commissioning between the Council and the CCG are currently subject to consultation and will be presented to the Health and Wellbeing Board on 19th March 2015. The proposals will ensure Wakefield has in place effective oversight and joint management arrangements for the Better Care Fund.

The governance arrangements must be in place from April 2015 and will include reporting arrangements into Wakefield District Health and Wellbeing Board (who have oversight of the BCF). The management arrangements for the Better Care pooled fund will need to include the following statutory functions for the Better Care Fund which are outlined in the Care Act 2014 (Part 4, section 121, (3)):

- to agree the strategic planning;
- manage the pooled budget; and
- oversee and performance manage the planning as well as the practical and financial implementation of the fund.

Appendix 1 highlights the proposed governance arrangements that will be considered across the integration agenda by the Health and Wellbeing Board on the 19th March 2015. It is proposed that the current Joint Strategic Commissioning Board and the Integration Executive, both of whom report into the Health and Wellbeing Board are replaced by the Connecting Care Executive. The terms of reference for this group will need to be approved by the Health and Wellbeing Board.
The Better Care Fund includes a performance related element, critical to the primary target of reducing emergency admissions. Negotiations are currently taking place to ensure a shared approach to the management of risk and a risk sharing agreement that includes the commissioners and providers of services, including the Acute Trust. However it should be noted that at the time of developing this paper, the national Payment for Performance guidance which informs the funds flows associated with performance has still not been published.

9 **Recommendations:**

It is recommended that the Governing Body:

(i) agree Wakefield Clinical Commissioning Group will enter into a section 75 agreement with Wakefield Council in relation to the governance and management of the Better Care Fund.

(ii) delegate approval for the final Section 75 Agreement to the Chief Officer and Clinical Leader within the approved sum of £42 million.

(iii) note the decision made by the Governing Body in January 2015 to delegate authority to the Chief Officer, Clinical Leader, Assistant Clinical Leader and Chair of Audit Committee to finalise arrangements for the Better Care Fund.

(iv) agree Wakefield Clinical Commissioning Group will host the Better Care Fund pool in 2015/2016, with the exception of the Integrated Community Equipment Service and the Disabled Facilities Grant which will be hosted and managed by Wakefield Council.
Appendix 1

Management of the Better Care Fund Structure

Wakefield Council/Cabinet

Wakefield District Health and Wellbeing Board

NHS Wakefield CCG

Connecting Care Executive (Commissioning)
Adults, Children and Young People

Joint Enablers (Across Children and Young People and Adults arena)
- IMT
- Communications and engagement
- Contracting and commissioning
- Estates

Joint Transformation Programme (Across Children and Young People and Adults arena)
- Mental Health
- Personal Budgets

Various Children Programmes including Children and Young Peoples Partnership

Connecting Care Health and Social Care Partnership (Providers and Commissioners)

Operational Commissioning Group
- Urgent Care
- Planned Care
- Public Health
- Mental Health Transformation Programmes
### Executive Summary:
The Month 10 Finance Report provides a year to date position as at 31\(^{st}\) January 2015.

The CCG has a year to date surplus of £6,528k. Forecast year end position is £7,612k.

Activity information is based on month 8 freeze data and month 9 flex with month 8 trading reports where available.

All key performance targets are green, with the exception of QIPP delivery and activity trends.

This month’s Key Focus Area is on budget setting.

### Highlights for this month are:
- The surplus position has increased due to the CCG element of the returned national underspend on the Continuing Health Care restitution claims risk pool as required by NHS England (NHSE).
- The running costs allowance has increased by £483k which relates to the Quality Premium Allocation (QP). NHSE have advised that expenditure for QP can be within programme or running costs, but the allocation should be included in running costs for NHSE accounts consolidation purposes.
- Mid Yorkshire Hospitals NHS Trust (MYHT) at month 10 is showing estimated £795k under trade. However the yearend forecast is breakeven due to the predicted over trade against plan in quarter 4.
- The application for Prime Ministers Challenge Fund wave 2 was submitted to NHSE on 16\(^{th}\) January 2015. The CCG has been informed that the bid has progressed through to the shortlist and the bid team are currently working on some additional information that NHSE have requested.
- Risks to the reported financial position include general contract stances, NHS property services, contract challenges and specialist commissioning transfer issues. In addition since completing the report there is an additional risk that the £1.1m of RTT funding expected from NHS England may not be paid in full.

### Link to overarching principles from the strategic plan:

<table>
<thead>
<tr>
<th>Citizen Participation and Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wider Primary Care at Scale including Network development</td>
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<td>Specialised Commissioning</td>
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<td>Mental Health Service Transformation</td>
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<tr>
<td>Maternity, Children and Young People Transformation</td>
</tr>
<tr>
<td>Organising ourselves to deliver for our patients</td>
</tr>
<tr>
<td><strong>Outcomes of Equality Impact Assessment:</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Outline public engagement:</strong></td>
</tr>
<tr>
<td><strong>Assurance departments/organisations who will be affected have been consulted:</strong></td>
</tr>
<tr>
<td><strong>Previously presented at committee/governing body:</strong></td>
</tr>
<tr>
<td><strong>Reference document(s)/enclosures:</strong></td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Finance/resource implications:</strong></td>
</tr>
</tbody>
</table>
Finance Report
Month 10
2014/15
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3. Key Focus Area – Budget Setting ............................................................................................. 14
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5. Quality, Innovation, Productivity and Prevention (QIPP) ......................................................... 15
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1. Executive Summary

- **Key financial headline position**

  The surplus position has increased due to the CCG element of the returned national underspend on the Continuing Health Care restitution claims risk pool as required by NHS England (NHSE).

  **Key financial headline position**

<table>
<thead>
<tr>
<th>Annual budget £000</th>
<th>FOT £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus</td>
<td>6,505</td>
</tr>
<tr>
<td>Managing within overall resource</td>
<td>480,923</td>
</tr>
<tr>
<td>Managing running cost allowance</td>
<td>9,043</td>
</tr>
</tbody>
</table>

  NHSE requires that the running costs allowance be increased by £483k which relates to the Quality Premium Allocation (QP). The cost of QP is included in programme costs.

- **Activity Data Available Month**

  Mid Yorkshire Hospitals NHS Trust - Month 8 Freeze Month 9 Flex

  Other NHS Trusts - Month 8 Trading Reports where available

- **Quality, Innovation, Productivity and Prevention (QIPP)**

  The forecast out-turn position shows an achievement of £13.3m however £3.5m is non recurrent.

  During the year, the CCG has made progress on a number of elements of transformation, risk sharing, demand management and cost control and the CCG is forecast to achieve c£9.7m recurrently.

- **Non-Recurrent**

  The CCG has been advised that the balance of the remaining funding relating to RTT phase 1 is c£1.2m after excluding the secondary care dental resources commissioned by NHSE. This is awaited from NHSE

  c£1.1m of the non-recurrent underspend relates to the national Continuing Health Care Risk
Pool which has been ring fenced to improve the CCG out-turn position as required by NHSE.

The CCG is awaiting confirmation of the process and value of the resources to support ‘match and move’ activity which has been moved to Independent Sector providers. This is awaited from NHSE. In addition health economies have received correspondence from Monitor, NHSE and NHS Trust Development Authority (NHSTDA) on 6th February 2015 with further RTT improvement initiatives.

- **Overall Position**

  **Acute**

  Mid Yorkshire Hospitals NHS Trust (MYHT) at month 10 is showing estimated £795k under trade. However the yearend forecast is breakeven as there has been a) a material increase in the costs of excluded drugs in the last quarter and b) a potential elective overtrade in the last quarter over and above the agreed plan.

  The adjusted position on Leeds Teaching Hospitals NHS Trust (LTHT) is an £861k overtrade. The main areas of overtrade are Critical Care £241k, Maternity pathway £152k, Radiology £165k and Rheumatology £199k. These are under review by the lead commissioners.

  There are large under trades on Sheffield Teaching Hospitals NHS Trust (STHT) in critical care and electives and also on maternity pathway and critical care at Doncaster and Bassetlaw NHS Foundation Trust.

- **Continuing Care**

  Adults Continuing Care is forecasting an overtrade of £737k at year end. The full year position has stabilised in the last few months as a revised forecasting method has been introduced. From 1st April 2014 patients were able to request a Personal Health Budget (PHB). The expenditure to date on Adults PHBs is £269k year to date.

  PHB’s are being closely monitored as patients may choose to have care delivered in a different way to meet their need.

  Children’s Complex Care is forecast to be £680k overspent at year end. The position and factors influencing this continue to be monitored closely.

- **Running Costs**

  There is a forecast year end under-spend of £1,142k. £400k is identified as QIPP from savings to date on NHS Property Services (NHSPS) costs and £483k relates to the QP allocation. NHSE have
advised that expenditure for QP can be within programme costs or running costs, but the allocation should be included in running costs for NHSE accounts consolidation purposes. The remainder is made up of underspends on pay and small non-pay areas.

• Risks

A detailed analysis of risks and opportunities is included later in the report. The main risks are:

• Over-trades on acute contracts
• Additional charges from NHSPS
• Contract challenges from Non NHS provider
• Specialist Services allocation transfers
2. Finance and Activity Dashboards & Trends

NHS Wakefield CCG key financial performance indicators are detailed below:

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>RAG Measure</th>
<th>RAG - 10 9 8</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying recurrent surplus</td>
<td>Green: &gt;= 2% Amber/Green: 1-1.99% 95% Amber Red: 0-0.99% Red: &lt;0%</td>
<td>✓ ✓ ✓</td>
<td>Exit level &gt;2% of total CCG allocation</td>
</tr>
<tr>
<td>Surplus - year to date performance (variance to plan as % of allocation)</td>
<td>Green: &lt;= 0.1% Amber/Green&lt;0.25% Amber/Red: &lt;0.5% Red: &gt;0.5%</td>
<td>✓ ✓ ✓</td>
<td>Variance to Plan = £1107k at Month 10 which relates to the nationally returned underspend on CHC restitutions claims Risk Pool</td>
</tr>
<tr>
<td>Surplus - Full year (forecast variance to plan as % of allocation)</td>
<td>Green: &lt;= 0.1% Amber/Green&lt;=0.25% Amber/Red: &lt;0.5% Red: &gt;0.5%</td>
<td>✓ ✓ ✓</td>
<td>Variance to Plan = £1107k at Month 10 which relates to the nationally returned underspend on CHC restitutions claims Risk Pool</td>
</tr>
<tr>
<td>Management of 2.5% NR funds within agreed processes</td>
<td>Green=Yes Red=No</td>
<td>✓ ✓ ✓</td>
<td>YTD spend of £9.4m on-going submission against monitoring returns to NHSE</td>
</tr>
<tr>
<td>QIPP - year to date delivery</td>
<td>Green: &gt;= 95% of plan Amber: &gt;=95% of plan Red: &lt;75% of plan</td>
<td>✓ ✓ ✓</td>
<td>Phased QIPP plan YTD. Achievement £11.9m YTD</td>
</tr>
<tr>
<td>QIPP - full year in-year forecast</td>
<td>Green: &gt;= 95% of plan Amber: &gt;=95% of plan Red: &lt;75% of plan</td>
<td>✓ ✓ ✓</td>
<td>QIPP plan £14m. FOT £13.3m incl NR £3.5m</td>
</tr>
<tr>
<td>Recurring full year QIPP delivery</td>
<td>Green: &gt;= 95% of plan Amber: &gt;=95% of plan Red: &lt;75% of plan</td>
<td>✓ ✓ ✓</td>
<td>Forecast full year recurrent achievement £9.7m against £14m</td>
</tr>
<tr>
<td>Activity trends - year to date</td>
<td>Green: &lt;101% of plan Amber/Green: &lt;102% of plan Amber/Red: &lt;103% of plan Red: &gt;=103% of plan</td>
<td>✓ ✓ ✓</td>
<td>1.4 % year to date overtrade on MYHT month 8 activity</td>
</tr>
<tr>
<td>Activity trends - full year forecast</td>
<td>Green: &lt;101% of plan Amber/Green: &lt;102% of plan Amber/Red: &lt;103% of plan Red: &gt;=103% of plan</td>
<td>✓ ✓ ✓</td>
<td>1.4% overtrade on MYHT</td>
</tr>
<tr>
<td>Running costs</td>
<td>Green: &lt;= RCA Red: &gt;RCA</td>
<td>✓ ✓ ✓</td>
<td>Underspend to date</td>
</tr>
<tr>
<td>Clear identification of risks against financial delivery and mitigations</td>
<td>Green: Indicator met in full Amber/Green: Indicator partially met limited uncovered risk Amber/Red: Indicator partially met material uncovered risk Red: Indicator not met</td>
<td>✓ ✓ ✓</td>
<td>All risks identified with value and mitigation</td>
</tr>
<tr>
<td>Assessment of internal and external audit opinion and on timeliness and quality of returns</td>
<td>Based on assessment of returns</td>
<td>✓ ✓ ✓</td>
<td>No matters arising as part of year-end audit regarding quality or timeliness</td>
</tr>
<tr>
<td>Balance sheet indicators including performance against planned cash limit and BPPC performance.</td>
<td>BPPC: Green 95% of invoices to be paid within 30 days</td>
<td>✓ ✓ ✓</td>
<td>Cash at bank: £305k held at 31st January. BPPC: 99% of invoices paid by number and 100% paid by value.</td>
</tr>
</tbody>
</table>
NHS Wakefield CCG is notified of its allocation from NHSE prior to the start of the year. Adjustments to allocations can be made throughout the year. In 2014/15 allocations received are details below:

<table>
<thead>
<tr>
<th>Allocation Description</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/15 Opening Programme Allocations</td>
<td>457,483</td>
</tr>
<tr>
<td>14/15 Running Cost Allocation</td>
<td>8,560</td>
</tr>
<tr>
<td>14/15 Non-recurrent b/f surplus</td>
<td>5,505</td>
</tr>
<tr>
<td><strong>Total Allocation at 30th April and 31st May 2014</strong></td>
<td><strong>471,548</strong></td>
</tr>
<tr>
<td>GP IT allocation</td>
<td>905</td>
</tr>
<tr>
<td><strong>Total Available Resources 30th June 2014</strong></td>
<td><strong>472,453</strong></td>
</tr>
<tr>
<td>Offender Health</td>
<td>544</td>
</tr>
<tr>
<td><strong>Total Available Resources 31st July 2014</strong></td>
<td><strong>472,997</strong></td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>2,466</td>
</tr>
<tr>
<td>King Street Walk in Centre</td>
<td>1,056</td>
</tr>
<tr>
<td>Harrogate Contract (Duchy)</td>
<td>50</td>
</tr>
<tr>
<td>Cytology</td>
<td>-334</td>
</tr>
<tr>
<td><strong>Total Available Resources 31st August 2014</strong></td>
<td><strong>476,235</strong></td>
</tr>
<tr>
<td>2 mths King Street Walk in Centre</td>
<td>-176</td>
</tr>
<tr>
<td>14/15 CEOV and non-rechargable services</td>
<td>-403</td>
</tr>
<tr>
<td><strong>Total Available Resources 30th September 2014</strong></td>
<td><strong>475,656</strong></td>
</tr>
<tr>
<td>Winter Resilience Funding</td>
<td>2,486</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>88</td>
</tr>
<tr>
<td>Winter Resilience Funding 2nd tranche</td>
<td>1,954</td>
</tr>
<tr>
<td>Paediatric metabolic dietetic procedures</td>
<td>-14</td>
</tr>
<tr>
<td><strong>Total Available Resources 31st October and 30th November 2014</strong></td>
<td><strong>480,170</strong></td>
</tr>
<tr>
<td>Quality Premium Awards 2013-14</td>
<td>483</td>
</tr>
<tr>
<td>Mental Health Resilience 14/15</td>
<td>208</td>
</tr>
<tr>
<td><strong>Total Available Resources 31st December 2014</strong></td>
<td><strong>480,861</strong></td>
</tr>
<tr>
<td>LTH allocation transfer as per agreement with LW CCG</td>
<td>62</td>
</tr>
<tr>
<td><strong>Total Available Resources 31st January 2015</strong></td>
<td><strong>480,923</strong></td>
</tr>
</tbody>
</table>

Anticipated future adjustments are for RTT and other services where there is an overlap with specialist services which was not adjusted recurrently in the baseline e.g. vascular services, paediatric insulin pumps and HIV.

An analysis of the high level budget headings and financial performance is provided in the table below. It is important to note that £1.1m of the anticipated underspend relates to the CCGs elements of the nationally returned underspend in relation to CHC restitution claim risk pool. NHS
England required that this should be used to improve CCG’s financial position and not to be used for re-investment.

The allocation for Quality Premium (£483k) was received is included in running costs.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Opening Budget agreed by Governing Body</th>
<th>Change</th>
<th>Annual Budget</th>
<th>Budget to Date</th>
<th>Expenditure to Date</th>
<th>Variance to date</th>
<th>Change in Variance to Date</th>
<th>Forecast year end Variance</th>
<th>Change in forecast year end Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>38,521</td>
<td>5,319</td>
<td>43,839</td>
<td>36,533</td>
<td>36,615</td>
<td>82</td>
<td>↓</td>
<td></td>
<td>101</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals</td>
<td>220,311</td>
<td>-11,381</td>
<td>208,930</td>
<td>174,109</td>
<td>173,314</td>
<td>-795</td>
<td>↑</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Other NHS Providers (Inc Leeds, Sheffield etc)</td>
<td>40,460</td>
<td>-78</td>
<td>40,381</td>
<td>33,651</td>
<td>33,499</td>
<td>-152</td>
<td>↑</td>
<td></td>
<td>204</td>
</tr>
<tr>
<td>Other Acute including AQP</td>
<td>18,397</td>
<td>-471</td>
<td>17,926</td>
<td>14,938</td>
<td>17,331</td>
<td>2,392</td>
<td>↓</td>
<td></td>
<td>2,351</td>
</tr>
<tr>
<td>Prescribing</td>
<td>63,585</td>
<td>-2,000</td>
<td>61,585</td>
<td>51,568</td>
<td>51,522</td>
<td>-46</td>
<td>↑</td>
<td></td>
<td>-43</td>
</tr>
<tr>
<td>Primary Care and Out of Hours</td>
<td>4,267</td>
<td>2,946</td>
<td>7,214</td>
<td>6,012</td>
<td>6,002</td>
<td>-10</td>
<td>↑</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Continuing Care &amp; Free Nursing Care</td>
<td>28,762</td>
<td>-546</td>
<td>28,216</td>
<td>23,513</td>
<td>24,534</td>
<td>1,021</td>
<td>↓</td>
<td></td>
<td>1,250</td>
</tr>
<tr>
<td>Community Services</td>
<td>27,140</td>
<td>4,760</td>
<td>31,900</td>
<td>26,583</td>
<td>26,573</td>
<td>-10</td>
<td>↓</td>
<td></td>
<td>-14</td>
</tr>
<tr>
<td>Other</td>
<td>8,791</td>
<td>673</td>
<td>9,464</td>
<td>7,886</td>
<td>7,278</td>
<td>-608</td>
<td>↓</td>
<td></td>
<td>-577</td>
</tr>
<tr>
<td>GP IT</td>
<td>0</td>
<td>905</td>
<td>905</td>
<td>754</td>
<td>696</td>
<td>-58</td>
<td>↑</td>
<td></td>
<td>-69</td>
</tr>
<tr>
<td>QIPP</td>
<td>-14,000</td>
<td>12,471</td>
<td>-1,529</td>
<td>-1,274</td>
<td>0</td>
<td>1,274</td>
<td>↑</td>
<td></td>
<td>1,529</td>
</tr>
<tr>
<td>Contingency</td>
<td>2,380</td>
<td>0</td>
<td>2,380</td>
<td>1,983</td>
<td>830</td>
<td>-1,153</td>
<td>↑</td>
<td></td>
<td>-2,323</td>
</tr>
<tr>
<td>Non Recurrent resources - Other</td>
<td>17,091</td>
<td>-4,705</td>
<td>12,386</td>
<td>10,321</td>
<td>9,322</td>
<td>-999</td>
<td>↓</td>
<td></td>
<td>-1,291</td>
</tr>
<tr>
<td>Non Recurrent resources - CHC Risk Pool</td>
<td>1,778</td>
<td>0</td>
<td>1,778</td>
<td>1,482</td>
<td>376</td>
<td>-1,106</td>
<td>⇨</td>
<td>1,106</td>
<td>1,106</td>
</tr>
<tr>
<td>Programme Allocation (Exc Planned Surplus)</td>
<td>457,483</td>
<td>7,892</td>
<td>465,375</td>
<td>388,059</td>
<td>387,892</td>
<td>-167</td>
<td>↑</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>Running Costs</td>
<td>8,560</td>
<td>0</td>
<td>9,043</td>
<td>7,536</td>
<td>6,596</td>
<td>-940</td>
<td>↑</td>
<td></td>
<td>-1,142</td>
</tr>
<tr>
<td>Total</td>
<td>466,043</td>
<td>7,892</td>
<td>474,148</td>
<td>395,595</td>
<td>394,488</td>
<td>-1,107</td>
<td>⇨</td>
<td></td>
<td>-1,107</td>
</tr>
</tbody>
</table>

| 14 / 15                                     | 5,505                                  | 1,000  | 6,505         | 5,421          | 0                  | -5,421            | ↑                          |                              | -6,505                            |
| Total Allocation                            | 471,548                                | 8,892  | 480,423       | 401,016        | 394,488            | -6,528            | ↑                          |                              | -7,612                            |
Mid-Yorkshire Hospitals Trust (MYHT)

There are a number of emerging pressures associated with MYHT forecast outturn. These are included in the year end forecast.

Month 10 is showing an estimated £795k under trade. However the yearend forecast is breakeven as there has been a) a material increase in the costs of excluded drugs in the last quarter and b) a potential elective overtrade in the last quarter over and above the agreed plan.

These emerging pressures are being reviewed in detail and escalated to Executive Contract Board.

Leeds Teaching Hospitals NHS Trust (LTHT)

The position adjusted for penalties and challenges on LTHT is an overtrade of £861k.

The main overtrades are in critical care, maternity pathway, spinal surgery and rheumatology.

Critical care is due to longer than average lengths of stay and due to LTHT being a major trauma centre. The costs have stabilised in the last few months. Discussions are ongoing internally within LTHT relating to the use of high cost Rheumatology drugs. Additional data on the use of the drugs has been requested to enable shared protocols.

Other NHS Trusts

Sheffield Teaching Hospitals NHS Trust (STHT) has a large undertrade in critical care, electives and maternity pathway. In 2013/2014 there were high levels of activity in inpatients and outpatients that has not been replicated in 2014/2015.

Prescribing

Data has been received for month 8. Using this data and applying profiles published by NHS Business Service Authority (NHSBSA) the position to date is overspending. The overspend has reduced from last month. This is due to the recalculation and profiling by NHS Business Services Authority (NHSBSA). The position includes the forecasted effect of category M drugs price change. Category M drugs are those that are readily available and the reimbursement price to Pharmacists is calculated by the Department of Health based on information supplied by manufacturers. NHS England have amended the payment regime which has resulted in a cost pressure to CCG’s.

Continuing Care

Adults

The position at month 10 is overspending by 3% on Adults Continuing Care. The forecast out-turn has not increased in recent months.

In 2014/15 there have been changes in legislation affecting Continuing Care. This is mainly around creating choice and providing personalisation for patients.
The CCG and Yorkshire and Humber Commissioning Support (YHCS) teams have been working closely together to review the forecasting and reporting methods. Within CHC there are different funding streams such as joint funded, fully funded and personal health budget. These areas are monitored closely to ensure the correct funding stream continues to be applied. The main areas of cost increase from 2013/14 are:

- Fully Funded
  - Learning Disabilities <65
  - Physical Disabilities 65+

- Personal Health Budgets
  - Mental Health <65
  - Physical Disabilities <65

- Joint Funded
  - Learning Disabilities <65

**Childrens Continuing Care**

The budget is forecast to overspend by £680k. This is a 43% increase in costs from 13/14.

The number and complexity of children’s packages have increased in the last few years. An exercise is being completed to ensure that the expenditure splits between organisations is accurate and robust.
3. **Key Focus Area – Budget Setting**

Key headline figures have been calculated using national guidance and local intelligence to enable the CCG to prepare the financial plan for 2015/16.

The approach has been to define high level control totals over the main programme and running costs categories underpinned by detailed budgets and will be signed by budget holders.

**Programme Budgets**

Budgets have been calculated using month 8 out turn position adjusted for anticipated in year pressures and then applying nationally determined inflators and deflators.

Budget holders have been requested to provide intelligence about 2015/16 activity and cost patterns. This is to ensure that the budgets be set appropriately. This is particularly important with Any Qualified Provider (AQP) contracts, as the contracts are not set based on a guaranteed activity value to any one provider.

The Finance and Contracting team will work with contract providers to ensure that the agreed contract values triangulate.

Initially the contract financial values are determined gross before QIPP or investment is applied.

**Running Costs**

In 2015/16 running costs allowance (RCA) has been reduced nationally by 10%. Therefore the CCG RCA will reduce from £8.5m (before QP) to £7.6m. This represents approximately a 12-13% reduction in real terms after taking into account pay inflation and pension increases. Throughout the budget setting process areas of cost reduction have been considered. This has included revision of non-pay budgets, ensuring that any services decommissioned from YHCS are reported at a lower cost where possible.

4. **Running Costs**

The CCG is showing an underspend of £940k with year-end forecast of £1,142k. It is important to note that £400k contributes towards QIPP achievement and £483k relates to the QP allocation. Expenditure has been incurred during the year against an estimated allocation and has been shown within programme costs. NHSE require that the QP allocation should be shown under running costs but expenditure can be across programme or running costs.
5. Quality, Innovation, Productivity and Prevention (QIPP)

The unidentified element has reduced in month 10 as some of the schemes are over delivering.

The table below shows the value of each RAG rated category.

<table>
<thead>
<tr>
<th>RAG</th>
<th>£ 000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red - NR</td>
<td>3,525</td>
</tr>
<tr>
<td>Red - Unidentified</td>
<td>741</td>
</tr>
<tr>
<td>Amber</td>
<td>-</td>
</tr>
<tr>
<td>Green</td>
<td>9,734</td>
</tr>
<tr>
<td>Total</td>
<td>14,000</td>
</tr>
</tbody>
</table>
## Target QIPP Schemes

### Planned Care

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget Holder</th>
<th>Total £'000's</th>
<th>Phased Budget £'000's</th>
<th>YTD Variance £'000's</th>
<th>2014 / 2015 £'000's</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving outcomes, reducing variation &amp; demand</td>
<td>Linda Driver</td>
<td>50</td>
<td>34</td>
<td>0</td>
<td>-34</td>
<td>0 Red</td>
</tr>
<tr>
<td>Urology Service pathway transformation</td>
<td>Linda Driver</td>
<td>65</td>
<td>54</td>
<td>0</td>
<td>-54</td>
<td>0 Red</td>
</tr>
<tr>
<td>Gynaecology service / pathway transformation</td>
<td>Linda Driver</td>
<td>75</td>
<td>51</td>
<td>0</td>
<td>-51</td>
<td>0 Red</td>
</tr>
<tr>
<td>Gastroenterology - redesign FCP testing pathways</td>
<td>Linda Driver</td>
<td>350</td>
<td>292</td>
<td>318</td>
<td>26</td>
<td>381 Green</td>
</tr>
<tr>
<td>Ophthalmology - Single Point of Access</td>
<td>Linda Driver</td>
<td>225</td>
<td>188</td>
<td>767</td>
<td>579</td>
<td>919 Green</td>
</tr>
<tr>
<td>Dermatology - utilisation of pathway</td>
<td>Linda Driver</td>
<td>170</td>
<td>142</td>
<td>256</td>
<td>114</td>
<td>307 Green</td>
</tr>
<tr>
<td>Community cardiology pathway redesign</td>
<td>Linda Driver</td>
<td>80</td>
<td>54</td>
<td>0</td>
<td>-54</td>
<td>0 Red</td>
</tr>
<tr>
<td>Capita Report coding</td>
<td>Matt England</td>
<td>2,400</td>
<td>1,882</td>
<td>1,724</td>
<td>-158</td>
<td>2,069 Green</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>Rosemary Davison</td>
<td>500</td>
<td>417</td>
<td>417</td>
<td>0</td>
<td>500 Green</td>
</tr>
<tr>
<td>Risk Sharing - outpatients</td>
<td>Matt England</td>
<td>560</td>
<td>467</td>
<td>200</td>
<td>-267</td>
<td>240 Green</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Transport Transformation</td>
<td>Jenny Feeley</td>
<td>210</td>
<td>143</td>
<td>0</td>
<td>-143</td>
<td>0 Red</td>
</tr>
<tr>
<td>Risk Share arrangements</td>
<td>Matt England</td>
<td>1,840</td>
<td>1,651</td>
<td>1,740</td>
<td>87</td>
<td>2,088 Green</td>
</tr>
<tr>
<td>Conveyance review with YAS</td>
<td>Jenny Feeley</td>
<td>200</td>
<td>136</td>
<td>0</td>
<td>-136</td>
<td>0 Red</td>
</tr>
<tr>
<td><strong>Corporate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running costs reduction for 15/16</td>
<td>Andrew Pepper / Jo Pollard</td>
<td>400</td>
<td>334</td>
<td>400</td>
<td>64</td>
<td>400 Green</td>
</tr>
<tr>
<td>Review contributions to posts at other Organisations</td>
<td>Andrew Pepper / Jo Pollard</td>
<td>50</td>
<td>42</td>
<td>50</td>
<td>8</td>
<td>50 Green</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manage inflation through initiatives in primary care</td>
<td>Joanne Fitzpatrick</td>
<td>2,000</td>
<td>1,715</td>
<td>2,000</td>
<td>285</td>
<td>2,000 Green</td>
</tr>
<tr>
<td>Management of excluded drugs arrangement</td>
<td>Joanne Fitzpatrick</td>
<td>500</td>
<td>417</td>
<td>0</td>
<td>-417</td>
<td>0 Red</td>
</tr>
<tr>
<td>Review of diagnostics</td>
<td>Linda Driver</td>
<td>50</td>
<td>34</td>
<td>0</td>
<td>-34</td>
<td>0 Red</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aligning funding to service utilisation</td>
<td>Michele Ezro</td>
<td>295</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 Red</td>
</tr>
<tr>
<td>Out of Area Placements</td>
<td>Michele Ezro</td>
<td>205</td>
<td>171</td>
<td>192</td>
<td>21</td>
<td>230 Green</td>
</tr>
<tr>
<td>Reduction in baseline SLA</td>
<td>Michele Ezro</td>
<td>250</td>
<td>208</td>
<td>250</td>
<td>42</td>
<td>250 Green</td>
</tr>
<tr>
<td>Horizon Centre</td>
<td></td>
<td>250</td>
<td>250</td>
<td></td>
<td></td>
<td>300 Green</td>
</tr>
<tr>
<td><strong>sub total identified QIPP</strong></td>
<td></td>
<td>10,475</td>
<td>8,430</td>
<td>8,563</td>
<td>133</td>
<td>9,734 -</td>
</tr>
<tr>
<td><strong>Restriction of non-recurrent investment (formerly unidentified QIPP)</strong></td>
<td>Michele Ezro</td>
<td>3,525</td>
<td>2,600</td>
<td>2,600</td>
<td>0</td>
<td>3,525 Red</td>
</tr>
<tr>
<td><strong>Unidentified QIPP</strong></td>
<td></td>
<td>741</td>
<td>741</td>
<td></td>
<td></td>
<td>741 Red</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>14,000</td>
<td>11,030</td>
<td>11,904</td>
<td>133</td>
<td>14,000</td>
</tr>
</tbody>
</table>
6. Non-Recurrent Funding Resource

The table below shows the underspend to date on non-recurrent expenditure. It is important to note that £1.1m of the underspend relates to the Continuing Healthcare Risk Pool. Nationally there has been less expenditure against the pool than was anticipated. NHS England have instructed CCG’s to show their proportion of the underspend as an improvement to the overall financial position rather than a reinvestment of funds.
<table>
<thead>
<tr>
<th>Project Lead</th>
<th>Project and Source of Funding</th>
<th>Annual Budget £ 000's</th>
<th>Movement</th>
<th>Revised Budget</th>
<th>Spend to date £ 000's</th>
<th>FOT £ 000's</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.5% Non-recurrent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandy Sheffield</td>
<td>Multi Agency Safeguarding Hub (MASSH)</td>
<td>115</td>
<td>0</td>
<td>115</td>
<td>96</td>
<td>115</td>
<td>0</td>
</tr>
<tr>
<td>Liz Blythe</td>
<td>Outwood 7 day a week opening</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>17</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Gill Day</td>
<td>Podiatry MYHT Contract</td>
<td>32</td>
<td>0</td>
<td>52</td>
<td>43</td>
<td>52</td>
<td>0</td>
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<tr>
<td>Lisa Candler</td>
<td>Community Respiratory Services</td>
<td>33</td>
<td>0</td>
<td>33</td>
<td>28</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Greg Connor</td>
<td>Network Development Framework</td>
<td>1,992</td>
<td>0</td>
<td>1,992</td>
<td>1,660</td>
<td>1,992</td>
<td>0</td>
</tr>
<tr>
<td>Jo Webster</td>
<td>Additional Clinical Advisors (support)</td>
<td>0</td>
<td>50</td>
<td>50</td>
<td>0</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Michelle Ashbridge</td>
<td>Wakefield &amp; Pontefract Rapid Intervention Service (Hospices)</td>
<td>444</td>
<td>0</td>
<td>444</td>
<td>370</td>
<td>444</td>
<td>0</td>
</tr>
<tr>
<td>Michelle Ashbridge</td>
<td>Electronic Palliative Care Coordination System (EPatCCS)</td>
<td>26</td>
<td>0</td>
<td>26</td>
<td>22</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Jenny Feeley</td>
<td>Emergency Care Investment (GP Urgents 365)</td>
<td>300</td>
<td>0</td>
<td>300</td>
<td>0</td>
<td>280</td>
<td>(20)</td>
</tr>
<tr>
<td>Jenny Feeley</td>
<td>Walk-in-Centre additional funding</td>
<td>0</td>
<td>297</td>
<td>297</td>
<td>248</td>
<td>297</td>
<td>0</td>
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<tr>
<td>Andrew Pepper</td>
<td>Contract NR - MYHT</td>
<td>226</td>
<td>(26)</td>
<td>200</td>
<td>167</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>Andrew Pepper</td>
<td>Reconfiguration Transitional Costs</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
<td>833</td>
<td>1,000</td>
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<tr>
<td>Andrew Pepper</td>
<td>CHC legacy Support risk share</td>
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<td>1,778</td>
<td>671</td>
<td>1,107</td>
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<tr>
<td>Andrew Pepper</td>
<td>Programme Management Office</td>
<td>600</td>
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<td>554</td>
<td>600</td>
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<tr>
<td>Laura Elliott</td>
<td>MYHT Urinary Catheter Training</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>9</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Jo Webster</td>
<td>Strategic Programme Work</td>
<td>0</td>
<td>152</td>
<td>152</td>
<td>127</td>
<td>152</td>
<td>0</td>
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<tr>
<td>Ruth Unwin</td>
<td>Communications &amp; Engagement</td>
<td>0</td>
<td>100</td>
<td>100</td>
<td>83</td>
<td>100</td>
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<tr>
<td>Anthony Sadler</td>
<td>Supporting the Third Sector</td>
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<td>70</td>
<td>70</td>
<td>58</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>Michele Ezro</td>
<td>Health &amp; inequalities</td>
<td>0</td>
<td>76</td>
<td>76</td>
<td>63</td>
<td>76</td>
<td>0</td>
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<tr>
<td>Greg Connor</td>
<td>Co-Commissioning Support</td>
<td>0</td>
<td>40</td>
<td>40</td>
<td>0</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub total 1.5% Non Recurrent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Roll Out of integrated Care Teams by Network</td>
<td>2565</td>
<td>-2565</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>N4 Care Home Pilot</td>
<td>0</td>
<td>51</td>
<td>51</td>
<td>43</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Together Better</td>
<td>0</td>
<td>50</td>
<td>50</td>
<td>42</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Network - KAFAA</td>
<td>0</td>
<td>25</td>
<td>25</td>
<td>21</td>
<td>25</td>
<td>0</td>
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<tr>
<td>Melanie Brown</td>
<td>Social Prescribing</td>
<td>0</td>
<td>35</td>
<td>35</td>
<td>30</td>
<td>35</td>
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<tr>
<td>Melanie Brown</td>
<td>CC2H project support</td>
<td>0</td>
<td>148</td>
<td>148</td>
<td>123</td>
<td>148</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Wakefield Demand &amp; Capacity Model</td>
<td>0</td>
<td>64</td>
<td>64</td>
<td>64</td>
<td>64</td>
<td>0</td>
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<td>Melanie Brown</td>
<td>Un-allocated investment resource</td>
<td>0</td>
<td>1,534</td>
<td>1,534</td>
<td>95</td>
<td>200</td>
<td>(1,334)</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Integration and Health &amp; Wellbeing with WMDC</td>
<td>(1,600)</td>
<td>0</td>
<td>(1,600)</td>
<td>0</td>
<td>0</td>
<td>1,600</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>N3 and NS primary care approach to residential care</td>
<td>0</td>
<td>51</td>
<td>51</td>
<td>43</td>
<td>51</td>
<td>0</td>
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<tr>
<td>Melanie Brown</td>
<td>West Wakefield Implementation Team</td>
<td>0</td>
<td>106</td>
<td>106</td>
<td>88</td>
<td>106</td>
<td>0</td>
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<tr>
<td>Melanie Brown</td>
<td>Extension of SE (N2) Proof of Concept</td>
<td>0</td>
<td>121</td>
<td>121</td>
<td>0</td>
<td>121</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Proof of Concept GP N6 enhanced comm serv</td>
<td>0</td>
<td>227</td>
<td>227</td>
<td>0</td>
<td>227</td>
<td>0</td>
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<tr>
<td>Melanie Brown</td>
<td>CC2H mgt infrastructure</td>
<td>0</td>
<td>136</td>
<td>136</td>
<td>0</td>
<td>90</td>
<td>(46)</td>
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<td>Melanie Brown</td>
<td>Change - self management VCS provision</td>
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<td>70</td>
<td>70</td>
<td>0</td>
<td>70</td>
<td>(0)</td>
</tr>
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<td>Melanie Brown</td>
<td>Additional Social Worker Capacity</td>
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<td>125</td>
<td>125</td>
<td>0</td>
<td>125</td>
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<td>Melanie Brown</td>
<td>Communications Workstream</td>
<td>0</td>
<td>20</td>
<td>20</td>
<td>17</td>
<td>20</td>
<td>0</td>
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<tr>
<td>Melanie Brown</td>
<td>Healthwatch - project evaluation</td>
<td>0</td>
<td>42</td>
<td>42</td>
<td>35</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Support Function for meeting the challenge</td>
<td>0</td>
<td>110</td>
<td>110</td>
<td>92</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Network Chair backfill costs (Sept14-Aug15)</td>
<td>0</td>
<td>61</td>
<td>61</td>
<td>51</td>
<td>61</td>
<td>0</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Other Minor Project Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(70)</td>
<td></td>
</tr>
<tr>
<td>Jenny Feeley</td>
<td>Urgent Care Practitioners</td>
<td>300</td>
<td>(76)</td>
<td>224</td>
<td>187</td>
<td>224</td>
<td>0</td>
</tr>
<tr>
<td><strong>Non-Elective Re-admissions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Gateway to Care</td>
<td>200</td>
<td>0</td>
<td>200</td>
<td>12</td>
<td>14</td>
<td>(186)</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Optimisation of Systm-one</td>
<td>200</td>
<td>0</td>
<td>200</td>
<td>92</td>
<td>110</td>
<td>(0)</td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>GP Transport Service (Take home &amp; Tuck up)</td>
<td>200</td>
<td>0</td>
<td>200</td>
<td>0</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td><strong>Emergency Threshold adjustment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanie Brown</td>
<td>Early Support Discharge</td>
<td>335</td>
<td>(335)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Care Closer to Home (CC2H) sub-total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michele Ezro</td>
<td>Mental Health - Liaison Psychiatry</td>
<td>336</td>
<td>0</td>
<td>336</td>
<td>0</td>
<td>168</td>
<td>(168)</td>
</tr>
<tr>
<td>Michele Ezro</td>
<td>Mental Health - Support Funding</td>
<td>50</td>
<td>164</td>
<td>214</td>
<td>104</td>
<td>206</td>
<td>(8)</td>
</tr>
<tr>
<td>Michele Ezro</td>
<td>Mental Health - Various other business cases</td>
<td>614</td>
<td>(164)</td>
<td>450</td>
<td>75</td>
<td>456</td>
<td>6</td>
</tr>
<tr>
<td>Andrew Pepper</td>
<td>MYHT Reserve</td>
<td>2,568</td>
<td>0</td>
<td>2,568</td>
<td>2,140</td>
<td>2,568</td>
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<tr>
<td><strong>Sub total Call to Action 1% and CC2H</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub total Emergency Threshold Adjustment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operational Resilience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sally Bell</td>
<td>RTT - 66% of Allocation</td>
<td>0</td>
<td>3,886</td>
<td>3,886</td>
<td>3,238</td>
<td>3,886</td>
<td>0</td>
</tr>
<tr>
<td><strong>Winter Resilience Funding</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>4,440</td>
<td>4,440</td>
<td>3,700</td>
<td>4,440</td>
<td>(500)</td>
<td></td>
</tr>
<tr>
<td><strong>Sub total Operational Resilience</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub total Quality Premium</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To allocation surplus</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
<td>833</td>
<td>1,000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Surplus drawdown</td>
<td>980</td>
<td>(758)</td>
<td>222</td>
<td>0</td>
<td>222</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Allocation to GIPP</td>
<td>3,260</td>
<td>0</td>
<td>3,260</td>
<td>2,938</td>
<td>3,260</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Sub Total Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5,505</td>
<td>(758)</td>
<td>4,747</td>
<td>3,771</td>
<td>4,525</td>
<td>(222)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Funding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18,869</td>
<td>8,810</td>
<td>27,679</td>
<td>19,668</td>
<td>24,799</td>
<td>(2,880)</td>
<td></td>
</tr>
</tbody>
</table>

Subtotal to match: CHC Risk Pool (1,100)
Main report Other (1,291)
Within RCA (483)
Total (2,880)
7. Better Payment Practice Code (BPPC)

The NHS target is 95% of invoices to be paid within 30 days both in terms of value and on number of invoices. Actual performance for month 10 is shown below:

<table>
<thead>
<tr>
<th>Monthly position</th>
<th>Number</th>
<th>£000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total bills at the end of the month</td>
<td>850</td>
<td>5,740</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>841</td>
<td>5,731</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

This is an improvement over the last few months as the collaborative working between departments starts to take effect.

8. Shared Business Services Balance Sheet Control Report

The CCG receives a monthly balance sheet control account report from NHS SBS (Shared Business Service). This has been Red/Amber/Green (RAG) rated as green up to Month 9. This provides additional external assurances of control processes. The month 10 report is not yet available.

9. Risks and Opportunities

NHS England have initiated the match and move process from MYHT to Independent Sector providers for Trauma & Orthopaedics and ENT between December 14 to March 15. To date 349 patients have been transferred in Trauma and Orthopaedics and 230 in ENT. These are currently being assessed for clinical appropriateness and being booked where possible. The Patient Treatment Lists (PTL) has been requested from MYHT at Contract Management Group in order to calculate case mix and then apply costings. A financial risk assessment will be calculated on receipt.

In addition, the CCG is awaiting £1.1m residual RTT allocation and confirmation of allocation fundsflow regarding the “match and move” process. Confirmation of funds flow is awaited from NHSE.
The table below shows the current identified risks and opportunities.

<table>
<thead>
<tr>
<th>Item</th>
<th>Gross £m</th>
<th>%</th>
<th>Possible £m</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Contract Stances</td>
<td>1.00</td>
<td>45%</td>
<td>0.45</td>
<td>Contract monitoring</td>
</tr>
<tr>
<td>Paediatric Insulin Pumps</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Embedded in FOT</td>
</tr>
<tr>
<td>Continuing Healthcare Overtrade and impact of</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Embedded in FOT</td>
</tr>
<tr>
<td>Personal Health Budgets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>QIPP Red RAG</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Embedded in FOT</td>
</tr>
<tr>
<td>QIPP Amber RAG</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>NHS Property Services</td>
<td>0.45</td>
<td>55%</td>
<td>0.26</td>
<td>Currently working with NHS PS regarding potential risks on residual void spaces</td>
</tr>
<tr>
<td>Charge Exempt Overseas Visitors ( CEOV )</td>
<td>-</td>
<td>0%</td>
<td>-</td>
<td>Embedded in FOT</td>
</tr>
<tr>
<td>Category M Drugs rebasing from NHS England</td>
<td>-</td>
<td>0%</td>
<td>-</td>
<td>Embedded in FOT</td>
</tr>
<tr>
<td>Contract challenges from Non NHS Providers</td>
<td>0.60</td>
<td>20%</td>
<td>0.12</td>
<td>Risk that identified undertrades are challenged</td>
</tr>
<tr>
<td>Specialist Services allocation transfers</td>
<td>1.00</td>
<td>25%</td>
<td>0.25</td>
<td>On-going discussions with NHSE</td>
</tr>
<tr>
<td></td>
<td>3.05</td>
<td></td>
<td>1.08</td>
<td></td>
</tr>
<tr>
<td><strong>Opportunities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>0.10</td>
<td>100%</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Review of Non recurrent Including Local Authority funds</td>
<td>1.60</td>
<td>30%</td>
<td>0.48</td>
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</tr>
<tr>
<td>Quality Premium</td>
<td>0.50</td>
<td>100%</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.20</td>
<td></td>
<td>1.08</td>
<td></td>
</tr>
<tr>
<td>(Headroom)/Shortfall</td>
<td>0.85</td>
<td></td>
<td>(0.00)</td>
<td></td>
</tr>
</tbody>
</table>

10. **2015/16 Capital Plans**

2015/16 Capital Plans were submitted to NHSE in December 2014. Following this the CCG submitted a Project Initiation Document (PID) for core GP IT Capital in the sum of £277k. This will enable the CCG to be included in the first capital business case approval round targeted by NHSE for Q1 2015/16.

PIDs for the other Capital Plans will be submitted at a later date, to be confirmed.

The CCG’s 2015/16 submitted Capital Plans are:

- Core GP IT                                    £277k
- Digital Strategy                             £499k
- White Rose House Telephone system             £50k
11. Co-Commissioning

On 6\textsuperscript{th} January 2015, NHS England provided the CCG with revised Primary Care Allocations and split of 15/16 planned expenditure which were required to inform the co-commissioning application on 9\textsuperscript{th} January 2015. In the co-commissioning submission, the CCG has indicated that it is awaiting further information from NHS England regarding potential 15/16 QIPP opportunities and has not yet been agreed. The overall allocation is subject to further discussion and agreement.

12. Prime Ministers Challenge Fund 2 (PMCF 2)

The application for Prime Ministers Challenge Fund wave 2 was submitted to NHSE on 16\textsuperscript{th} January 2015. This was a collective GP members bid from networks 1, 2, 3, 4, 5 and 7. The bid includes a range of initiatives to support extended working and increased capacity in primary care and was costed at c£2.9m. The bid demonstrates sustainability after year 1 so that some of the initiatives could continue into the future if benefits were delivered.

The CCG has been informed that the bid has progressed through to the shortlist and the bid team are currently working on some additional information that NHSE have requested.

13. Planning

The deadline date for the first plan submission was 13\textsuperscript{th} January 2015 and the headlines were:

- QIPP £13.7m
- Surplus £4.9m
- Contingency £4.9m

This initial submission requires 2014/15 out turn and initial 15/16 high level planning assumptions. The full draft plans are due by 27\textsuperscript{th} February 2015. The Plan must be approved by Governing Body by 31\textsuperscript{st} March 2015 and submitted by 10\textsuperscript{th} April 2015.

As further discussions are ongoing with NHSE regarding the business rules and the drawdown surplus, it is likely that the second iteration of the plan will change, particularly with regard to the planned surplus.
14. Recommendation

Members are asked to receive and note the contents of the report.

Karen Parkin,
Associate Director of Finance, Governance and Contracting
05 March 2015
**Title of meeting:** Governing Body

**Date of Meeting:** 10 March 2015

**Paper Title:** Process for sign off of final accounts for 2014/15

**Public/Private Section:**
- Public ✓
- Private
- N/A

If private, insert here reason for inclusion as a private paper

**Purpose (this paper is for):**
- Decision ✓
- Discussion
- Assurance
- Information

**Report Author and Job Title:** Eamonn May, Corporate Financial Accountant

**Responsible Clinical Lead:** Not applicable

**Responsible Governing Board Executive Lead:** Andrew Pepper, Chief Finance Officer

**Recommendation(s):**
It is recommended that the Governing Body:

- Note the processes outlined and give approval to the proposals outlined there in.
- Delegate authority to the CCG Chair, Chief Officer and Audit Committee Chair to approve and submit the final audited accounts, annual report and supplementary information by the required deadlines.

**Executive Summary:**
The CCG is required to prepare and submit draft year end accounts by 23 April 2015 and final accounts by 29 May 2015.

An accounts plan has been provided to and assured by the Audit Committee. The plan covers all aspects of the production of the accounts, annual report and associated documentation in line with Department of Health guidelines. This paper seeks to assure the Governing Body that appropriate arrangements are in place and seeks delegated authority to transact the necessary submissions overseen and assured by the Audit Committee.

**Link to overarching principles from the strategic plan:**

<table>
<thead>
<tr>
<th>Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen Participation and Engagement</td>
</tr>
<tr>
<td>Wider Primary Care at Scale including Network development</td>
</tr>
<tr>
<td>A Modern Model of Integrated Care</td>
</tr>
<tr>
<td>Access to the Highest Quality Urgent and Emergency Care</td>
</tr>
<tr>
<td>A Step Change in the Productivity of Elective Care</td>
</tr>
<tr>
<td>Specialised Commissioning</td>
</tr>
<tr>
<td>Mental Health Service Transformation</td>
</tr>
<tr>
<td>Maternity, Children and Young People Transformation</td>
</tr>
<tr>
<td>Organising ourselves to deliver for our patients ✓</td>
</tr>
</tbody>
</table>

**Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA):** Not applicable

**Outline public engagement – clinical, stakeholder and public/patient:** Not applicable

**Assurance departments/organisations who will be affected have been consulted:** Finance and Governance teams.

**Previously presented at committee / governing body:** On 26 February 2015, the Audit Committee received a paper outlining the processes for delivering accounts from a CCG and Audit perspective. This also covered the assurance level that could be gained from the Finance Department and that the accounts will be delivered in a robust, timely and accurate manner.
<table>
<thead>
<tr>
<th>Reference document(s) / enclosures:</th>
<th>The following is a hyperlink to the full guidance, which appears under the heading of CCG Finance <a href="http://www.england.nhs.uk/resources/resources-for-ccgs/">http://www.england.nhs.uk/resources/resources-for-ccgs/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment:</td>
<td>Accounts matters were discussed in detail at the Audit Committee on 26 February 2015, including the proposed Greenbury Pension disclosures. In addition, estimates and judgements were discussed including where critical judgements or estimations are required.</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>None identified</td>
</tr>
</tbody>
</table>
1 Introduction

The CCG is required to prepare and submit draft year end accounts by 23 April 2015 and final accounts by 29 May 2015.

An accounts plan has been provided to and assured by the Audit Committee. The plan covers all aspects of the production of the accounts, annual report and associated documentation in line with Department of Health guidelines. This paper seeks to assure the Governing Body that appropriate arrangements are in place and seeks delegated authority to transact the necessary submissions overseen and assured by the Audit Committee.

2 CCG Annual Reporting Guidance 2014-15

The key dates relating to the submission of draft and final accounts and annual reports are provided below.

- 2 – 16 January 2015: Pension data submitted to NHS Pension Agency
- 16 – 20 February: Interim audit
- 10 March: Accounts templates issued
- 23rd April (noon): Submit full draft accounts, ISFE consistent data collection and statement, signed by the CE and CFO
- 27 April – 8 May planned final audit
- 29 May (noon): Full draft accounts, ISFE consistent data collection and statement, signed by the CE and CFO
- 29 May (noon): Auditors to submit one original signed copy of the full Annual Report & Accounts to NHS England
- No later than 17.00 on 29 May: Publish Annual Report & Accounts in full on the public website

The Governing Body meeting on 12 May 2015 will receive a copy of the draft accounts and draft Annual Report. Audit Committee meetings to review the draft accounts and provide assurance to the development of the Annual Report and final accounts are scheduled for 14 May and 21 May 2014.

3 CCG Annual Reporting

NHS bodies are required to publish, as a single document, an annual report and accounts (ARA). This document includes:

- The annual report comprising the:
  - strategic report (replaces the business review and must include, inter alia environmental matters; details of employees equal opportunities policy and gender distribution; social, community and human rights issues; business information
including the CCG’s history, development and performance; and any other matters considered to be of strategic significance

- members’ report (this must include, inter alia, details of directors; pension liabilities; external auditors remuneration; employee sickness absence data; fraud, Better Payment Practice Code)
- remuneration report
- sustainability report

- A statement of the Accountable Officer’s responsibilities
- An Annual Governance Statement
- The primary financial statements and notes to the accounts (also published separately)
- The audit opinion and report

4 Other supporting documentation

The Accountable Officer (The Chief Officer) should explain their responsibility for preparing the financial statements in a statement that should be positioned after the Annual Report and before the Governance Statement.

A model Statement of Accountable Officer’s Responsibilities must be used unchanged by all clinical commissioning groups, other than the replacement of items with clinical commissioning group specific information. The Statement of Accountable Officer’s Responsibilities is a personal statement by the Accountable Officer, and should be signed and dated by them.

It is expected that to provide assurance to NHS England and the Department of Health that signed Financial Statements are accurately reflected in the data drawn from ledger systems and supplementary data collection templates; clinical commissioning group Chief Officers and Chief Financial Officers will be required to sign and submit two consistency statements, as last year.

The first should confirm that the Integrated Single Financial Environment (CCG ledger system) accurately reflects the data used to compile the signed Financial Statements and is consistent with the signed Financial Statements; and,

The second should confirm that the data contained in the supplementary data collection templates is an accurate reflection of the data in the signed Financial Statements.

The Chief Financial Officer also is required to sign to say that summary returns are consistent with the CCG accounts.

These would be required at both draft and audited and signed submissions.

The supplementary data collection templates, pro forma consistency statements and more detailed technical guidance are not currently available and will be issued to clinical commissioning groups at a later date to be confirmed.
Assurance

The CCG is in regular contact with both external and internal auditors to ensure that any matters arising are dealt with promptly. This open approach also ensures that technical guidance can be shared and interpreted. The Audit Committee has received 2 papers on the accounts and audit processes including the proposed Greenbury Pension disclosures. In addition, estimates and judgements were discussed including where critical judgements or estimations are required.

Recommendation

The Governing Board is requested:

• To note the processes outlined and give approval to the proposals outlined there in.
• Delegate authority to the CCG Chair, Chief Officer and Audit Committee Chair to approve and submit the final audited accounts, annual report and supplementary information by the required deadlines.

Eamonn May
Corporate Financial Accountant
05 March 2015
Recommendation:
It is recommended that the Governing Body:
1) Approve the terms of reference for and membership of the Nominations Committee (noting that establishment of the committee is subject to NHS England approval of the revised constitution).

2) With regards to terms of office for the Governing Body:
   a. Approve the reappointment of the three Lay Members.
   b. Approve the reappointment of the Registered Nurse
   c. Note that in early 2016 the Governing Body will consider whether the Secondary Care Consultant should be reappointed for a further term of office.
   d. Note the proposed timetable for the election of GPs and a practice member to the Governing Body.

Executive Summary:
The new Nominations Committee will consider all appointments to the Governing Body (excluding the Chief Officer, Chief Finance Officer and Chief of Service Delivery and Quality). The committee will support the Governing Body and ensure that there is a formal, rigorous and transparent procedure for appointments to the Governing Body. Terms of reference for the Nominations Committee are presented for approval.

The terms of office for all three Lay Members appointed to the Governing Body will end on 31 March 2015. It is proposed that all three Lay Members are reappointed as follows:
One year – Sandra Cheseldine
Two years – Stephen Hardy
Three year – Rhod Mitchell

The term of office for the Registered Nurse appointed to the Governing Body will end on 31 March 2015. It is proposed that the Registered Nurse is reappointed for a second (three year) term of office.

Elections for four GP positions and the Practice Manager position on the Governing Body will take place between April and June 2015.

Link to overarching principles from the strategic plan:

| Citizen Participation and Engagement |
| Wider Primary Care at Scale including Network development |
| A Modern Model of Integrated Care |
| Access to the Highest Quality Urgent and Emergency Care |
| A Step Change in the Productivity of Elective Care |
| Specialised Commissioning |
| Mental Health Service Transformation |
| Maternity, Children and Young People Transformation |
| Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA) | Not applicable |
| Outline public engagement – clinical, stakeholder and public/patient: | Not applicable |
| Assurance departments/organisations who will be affected have been consulted: | Chair & Clinical Leader  
Local Medical Committee  
Governing Body  
Human Resources |
| Previously presented at committee / governing body: | March 2014 |
| Reference document(s) / enclosures: | Appendix 1 – Nominations Committee: Terms of Reference |
| Risk Assessment: | A number of posts on the Governing Body are scheduled for appointment / election during 2015. There is a risk that a number of members of the Governing Body will depart unexpectedly, resulting in the loss of skills, knowledge and experience. |
| Finance/ resource implications: | None identified |
NHS Wakefield Clinical Commissioning Group Governing Body: terms of office and appointment procedures

1. Purpose

This paper:
- Recommends the establishment of a new Nominations Committee;
- Clarifies the terms of office for members of the Governing Body and the procedure for their appointment;
- Outlines arrangements in place for the induction of new members of the Governing Body.

2. Nominations Committee

The Governing Body are invited to establish a Nominations Committee. The proposal to establish a new Nominations Committee was included in the consultation with member practices (in September 2014) about changes to the CCG’s constitution. Positive feedback was received from member practices, the Local Medical Committee (LMC) and the Governing Body – therefore a reference to the Nominations Committee was included within the revised constitution. The CCG awaits confirmation (expected mid-march) from NHS England that the constitution amendments have been approved.

The role and purpose of the Committee is as follows:
1. The Committee will consider all appointments to the Governing Body except the Chief Officer, Chief Finance Officer and Chief of Service Delivery and Quality.
2. The Nominations Committee will support the Governing Body and ensure that there is a formal, rigorous and transparent procedure for appointments to the Governing Body.
3. The Nominations Committee will lead the process for Governing Body appointments and make recommendations to the Governing Body.
4. Furthermore the Nominations Committee should evaluate the balance of skills, experience, independence and knowledge on the Governing Body.

Membership of the Nominations Committee will include:
- Chair & Clinical Leader: Dr Phillip Earnshaw
- Chief Executive: Jo Webster
- Two Lay Members:
  - Lay Member, Deputy Chair: Rhod Mitchell
  - Lay Member, Patient & Public Involvement: Stephen Hardy
- Two GP members:
  - Elected GP: Dr Ann Carroll
  - Elected GP: Dr David Brown

In addition when the Committee considers the appointment of GPs or the Practice Manager:
- A representative from the LMC will join the committee and have a right to vote

The draft terms of reference (included at Appendix One) for the Nominations Committee are presented for approval by the Governing Body.

3. Governing Body – terms of office and appointment
Appendix two to this report outlines the terms of office and appointment processes for all members of the Governing Body.

3.1. Lay Members

The terms of office for all three Lay Members appointed to the Governing Body will end on 31 March 2015. The constitution requires that Lay Members are appointed / reappointed by the Governing Body.

It is proposed that all three Lay Members are reappointed; one for a one year term, one for a two year term and one for a three year term. This approach will stagger the terms of office and therefore help to ensure a smooth and consistent approach. To ensure a fair and impartial approach to determining which Lay Member will serve each term of office the candidates were ‘pulled out of a hat’:

- One year – Sandra Cheseldine
- Two years – Stephen Hardy
- Three year – Rhod Mitchell

In future years the appointment of Lay Members will revert to the process outlined in the CCG’s Constitution, and successful candidates will be appointed for terms of three year.

3.2. Registered Nurse

The term of office for the Registered Nurse appointed to the Governing Body will end on 31 March 2015. The constitution requires that the Registered Nurse is appointed / reappointed by the Governing Body.

It is proposed that the Registered Nurse is reappointed; for a three year term of office.

3.3. Secondary Care Consultant

The term of office for the Secondary Care Consultant appointed to the Governing Body will end on 31 March 2016. The constitution requires that the Secondary Care Consultant is appointed / reappointed by the Governing Body.

It is proposed that the Governing Body consider in early 2016 whether the Secondary Care Consultant should be reappointed for a further term of office.

3.4. GP Elections

The eight GPs who sit on the Governing Body are elected by GPs working in Wakefield (on a one GP one vote basis). There is currently one vacant position and three additional positions up for election in 2015. To encourage GPs to stand as candidates for election further information about the role of GP members of the Governing Body will be sent to practices.

The procedure for elections to the Governing Body is outlined in the CCG’s constitution. The indicative timetable below provides further information about the process:

<table>
<thead>
<tr>
<th>Action</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentations to GPs across the district - this will</td>
<td>March / April 2015</td>
</tr>
</tbody>
</table>
include a presentation at the CCG members meeting (March 2015).

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominations Committee meets to consider and agree the role description</td>
<td>TBC</td>
</tr>
<tr>
<td>Advance sent letter to practices detailing the election process and inviting expressions of interest from candidates</td>
<td>Monday 13th April 2015</td>
</tr>
<tr>
<td>Expressions of interest forms returned by deadline to LMC</td>
<td>Friday 15th May 2015</td>
</tr>
<tr>
<td>Nominations Committee meets to consider the candidates</td>
<td>TBC</td>
</tr>
<tr>
<td>Elections opens</td>
<td>Monday 1st June 2015</td>
</tr>
<tr>
<td>Election closes</td>
<td>Friday 12th June 2015</td>
</tr>
<tr>
<td>Member practices formally notified of outcome of the election</td>
<td>Monday 29th June 2015</td>
</tr>
<tr>
<td>Appointment to the Governing Body commences</td>
<td>Wednesday 1st July 2015</td>
</tr>
</tbody>
</table>

3.5. Practice Manager Election

The Practice Manager who sits on the Governing Body is elected by Practice Managers working in Wakefield (on a one Practice Manager one vote basis).

To encourage Practice Managers to stand as candidates for election further information about the role of the Practice Manager member on the Governing Body will be sent to practices.

The timetable for the election process will mirror the schedule for the election of GPs.

4. Governing Body Induction

In anticipation of new members joining the Governing Body a comprehensive induction programme for new starters has been prepared.

Recommendations:

1) Approve the terms of reference for and membership of the Nominations Committee (noting that establishment of the committee is subject to NHS England approval of the revised constitution).

2) With regards to terms of office for the Governing Body:
   a. Approve the reappointment of the three Lay Members.
   b. Approve the reappointment of the Registered Nurse
   c. Note that in early 2016 the Governing Body will consider whether the Secondary Care Consultant should be reappointed for a further term of office.
   d. Note the proposed timetable for the election of GPs and a practice member to the Governing Body.

Enclosures:
Appendix One – Terms of reference – Nominations Committee
Appendix Two – NHS Wakefield CCG Governing Body - terms of office

Katherine Bryant – Governance & Board Secretary, March 2015
# TERMS OF REFERENCE FOR THE NHS WAKEFIELD CLINICAL COMMISSIONING GROUP NOMINATIONS COMMITTEE

| Accountability arrangements and authority | The Governing Body for NHS Wakefield Clinical Commissioning Group (CCG) resolves to establish a committee of the Governing Body to be known as the Nominations Committee. The committee will operate within the legal framework for NHS Wakefield CCG. The powers and responsibilities of the Nominations Committee are set out in these terms of reference. The Nominations Committee is established to advise and support the Governing Body to ensure that there is a formal, rigorous and transparent procedure for the appointment of members to the Governing Body. The Nominations Committee has no executive powers, other than those specifically delegated in these terms of reference. Appointments to the Nominations Committee will be approved by the Governing Body. The Nominations Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee within its remit as described in these terms of reference. The committee is delegated to approve policies and procedures for all areas within the committee’s remit. The committee has full authority to commission any reports or surveys it deems necessary to help fulfil its obligations. |
| Relationship and reporting | The Nominations Committee is a committee of the Governing Body for NHS Wakefield CCG and will submit the minutes of its meetings to the Governing Body. Reports on specific issues will also be prepared when necessary for consideration by the Governing Body. In addition, regular reports will be prepared for the Audit Committee in relation to this committee’s progress against its work plan. |
| Role and function | The purpose of the committee is to ensure that there is a formal, rigorous and transparent procedure for the appointment of members to the Governing Body. The committee does not have a role in the appointment of the: |
- Chief Officer,
- Chief Finance Officer
- Chief of Service Delivery & Quality
- Director of Public Health
- Local Authority Executive

### Responsibilities

#### Election of GPs to the Governing Body
- on behalf of the CCG, agree a competency framework with the Local Medical Committee (LMC);
- ensure that candidates have demonstrated satisfactory leadership potential against the competency framework that is agreed between the LMC and the CCG;
- provide support to the LMC when the LMC runs the election process to appoint GPs to the Governing Body, ensure that the election is run in accordance with the CCG’s constitution.

#### Election of Practice Manager to the Governing Body
- on behalf of the CCG, agree a competency framework with the LMC;
- ensure that candidates have demonstrated satisfactory leadership potential against the competency framework that is agreed between the LMC and the CCG;
- ensure that the election process to appoint the Practice Manager to the Governing Body to run in accordance with the CCG’s constitution.

#### Registered Nurse
- oversee the recruitment and selection process for the Registered Nurse;
- make recommendations to the Governing Body regarding the appointment of the Registered Nurse;
- ensure that candidates meet the requirements set out in the CCG’s constitution and any other additional statutory requirements;
- consider and make recommendations to the Governing Body regarding the reappointment of the Registered Nurse at the end of their term of office.

#### Secondary Care Consultant
- oversee the recruitment and selection process for the Secondary Care Consultant;
- make recommendations to the Governing Body regarding the appointment of the Secondary Care Consultant;
- ensure that candidates meet the requirements set out in the CCG’s constitution and any other additional statutory requirements;
- consider and make recommendations to the Governing Body regarding the reappointment of the Secondary Care Consultant at the end of their term of office.

#### Lay Members
- oversee the recruitment and selection process for the Lay Members;
- make recommendations to the Governing Body regarding the appointment of the Lay Members;
- ensure that candidates meet the requirements set out in the CCG’s constitution and any other additional statutory requirements;
- consider and make recommendations to the Governing Body regarding the reappointment of the Lay Members at the end of their term of office.

**Other Duties**
- the committee will agree an annual work plan to ensure that it covers all the duties above. The committee will also contribute to the Governing Body’s annual self assessment.
- as appropriate, the committee will support development and monitoring of the CCG’s Strategic Plan and supporting annual delivery plan.
- the committee may agree other areas of responsibility as appropriate with the Governing Body.

**Membership**
The membership of the Nominations Committee is given below.

Committee members will be appointed by the Governing Body on an annual basis and will consist of the following:

- Lay Member (Chair of the Committee);
- Chair & Clinical Leader
- Lay Member - PPI
- GP member
- GP member
- Chief Officer

In addition when the Committee considers the appointment of GPs or the Practice Manager:
- A representative from the LMC will join the committee and have a right to vote

All members of the committee have one vote. In the event of a tied vote the Chair of the Committee will hold a second and casting vote.

Other officers may be requested to attend in an advisory capacity.

**In Attendance**

- Governance & Board Secretary
- HR Advisor

Any Governing Body member wishing to attend.

**Chair**
The Chair of the committee will be the Lay Member who is the Governing Body’s Deputy Chair

The Chair & Clinical Leader will be the Vice Chair.
<p>| <strong>Quoracy</strong> | The committee will be considered quorate when at least half of the members are present, including as a minimum the Chair or Vice Chair of the Committee, and in addition a GP and a Lay Member. |
| <strong>Frequency of meetings</strong> | There shall be appropriate flexibility as the frequency of meetings but these shall normally be on an annual basis. |
| <strong>Frequency of attendance</strong> | Members are expected to attend all meetings; however a nominated appropriate equivalent deputy can attend in extenuating circumstances. Deputies will only be in attendance. Where an elected clinical member cannot attend, only another elected clinical member may deputise. |
| <strong>Sub-Committees / Groups</strong> | The committee may establish groups to support it in its role. The scope and membership of those groups will be determined by the committee. |
| <strong>Conduct</strong> | Members of the committee and those in attendance at meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Citizen’s Charter and Code of Practice on Access to Government Information. All members will have due regard to, and operate within, the prime financial policies, standing orders, the constitution and other policies and procedures of NHS Wakefield CCG. |
| <strong>Declaration of interests</strong> | A member of the committee will not take part in the committee when the appointment or reappointment of their post will be considered. This will apply in all instances, including when the individual will retire from the Governing Body. All potential conflicts of interest will be declared and dealt with in line with the CCG’s policies / procedures for handling conflicts of interest. All declarations of interest will be recorded in the minutes. |
| <strong>Administration</strong> | Secretariat support for the committee will be provided by the governance function within the CCG. They will ensure that minutes of the meeting are taken and provide appropriate support to the Chair and Committee members. Duties will include: |
|  | • agreement of agenda with Chair and attendees and collation of papers; |
|  | • ensuring that minutes are taken and keeping a record of matters arising and issues to be carried forward; |
|  | • timely distribution of papers, no later than five working days before a meeting for agenda and papers and no later than five working days |</p>
<table>
<thead>
<tr>
<th><strong>Urgent matters arising between meetings</strong></th>
<th>The Chair of the Committee and the CCG’s Chair &amp; Clinical Leader in consultation together, may also act on urgent matters arising between meetings of the Committee. These matters will be ratified at the next meeting of the Committee.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monitoring of compliance</strong></td>
<td>The Governing Body will monitor the effectiveness of the committee through receipt of the minutes and reports regarding the organisation’s risk management arrangements.</td>
</tr>
<tr>
<td><strong>Date agreed</strong></td>
<td>TBC</td>
</tr>
<tr>
<td><strong>Review date and monitoring</strong></td>
<td>Annually, or as and when legislation or best practice guidance is updated. Any amended Terms of Reference will be agreed by the committee for recommendation to a subsequent meeting of the Governing Body.</td>
</tr>
</tbody>
</table>
## NHS Wakefield CCG Governing Body - Terms of Office

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Date Appointed</th>
<th>Term</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Officer</td>
<td>Jo Webster</td>
<td>-</td>
<td>Permanent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Financial Officer</td>
<td>Andrew Pepper</td>
<td>-</td>
<td>Permanent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Service Delivery &amp; Quality</td>
<td>Jo Pollard</td>
<td>-</td>
<td>Permanent</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay Member</td>
<td>Stephen Hardy</td>
<td>01/04/2013</td>
<td>2 years</td>
<td></td>
<td></td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay Member</td>
<td>Rhod Mitchell</td>
<td>01/04/2013</td>
<td>2 years</td>
<td></td>
<td></td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lay Member</td>
<td>Sandra Cheseldine</td>
<td>01/04/2013</td>
<td>2 years</td>
<td></td>
<td></td>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Clinical Leader</td>
<td>Dr Adam Sheppard</td>
<td>01/04/2013</td>
<td>2 years</td>
<td></td>
<td></td>
<td></td>
<td>E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP member</td>
<td>Dr Ann Carroll</td>
<td>08/07/2013</td>
<td>3 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>GP member</td>
<td>Dr Avijit Biswaz</td>
<td>01/04/2013</td>
<td>1 year</td>
<td></td>
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</tr>
<tr>
<td>GP member</td>
<td>Dr Clive Harries</td>
<td>01/04/2013</td>
<td>2 years</td>
<td></td>
<td></td>
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<tr>
<td>GP member</td>
<td>Dr David Brown</td>
<td>01/04/2013</td>
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<tr>
<td>GP member</td>
<td>Dr Paul Dewhirst</td>
<td>01/04/2013</td>
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<td></td>
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<tr>
<td>Clinical Leader</td>
<td>Dr Phil Earnshaw</td>
<td>01/04/2013</td>
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<tr>
<td>Practice Manager</td>
<td>Steve Bryan</td>
<td>01/04/2013</td>
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<td></td>
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<tr>
<td>Consultant</td>
<td>Hany Lotfallah</td>
<td>01/04/2013</td>
<td>3 years</td>
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<tr>
<td>Nurse Specialist</td>
<td>Sharon Fox</td>
<td>01/04/2013</td>
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**Key:**
- **E** - election or appoint
- **A** - proposed second term of office
- **E** - election or appoint
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<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
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<tr>
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<td>10 March 2015</td>
<td>Public/Private Section:</td>
<td></td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Service Level Agreement (SLA) Negotiations with Yorkshire and Humber Commissioning Support (Y&amp;HCS)</td>
<td>Public</td>
<td>✔</td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision</td>
<td>Discussion</td>
<td>Assurance</td>
</tr>
<tr>
<td>Report Author and Job Title:</td>
<td>Karen Parkin, Associate Director of Finance, Governance and Contracting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Andrew Pepper, Chief Finance Officer</td>
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</table>

**Recommendation:**

The Governing Body are asked to note the current progress in relation to agreement of the CSU contract and to delegate authority to the Chief Financial Officer (CFO) to agree the final contract to ensure delivery of sustainable commissioning support services in line with NHS England guidance.

**Executive Summary:**

The purpose of this paper is to update the Governing Body on the current status of contract negotiations with the Y&HCS for 2015/16 and seek delegated authority to the Chief Finance Officer to agree a final contract which delivers sustainable commissioning support services to the Clinical Commissioning Group (CCG).

The current 2014/15 service level agreement provides for a range of services at a cost of c. £2.8m.

In-year, contract variations were agreed in order to deliver GP IT £0.8m, CHC transfer c. £1m and other ad-hoc variations for short-term support to projects.

On 5 February 2015 the outcome of the national lead provider framework was announced against 3 Lots.

Y&HCS were unsuccessful under Lot 1 (end to end services) and Lot 2a (medicines management) but successful under Lot 2b (continuing healthcare).

This means that Y&HCS will cease to exist in their current form from 31 March 2016 and are in discussion with North East Commissioning Support (NECS) regarding future arrangements. In addition, a Transition Board has been established to oversee the transition to the new arrangement.

Contract negotiations have been led at Chief Finance Officer level for both CCG and Y&HCS organisations and a number of principles have been established.

At the time of writing the CCG had yet to receive a final pricing schedule or a detailed transition plan from Y&HCS.

**Link to overarching principles from the strategic plan:**

<p>| Improve health equality across our population |
| Support for individual health and wellbeing |
| Care provided in the right setting and close to home |
| Appropriate access and choice for all |</p>
<table>
<thead>
<tr>
<th>Understanding our population and putting patients at our centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and high quality experiences and clinical outcomes</td>
</tr>
<tr>
<td>Transparent clinically-led commissioning ✓</td>
</tr>
<tr>
<td>Service transformation through redesign ✓</td>
</tr>
<tr>
<td>Improvement through collaboration and integration ✓</td>
</tr>
<tr>
<td>Financial efficiency, probity and balance ✓</td>
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</table>

<table>
<thead>
<tr>
<th>Outcome of Equality Impact Assessment:</th>
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<td>Outline public engagement:</td>
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<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>The Y&amp;HCS have liaised with CCGs on any relevant strategy</td>
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<td>Previously presented at committee / governing body:</td>
<td>A verbal progress report on SLA negotiations with the Y&amp;HCS was presented to Integrated Governance Committee on 18 December 2014. This included a review of service lines in terms of performance. The Committee agreed that the following series should be considered for review:</td>
</tr>
<tr>
<td></td>
<td>• Provider management</td>
</tr>
<tr>
<td></td>
<td>• Communications</td>
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<tr>
<td></td>
<td>• Governance</td>
</tr>
<tr>
<td></td>
<td>• IT support and IT strategic overview</td>
</tr>
<tr>
<td></td>
<td>• Invoice validation</td>
</tr>
<tr>
<td></td>
<td>• Transformation</td>
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<table>
<thead>
<tr>
<th>Reference document(s) / enclosures:</th>
<th>None.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment:</td>
<td>Risk is that the Y&amp;HCS become unsustainable resulting in stranded costs and services. Mitigation of this is being managed through the Y&amp;H Transition Board which has representation from all CCGs, NHSE and Y&amp;HCS.</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>Total Cost c. £4.5m with ongoing negotiation. Likely to be a cost reduction in 2015/16 on current contract value.</td>
</tr>
<tr>
<td></td>
<td>Any change in provision of services and associated costs will form part of the NHSE business case process via Transition Board.</td>
</tr>
</tbody>
</table>
2015/16 Service Level Agreement (SLA) Negotiations with Yorkshire and Humber Clinical Support (Y&HCS)

Progress Update Report for Governing Body

Tuesday 10 March 2015

1 Purpose of the Paper

The purpose of this paper is to update the Governing Body on the current status of contract negotiations with the Y&HCS for 2015/16 and seek delegated authority to the Chief Finance Officer to agree a final contract which delivers sustainable support services to the Clinical Commissioning Group (CCG).

2 Context

The current 2014/15 service level agreement provides for a range of services at a cost of c. £2.8m.

In year, contract variations were agreed in order to deliver GP IT £0.8m, CHC transfer (part-year effect) c. £1m and other ad-hoc variations to deliver services including a number of contract variations for short term support to projects.

Performance monitoring systems against the current 2014/15 SLA include:

- Individual CCG service lead monitoring – each service area has a specific CCG lead who has responsibility for monitoring against the service specification / work plan.

- Service lines have service specifications in place.

- Weekly meetings between the CCG contract lead and the Y&HCS Client Relations Manager.

- Completion of monthly satisfaction scores which form one element of the overall performance report submitted by Y&HCS.

- Monthly contract monitoring meetings between the CCG and Y&HCS at director level. The Y&HCS performance report is presented and any concerns are discussed.

- A dominant KPI for each service line effective from 1 June 2014. Y&HCS are currently in the process of gathering data to calculate the outcome of these KPIs.
During the year, the CCG saw the planned transfer of CHC services to the WYSYBCSU and the planned transfer of FOI and complaints services to the CCG. In addition, the unplanned transfer of provider management services took place on 1 January 2015 due to service failures at Y&HCS.

National and Local System Changes

In June 2014 the merger between West and South Yorkshire and Bassetlaw Commissioning Support Unit and North Yorkshire and Humber Commissioning Support Unit was announced. There is now one Commissioning Support Unit across the whole of the Yorkshire and Humber which was effective from 1 October 2014.

On the 5 February 2015, the outcome of the national lead provider framework was announced against 3 Lots. This is a national process run by NHS England which has an impact on all Commissioning Support Units across the country.

There were 3 Lots:

- Lot 1 - to bid for the provision of a full end to end service for a range of services listed as clinical support.
- Lot 2a was specifically for medicines management services.
- Lot 2b was specifically for supporting the assessment of continuing healthcare and individual funding requests.

Y&HCS were unsuccessful under Lot 1 and Lot 2a but were successful under Lot 2b.

This means that Y&HCS will cease to exist in their current form from 31 March 2016 and are in discussion with North East Commissioning Support (NECS) regarding future arrangements. In addition, a Transition Board has been established to oversee the transition to the new arrangement.

3 Current SLA Progress for 2015/16

A verbal progress report on SLA negotiations with the Y&HCS was presented to Integrated Governance Committee on 18 December 2014. This included a review of service lines in terms of performance. The Committee agreed that the following series should be considered for review:

- Provider management
- Communications
- Governance
- IT support and IT strategic overview
• Invoice validation

• Transformation

Contract negotiations have been led at a Chief Finance Officer level for both CCG and Y&HCS organisations. Regular meetings are ongoing. Principles established to date are:

• An exit strategy to be agreed for agreed services.

• Baseline contract value to be no more than the 2013/14 contract value and a required further reduction in 2015/16 equating to a 10% reduction should be delivered.

• Development of service specifications and work plans where appropriate to be drafted by Y&HCS/CCG leads for each service and incorporated into the final contract.

• Further development of dominant KPIs.

Y&HCS have identified, however, that following internal review that delivery of an overall 10% reduction will be challenging. They have issued a draft schedule of costs to all CCGs (including Wakefield) and a series of clarification questions have been submitted. In addition, the Transition Board process requires CCGs to prepare business cases for any in-housing proposal not transacted before November 2014. At the time of writing, the CCG is awaiting both a final pricing schedule and a detailed transition plan from Y&HCS.

4 Governance

The CCG scheme of delegation requires Governing Body approval for commitment of non-healthcare expenditure over £1M.

Given the national position regarding the lead provider framework and current position regarding detailed pricing schedules available, delegated authority is sought to enable an agreement to be entered into which maintains services from 1 April 2015 and allows ongoing discussion and agreement of the substantive 2015/16 contract.

5 Recommendations

The Governing Body are asked to note the current progress and to delegate authority to the Chief Finance Officer to agree the final contract and to ensure delivery of sustainable support services in line with NHS England guidance.
Karen Parkin,
Associate Director of Finance, Governance and Contracting

24 February 2015

v:\wakefield ccg\finance & governance\finance\wcgg\finance team\karen parkin\typing\2014-15\2014-15 sla negotiations with yhcs - governing body - 2015-03-10.doc
Title of meeting: Governing Body

Date of Meeting: 10 March 2015

Paper Title: NHS Wakefield CCG Assurance Framework

Purpose (this paper is for): Decision Discussion Assurance ✓ Information

Report Author and Job Title: Adam Bassett, Senior Associate Governance and Risk, Yorkshire and Humber Commissioning Support

Responsible Clinical Lead: Dr Phil Earnshaw, Chair

Responsible Governing Board Executive Lead: Andrew Pepper, Chief Finance Officer

Recommendations:

The Governing Body is asked to:

i approve the updated 2014/15 Assurance Framework for NHS Wakefield Clinical Commissioning Group;

ii consider whether the Assurance Framework provides the Governing Body with assurance that the CCG has a robust process for managing risks to the achievement of its strategic objectives.

Executive Summary:

This report outlines the updated 2014/15 NHS Wakefield Clinical Commissioning Group (CCG) Assurance Framework (AF). The AF provides the Governing Body with assurance that the CCG has a robust process for managing risks to the achievement of its strategic objectives.

During January and February 2015 the AF has been refreshed through discussions with each lead to identify the following:

- Risk appetite which relates to the ideal score for each
- Rationale for the score
- Actions from gaps in controls
- Actions from gaps in assurances

Following this review there are now 11 risks identified.

The AF was considered by the Audit Committee on 16 December 2014. Following consideration of the AF the Audit Committee made the following recommendations:

- The AF should include an explanation regarding the reason for the appetite score;
- There was a concern that risks were not actively owned and it was felt that the document needs to be a live document;
- It was acknowledged that it would be helpful if clinician and CCG lead manager meet together to discuss the risks;
- Consider timeline of risks and whether this should be a longer timeframe; and
- Review controls and external assurance to ensure that these are correctly reflected.
The AF was also considered by the Integrated Governance Committee on 19 February 2015 who agreed that this should now be considered by the Governing Body.

The updated AF is attached to the report.

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<thead>
<tr>
<th>Link to overarching principles from the strategic plan:</th>
<th>Citizen Participation and Engagement</th>
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<tbody>
<tr>
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<td>Wider Primary Care at Scale including Network development</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>A Modern Model of Integrated Care</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Access to the Highest Quality Urgent and Emergency Care</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>A Step Change in the Productivity of Elective Care</td>
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</tr>
<tr>
<td></td>
<td>Specialised Commissioning</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Mental Health Service Transformation</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Maternity, Children and Young People Transformation</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients</td>
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<table>
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<tr>
<th>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)</th>
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<table>
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<tr>
<th>Outline public engagement – clinical, stakeholder and public/patient:</th>
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<table>
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<tr>
<th>Assurance departments/organisations who will be affected have been consulted:</th>
<th>Each risk on the Assurance Framework has a lead manager and Governing Body lead who have been consulted on the applicable update.</th>
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<th>Previously presented at committee / governing body:</th>
<th>The Assurance Framework was considered by the Governing Body on 9 September 2014, the Audit Committee on 16 December 2014 and by the Integrated Governance Committee on 19 February 2015.</th>
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<tr>
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<thead>
<tr>
<th>Finance/ resource implications:</th>
<th>None identified</th>
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NHS Wakefield Clinical Commissioning Group Assurance Framework

1. Introduction

This report outlines the updated 2014/15 NHS Wakefield Clinical Commissioning Group (CCG) Assurance Framework (AF). The AF provides the Governing Body with assurance that the CCG has a robust process for managing risks to the achievement of its strategic objectives.

Following the update to the NHS Wakefield CCG Strategic Plan the NHS Wakefield CCG AF has been refreshed for 2014/15.

2. Development of the Assurance Framework

A workshop was held on 10 June 2014 where Governing Body members considered the Strategic Plan and then identified any threats against the characteristics and visions outlined with Plan. A Governing Body and senior manager lead for each threat was identified. During January and February 2015 the AF has been refreshed through discussions with each lead to identify the following:

- Risk appetite which relates to the ideal score for each
- Rationale for the score
- Actions from gaps in controls
- Actions from gaps in assurances

The scores have been found following the risk assessment process to identify:

- Likelihood, how likely something is to happen
- Consequence, the potential impact that this might have

The overall risk score was then achieved by multiplying the potential consequence by the potential likelihood to provide a risk score utilising a 5 x 5 matrix scoring system, which produces a range of scores from 1 to 25. This is as follows:

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Likelihood</th>
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<tr>
<td></td>
<td>Rare 1</td>
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<td>Insignificant</td>
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<td>Minor</td>
<td>2</td>
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<tr>
<td>Moderate</td>
<td>3</td>
</tr>
<tr>
<td>Major</td>
<td>4</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>5</td>
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</table>

3. Current threats

11 threats have now been identified against the characteristics and visions outlined in the Strategic Plan

Critical Risks (scoring 25-20) – 0
Serious Risks (scoring 16-15) – 5
High Risks (scoring 12-8) – 6

The serious risks are as follows:

- **Scoring 16**

  Characteristic and Vision 2: Wider Primary Care at Scale

  Vision: Vibrant networks of high quality practices working together with citizens, patients and health and social care professionals to identify and meet local people’s health needs.

  There is a risk of a fragmentation of primary care and destabilisation of GP practices

  Due to

  - changes in the GP contract
  - workforce pressures in general practice and increasing workload
  - Lack of national investment in general practice
  - failure to engage in integration agenda
  - Demographic changes with increased elderly population

  Resulting in inability to deliver the vision for wider primary care delivered at scale

- **Scoring 16**

  Characteristic and Vision 4: Access to the Highest Quality Urgent and Emergency Care

  Vision: An integrated 24/7 urgent care system with clearer and faster access that makes best use of alternatives to A&E and hospital admission.

  There is a risk of not maintaining system resilience to deliver constitutional standards due to:

  - Potential for lack of engagement of Systems Resilience Group Partners
  - Increased demand, acuity of patients, workforce capability, capacity and availability over seven days

  This will result in:

  - Poor patient experience
  - Non achievement of the 95% standard in 4 hours at A&E
  - Non achievement of Ambulance Red 8 minute response target locally
  - Poorer patient outcomes
  - Negative impact on Ambulance Quality Indicators (AQI)
  - Poorer handover and turnaround times
  - Reputational damage for the CCG and wider health and social care system
  - Potential for increased costs

- **Scoring 16**

  Characteristic and Vision 8: Specialised Commissioning in Yorkshire and the Humber is a system comprised of partners from CCGs & Area Teams who have come together to agree, refine and implement the following vision:

  Vision: To commission specialised services, concentrated in 15-30 centres, that are sustainable, high quality, innovative and seamless

  There is risk that the current configuration for specialised commissioning does not match with the geographical footprint for individual specialised services due to:

  - Collaboration issues
  - Inflexible geographical legal entities not always matching the needs services require to run
  - National policy on specialised commissioning from NHS England
  - NHS England service specifications limit opportunities for provision of specialised services
  - Lack of appropriate infrastructure to support devolved responsibility for specialised commissioning

  Resulting in inappropriate commissioning of specialist services and poor outcomes for patients

- **Scoring 16**

  Financial Efficiency Probity and Balance
The risk of not delivering financial duties due to lack of budgetary control and efficiency resulting in the restriction of services for patients and the risk that NHS resources are limited in a national and local context resulting in changes to commissioned services.

- **Scoring 16**
  Safe and high quality experiences and clinical outcomes
  The Risk of
  a. Avoidable harm to patients due to unsafe services and inadequate controls and assurances resulting in higher mortality, untoward incidents and poorer services.
  b. The risk of poor patient experience due to the quality of provider services resulting in lower levels of satisfaction.
  c. The risk of Wakefield residents not being able to access the best available care due to the commissioning of services rated less than good.

4. Consideration of the Assurance Framework by the Audit Committee

The Assurance Framework was also considered by the Audit Committee on 16 December 2014 where the role of the Audit Committee and the Assurance Framework following the recommendations of the Audit Committee handbook. The Audit Committee was asked to consider whether:

- The format of the AF is appropriate for the organisation
- The way in which the AF is developed is robust and relevant
- The objectives in the AF reflect the Governing Body’s priorities and that both the objectives and priorities are well defined, agreed and recorded
- The key risks are identified and linked to objectives
- The controls in place are sound and complete
- The assurances are reliable and of good quality with all key sources identified
- The underlying data on which assurances are based is reliable, accurate and timely
- There are actions in place to address gaps in control and/or assurance and they are implemented in line with agreed timescales

Following consideration of the AF the Audit Committee made the following recommendations:

- The AF should include explanation regarding the reason for the appetite score;
- There was a concern that risks were not actively owned and it was felt that the document needs to be a live document;
- It was acknowledged that it would be helpful if clinician and CCG lead manager meet together to discuss the risks;
- Consider timeline of risks and whether this should be a longer timeframe; and
- Review controls and external assurance to ensure that these are correctly reflected.

The AF was also considered by the Integrated Governance Committee on 19 February who agreed that this should now be considered by the Governing Body.

5. Questions for committee members to consider

When considering the AF, committee members may wish to ask themselves the following questions:

1. Am I aware of all the risks on the Assurance Framework?
2. Are there any other strategic risks or new strategic risks to add risks that could compromise the achievement of the CCG’s strategic objectives?
3. Am I specifically aware of those risks relating to my lead area?
4. Where are there gaps about confidence in the current position and achievement against strategic objective and therefore what items need to be added to future Governing Body agendas?
5. Is it clear what the strategic objective is and what is being measured to demonstrate success?
6. Am I assured that:
   - controls are in place to help the organisation achieve the objective
   - those controls will lead to the desired outcomes
   - the controls are implemented/adhered to?
7. Do I have performance information about current achievement and assurance regarding the reliability of the performance information?
8. Am I assured that risks are graded consistently in relation to each strategic objective?
9. Am I assured that:
   - the actions address the root cause
   - the actions agreed are being implemented and will be monitored
   - the systems used to generate the above assurances are sound and robust

The updated AF is attached to the report.

6. Recommendations

The Governing Body is asked to:

i approve the updated 2014/15 Assurance Framework for NHS Wakefield Clinical Commissioning Group;

ii consider whether the Assurance Framework provides the Governing Body with assurance that NHS Wakefield Clinical Commissioning Group has a robust process for managing risks to the achievement of its strategic objectives.

Adam Bassett, Senior Associate Governance and Risk,
Yorkshire and Humber Commissioning Support

March 2015
### Characteristic and Vision 1: Citizen Participation and Empowerment

**Vision:** We aspire to commission quality services that will improve our patient’s experience of care by involving our patients and the citizens of Wakefield district to drive commissioning decisions

<table>
<thead>
<tr>
<th>Threats against the achievement of the characteristic and vision:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a risk of not being able to meet patient expectations.</td>
</tr>
<tr>
<td>Due to reducing health and social care budgets and service reconfiguration.</td>
</tr>
<tr>
<td>Resulting in patient dissatisfaction.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Rating</th>
</tr>
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<tbody>
<tr>
<td>Initial: 2 x 4 = 8</td>
</tr>
<tr>
<td>Previous: 2 x 4 = 8</td>
</tr>
<tr>
<td>Current: 2 x 4 = 8</td>
</tr>
<tr>
<td>Appetite: 1 x 4 = 4</td>
</tr>
</tbody>
</table>

#### Key controls in place

**Engagement**
2. Comprehensive process for quality monitoring which feeds into the commissioning cycle.
3. Award winning ‘Putting patients first’ work.
5. Network Development Framework requirement for engagement at network level and care planning to support people with long term conditions.
6. Relationship matrix links with 9 quality characteristics and highlights if missing any vulnerable group.

#### Internal Assurances
1. PIPEC minutes are considered by the Integrated Governance Committee (IGC) and provide information on engagement with the local community.
2. Quality Intelligence Group (QIG) minutes are considered by the IGC which shows where we are mapping soft intelligence and identifying where we need to take improvement action.
3. Evaluation of integrated hubs started in September 2014 in the South East hub will give retrospective feedback on patient experience to inform future development.
4. Findings of Gateway review to assess progress with implementation of Meeting the Challenge (January 2015)
5. Evaluation of South East integrated hub presented to Integration Executive.

#### External Assurances
1. Internal Audit on ‘Learning to Improve’ listed QIG intelligence template as good practice.
2. NHS Wakefield CCG was shortlisted by NHS England Excellence in Participation Awards 2014 for ‘Putting Patients First’ Programme.
3. Meeting the Challenge plans upheld when referred to Secretary of State.

#### Date last reviewed: January 2015

**Rationale for Current Score**
Over the two years the CCG has put in place systems and processes to meet our vision to effectively engage with our patients and the citizens of Wakefield to drive commissioning decisions. The controls listed demonstrate the actions we have taken to mitigate the consequence of this risk by enabling people to influence priorities and decisions and by ensuring the public are kept informed and expectations are managed. The risk appetite recognises that managing public expectations needs a continuing dialogue and although the risk can be further reduced, it cannot be completely avoided.
<table>
<thead>
<tr>
<th>Gaps in controls</th>
<th>Gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Roll out of evaluation of integrated hubs during 2015/16.</td>
<td>1. Evaluation of other two integrated hubs will be presented to Integration</td>
</tr>
<tr>
<td>2. Extended workforce required for two co-located hubs (Central and East).</td>
<td>Executive once completed. (This links to risks 300 and 302 on the risk</td>
</tr>
<tr>
<td>3. Ensure consistent approach to engagement on transformation programmes to</td>
<td>register).</td>
</tr>
<tr>
<td>include explanations of the context and environment of the changes to help</td>
<td>2. Final approach to engagement with Health and Wellbeing Board members.</td>
</tr>
<tr>
<td>manage public expectations.</td>
<td>3. Recommendations from findings of Gateway review.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Actions from gaps in controls</strong></td>
<td><strong>Actions from gaps in assurances.</strong></td>
</tr>
<tr>
<td>1. Roll out evaluation of integrated hubs throughout 2015/16. (this links to</td>
<td>1. Final paper to March HWBB members to endorse more collaborative</td>
</tr>
<tr>
<td>risks 426, 456, 450 and 492 on the risk register).</td>
<td>engagement processes across the district.</td>
</tr>
<tr>
<td>2. Recruit to extended workforce for two co-located hubs (Central and East) by</td>
<td>2. Action recommendations from the Gateway Review once published.</td>
</tr>
<tr>
<td>April 2015</td>
<td></td>
</tr>
<tr>
<td>3. Review engagement plans for 2015/16 to ensure consistent approach to</td>
<td></td>
</tr>
</tbody>
</table>
**Characteristic and Vision 2: Wider Primary Care at Scale**

**Vision:** Vibrant networks of high quality practices working together with citizens, patients and health and social care professionals to identify and meet local people’s health needs.

**Threats against the achievement of the characteristic and vision:**

There is a risk of a fragmentation of primary care and destabilisation of GP practices

**Due to**

- changes in the GP contract
- workforce pressures in general practice and increasing workload
- Lack of national investment in general practice
- failure to engage in integration agenda
- Demographic changes with increased elderly population

**Resulting in**

- inability to deliver the vision for wider primary care delivered at scale

**Risk Rating**

<table>
<thead>
<tr>
<th>(likelihood x consequence)</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial: 4x4=16</td>
<td>Risk</td>
</tr>
<tr>
<td>Previous: 4x4=16</td>
<td>Appetite</td>
</tr>
<tr>
<td>Current: 4x4=16</td>
<td></td>
</tr>
<tr>
<td>Appetite: 3x4=12</td>
<td></td>
</tr>
</tbody>
</table>

**Date last reviewed:** January 2015

**Rationale for Current Score**

Progress has been made in a number of areas including the formation of a local federation in west Wakefield, the CCG has taken on responsibility for general practice co-commissioning and the award of funds via the Prime Ministers Challenge Fund. However the level of the local ambition has increased leaving the risk score at 16. The rationale for the appetite score is that a certain level of risk is accepted as it unavoidable due to the pressures and changes within primary care. More recently these have included the Equitable Funding Review and increasing workforce pressures due to increasing patient demand and the move towards 7 day working.

**Key controls in place**

1. Co-commissioning - from January 2015 the CCG has taken on de facto responsibility for the commissioning of general practice primary care services.
2. System Resilience
   - The CCG has undertaken a programme of work, with NHS England to obtain a comprehensive understanding of the local general practice to identify gaps and to become aware of the risks across Wakefield. This is also a lever to ensure consistency and collaboration across practices
   - Capsticks LLP have undertaken a review of the PMS contract in Wakefield as a stocktake
   - Allocated Executive Team member and corporate lead for each of the seven clinical networks. This helps to better align practices to vision and matches CCG resources to achieving that vision.
   - Sound financial control has enabled sufficient non-recurrent funds for investment for 2015/16 which is ring fenced for community development.
   - National funding invested into primary care and consolidated into baseline of the CCG which is being used to improve access to GP services seven days a week.
   - Clinical networks are working with care homes to deliver more innovative practice
3. Workforce Planning
   - The CCG is working with NHS England to identify risks across the Wakefield area
   - A workforce tool has been completed by every practice in the CCG area with a completion date of the end of March 2015
   - The CCG is working with the Health and Education Training Board to become aware of the workforce risks across Wakefield through the workforce survey
   - Advance Training Practice (ATP) run by College Lane Surgery to recruit spokes for student nurse training in order to encourage newly qualified nurses to work in primary care to increase capacity
   - ST4 GP Commissioning fellow training pilot commencing in August 2014 to equip newly qualified GPs with commissioning

**Internal Assurances**

1. 7 day general practice working has been introduced.
2. Quarterly report to the Executive Approvals Group has shown there were 107,399 additional primary care contacts during Q1 to Q3 2014/15.

**External Assurances**

1. NHS England has indicated they are satisfied with CCG arrangements for co-commissioning.
2. National Annual Workforce Survey has 100% compliance with GP practices in the CCG area.
3. The Care Quality Commission have tested 11 of 40 practices and the results were positive. Remaining practices to be tested before October 2016.
skills and encourage retention following completion of training to support workforce capacity planning.

4. Fragmentation
   - Connecting Care Hubs working with networks to provide connected care closure to home
   - Allocated CCG Executive lead for each GP practice
   - Prime Ministers Challenge Fund

<table>
<thead>
<tr>
<th>Gaps in controls</th>
<th>Gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ATP and ST4 programme have not been in operation for sufficient time to assess success.</td>
<td></td>
</tr>
<tr>
<td>2. Workforce tool completed by 100% practices and Network action plans due end of March 2015.</td>
<td></td>
</tr>
<tr>
<td>3. Formal approval co-commissioning not yet known and does not commence until April 2015.</td>
<td></td>
</tr>
<tr>
<td>4. Awaiting decision of Prime Minister’s Challenge Fund Wave 2.</td>
<td></td>
</tr>
<tr>
<td>5. Introduction of general practice performance management arrangements and team.</td>
<td></td>
</tr>
<tr>
<td>6. There are no additional resources being provided to the CCG for undertaking co-commissioning.</td>
<td>1. At this point there are not felt to be any gaps in assurances.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contingency Plan required if not successful in Prime Minister’s Challenge Fund application to be developed by Dr Connor by the end of March 2015.</td>
<td></td>
</tr>
<tr>
<td>2. General practice performance management arrangements and team to be in place by 1 October 2015.</td>
<td>1. At this point there are not felt to be any actions from gaps in assurances.</td>
</tr>
</tbody>
</table>
### Characteristic and Vision 3: A Modern Model of Integrated Care

**Vision:** People achieve the best possible outcomes for themselves and their families, through services which are well coordinated and are available as close to home as possible

| Lead Governing Body Member: Dr Avijit Biswas, GP Member |
| Lead Manager: Melanie Brown, Programme Commissioning Director Integrated Care |

#### Threats against the achievement of the characteristic and vision:

Ongoing recruitment of workforce model needed to deliver integrated care and ongoing fragmentation and un-coordinated care between health and social care organisations

- Potential increased demand on Adult social care services due to implementation of the Care Act
- Managing system resilience and challenges of recruiting clinical staff
- Reduction in resources across public sector organisations, improved efficiency
- Joint commissioning arrangements with the local authority not fully understood and developed

#### Resulting in

- Poor patient experience and outcomes
- Unsustainable future for provider landscape, in particular acute service
- Non-delivery of financial targets
- Unable to meet needs and expectations and respond effectively to the Health and Wellbeing Board and Joint Strategic Needs Assessment
- Potential on Quality and Safety

#### Risk Rating

<table>
<thead>
<tr>
<th>(likelihood x consequence)</th>
<th>Initial: 4x5=20</th>
<th>Previous 4x5=20</th>
<th>Current: 3x4 = 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Appetite:</td>
<td>2x5 = 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Appetite:</td>
<td>2x4 = 8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Key controls in place

1. Meeting the Challenge detailed workforce development plan that identifies a number of roles that can be redistributed across primary care and community care services.
2. Networks interface with Hubs building momentum to support development of new roles. It is critical that new Hubs have strong interface with networks to provide GPs confidence that patients can services within Hubs.
3. Voluntary and Community Services (Age UK and Carers Wakefield have recruited workforce and these are now located within additional Hubs.
4. CCG intends to work in partnership with NHS England Local Area Team regarding PMS review and co-commissioning of Primary Care.
5. Investment of non-recurrent resources to support the development of new roles and local teams.
6. Providers currently responding to Connecting Care specification and therefore are currently reviewing governance arrangements to work collaboratively. Primary care representation to join the Provider Alliance has recently been identified.
7. Development of programme office for Connecting Care to ensure responsiveness to learning from proof of concept (south-east Hub) to ensure Wakefield has the right workforce mix in hubs moving forward.

#### Gaps in controls

1. Impact of network developments and local integration models not fully understood in agreed currency. (This links to risks 300 and 302 on the risk register).
2. Delays in implementing new Connecting Care model due to lack of staffing capacity. (This links to risk 445 on the risk register).

#### Rationale for Current Score

Inability to integrate model of integrated care without an adequate workforce.
Inability to deliver emergency bed day reductions in Meeting the Challenge without fully recruiting workforce in the Central and East Hubs.
Score reduced due to more confidence in system and announcement that any funding released from PMS review, must be spent on local primary care provision.
The appetite score is due to the fact that service reconfiguration will be an element of risk which cannot be avoided.

#### Date last reviewed: January 2015

**Internal Assurances**

1. Chief Officer is nominated HWB Joint SRO (senior responsible officer) and Joint Chair of Integration Executive.
2. Integration Executive meets monthly and reports to Health and Wellbeing Board and considers the roll out of progress of integration across the adults and children and young people’s agenda.
3. Programme Management Office has been developed to support roll out of Connecting Care Programme.
4. Meeting the Challenge Programme Executive is in place supported by Strategic Impact Group, ensuring all programmes deliver.

**External Assurances**

1. Health and Wellbeing Board (HWB) overseeing integration agenda.
2. Local Services Board holding HWB to account for delivery of District Outcomes Framework.
3. Better Care Fund has been approved by NHS England.

**Gaps in assurances**

1. Governance structures will be developed through the governance review to ensure that Provider Alliance is held to account by the Integration Executive.
3. PMS review and associated funding and service reviews not fully understood to assess capacity restraints on workforce. (This links to risk 100 on the risk register).
4. Provider Alliance is evolving it’s governance arrangements and needs to collectively respond to the service specification for Connecting Care. Furthermore Provider Alliance needs to continue to increase primary care involvement.

<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Secure additional workforce capacity to work in the Hubs in both the local authority and MYHT.</td>
<td>1. Provider Alliance to develop governance structure and share with CCG by March 2015.</td>
</tr>
<tr>
<td>2. Provider Alliance needs to develop a implementation plan to respond to Connecting Care service specification. This needs to be submitted to Integration Executive by 12th March 2015</td>
<td>2. Liaise with and influence NHS England with regards to timescale of PMS review and procedures for co-commissioning of primary care services. (This links to risk 100 on the risk register).</td>
</tr>
<tr>
<td>3. Renew commissioning capacity across local authority and NHS Wakefield CCG. (This links to risk 348 on the risk register)</td>
<td></td>
</tr>
<tr>
<td>4. Renew existing governance structures to ensure fit for purpose for the future. These new arrangements will be in place April 2015.</td>
<td></td>
</tr>
<tr>
<td>5. Investment in supporting the Provider Alliance by sharing a PMO between Connecting Care Commissioning Programme and the Provider Alliance. To commence April 2015.</td>
<td></td>
</tr>
</tbody>
</table>
**Characteristic and Vision 4: Access to the Highest Quality Urgent and Emergency Care**

**Vision:** An integrated 24/7 urgent care system with clearer and faster access that makes best use of alternatives to A&E and hospital admission.

**Threats against the achievement of the characteristic and vision:**

**Threat 1.** There is a risk of the transformation of services not being delivered due to:
- A significant focus on maintaining operational resilience to deliver constitutional standards and integration with other work programmes and key stakeholders including capacity to maintain the workplan

This will result in:
- Poor patient experience
- Reduction of conveyance does not occur
- Poorer patient outcomes
- Poorer handover and turnaround times
- No improvement in Length of Stay for emergency admissions
- Reputational damage for the CCG and wider health and social care system
- Potential for increased costs

**Risk Rating**

(likelihood x consequence)

| Initial | 3x3 = 9 |
| Previous | 3x3 = 9 |
| Current | 3x3 = 9 |
| Appetite | 2x3 = 6 |

**Date last reviewed:** January 2015

**Rationale for Current Score**

Operational issues
- Delayed delivery of Accident and Emergency Discharge Transport Service
- Interdependencies with other Meeting the Challenge Programmes.

The rationale for the appetite score that the consequence of not meeting delivery is that we will not meet the requirements of the Meeting the Challenge consultation and therefore there is a risk to reputation and media interest, as well as not delivering the quality of service or not designing the service around the demand; if demand doesn’t meet the 1% growth. Likelihood, will be acceptable at 2 due to the complexity of the programme and interdependencies of other programmes in achieving their objectives and maintaining the growth in demand at 1%.

**Key controls in place**

1. Meeting the Challenge (MtC) programme management documentation in place which describes how the programme will be managed and brings together timelines, strategy and governance.
2. Urgent Care Strategy in place which sets out the key interventions undertaken as part of transformation work.
3. Agreed governance structure in place via the Systems Resilience Group (SRG) and the Meeting the Challenge (MtC) Implementation Group.
4. Programme of work agreed is described in the MtC Outline Business Case and the Project Initiation Documentation (PID) and is managed through the wider Programme Management Office.
5. NHS Wakefield CCG commissioners work with the contracting team to ensure that new schemes form part of the core contractual agreements through regular contract meetings and there are governance arrangements for these.

**Internal Assurances**

1. Urgent Care Strategy has been agreed by the Clinical Cabinet.
2. Clinical specification has been approved by the Clinical Cabinet.

**External Assurances**

1. The MtC Implementation Group have signed off the programme management documents.
2. The MtC Implementation Group receive regular highlight reports, the risk register and timescales for implementation.
3. Joint Overview and Scrutiny Committee have overview of any service changes and the evaluation undertaken.
4. SRG have signed off the programme management documents.
5. SRG receive regular highlight reports, the risk register and timescales for implementation.

**Gaps in controls**

1. Workforce plan to deliver transformational change. (This links to risks 419, 445 and 456 on the risk register).
2. Lack of evidence base for services for example re-design of A&E & models.
3. Reporting and monitoring of Length of Stay by condition (HRG) or speciality.
4. Need to agree a joint Clinical Cabinet meeting with North Kirklees CCG to ensure final sign

**Gaps in assurances**

1. Revised version of the PID awaiting sign off by year end by MtC Senior Responsible Officer and Programme Management Office.
2. The role of the West Yorkshire Urgent and Emergency and Emergency Care Network still in development and not aligned to local transformational programmes.
3. Clear set of objectives for networks
5. Development of stakeholder engagement strategy.

<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Seven Day working action plan to address workforce gaps. (This links to risks 419, 445 and 456 on the risk register).</td>
<td>1. Sign off of PID by end of 2014/15.</td>
</tr>
<tr>
<td>2. Review of evidence and what local systems are already working being undertaken as part of developing the new commissioning specification for integrated emergency departments.</td>
<td>2. Networks have clear set of objectives and are working to these by summer 2015.</td>
</tr>
<tr>
<td>3. A joint Clinical Cabinet meeting with North Kirklees CCG to be arranged to ensure final sign off of the Emergency Department specification is completed and jointly owned by May/June 2015.</td>
<td></td>
</tr>
<tr>
<td>4. A stakeholder engagement strategy to be developed by end of February 2015.</td>
<td></td>
</tr>
</tbody>
</table>
**Characteristics and Vision**

**4: Access to the Highest Quality Urgent and Emergency Care**

**Vision:** An integrated 24/7 urgent care system with clearer and faster access that makes best use of alternatives to A&E and hospital admission.

**Lead Governing Body Member:** Dr Adam Sheppard, Assistant Clinical Chair

**Lead Manager:** Sally Bell, Mid Yorkshire Systems Resilience Lead

---

**Threats against the achievement of the characteristic and vision:**

**Threat 2.** There is a risk of not maintaining system resilience to deliver constitutional standards due to:

- Potential for lack of engagement of Systems Resilience Group Partners
- Increased demand, acuity of patients, workforce capability, capacity and availability over seven days

This will result in:

- Poor patient experience
- Non achievement of the 95% standard in 4 hours at A&E
- Non achievement of Ambulance Red 8 minute response target locally
- Poorer patient outcomes
- Negative impact on Ambulance Quality Indicators (AQI)
- Poorer handover and turnaround times
- Reputational damage for the CCG and wider health and social care system
- Potential for increased costs

**Risk Rating**

(likelihood x consequence)

<table>
<thead>
<tr>
<th></th>
<th>Initial:</th>
<th>Previous:</th>
<th>Current:</th>
<th>Appetite:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3x4 = 12</td>
<td>3x4 = 12</td>
<td>4x4 = 12</td>
<td>2x4 = 8</td>
</tr>
</tbody>
</table>

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**Rationale for Current Score**

Currently score increased due to:

- Lack of achievement of 8 minute response times.
- Lack of achievement of emergency care standard
- Integration of partner organisations into innovative system resilience
- The rationale for the appetite score that the consequence of not meeting delivery is that we will not meet the requirements of the Meeting the Challenge consultation and therefore there is a risk to reputation and media interest, as well as not delivering the quality of service or not designing the service around the demand, if demand doesn’t meet the 1% growth. Likelihood, will be acceptable at 2 due to the complexity of the programme and interdependencies of other programmes in achieving their objectives and maintaining the growth in demand at 1%.

---

**Key Controls in Place**

1. Formation of Systems Resilience Group (SRG) to provide assurance that all partners have effective plans in place to deliver constitutional standards.
2. Weekly Executive meetings of key partners to maintain focus and review and remove blockages across the system.
3. Weekly operational meetings to review progress against plan to ensure action across partner organisations are undertaken with all key stakeholders and with representation of all partners of the SRG.
4. Daily A&E performance information on 95% standard circulated to all SRG partners to ensure that all partners are aware of performance.
5. Weekly winter teleconferences with NHS England (West Yorkshire) (November to April)
6. SRG owned dedicated operational plans for known periods of surge e.g. bank holidays and winter – Surge and Escalation Plan which includes ensuring system safety that impacts on the quality of patient care.
7. Patient representation on the SRG to provide patient perspective on access and quality of services.
9. Mid Yorkshire Contract Management Board have agreement of risk share for payment of non-elective activity for 2014/15.

---

**Date last reviewed:** January 2015

**Internal Assurances**

1. Agreed governance arrangements are in place via CCG Governing Body who have agreed approval of system resilience funding.
2. Regular strategic updates and discussion with the Clinical Cabinet and the Integrated Governance Committee on progress of funding arrangement and evaluation of impact.
3. Daily report of performance against the 95% A&E standard as the indicator of the quality of patient care across the health and social care system.
4. Monthly Quality and Performance Report to Integrated Governance Committee and Governing Body showing performance against national standing

**External Assurances**

1. Robust national oversight of resilience plans including funding.
2. Approval by Health and Well Being Board of resilience plans.
3. Strategic and Resilience plans across the Mid Yorkshire Health and Social Care footprint have been signed off by SRG.
4. Performance monitoring reports of local provider organisations to other external organisations, Care Quality Commission and NHS Trust Development Agency.
5. Weekly identification of acute service risk of staffing, activity and finance by Trusts which is provided to NHS England and the Trust Development Agency.
10. West Yorkshire Local Health Resilience Plan in place for health service resilience.

<table>
<thead>
<tr>
<th>Gaps in controls</th>
<th>Gaps in assurances</th>
</tr>
</thead>
</table>
| 1. In complete daily dashboard to show system pressures that could impact on the quality of patient care across the health and social care system. (This links to risk 323 and 451 on the risk register).  
2. Ambulance AQI data is not feasible at CCG level, alternative patient outcome data around key conditions to be reviewed for locality. (This links to risks 426 and 427 on the risk register).  

<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
</table>
| 1. Development of community wide operational dashboard by the end of April 2015.  
2. Review with quality team on availability of benchmarking data e.g. through Dr Foster by the end of April 2015.  
3. Review with performance team on availability of data availability by the end of April 2015.  
4. To liaise with quality and BI team to understand data availability and agree formal process for monitoring by end of April 2015. | 1. On-going discussions of Yorkshire Ambulance Service (YAS) through the YAS Contracts Board. |
**Characteristic and Vision 5: A Step Change in the Productivity of Elective Care**

**Vision:** To commission a choice of accessible, high quality, safe, patient focused and cost effective services that deliver the right care, at the right time in the right place.

**Threats against the achievement of the characteristic and vision:**
There is a risk the CCG will fail to deliver a step change in improvements to elective care.

Due to:
- increased demand due to referral to treatment (RTT) performance
- delays in access to diagnostics
- a failure to maximise technology as a key enabler to service improvement and efficiency
- a failure to maximise opportunities to adopt and spread innovation approaches
- the need to reduce the current waiting list backlog prior

Resulting in:
- poor patient experience and a potential reduction in quality
- the failure to meet NHS Constitution measures associated with planned care
- the failure to achieve QIPP targets
- failure to achieve the step change in productivity of elective care in line with national and CCG strategic priority
- Failure to achieve the 18 week referral to treatment performance levels

**Risk Rating**
(likelihood x consequence)

<table>
<thead>
<tr>
<th>Initial</th>
<th>4x3=12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous</td>
<td>4x3=12</td>
</tr>
<tr>
<td>Current</td>
<td>4x3=12</td>
</tr>
<tr>
<td>Appetite</td>
<td>3x3=9</td>
</tr>
</tbody>
</table>

**Risk Score**

- 15
- 10
- 5
- 0

**Risk Appetite**

**Date last reviewed:** January 2015

**Rationale for Current Score**
Significant monitoring is undertaken by the CCG to identify performance variance in relation to NHS Constitution elective care measures such as the 2 week cancer waits, 62 day cancer waits, 18 week referral to treatment (RTT), 52 week breaches, 6 week diagnostic waits and transformation and QIPP planned care schemes.

The risk appetite score is due to a level of risk being inevitable due to the implementation of the Clinical Services Strategy.

**Key controls in place**
1. Routine contract monitoring of all contracts via contract/finance activity & quality reports and monitoring meetings.
2. Performance monitoring against all key elective NHS constitution targets.
3. Programme and project management approach to QIPP.
4. Triangulation of ‘soft intelligence’ re elective care complaints by the CCG’s Quality Intelligence Forum.
5. Patient walkabouts and feedback.
6. Risk Register process.
7. Annual demand planning process to inform setting of contracts and associated budgets.
8. Network engagement and active involvement in service transformation.
9. Strategic planning process to identify priorities and contracts.
10. Service review process re elective care (CCG 3 year procurement plan.)

**Internal Assurances**
1. Monthly summary contract monitoring and finance report to Integrated Governance Committee and Board.
3. Regular highlight reports and actions to mitigate areas of variance from QIPP targets reported to QIPP Group and QIPP report to Integrated Governance Committee and Governing Body.
4. Triangulation of elective care feedback/issues from referring clinicians, complaints, contract monitoring meetings, complaints, MP and their constituents, safeguarding, staff etc. reported via Quality Intelligence Forum.
5. Named commissioning lead, Senior Manager & Director assigned to all elective care risks on corporate Risk Register.
6. Approval of strategic planning process by IGC, Clinical Cabinet and Governing Body.
7. Updates on elective care developments to Patient Involvement & Patient Experience Committee (PIPEC).
8. Updates to networks via corporate leads report and NDU news letters to inform discussion, engagement, involvement & promote innovation of networks in transformation work streams.
9. Monthly Executive Quality and Contracting Board meeting with providers.
10. Planned Care delivery care group instigated in November 2014 and reports into Clinical Cabinet.
11. Review of planned care transformation QIPP programme to be completed by March 2014.
### Gaps in controls
1. Require an holistic overview of all planned care activity/costs/quality and benchmark to ascertain scale of opportunity to improve commissioning of high quality cost effective elective care services for our local patients. (This links to risk 433 on the risk register).
2. Lack of alignment between QIPP, network, service review and existing planned care work streams (different and often competing drivers and timescales). (This links to risk 433 on the risk register).
3. Need to build on patient engagement and involvement in some elective and commissioning projects. (This links to risk 433 on the risk register).
4. Workforce resources to deliver identified priorities and associated workstreams are not clarified from the outset. (This links to risks 445 and 456 on the risk register).
5. Approval of the MYHT Health Economy, Sustainability and Recovery Plan for RTT in line with the Operational resilience and capacity planning guidance and funding. (This links to risk 450 on the risk register).

### Actions from gaps in controls
1. Regular updates via Network Development Unit (NDU). How?
2. Ensure resources are aligned to prioritised work streams from the outset by 1 March 2015. (This links to risk 433 on the risk register).
3. Annual workplan is in development to ensure alignment of all planned care commissioning activities.

### Gaps in assurances
1. Lack of service specific patient involvement and feedback re changes and change processes in some elective care work streams.
2. Need to increase the use of knowledge management and evidence based approaches to learn from innovation elsewhere.

### Actions from gaps in assurances
1. Overall approach to business continuity in relation to contract monitoring to be developed by the end of March 2015.
| Characteristic and Vision 6: Mental Health Service Transformation |
| Vision: To improve and raise awareness of Mental Health and Psychological Wellbeing across Wakefield |
| Threats against the achievement of the characteristic and vision: |
| There is a risk that the commissioning of mental health services will not be fully integrated, will not move people towards recovery, will fail to capitalise on the opportunities for joint working and will fail to deliver services where no one falls through the gaps. |
| Due to unintended consequences of wider system changes and failure to communicate these as well as a failure to make mental health a priority for all partners. |
| Resulting in poor services for patients, poorer patient outcomes, an unsustainable model of service delivery which ultimately will not be able to cope with increasing levels of demand and achieve parity of esteem. |

| Risk Rating |
| (likelihood x consequence) |
| Initial: 3 x 4 = 12 |
| Previous: 3 x 4 = 12 |
| Current: 3 x 4 = 12 |
| Appetite: 2 x 4 = 8 |

| Date last reviewed: February 2015 |
| Rationale for Current Score |
| The transformation of mental health services is a journey, and the successful delivery of a new model of integrated care for a person’s mental and physical health will challenge long established ways of working. In addition austerity in the local authority is increasingly challenging. |
| The appetite score is because the approach being taken has inherent risk due to the nature of the change proposed. |

| Key controls in place |
| Governance |
| 1. Mental Health and Learning Disability Services Programme Group in place to ensure engagement of all key partners and break down of organisational barriers. |
| 2. Ownership of the “approach” to transforming mental health services owned by the Health and Wellbeing Board (HWB) and regular reports to be provided to ensure progress is being made. |
| 3. Development of formalised partnership agreement with Local Authority to ensure roles and responsibilities are clear and that there is a commitment to resources. |
| 4. Work stream design group established to ensure solutions are collectively owned. |

| Programme Management |
| 5. GP network engagement being undertaken to ensure alignment of models. |
| 6. Project management approach being taken and resource allocated to ensure robust audit trail of “you said, we did”. |
| 7. Programme team working with internal colleagues on “intermediate care” review to ensure solutions are aligned. |
| 8. Programme team working with Urgent Care lead to ensure potential future models of service delivery support urgent care needs. |

| Planning |
| 10. Robust engagement plan aligned to the Integrated Care engagement to ensure joined up conversations about future models of care. |

| Enablers |
| 11. Clear process identified and planned for collecting intelligence, mapping and analysing need and identifying integrated solutions. |
| 12. Our commitment as a CCG to improving communication, collaboration and sharing of information and knowledge with ICT solutions internally and, where possible, across partner organisations. |
| 13. Mental health incorporated into the Better Care Fund which enhances the profile of mental health. |
| 14. Investment of non-recurrent monies to address stigma and culture component of culture change. |

| Gaps in controls |
| 1. Currently the transformation agenda has no linkage back to the formal contract and quality monitoring for providers. (This links to risks 80, 433 and 452 on the risk register). |

| Internal Assurances |
| 1. Project management approach being taken to the transformation of mental health services, including management of risk. |
| 2. Regular reporting to the Mental Health & Learning Disability Services Programme Group on progress against the plan. |
| 3. Reports and briefings are presented to Clinical Cabinet, IGC, Executive Team and Governing Body as appropriate, resulting in appropriate challenge and sign off. |

| External Assurances |
| 1. Reporting to HWB on progress of each item on operational plan. |
| 2. Annual reporting against district outcomes framework to HWB. |
| 3. Psychiatric liaison reporting to Overview and Scrutiny Committee to update on progress. |

| Gaps in assurances |
| 1. Reporting to Integrated Governance Committee. |
2. Mental health not currently included in the work being undertaken by the Provider Alliance.
3. No dedicated mental health commissioner representation on the Integration Executive. (This links to risk 80 on the risk register).
4. To date the programme team has not been sufficiently engaged in the development of the Gateway to Care.
5. Insufficient co-production with primary care as a provider.

<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Programme team to work with Director of Integrated Care to influence the Provider Alliance on ongoing basis. (This links to risk 445 on the risk register).</td>
<td>1. Commissioning Manager to link into Integrated Governance Committee by Summer 2015</td>
</tr>
<tr>
<td>3. Integration Executive to ensure membership is appropriate. (This links to risk 445 on the risk register).</td>
<td></td>
</tr>
<tr>
<td>4. Prioritise involvement in Gateway to Care development by end of March 2015. (This links to risk 445 on the risk register).</td>
<td></td>
</tr>
<tr>
<td>5. Engagement with Network Chairs through Clinical Cabinet and Network Development Unit.</td>
<td></td>
</tr>
</tbody>
</table>
**Characteristics and Vision 7: Maternity Children and Young People Transformation**

**Vision:** All children will have timely access to high quality care and support to maximise child health and wellbeing; providing safe care as close to home as possible

**Lead Governing Body Member:** Dr Ann Carroll, GP Member

**Lead Manager:** Michele Ezro, Associate Director - Service Delivery and Quality

---

**Threats against the achievement of the characteristic and vision:**

There is a risk that the emerging system model will not deliver timely access to high quality care and support delivered close to home due to:

- early intervention activities not supporting activities which impact on health care demand, including mental health
- difficulties in accessing primary care appointments at time of need to avoid attendance at A&E
- insufficient workforce capacity with appropriate competencies leading to increasing long waiting times in secondary care
- Insufficient secondary care capacity including bed base, particularly in maternity services
- Local authority budget reductions

**Resulting in:**

- Patients experience of services being sub-optimal
- Increase in costs to the CCG of service delivery
- Increase in or failure to stem demand for secondary care services including A&E
- Long waiting times for assessment and diagnosis of ADHD and ASD

---

**Risk Rating**

<table>
<thead>
<tr>
<th>(likelihood x consequence)</th>
<th>Initial: 3x3=9</th>
<th>Previous: 3x3=9</th>
<th>Current: 3x3=9</th>
<th>Appetite: 2x3=6</th>
</tr>
</thead>
</table>

**Date last reviewed:** January 2015

**Rationale for Current Score**

There has been a change in emergency care which has reduced the need for urgent care. However the waiting times for ASD keep the score as before. The appetite score remains as before due to the continued uncertainty concerning service reconfiguration and the impact on children’s services.

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**Key Controls in Place**

1. Children & Young People’s Partnership Board with Governing Body level membership from NHS Wakefield CCG which oversees the work of relevant partners, ensuring they co-operate to improve outcomes for children and young people.
2. The Health and Resilience Board, jointly chaired by the CCG and Wakefield Council reviews the performance framework and ensures that targets are being met. This is reviewed at the Children’s and Young Peoples Board.
3. Integration Executive Board and the Joint Strategic Commissioning Board seek to improve joint working between Health and Local Authority services.
5. Meeting the Challenge Programme Board in place to oversee implementation of necessary changes in the health economy to deliver whole system changes.
6. ASD Strategy Group is addressing the problem with the ASD waiting list.
7. Maternity quality dashboard provides performance information and is monitored by the Executive Quality Board. This is also reviewed by the CCG clinical lead and commissioning manager.
8. Quarterly meetings take place with Mid Yorkshire Hospitals (MYHT) lead clinician on maternity services and CCG clinical lead and commissioning manager.

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**Internal Assurances**

1. CCG clinical lead & commissioning manager meets fortnightly to consider current issues and risks, secondary care service usage, produce briefing and reports for clinical cabinet, Integrated Governance Committee (IGC) and Governing Body as appropriate.
2. Reports and briefings are presented to Clinical Cabinet, IGC, Executive Team and Governing Body as appropriate, resulting in appropriate challenge and sign off.
3. QIPP project reporting monthly on progress against agreed QIPP performance trajectory.

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**External Assurances**

1. Reporting to Children’s Partnership Board including report on outcomes framework quarterly.
2. Operation of Joint Strategic Commissioning Board (JSCB) to consider joint / collaborative commissioning arrangements and use of pooled budgets.
3. Health and Well Being Board have oversight of the overall children’s and maternity plan.

---

**Gaps in controls**

1. None identified. Appropriate controls are in place.

**Actions from gaps in controls**

1. None identified.

---

**Gaps in assurances**

1. Lack of provider ownership of ASD waiting list issue.

**Actions from gaps in assurances**

1. Letter to be issued from CCG to MYHT requesting senior oversight of the ASD waiting list issue.
Characteristic and Vision 8: Specialised Commissioning in Yorkshire and the Humber is a system comprised of partners from CCGs & Area Teams who have come together to agree, refine and implement the following vision:
Vision: To commission specialised services, concentrated in 15-30 centres, that are sustainable, high quality, innovative and seamless

Lead Managing Body Member: Dr Phil Earnshaw, Clinical Lead
Lead Manager: Jo Webster, Chief Officer

Threats against the achievement of the characteristic and vision:
There is risk that the current configuration for specialised commissioning does not match with the geographical footprint for individual specialised services due to:
- Collaboration issues
- Inflexible geographical legal entities not always matching the needs services require to run
- National policy on specialised commissioning from NHS England
- NHS England service specifications limit opportunities for provision of specialised services
- Lack of appropriate infrastructure to support devolved responsibility for specialised commissioning

Resulting in inappropriate commissioning of specialist services and poor outcomes for patients

<table>
<thead>
<tr>
<th>Risk Rating</th>
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</thead>
<tbody>
<tr>
<td>(likelihood x consequence)</td>
<td>Initial: 4x4=16</td>
<td>Previous: 4x4=16</td>
<td>Current: 4x4=16</td>
</tr>
<tr>
<td>Appetite: 2x4=8</td>
<td>20</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

Initial | Jun-14 | Feb-15
---|---|---
Risk Score | Risk Appetite

Date last reviewed: January 2015

Rationale for Current Score
Policy planning around specialised care is yet to be formalised and is still emerging. NHS Wakefield CCG will become more involved in the commissioning of specialist services and therefore will realise fully the impact on provider landscape and patient flow.

Key controls in place
1. Improved collaborative commissioning with Area Team across West and South Yorkshire to drive quality and efficiency across specialist areas.
2. NHS Wakefield CCG is committed to working with South Yorkshire commissioners and providers through the working together programme to improve services for those populations that cross boundaries.
3. Chief Officer and Chair are members of the 10 CC’s which defines areas of work that requires area based commissioning.
4. There are identified Clinical Leads and Executive Officers to engage in decision making around specialist services across West Yorkshire.
5. CCG has a lead for specialised commissioning.
6. There is a Specialist Commissioning Oversight Group (SCOG) that was set up during 2014/15 and NHS Wakefield CCG is a key partner involved in this work. Nominated 10 CC representatives attend the monthly SCOG meetings on behalf of all 10 CC (CCG) members and report key messages/issues/risks back into the 10 CC Accountable Officer & Chair meetings which are held monthly.
7. The Head of Service Development & Transformation, HOS Finance and Head of Contract and Procurement also meet monthly to ensure the impact of specialised commissioning developments are integrated into our local strategic and financial plans for 15/16 and beyond. Specialised Commissioning is also included in the CCG risk log.

Internal Assurances
1. CCG is aware of issues and has nominated a lead for specialised commissioning.
2. Head of Strategy examines any changes to national policy and reports this to Executive Team and Governing Body if required.
3. the CCG receives all agenda’s and minutes of the SCOG meeting and is able to liaise directly with the 10 CC reps and/or NHSE Yorkshire & Humber Specialised Commissioning Team
4. Regular updates on Specialised Commissioning developments have been provided to NHS Wakefield CCG Governing Board, Clinical Cabinet and IGC. Specialised commissioning developments are a regular agenda item on the MYHT CMG and ECB.

External Assurances
1. NHS England remains the lead commissioner for specialised services.

Gaps in controls
1. Governance structures to enable specialised commissioning are new and emerging. There will be a need to ensure that there is connectivity with other commissioners to enable clear leadership and lines of accountability.
2. Requirement to identify adequate resources to service specialised commissioning.
3. Chair and Chief Officer to participate in a West Yorkshire wide network.
4. Alliance with West Yorkshire providers is new/emerging and will require development. (This links to risk 445 on the risk register).
5. Lack of specialist advise and support to commissioners at a regional level.
6. CCG responsibility for specialised services is not yet clear.

Gaps in assurances
1. To be further identified once the policy direction is clear.
<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chief Officer to identify clear leadership and accountability within wider NHS.</td>
<td>1. Actions to be updated once policy direction has been clarified.</td>
</tr>
<tr>
<td>2. Executive Team to consider adequate resources to service specialised commissioning.</td>
<td></td>
</tr>
<tr>
<td>3. A review internal commissioning structures is underway being lead by Chief Officer to</td>
<td></td>
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<tr>
<td>ensure the development of specialist services is embedded within the organisation. Due</td>
<td></td>
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<tr>
<td>to be completed by end of March 2015.</td>
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</tbody>
</table>

**Threats against the achievement of the principles:** The risk of not delivering financial duties due to lack of budgetary control and efficiency resulting in the restriction of services for patients and the risk that NHS resources are limited in a national and local context resulting in changes to commissioned services.

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Risk Score</th>
<th>Risk Appetite</th>
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</thead>
<tbody>
<tr>
<td>Initial: 4x4 = 16</td>
<td>Risk Score</td>
<td>Risk Appetite</td>
</tr>
<tr>
<td>Previous: 4x4 = 16</td>
<td></td>
<td></td>
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<tr>
<td>Current: 4x4 = 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appetite: 2x4 = 8</td>
<td>Internal: Jun-14</td>
<td>Feb-15</td>
</tr>
</tbody>
</table>

**Key controls in place**
1. The CCG’s Scheme of Delegation and Prime Financial Policies ensures effective financial governance.
2. Long term financial plans aligned across the health economy across health and social care i.e. 5 year Strategic Plan, operational plan ensure robust financial planning to achieve strategic aims.
3. Robust Better Care Fund (BCF) plan which aligns expectations to achieve strategic aims and objectives.
4. Agreed budget and budgetary control with identified budget managers.
5. Embedded financial systems as demonstrated by the first year of operation.
6. Routine financial reporting to the Integrated Governance Committee (IGC) and Governing Body which monitors delivery against the financial plan.
7. QIPP (transactional) approach with weekly monitoring group chaired by Head of Strategy which routinely reports to the Clinical Cabinet.
8. QIPP (transformational) – Governing Body agreed approach to embedding efficiency at network level designed to deliver long term efficiency across all areas of commissioning with membership support. The focus during 2015/16 is on planned care.
9. NHS Wakefield CCG have been granted delegated authority for co-commissioning of primary care services.
10. Finance and Business Intelligence Group (F&BI) feeds into health and social care integration meetings.
11. System Resilience Group (SRG) has embedded resource and is expected to maintain quality and financial balance to improve performance in areas of need to maintain and improve constitutional targets.
12. Governance controls introduced in preparation for the delegation of primary care services to the CCG.

**Gaps in controls**
1. Standing Financial Instructions to be updated to ensure these are fit for purpose in changing environment.
2. Primary care not fully engaged in BCF finance discussions to date and BCF not fully embedded in the integration agenda.
3. Consideration of how co-commissioning of primary care can be a lever to the integration of primary care services.
4. Need to maintain business continuity of commissioning support services.
5. Need to fully embed QIPP aspiration of the Governing Body across the membership.
6. Health Economy overall financial challenge understood but of a material scale for health and social care partners and where provider activity is higher than plan will need to be considered as part of forward demand planning. (This links to risk 100 and 348 on the risk register).
7. CCG remains above target in national funding formula.

**Lead Director:** Andrew Pepper, Chief Finance Officer

**Lead Clinician:** Dr Adam Sheppard, Assistant Clinical Leader

**Date last reviewed:** February 2015

**Rationale for Current Score**
National efficiencies and financial challenge across health and social care place pressure on local health economy.

The rationale for the appetite score is that the long term strategic finance risks should be graded as greater than rare; and will likely be of a material risk should they crystallise.

**Internal Assurances**
1. Financial reports to the Governing Body provide assurances on financial delivery and risk.
2. IGC challenges and assures on current financial performance.
3. Clinical Cabinet is held to account on QIPP delivery.
4. Audit Committee scrutinises and provides guidance on Internal Audit reports.
5. Annual Governance Statement is the Governing Body assessment of how well governed the organisation is.
6. Financial targets for 2013/14 achieved and 14/15 on track.

**External Assurances**
1. Head of Internal Audit reports confirms assurance of organisations governance.
2. Lead Director External Audit has given a true and fair assessment.
3. Lead Director External Audit has given a use of resources opinion.
4. NHS England have the opportunity to review and challenge through monthly financial reporting.
5. Shared Business Services (SBS) auditor reports.

**Gaps in assurances**
1. Yorkshire and Humber Commissioning Support service auditor report has limited scope to provide assurance.
2. Internal Audit / Counter Fraud to complete workplan in March 2015.
3. Service Auditor Reporting reports will require a refresh in March 2015.
4. KPMG ISA260 Audit Highlights Memorandum – recommendation regarding pooled budget and lead commissioning arrangements that the CCG ensure that the financial governance arrangements are complete, this also links to the BCF.
5. New Internal Audit and counter fraud workplan to be developed for 15/16.
6. Interim external audit planned for Q4.
### Actions from Gaps in controls

1. Governance arrangements to be refreshed by end of March 2015 by Governance and Board Secretary.
2. Assistant Clinical Chair to consider how co-commissioning of primary care can be a lever to the integration of primary care services during 2015/16.
3. Contract management arrangements to be revised to ensure strong partnership arrangements in the context of the health economy integration business including demand risk, financial risk and maintaining high quality service provision. (This links to risk 129 on the risk register).
4. Ensure that the overall health economy challenge is fully understood by health and social care partners.

### Actions from Gaps in assurances

1. Completion of internal audit annual plan in March 2015.
2. External audit to be undertaken in early 2015.
3. Continued dialogue with CSU regarding service Auditor reports.
10. Safe and high quality experiences and clinical outcomes

Threats against the achievement of the principles: The Risk of

a. Avoidable harm to patients due to unsafe services and inadequate controls and assurances resulting in higher mortality, untoward incidents and poorer services.

b. The risk of poor patient experience due to the quality of provider services resulting in lower levels of satisfaction.

c. The risk of Wakefield residents not being able to access the best available care due to the commissioning of services rated less than good.

<table>
<thead>
<tr>
<th>Risk Rating</th>
<th>Date last reviewed: February 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>(likelihood x consequence)</td>
<td>Rationale for Current Score</td>
</tr>
<tr>
<td>Initial: 4x4 = 16</td>
<td>The CCG has robust quality assurance arrangements in place, in collaboration with other CCGs where appropriate, for all our providers. As host commissioner, and as the majority of our services are provided by the Mid Yorkshire Hospitals NHS Trust the score reflects the current concerns about patient safety ie staffing on elderly care / medical wards identified through Patient Safety Walkabouts and whistleblowing allegations. The Trust is on a quality improvement trajectory demonstrated through an internal and external assurance process. A recent Care Quality Commission report on MYHT shows ‘requires improvement’ so the score remains at 16. The appetite score reflects a reduced risk to quality and patient safety once MYHT has implemented all the improvements identified by the CQC.</td>
</tr>
<tr>
<td>Previous: 4x4 = 16</td>
<td></td>
</tr>
<tr>
<td>Current: 4x4 = 16</td>
<td></td>
</tr>
<tr>
<td>Appetite: 2x4 = 8</td>
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Key controls in place

1. Executive Quality Boards for main providers: MYHT, South West Yorkshire Partnerships Foundation Trust (SWYPFT) and Yorkshire Ambulance Service (YAS) 111 service to gain assurance from providers of quality of care and to do discuss remedial actions where quality is not assured. Quality is discussed as part of the YAS 999 Contract Management Board.
2. Monthly CCG Patient Safety Walkabouts at MYHT and six-monthly 15 steps walkabouts at SWYPFT.
3. Adult and children NHS safeguarding issues reviewed monthly, designated GP & nurse for adults and children and in post.
4. Signed up to national ‘Sign up to Safety’ campaign to reduce avoidable harm to patients.
5. CCG member of the West Yorkshire Quality Surveillance Group hosted by NHS England (West Yorkshire)
6. Single Item QS5s convened by NHS England held for YAS in July 2014 and MYHT in August and December 2014
7. MYHT Quality Summit held on 10 February 2014 (included NHS England, Care Quality Commission, Trust Development Authority, Healthwatch) with follow-up conference call on 9 July 2014.
8. Monthly Quality Intelligence Group gathers and themes soft intelligence on services in a systematic, rigorous and regular basis to identify appropriate actions.
9. Presentation to MYHT Executive Quality Board on Nurse Staffing Review and Proposal - 20 March 2014. Monthly nurse staffing reports presented to MYHT Executive Quality Board give assurance about progress with recruitment and nurse staffing ratios by ward
10. New risk concerning the Care Quality Commission to be added by Laura Elliott to CCG Risk Register (risk S29 on the NHS Wakefield CCG risk register).

Internal Assurances

1. Monthly Integrated Quality & Performance report, details key performance, activity and quality data and actions to address performance issues. Improvement in measures show reduction in threat of avoidable harm at MYHT.  
2. Separate adult and children safeguarding report to the Integrated Governance Committee and Governing Body.
3. Local Quality Intelligence Group aims to capture soft information from numbers of sources. Accountable to the Integrated Governance Committee. Summary of outputs and actions included in monthly Integrated Quality & Performance report.
4. Internal Task & Finish Group established to review and act on the recommendations of the external review of commissioning quality assurance processes and all actions completed.
5. Six month development programme agreed with MYHT to implement the recommendations of the external review of commissioning quality assurance processes (March – September 2014).
6. Report on Review of Key Quality and Performance Measures for the MYHT evidences the Trust’s journey in relation to performance and quality measures and indicates whether quality performance has improved, deteriorated, is a cause for concern, or a potential cause for concern mapped against the Quality Curve (presented to IGC in September 2013, February 2014 and November 2014).

External Assurances

2. Care Quality Commission Inspections.
3. External Review of commissioning quality assurance processes – December 2013 showed that a good governance structure was in place within the CCG with evidence of good clinical engagement; however more rigour is needed in some areas of our committee work regarding accountability, escalations and deadlines. Update on progress with recommendations presented to IGC in June 2014.
4. MYHT received a Highly Commended award from Dr Foster for reduction in weekend mortality – December 2013.
5. NHS Wakefield CCG was shortlisted by NHS England Excellence in Participation Awards 2014 for ‘Putting Patients First’ Programme which reflects the work of the Quality Intelligence Group.
<table>
<thead>
<tr>
<th>Gaps in controls</th>
<th>Gaps in assurances</th>
</tr>
</thead>
</table>
| 1. CCG not assured that the monitoring and assuring of quality for providers managed by the CSU provider management team. (This links to risks 74 on the risk register).  
2. Lack of patient/carer involvement in every commissioning decision.          | 1. Update to IGC in March 2014 on the completion actions following the external review of commissioning quality assurance processes.  
2. Current contracts and quality assurance measures do not measure across a patient pathway. (This links to risk 74 on the Risk Register  
3. Monitoring and reporting of other providers performance and quality is not developed. (This links to risks 74 and 450 on the Risk Register). |

<table>
<thead>
<tr>
<th>Actions from gaps in controls</th>
<th>Actions from gaps in assurances</th>
</tr>
</thead>
</table>
| 1. CCG and local authority agreed to review current learning disability commissioning, contracting and quality monitoring across the partnership.  
2. In discussion with NHS England to work jointly on the co-commissioning, contracting and quality of primary care services in shadow from 1 April 2015. | 1. CCG and local authority agreed to review current commissioning, contracting and quality monitoring across the partnership. |
**Title of meeting:** Governing Body  
**Date of Meeting:** 10 March 2015  
**Paper Title:** NHS Wakefield Clinical Commissioning Group Risk Register  
**Purpose (this paper is for):**  
- Decision  
- Discussion  
- Assurance  
- Information  
**Report Author and Job Title:** Adam Bassett, Senior Associate Governance and Risk, Yorkshire and Humber Commissioning Support  
**Responsible Clinical Lead:** Dr Phil Earnshaw, Chair  
**Responsible Governing Board Executive Lead:** Andrew Pepper, Chief Financial Officer

## Recommendation:

It is recommended that Governing Body:

i. notes the Risk Register as of 11 February 2015.

## Executive Summary:

The Risk Register was considered at the February Integrated Governance Committee where it was agreed that it be presented to the Governing Body.

Prior to this the Risk Register was subject to a new review cycle. A review cycle consists of a review by the Risk Owner, Senior Manager and Director.

Part of the review cycle for Senior Managers included checking that the guidelines had been followed.

The Senior Manager’s review also includes a requirement to identify and inform the Clinical Lead of relevant risks. All Clinical Leads have access to the risk register.

As of 11 February 2015 there are 59 risks on the risk register as follows:

- Critical Risks (scoring 25-20) – 1
- Serious Risks (scoring 16-15) – 9
- 426 – Increasing scoring 20
  - There is a risk that YAS will not meet the end of year red performance target (75% of red calls to be responded to in 8 minutes) due to staff vacancies, increased demand and rota changes. This will result in poor patient experience and potential increase risk of harm to patients.
- 529 – new risk scoring 16
  - There is a continued risk to patient safety and experience, and organisational reputation
  - Due to concerns about staffing levels and skill mix, and the significant backlog of outpatient appointments Resulting in care at the Mid Yorkshire Hospitals Trust given an overall rating by the CQC as 'requires improvement' with Are services safe? rated as 'inadequate' in November 2014.
- 492 – static risk scoring 16
  - There is a risk that the CCG will fail to meet the required standards within the NHS Constitution for the Cancer
Waits (2 weeks, 31 days and 62 days), due to operational performance at Mid Yorkshire Hospital Trust, resulting an adverse impact on the quality of care and patient experience, and a failure to meet key national targets.

450 – Static for two cycles scoring 16
There is a risk that the CCG will fail to meet the required standard within the NHS Constitution for the Admitted, Non Admitted and Incomplete 18 week Referral to Treatment Waiting Time standards, due to operational performance at Mid Yorkshire Hospital Trust, resulting an adverse impact on the quality of care and patient experience, and a failure to meet key national targets.

433 – Static scoring 16
There is a risk of delay to procurement decisions due to the significant number of service reviews scheduled to take place in 2014/15 or due to completed service reviews being aligned to wide service transformation resulting in contracts requiring tender waiver in order to avoid gaps in services and the risk that services are extended without market testing.

323 – Static for one cycle scoring 16
There is a risk that Local Care Direct will not meet the contractual KPIs due to the out-of-hours service experiencing significantly higher activity than is contractually planned for 2014-15. Resulting in delays to patient care.

100 – increasing scoring 16
There is a risk that the CCG fails to forecast its long term financial plan accurately due to incorrect assumptions, changing funding landscape or lack of planning guidance, resulting in inappropriate commissioning decisions being made. The health economy overall financial challenge is of material scale for health and social care partners which requires health and social care transformation.

535 – new risk scoring 15
There is a risk that children will wait for a multi-disciplinary assessment for autism due to a waiting list at Mid Yorkshire Hospitals NHS Trust. This will result in adverse impact on the quality of care and patient experience.

448 – increasing scoring 15
There is a risk that the CCG providers are not being managed appropriately leading to sub optimal activity, finance, payment, performance and CQUINs performance and that relationships with suppliers are being affected due to a lack of quality contract management from the Provider Management team in the CSU.

Those risks scoring 15 and above are outlined in full in appendix 1 to the report.

High Risks (scoring 12-8) – 25
Other risks (scoring 6 or below) – 25

Never Risks – Those risks which have a potential consequence of 5 or catastrophic but a likelihood of 1.
There is one risk identified as follows:

- 289 Scoring 5
There is a risk that the health system in Wakefield will be unable to meet the level of demand due to a large scale incident (eg natural disaster, terrorist attack, pandemic, etc). This will result in mass harm to the population of Wakefield district.

During this review cycle 9 risks have been identified for closure and 8 new risks have been added (one of which has also been closed).

The full risk register is available on request from Adam Bassett at adam.bassett@nhs.net.
Statistics.
There are 59 risks on the register (previous period 54 of which 3 were marked for closure at the end of the cycle leaving 51 live risks)
The total risk score is 495 (previous period 463)
The mean average risk score is 8.38 (previous period 8.57)
The proportion of serious risk scores to the total risk is 29.49% or 146 (previous period 23.9% or 111)

<table>
<thead>
<tr>
<th>Link to overarching principles from the strategic plan:</th>
<th>Citizen Participation and Engagement</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wider Primary Care at Scale including Network development</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>A Modern Model of Integrated Care</td>
<td>✓</td>
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<tr>
<td></td>
<td>Access to the Highest Quality Urgent and Emergency Care</td>
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<td></td>
<td>A Step Change in the Productivity of Elective Care</td>
<td>✓</td>
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<tr>
<td></td>
<td>Specialised Commissioning</td>
<td>✓</td>
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<tr>
<td></td>
<td>Mental Health Service Transformation</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Maternity, Children and Young People Transformation</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Organising ourselves to deliver for our patients</td>
<td>✓</td>
</tr>
</tbody>
</table>

Outcome of Equality Impact Assessment:
The relevant equality impact assessment was carried out as part of the Integrated Risk Management Framework.

Outline public engagement:
Not applicable.

Assurance departments/ organisations who will be affected have been consulted:
All sections of NHS Wakefield CCG have been consulted regarding the Risk Register.

Previously presented at committee / governing body:
Integrated Governance Committee on 19 February 2015.

Reference document(s) / enclosures:
Attached to the report are the high level risks, new risks, closed risks and never risks as at 11 February 2015.

Risk Assessment:
This is the risk assessment mechanism for NHS Wakefield CCG.

Finance/ resource implications:
None identified.
<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A clinical task list has been created to ensure that the required standards are met. The task list includes key operational targets and milestones that must be achieved within specific timeframes. This ensures that the CCG's operational performance is maintained. The task list is regularly reviewed and updated to reflect any changes or improvements.</td>
</tr>
<tr>
<td>2.</td>
<td>A work plan has been developed to ensure that the required standards are met. The work plan includes key operational targets and milestones that must be achieved within specific timeframes. This ensures that the CCG's operational performance is maintained. The work plan is regularly reviewed and updated to reflect any changes or improvements.</td>
</tr>
<tr>
<td>3.</td>
<td>The effectiveness of the task list and work plan has been reviewed and updated to reflect any changes or improvements. This ensures that the CCG's operational performance is maintained. The review and update of the task list and work plan is regularly conducted to reflect any changes or improvements.</td>
</tr>
<tr>
<td>4.</td>
<td>A work plan has been developed to ensure that the required standards are met. The work plan includes key operational targets and milestones that must be achieved within specific timeframes. This ensures that the CCG's operational performance is maintained. The work plan is regularly reviewed and updated to reflect any changes or improvements.</td>
</tr>
<tr>
<td>5.</td>
<td>The effectiveness of the task list and work plan has been reviewed and updated to reflect any changes or improvements. This ensures that the CCG's operational performance is maintained. The review and update of the task list and work plan is regularly conducted to reflect any changes or improvements.</td>
</tr>
<tr>
<td>6.</td>
<td>A work plan has been developed to ensure that the required standards are met. The work plan includes key operational targets and milestones that must be achieved within specific timeframes. This ensures that the CCG's operational performance is maintained. The work plan is regularly reviewed and updated to reflect any changes or improvements.</td>
</tr>
<tr>
<td>7.</td>
<td>The effectiveness of the task list and work plan has been reviewed and updated to reflect any changes or improvements. This ensures that the CCG's operational performance is maintained. The review and update of the task list and work plan is regularly conducted to reflect any changes or improvements.</td>
</tr>
</tbody>
</table>
Appendix C – Risk Aversion Appraisal

In January 2014, the Health and Social Care Information Centre (HSCIC) published its report on the eHealth National Programme (eHNP) and the future of the programme. The report highlighted the significant challenges faced by the programme and the need for a new approach to delivering eHNP. The report recommended that the programme should focus on delivering a limited number of key initiatives that are aligned to the national priorities and that are shown to have a measurable impact on improving patient outcomes.

The Risk Aversion Appraisal (RAA) was developed to help the programme identify and prioritize the key initiatives that should be included in the programme. The RAA is a tool that helps to identify and manage risks associated with the programme and to ensure that the programme is delivered in a safe and effective way.

The RAA is a process that is used to identify and assess the risks associated with the programme. The process involves the following steps:

1. Identification of risks: This step involves identifying the potential risks that could affect the programme. The risks are identified through a systematic process that involves the programme team, stakeholders, and risk assessment experts.

2. Assessment of risks: This step involves assessing the likelihood and impact of each risk. The assessment is based on a range of factors, including historical data, expert opinion, and stakeholder input.

3. Prioritization of risks: This step involves prioritizing the risks based on their likelihood and impact. The prioritization is used to determine the order in which the risks should be addressed.

4. Risk management: This step involves developing risk management strategies to mitigate the impact of the risks. The strategies are developed through a collaborative process that involves the programme team, stakeholders, and risk management experts.

The RAA is an iterative process that is used throughout the programme to ensure that risks are managed effectively. The process is reviewed regularly to ensure that it is aligned to the needs of the programme and that it is delivering the desired outcomes.

The RAA is an important tool that helps to ensure that the programme is delivered in a safe and effective way. It is used to identify and manage risks associated with the programme and to ensure that the programme is delivered in a way that is aligned to the national priorities and that is shown to have a measurable impact on improving patient outcomes.
NHS Wakefield CCG Risk Profile

### CCG Risk Overview

- **Key**
  - New Risk
  - Risk Score Increasing
  - Risk Score Decreasing
  - Risk Marked for Closure

### Score Risk Level

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Low risk</td>
</tr>
<tr>
<td>4-6</td>
<td>Moderate risk</td>
</tr>
<tr>
<td>8-12</td>
<td>High risk</td>
</tr>
<tr>
<td>15-16</td>
<td>Serious risk</td>
</tr>
<tr>
<td>20-25</td>
<td>Critical risk</td>
</tr>
</tbody>
</table>

### Movement of Risks

<table>
<thead>
<tr>
<th>Movement</th>
<th>Risk Score Increasing</th>
<th>Risk Score Decreasing</th>
<th>Risk Score Static</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>8</td>
<td>9</td>
<td>29</td>
</tr>
<tr>
<td>Closed</td>
<td>9</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

### Open Risks

- Graph showing the movement of open risks from May 14 to Feb 15.
<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>10 March 2015</td>
</tr>
<tr>
<td>Paper Title:</td>
<td>Audit Committee: presentation of minutes and items for approval by Governing Body</td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision ✓ Discussion Assurance Information</td>
</tr>
<tr>
<td>Committee chair:</td>
<td>Sandra Chesidine – Lay Member</td>
</tr>
<tr>
<td>Meeting minutes enclosed:</td>
<td>16 December 2014</td>
</tr>
</tbody>
</table>

**Recommendation:**

It is recommended that the Governing Body receive and note the minutes of the Audit Committee held on 16 December 2014.

**Executive Summary:**

**16 December 2014**

- In line with good practice and recommendations in the NHS Audit Committee Handbook an **Audit Committee Assessment Part 1 : Review of Committee Processes** was undertaken and the findings were shared with the Audit Committee.
- **CCG Declaration of Interest** as at 1 October 2014 were shared for information including the declared interests of the Clinical Network Chairs and Clinical Leads.
- **CCG Assurance Framework** was presented following approval by the Integrated Governance Committee on 21 August and Governing Body on 9 September 2014.
- The regular **Governance Exceptions Report** was presented.
- A report on the **GP Remuneration/Greenbury accounting update** was presented noting that following updated advice from HR, the CCG reviewed its position with regard to GP remuneration to clarify tax, NI and superannuation arrangements. Baker Tilly are to undertake a backdated review to ascertain whether tax and NI has been paid correctly to HMRC. Discussions will continue and an update will be provided at the February 2015 Audit Committee meeting.
- **Losses and Special Payments** update was presented noting there have been no losses or special payments since the Audit Committee meeting held on 25 September 2014.
- **2014/15 Accounts Planning Update** presented confirming that the final Manual for Accounts was published during December 2014. A proposed high level timetable for the year end process was shared for information.
- **Continuing Health Care Provision** update was presented noting that NHS England have requested that CCGs complete a monthly monitoring return to estimate the potential restitution claims pending, paid and subsequent balance against the provision. The CCG Finance Team are working closely with the Continuing Healthcare Team to review the level of provision to include in the month 9 return to NHS England.
- **A Legacy Balances** paper was presented noting that NHS England had issued guidance that all CCGs have to clear the X25 legacy ledger balances as part of the accounts planning process by 31 December 2014.
- **A Policy Update** paper detailing the current position regarding CCG policies and procedures was presented.
- **KPMG Statutory Functions** paper presented advising an action plan has been developed following the KPMG review of arrangements the CCG has in place to discharge its statutory functions to address a small number of areas which require some further work.
- A verbal update was given on the **Transfer Scheme** and a written report will be presented at the February Audit Committee.
- **Contract Award** update presented noting there were no health care contracts awarded during the period
September to November 2014. One non-healthcare contract was awarded to Capsticks and United Health Solutions for the PMS contract review.

- **CHKS – MYHT Waiting List** – following the system resilience review undertaken by CHKS information at MYHT is now available. Findings have been superceded due to actions taken during or after the audit period. A further audit will be undertaken.

- **Internal Audit and Counter Fraud Progress Report** was presented. A workshop will be developed in respect of the governance arrangements for the Better Care Fund, representatives from the CCG and Local Authority will be in attendance.

- **External Audit Technical** update was presented advising that planning guidance for 2015/16 is due to be published on 24 December 2014. The Mandate will be broadly stable for 2015/16, the only additional major requirement will relate to mental health access.
Welcome and Chair’s opening remarks

Sandra Cheseldine shared copies of part two of the NHS Audit Committee Handbook - Audit Committee Effectiveness Checklist and asked members to add their comments and feedback on the paper copy and pass back to Sandra or Katherine at the end of the meeting. The comments and feedback will help inform the second part of the assessment process.

Apologies for absence

Apologies for absence were received from Dr Adam Sheppard, Linda Wild, Clare Partridge, Karen Parkin and Eamonn May.

Minutes of the meeting held on 18 September 2014

The minutes of the meeting held on the 18 September 2014 were approved as an accurate record.

Action Sheet from the meeting held on 18 September 2014

14/78 Capital Expenditure

Andrew Pepper confirmed that discussions had taken place with KPMG and it was agreed that this was not an issue for the CCG as procurement is processed by the Yorkshire and Humber Commissioning Support.
14/81 HMRC VAT compliance visit

This action was noted as completed. Matthew Moore agreed to follow up with KPMG colleagues to confirm that the issue was now closed.

14/102 Declarations of interest

Sandra Cheseldine invited the meeting to declare any conflicts of interest.

Dr Clive Harries declared an interest in item 14/107.

14/103 Audit Committee Assessment Part 1: Review of Committee Processes

Sarah Dick attended the meeting to present this paper explaining that in line with good practice and recommendations in the NHS Audit Committee Handbook, periodic evaluation of the Audit Committee’s processes and effectiveness should be undertaken. The Committee considered the findings and suggestions arising from this assessment and their comments were noted.

Four questions were posed as part of the paper and the following answers were agreed:

1. Are committee papers distributed in sufficient time for members to give them due consideration? – YES
2. Is the committee confident that the audit plan is derived from a clear risk assessment process that links closely to the assurance framework? – YES, Board Assurance Framework three year audit plan
3. Is the committee confident that internal audit is free of any scope restrictions and, if not, has it considered the impact of these on the annual Head of Internal Audit opinion? – YES, Internal Audit is free of any restrictions.
4. Is the committee confident that internal audit is free from any operational responsibilities or conflicts of interest that could impair its objectivity? – YES, the committee are not aware of any conflicts of interest.

It was RESOLVED that:

i) The Committee noted the report.

14/104 NHS Wakefield CCG Declarations of Interest

Adam Bassett attended the meeting and presented the formal record of declared interests for members of the NHS Wakefield CCG Governing Body and its Committees as at 1 October 2014. In line with constitutional requirements, this information will be published on the NHS Wakefield CCG website. It was noted that the report also outlines the declared interests of the NHS Wakefield CCG Clinical Network Chairs and the Clinical Leads.
It was RESOLVED that:

i) The Committee noted the declared interests of members of the NHS Wakefield CCG Governing Body and its Committees as at 1 October 2014.

14/105 Board Assurance Framework

Adam Bassett presented this paper and advised that following the update to the NHS Wakefield CCG Strategic Plan, the NHS Wakefield CCG Assurance Framework has been refreshed for 2014/15. The document has been reviewed and approved by the Integrated Governance Committee on 21 August 2014 and the Governing Body on 9 September 2014.

A discussion took place and the following comments and suggestions were made:

- Include explanation regarding the reason for the appetite score;
- Concern that risks are not actively owned and it was felt that the document needs to be a live document;
- Acknowledged that it would be helpful if clinician and CCG lead manager meet together to discuss the risks;
- Consider timeline of risks and whether this should be a longer timeframe; and
- Review controls and external assurance to ensure correctly reflected.

It was noted that Internal Audit will review the Assurance Framework in early 2015, suggestions will be made to improve the format and content of the document.

Sandra Cheseldine acknowledged the document but noted that there were still improvements to make.

It was RESOLVED that:

i) the Committee noted the Assurance Framework.

14/106 Governance Exceptions Report

Katherine Bryant presented this report detailing the governance control exceptions as follows:

- four declarations under the CCG’s Standards of Business Conduct relating to hospitality;
- one Rebate Scheme approval;
- CCG’s seal has not been used to execute any documents;
- there have been no suspensions of Standing Orders; and
- one tender waiver has been approved for Improving Access to Psychological Therapies.

Katherine confirmed that she has been working closely with the Medicines Optimisation team and the Network Development Unit to promote the new Standards of Business Conduct and Receipt of Hospitality Policy and the Joint Working and Sponsorship Policy to CCG staff.
With regard to the IAPT tender waiver the early completion of this twelve month tender waiver was questioned. Dr Clive Harries confirmed that the review to re-design the service would take some considerable time hence the twelve month tender waiver.

It was RESOLVED that:

i) the Committee noted the report.

14/107  GP Remuneration/Greenbury accounting update

Andrew Pepper presented this report advising that following update advice from HR, the CCG reviewed its position with regard to GP remuneration to clarify tax, NI and superannuation arrangements via the Remuneration Committee. It was noted that the CCG have engaged Baker Tilly to undertake a backdated review to ascertain whether tax and NI has been paid correctly to HMRC.

The Committee were informed that HR are currently liaising with payroll to accurately calculate and transact pension contributions. This will then make the NHS pension information accurate. The NHS Business Services Authority (NHSBSA) has recently issued Greenbury guidance in preparation for year-end accounts. CCGs must file a request for information to NHSBSA between 2 January and 16 January 2015.

Andrew highlighted that the disclosure arrangements may be different in 2014/15 compared to 2013/14, therefore the CCG will need to work closely with GPs to ensure that the process is clear. Due to the earlier Greenbury deadline, practice managers and accountants will be asked to work in partnership with the CCG to provide relevant information should the information from the NHSBSA not be available in a timely manner.

A discussion followed and it was acknowledged that this is a complex issue. Discussions will continue and an update will be provided at the Audit Committee meeting in February 2015.

It was RESOLVED that:

i) the Committee noted the content of the report.

14/108  Losses and Special Payments Update

Andrew Pepper presented this update confirming that there have been no losses or special payments since the Audit Committee meeting held on 25 September 2014.

It was RESOLVED that:

i) the Committee noted the report.

14/109  2014/15 Accounts Planning Update

Andrew Pepper presented this paper confirming that the draft Manual for Accounts (MfA) was published during November 2014 and the final document was published in
early December. It was noted that there will be no separate CCG guidance this year, instead additional CCG guidance will be provided for in an Annex to the MfA. The paper described key risks at a national level.

An appendix to the paper detailed the proposed high level timetable for the year end process.

It was RESOLVED that:

i) the Committee noted the processes outlined and approved the proposals outlined in the paper.

14/110 Continuing Health Care Provision Update

Andrew Pepper presented this paper explaining that NHS England undertake a review of legacy provisions in preparation for year-end accounts and have requested that CCG’s complete a monthly monitoring return to estimate the potential restitution claims pending, paid and the subsequent balance against the provision.

Andrew informed the Committee that due to the lower number of cases reported via the Continuing Healthcare team and the lower average cost per case, Wakefield CCG could now consider a reduction in the provision. After discussion, it was felt that in principle a fair and reasonable approach would be to reduce the level of provision in consideration of more current information.

It was noted that the CCG Finance Team are working closely with the Continuing Healthcare Team to review the level of provision to include in the month 9 return to NHS England.

It was RESOLVED that:

i) the Committee noted the report and supported the processes outlined.

14/111 Legacy Balances

Andrew Pepper presented this paper advising that NHS England had issued guidance that all CCGs have to clear the X25 legacy ledger balances as part of the accounts planning process by 31 December 2014.

It was noted that there are four legacy Primary Care Trust invoices left on the X25 Ledger system.

Sandra Cheseldine queried the progress with regard to the legacy credit note. It was agreed that a position statement will be presented at the February 2015 Audit Committee meeting.

It was RESOLVED that:

i) the Committee noted the content of the report.

14/112 Policy Update
Katherine Bryant presented this paper detailing the current position regarding CCG policies and procedures and outlines the process for their regular review. Katherine reported that the current position regarding policy review is much improved since the update provided at the September Audit Committee meeting.

Although the Audit Committee do not have a role in approving policies, the paper provides assurance that the organisation has a robust management and review process in place for policies.

The next policy update will be presented to the Audit Committee in September 2015.

It was RESOLVED that:

i) the Committee noted the policy update and agreed that an update will be provided in September 2015.

14/113 KPMG Statutory Functions

Katherine Bryant presented this paper, advising that following the KPMG review of arrangements the CCG has in place to discharge its statutory functions, an action plan has been developed to address a small number of areas which require some further work.

Katherine advised that there are two outstanding actions:

1. Map all groups and committees of the organisation to provide assurance on the decision making process
2. Agree process to monitor the payment of invoices for medical examinations before application for admission to hospital under the Mental Health Act. A response is awaited from Wakefield Council regarding this action.

It was RESOLVED that:

i) the Committee noted the progress to implement the action plan; and
ii) agreed that a further update should be provided in April 2015.

14/114 Transfer Scheme

Katherine Bryant gave a verbal update advising that following the CCG not previously agreeing the Revised Modification Scheme in respect of transfer of assets from the Primary Care Trust to the CCG, it has been noted that following legal advice there does not appear to be any material risk to the CCG in relation to adopting this approach.

Katherine advised that a written report on the Transfer Scheme will be presented at the February Audit Committee meeting to provide further clarity on the issue.

It was RESOLVED that:

i) the Committee noted the verbal update.
14/115  **Contract Award Update**

Matt England attended the meeting to present this paper detailing the contracts awarded in the period from September to November 2014. It was noted that there were no health care contracts awarded during this period. One non health care contract was awarded to Capsticks and United Health Solutions for the PMS contract review.

It was **RESOLVED** that:

i) the Committee noted the update.

14/116  **CHKS – MYHT Waiting List**

Matt England gave a verbal update advising that the final draft document following the systems resilience review undertaken by CHKS in respect of waiting list information at Mid Yorkshire Hospitals NHS Trust is now available. MYHT have raised a number of comments regarding the data and have advised that the findings are superceded due to actions taken during or after the audit period.

Andrew Pepper advised that a further audit will be undertaken.

Sandra Cheseldine commented that a further check of the data and an update to a future Audit Committee would be helpful.

It was **RESOLVED** that:

i) the Committee noted the verbal update.

14/117  **Internal Audit and Counter Fraud Progress Report**

Michelle Marsden presented this report advising that two final reports have been issued in respect of W02/2015 - Better Care Fund and W03/2015 - CSU Assurance. Internal Audit Opinion was not applicable in respect of the Better Care Fund and the CSU Assurance achieved a Significant Assurance.

Michelle advised that following a meeting with the Better Care Fund and Integration Lead on 1 December, a workshop will be developed for both the CCG and Local Authority representatives regarding the governance arrangements that are in place, it is intended this will take place in January 2015.

A discussion followed regarding the Better Care Fund acknowledging that as a joint agreement between the CCG and the Local Authority a robust Section 75 agreement will need to be put in place to ensure the correct processes are followed.

It was noted that Internal Audit continue to work with the Yorkshire and Humber Commissioning Support to improve the format and content of the Assurance Framework. Following discussion it was suggested that a one page summary document is developed to support the Assurance Framework.
It was **RESOLVED** that:

i) the Committee noted the report.

14/118 **External Audit Technical Update**

Matthew Moore presented this report advising that following the KPMG Healthcare Audit Committee Institute Seminar held on 21 November there will be a further event in January 2015 to be held in Manchester.

Matthew informed members that planning guidance for 2015/16 is due to be published on 24 December 2014. The Mandate will be broadly stable for 2015/16, the only additional major requirement will relate to mental health access.

It was noted that NHS England has published its year-end summaries of authorisation and assurance for CCGs in England up to the end of March 2014. The figures demonstrate the significant progress that CCGs have made since being established and their continued commitment to fulfilling their commissioning role and improving health outcomes for their local communities.

It was **RESOLVED** that:

i) the Committee noted the report

14/119 **Any other business**

No other business was discussed.

14/120 **Date and time of next meeting**

Thursday, 26 February 2015, 1.00 to 3.00 pm, Boardroom, White Rose House.
Title of meeting: Governing Body

Date of Meeting: 10 March 2015

Paper Title: Integrated Governance Committee: presentation of minutes and items for approval by Governing Body

Purpose (this paper is for): 
- Decision ✓
- Discussion
- Assurance
- Information

Committee chair: Rhod Mitchell – Lay Member

Meeting minutes enclosed: 18 December 2014 and 20 January 2015

Recommendation:

It is recommended that the Governing Body receive and note the minutes of the Integrated Governance Committee held on 18 December 2014 and 20 January 2015.

Executive Summary:

18 December 2014

- **Integrated Quality and Performance** report presented highlighting:
  - Mid Yorkshire Hospitals NHS Trust (MYHT) achieved all CQUIN indicators in quarter two;
  - MYHT harm free care performance dipped in September, however all local acute providers are failing to achieve the 95% target;
  - the remaining GP Care Quality Commission reports have now been published;
  - in quarter two of 2014/15 South West Yorkshire Partnership Foundation Trust has achieved 100% against the target to improve timeliness of access to the Child and Adult Mental Health Services;
  - Care Quality Commission will be undertaking an inspection of Yorkshire Ambulance Service in January 2015;
  - it was noted that there is still pressure for MYHT to meet the December standard regarding Referral to Treatment activity.

- **Continuing Health Care Policy on the Commissioning of Care Provision and Adult Personal Health Budget Policy** were approved.

- **Continuing Health Care Quarterly Report** presented providing details of overdue reviews. Details of a re-structure of the Continuing Health Care team will shortly be shared with the CCG. The Continuing Health Care team are working with the CCG and MYHT to look at re-designing the MYHT discharge to assess process over the winter period and consider how the patient referral process can be improved.

- **Security Policy** approved.

- **Month 8 Finance Report** presented highlighting;
  - MYHT is showing an estimated £694k under trade relating to the reduced activity and penalties at quarter 1;
  - activity at Leeds Teaching Hospitals NHS Trust has increased therefore spend has also increased;
  - the number of Children’s Complex Care packages is increasing;
  - Key focus area this month is Continuing Health Care and Personalisation;
  - MYHT increased activity is putting the system and finances under pressure, in particular regarding Referral to Treatment targets.

- **Information Governance quarterly update** presented noting the IG Toolkit version 12 released in June 2014 remains unchanged at 28 requirements and will be submitted at the end of January 2015. Following minor changes, the revised CCG’s Fair Processing Notice has been added to the intranet. Of the 42 information assets documented on the information asset register none were identified as being critical assets. Internal
Audit will be conducting an audit on information governance in January 2015.

- **Freedom of Information update** presented noting no exemptions were applied to any FOI requests received in September, October and November 2014. Awaiting final sign off of the Publication Scheme.

- SIRO/Caldicott Guardian update presented noting there are four open requests.

- The following **Information Governance** policies were approved;
  - Access to Records;
  - Confidentiality and DPA, Privacy Impact Assessment Procedure;
  - IG Policy and Framework;
  - Information Security;
  - Network Security;
  - Records Management;
  - Safe Haven Guidelines and Procedure;
  - Information Governance Strategy and Strategic Vision.

- Regular **Contract Governance and Assurance** report presented highlighting one contract variation agreed, new service specification has been developed for Non Urgent General Gastroenterology Service and the Star Bereavement contract will expire at the end of March 2015.

- **Procurement Policy** was approved with a review date of one year.

- Verbal update on **Yorkshire and Humber Commissioning Support** noting a decision on what services need to be reviewed to implement change from 1 April 2015 is to take place.

- Regular **Workforce Update** report presented noting a new process has been implemented for recording and recording sickness absence to improve the management of sickness absence.

- The following **Workforce Policies** were approved;
  - Annual Leave and General Public Bank Holidays;
  - Disciplinary;
  - Grievance;
  - Recognition Agreement;
  - Special Leave;
  - Whistleblowing;
  - Pay Progression.

20 January 2015

- **Integrated Quality and Performance** report presented highlighting:
  - A&E performance at MYHT has met the required standard for November and the year to date position;
  - Yorkshire Ambulance Service Cat A(Red 1) and Cat A(Red2) 8 minute response times have failed to meet the operational standard for year to date;
  - CCG and MYHT met the monthly Referral to Treatment – incomplete pathway performance for the third consecutive month
  - MYHT achieved encouraging results in the National A&E Patient Survey
  - Following unprecedented demand in December MYHT made a decision to open additional beds at Dewsbury and Pinderfields. The decision to open additional capacity placed a number of wards in the position that they have been unable to staff at the recommended 1:8 ratio.
  - As part of the Dementia Strategy there is an aim to improve the dementia diagnosis rates and the December target has been achieved by GP practices

- **Finance Report Month 9** presented highlighting:
  - Surplus position has increased due to the CCG element of the returned national underspend on the Continuing Health Care restitution claims risk pool as required by NHS England;
  - Change to the prescribing position resulted in an overspend which is a shift from a small undertrade last Month;
  - Key focus area is on Agreement of Balances and Annual Accounts presentation;
  - The Co-commissioning bid has been approved subject to minor amendments.

- Approved in principle for the existing provider of the **Community Specialist Contact Lens Service** to continue to provide the service.

- Approved the commencement of an **Any Qualified Provider** accreditation process for the provision of
Community Low Vision Aids Service.

- Draft Public Sector Equality Duty report approved for publishing deadline of 31 January 2015.
- Verbal update provided on Intellectual Property Policy advising that there are national changes in relation to the research governance framework and the policy will be revised to incorporate any changes when the changes are known.
Agenda item: 20b (i)

NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 18 December 2014

Present:  
Rhod Mitchell (Chair) Lay Member  
Stephen Hardy Lay Member  
Dr Phillip Earnshaw Nominated Clinical Member  
Dr David Brown Nominated Clinical Member  
Andrew Pepper Chief Finance Officer  
Jo Pollard Chief of Service Delivery and Quality  
Sharon Fox Governing Body Nurse

In Attendance:  
Sandra Cheseldine Lay Member  
Karen Parkin Associate Director of Finance, Governance and Contracting  
Katherine Bryant Governance and Board Secretary  
Matt England Head of Contracting and Commercial Strategy (14/331)  
Laura Elliott Head of Quality and Engagement (14/331)  
Toni Smith Quality Manager (14/332, 14,333)  
Alison Hall Deputy Lead Nurse for CHC – YHCS (14/334)  
Sam Byrnes Senior Associate Information Governance – YHCS (14/337)  
David Warsop Deputy Head of Procurement – YHCS (14/342)  
Esther Short HR Manager – YHCS (14/344 & 14/345)  
Angela Peatfield Minute taker

14/326 Apologies for Absence  
Apologies for absence were received from Jo Webster and Dr Avijit Biswas.

14/327 Declarations of Interest  
No declarations of interest were declared.

14/328 Minutes of the Meeting held on 20 November 2014  
The minutes of the meeting held on 20 November 2014 were approved as an accurate record.

14/329 Action Sheet from the Meeting held on 20 November 2014
14/310 – Urgent Transport Procurement

Andrew Pepper advised that discussions continue and the Audit Committee Chair will be briefed on the current position.

14/330 Matters Arising

There were no matters arising.

14/331 Integrated Quality and Performance Report

Matt England and Laura Elliott attended the meeting to present this report providing an update against the CCG strategic objectives, quality premium and details key exceptions and successes.

Laura and Matt highlighted the following:

- Mid Yorkshire Hospitals NHS Trust achieved all CQUIN indicators in quarter two;
- MYHT harm free care performance dipped in September, however all local acute providers are failing to achieve the 95% target;
- Following a Care Home inspection on 18 and 25 September 2014 by the Care Quality Commission, actions have been identified and the Local Authority and the CCG held a quality assurance meeting on 27 October 2014 at which the Care Home evidenced a number of improvements. A further meeting is scheduled.

A discussion took place and the following issues were raised:

- Dr David Brown queried why the report included some Cancer Wait targets not achieved when the report presented at the MYHT Executive Quality Board meeting showed all targets achieved. Matt England explained there are two reasons. Firstly, where there is a joint pathway with Leeds Teaching Hospitals NHS Trust the breach is split half and half between the two Trusts. Secondly, MYHT have a quarterly target, therefore targets move monthly between red and green but as MYHT are contracted to deliver quarterly the target is achieved based on quarterly performance;
- Dr Phil Earnshaw advised that the remaining GP Care Quality Commission reports have now been published. Laura agreed to update the report to include this information before it is presented to the Public Governing Body meeting on 13 January 2015;
- It was noted that in 2014/15 quarter two South West Yorkshire Partnership Foundation Trust have achieved 100% against the target to improve timeliness of access to the Child and Adult Mental Health Services;
- Stephen Hardy referred to the MYHT report presented to the Quality Intelligence Group in October 2014 advising of at least an eight week wait for urgent gastroenterology and queried whether this had been fed back to
GP practices? It was acknowledged that for those practices using the Choose and Book system they will be aware and details were also included through the Network Briefings.

- Rhod Mitchell asked what the CCG can do to support the Yorkshire Ambulance Service. Matt England advised that Jo Webster, Chief Officer is in daily discussions with YAS regarding the current pressure. Dr Phil Earnshaw queried what additional requirements are involved as YAS Lead Commissioner. Phil suggested that a paper detailing the governance arrangements for YAS and the CCG responsibilities as Lead Commissioner is presented at the Public Governing Body meeting in March 2015. Andrew Pepper referred to the Good Governance report and how this proposes commissioner collaborative working, it was agreed that this report would be shared at the Integrated Governance Committee in due course. Laura Elliott advised that the Care Quality Commission will be undertaking at inspection at YAS in January 2015.

- Matt confirmed that there is still pressure for MYHT to meet the December standard regarding Referral to Treatment activity. Andrew Pepper advised that MYHT are preparing to transfer patients to the independent sector to assist in meeting the standard and this has an impact on targets although it was acknowledged that this was right for patients.

- Rhod Mitchell raised the issue regarding the number of pressure ulcers identified during the recent CQC inspection at MYHT. Laura confirmed that as part of the Serious Incident guidance category 3 and 4 pressure ulcers are reported through the incident reporting system. It was noted that the initiative to reduce the number of pressure ulcers is included in the CQC action plan and will also be tracked through CQUIN targets.

It was RESOLVED that:

i) the Committee noted the current performance against the CCG strategic objectives and Quality Premium;

ii) approve the actions being taken to address areas of poor performance.

14/332 Continuing Health Care Policy on the Commissioning of Care Provision

Toni Smith attended the meeting to present this paper advising that the policy was reviewed by the Integrated Governance Committee Policy Working Group on 9 December 2014 and recommended to the Integrated Governance Committee for approval.

The policy details the legal requirements and CCG responsibilities in commissioning Continuing Healthcare which meets the individual’s assessed needs. It has been developed to assist the CCG to meet its responsibilities under the sources of guidance listed within the policy.
It was **RESOLVED** that:

i) the Committee approved the Continuing Health Care Policy on the Commissioning of Care Provision.

### 14/333 Adult Personal Health Budget Policy

Toni Smith attended the meeting to present this paper advising that the policy was reviewed by the Integrated Governance Committee Policy Working Group on 9 December 2014 and recommended to the Integrated Governance Committee for approval.

Toni explained that the ‘right to ask’ for a Personal Health Budget has been in place since April 2014, with the ‘right to have’ from October 2014. NHS Wakefield CCG has commissioned Yorkshire and Humber Commissioning Support to undertake the function on its behalf, however retains the statutory responsibility for delivery.

This policy identifies the CCG responsibilities for this delivery, including the expectations of the provider organisation, and describes the required clinical, financial and organisational governance structures in place to mitigate against risk.

It was **RESOLVED** that:

i) the Committee approved the Adult Personal Health Budget Policy.

### 14/334 Continuing Health Care Quarterly Report

Alison Hall attended the meeting to present this report which includes details of key areas of work, including new responsibilities; patient reviews including the percentage overdue and the work to be undertaken to address this and the Quality Assessment Tool. Appendix 1 provides details of overdue reviews as requested at a previous Integrated Governance Committee meeting.

Alison advised that the work to develop a new staffing structure has now been completed and communication with staff about the service re-design will commence this month. Details of the re-structure will be shared with the CCG over the next few weeks.

Alison advised that the Continuing Care Team are working with the CCG and Mid Yorkshire Hospital Trust to look at re-designing the MYHT discharge to assess process over the Winter period and consider how the patient referral process can be improved.

A discussion followed and the issue of delayed assessments by South West Yorkshire Partnership Foundation Trust was raised. Jo Pollard agreed to
investigate this matter with SWYPFT and an update will be provided to the Integrated Governance Committee.

It was RESOLVED that:

i) the Committee noted the content of the report.

14/335 Security Policy

Katherine Bryant presented this policy advising that the policy was reviewed by the Integrated Governance Committee Policy Working Group on 9 December 2014 and recommended to the Integrated Governance Committee for approval.

It was RESOLVED that:

i) the Committee approved the Security Policy.

14/336 Finance Report Month 8

Karen Parkin presented this report noting that the CCG has a year to date surplus of £4,337k and forecast year end position is in line with plan at £6,505k. All key performance targets are green with the exception of QIPP delivery and activity trends.

Karen highlighted the following from the report:

- Mid Yorkshire Hospitals NHS Trust at month 8 is showing estimated £694k under trade, this relates to the reduced activity and penalties at quarter 1.
- Activity at Leeds Teaching Hospitals NHS Trust (LTHT) has increased, therefore spend has also increased. The main areas of overtrade are Critical Care, Maternity pathway, Radiology and Rheumatology, these are under review by the lead commissioners and Wakefield CCG are being kept informed.
- The number of Children’s Complex Care packages is increasing. A project is being completed to review the Complex Care governance process to ensure that costs are allocated across the Health Economy on an appropriate basis.

The key focus area this month is Continuing Health Care and Personalisation, noting that due to legislative change in April 2014, patients now have more choice and control over the care they receive and how the care is delivered. The choice to move to a Personal Health Budget will provide intelligence for the CCG for future commissioning considerations.

Discussion followed and Andrew Pepper noted that increased activity at MYHT is putting the system and finances under pressure, in particular with regard to Referral to Treatment targets, and this can result in risks in the system. Sandra
Cheseldine raised concerns regarding the QIPP position, requesting that it would be helpful to have further detail including numbers and a timeline with regard to QIPP. Andrew Pepper agreed to discuss further with Pat Keane, Interim Director Strategic Projects and it was noted that discussions will also take place at Clinical Cabinet.

Dr David Brown queried whether the additional Referral to Treatment monies would be repaid. Andrew Pepper responded advising that NHS England (NHSE) had written to CCGs in October to suspend penalties at that point until performance was recovered from 1 December 2014.

Sharon Fox commented that some Trusts in financial challenge had received additional funding and queried whether MYHT had received additional funding. It was confirmed that MYHT had received non-recurrent monies from NHS Trust Development Agency but that this did not change the underlying position.

It was RESOLVED that:

i) the Committee noted the content of the report.

14/337  Information Governance Quarterly Update

Sam Byrnes attended the meeting to present this paper detailing the activities undertaken since the report in October 2014. It was noted that the IG Toolkit Version 12 which was released in June 2014 remains unchanged at 28 requirements and will be submitted at the end of January 2015.

Sam advised that some minor changes to the CCG’s Fair Processing Notice have been made and the revised version is attached as Appendix K and also available on the intranet.

Appendix L of the report provides a summary report on Information Assets noting that a total of 42 information assets were documented on the information asset register. None of the information assets were identified as being critical assets.

The Information Asset Risk Management Plan and Work Package for 2014/15 are detailed in Appendix M.

Sandra Cheseldine commented that Internal Audit will be conducting an audit on information governance and Katherine Bryant confirmed that the audit will take place in January 2015.

It was RESOLVED that:

i) the Committee noted the Information Governance update;

ii) approved the updated Fair Processing Notice;
iii) approved the Information Asset Register Report 2014/15; and

14/338 Freedom of Information Update

Katherine Bryant presented this update providing details of the FOI requests received from April to November 2014 broken down by type of organisation who requested the information and the CCG teams who responded. It was noted that responses to all requests had been provided within the statutory deadline of 20 days and no exemptions were applied to any Freedom of Information requests for the months September, October and November 2014.

Following final sign off of the Publication Scheme in the New Year it is anticipated that this may reduce the number of Freedom of Information requests.

It was RESOLVED that:

i) the Committee noted the CCG’s compliance against the statutory deadline for responses to FOI requests.

14/339 SIRO/Caldicott Guardian Update

Katherine Bryant presented this regular report offering assurance that appropriate systems and processes are in place regarding Caldicott Guardian / Senior Information Risk Owner requests. It was noted that there are currently four open requests and details are included in the paper.

It was RESOLVED that:

i) the Committee noted the report.

14/340 Information Governance Policies

Katherine Bryant presented the Information Governance policies advising that the policies were reviewed by the Integrated Governance Committee Policy Working Group on 9 December 2014 and recommended to the Integrated Governance Committee for approval.

It was RESOLVED that:

i) the Committee approved the following Information Governance policies:
   (a) Access to Records
   (b) Confidentiality and DPA
   (c) Privacy Impact Assessment Procedure
   (d) IG Policy and Framework
(e) Information Security  
(f) Network Security  
(g) Records Management  
(h) Safe Haven Guidelines and Procedure  
(i) Information Governance Strategy and Strategic Vision

14/341  Contract Governance and Assurance

Matt England presented this update providing details of contracts awarded, varied and notices served.

Matt highlighted that during October and November there has been one contract variation agreed between Phoenix Health Solutions and The Grange Surgery. A new service specification has been developed with a revised pricing structure for the Non Urgent General Gastroenterology Service.

Matt advised that the Star Bereavement Contract will expire at the end of March 2015 and a paper will be presented to Clinical Cabinet for a decision regarding the future of the service.

Details of the draft Public Contracts Regulations 2015 were shared for information advising that the distinction between Part A and Part B services has been removed. All service contracts which exceed the threshold must adhere to the full procurement regime unless they are listed in Schedule 3. This list contains many of the services that are currently categorised as Part B services including health, social care and education services. Schedule 3 contracts must be awarded in compliance with a “light touch regime” which is for member states to determine, where they exceed a new threshold of EUR 750,000.

The EU rules for Part B healthcare services will be replaced by a new “light touch Regime” in April 2016. The CCG’s current Procurement Policy will therefore continue to reflect the applicable regulations until that time. It should be noted that the Schedule 3 rules will be implemented following the General Election in the UK and therefore there is the potential for further changes to the way NHS Healthcare Procurement will be handled.

It was RESOLVED that:

i) the Committee noted the Contract Governance and Assurance update.

14/342  Procurement Policy

David Warsop presented this policy advising that the policy was reviewed by the Integrated Governance Committee Policy Working Group on 9 December 2014 and recommended to the Integrated Governance Committee for approval.
David explained that this document has been updated to reflect changes in legislation and guidance. The review date for this policy is one year to enable the provisions of the new ‘light touch’ procurement regime for healthcare procurement due to come into force in March 2016 is reflected in the CCG’s policy at its inception.

It was RESOLVED that:

i) the Committee approved the Procurement Policy.

14/343 Yorkshire and Humber Commissioning Support

Andrew Pepper gave a verbal update on the review of the contract with Yorkshire and Humber Commissioning Support. Andrew acknowledged that some of the services were being delivered successfully, however it was felt that some of the services provided were not offering the same value for money. A decision on what services need to be reviewed to implement change from 1 April 2015 is to take place.

A discussion followed and it was agreed that the following services should be considered for review:

- Provider Management
- Communications
- Governance
- IT – noting there are two components, IT support provided by THIS and the IT strategic overview.
- Invoice validation
- Transformation

Andrew advised that a letter will be sent to YHCS in the New Year to advise them of this review.

It was RESOLVED that:

i) the Committee noted the verbal update.
**Workforce Update Report**

Esther Short presented this report in its new format providing workforce information and intelligence together with key workforce headlines.

A discussion followed regarding sickness reporting and Esther advised that there are plans to hold health and wellbeing at work events in January 2015 and these are currently being developed in partnership with the Staff Forum. A staff benefits leaflet is also to be included on the intranet.

New processes for reporting and recording sickness absence in the HR and Payroll system were implemented on 1 November 2014. This has enabled the HR team to proactively manage sickness absence and arrange formal sickness review meetings in a timely manner.

It was **RESOLVED** that:

i) the Committee noted the Workforce Update Report.

**Workforce Policies**

Esther Short presented these policies advising that the policies were reviewed by the Integrated Governance Committee Policy Working Group on 25 November 2014 and recommended to the Integrated Governance Committee for approval subject to some minor amendment detailed in the covering paper.

It was noted that the revisions to the policies reflect best practice, employment legislation and have been discussed and approved by staff side representatives.

It was **RESOLVED** that:

i) the Committee approve the following Workforce Policies:
   (a) Annual Leave and General Public Bank Holidays
   (b) Disciplinary
   (c) Grievance
   (d) Recognition Agreement
   (e) Special Leave
   (f) Whistleblowing
   (g) Pay Progression

**Minutes of meetings**

The minutes of the following meetings were shared for information:

(i) Mid Yorkshire Hospitals NHS Trust Executive Contract Board – minutes of meeting held on 18 September 2014
(ii) South West Yorkshire Partnership Foundation Trust Partnership Board –
Minutes of meeting held on 18 September 2014
(iii) South West Yorkshire Partnership Foundation Trust Quality Board – minutes of meeting held on 27 October 2014
(iv) NHS111 West Yorkshire Clinical Quality Group – minutes of meeting held On 14 October 2014
(v) Quality Intelligence Group – minutes of meeting held on 14 October 2014

14/347 Consider future topics for Deep Dive

The following topics were suggested:

- Outpatient Department (following winter period)
- Children’s Services

14/348 Any other business

No other business discussed.

14/349 Date and time of next meeting:

Tuesday, 20 January 2015, 3.30 to 5.00 pm in the Boardroom, White Rose House.
NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 20 January 2015

Present: Rhod Mitchell (Chair) Lay Member
Stephen Hardy Lay Member
Dr Phillip Earnshaw Nominated Clinical Member
Dr David Brown Nominated Clinical Member
Jo Webster Chief Officer
Andrew Pepper Chief Finance Officer
Jo Pollard Chief of Service Delivery and Quality
Sharon Fox Governing Body Nurse

In Attendance: Sandra Cheseldine Lay Member
Karen Parkin Associate Director of Finance, Governance and Contracting
Matt England Head of Contracting and Commercial Strategy (item 15/06)
Laura Elliott Head of Quality and Engagement (items 15/06 & 15/09)
Jamie Marsh Planning and Performance Manager (item 15/06)
Simon Rowe Senior Commissioning Manager (item 15/08)
Granville Thirwell Interim Equality and Diversity Manager – YHCS (item 15/09)
Stella Johnson Research – YHCS (item 15/10)
Angela Peatfield Minute taker

15/01 Apologies for Absence

Apologies for absence were received from Dr Avijit Biswas and Katherine Bryant.

15/02 Declarations of Interest

No declarations of interest were declared.

15/03 Minutes of the Meeting held on 18 December 2014

The minutes of the meeting held on 18 December 2014 were approved as an accurate record.

15/04 Action Sheet from the Meeting held on 18 December 2014

14/236 – Mobile Phone Policy

This policy will be presented for approval at the Integrated Governance Committee on 19 February 2015. It was noted that the consolidation of contracts in respect of
mobile devices has taken a little longer than expected.

14/334 – Continuing Health Care Quarterly Report

Jo Pollard advised that South West Yorkshire Partnership Foundation Trust (SWYPFT) has been contacted with regard to delayed assessments, no response has as yet been received. It was noted that this issue will be picked up through the SWYPFT Contract Management Group.

15/05 Matters Arising

There were no matters arising.

15/06 Integrated Quality and Performance Report

Matt England, Jamie Marsh and Laura Elliott attended the meeting to present this report providing an update against the CCG strategic objectives, quality premium and details of key exceptions and successes.

Matt highlighted the following:

- A&E performance at Mid Yorkshire Hospitals NHS Trust (MYHT) has met the required standard for November and the year to date position. It was acknowledged that December and January are challenging months.
- Yorkshire Ambulance Service (YAS) Cat A (Red 1) and Cat A (Red 2) 8 minute response times have failed to meet the operational standard for year to date. Noting a significant increase in demand level impacting on the target.
- The CCG and MYHT have met the monthly Referral to Treatment – Incomplete pathway performance for the third consecutive month. The validated November position for MYHT shows a 93% achievement in the Incomplete pathway.

Laura highlighted the following:

- MYHT achieved encouraging results in the National A&E Patient Survey.
- MYHT Inpatient Friends and Family test response rate is deteriorating.
- Following unprecedented demand in December MYHT made a decision to open additional beds at Dewsbury and Pinderfields. The decision to open additional capacity placed a number of wards in the position that they have been unable to staff at the recommended 1:8 ratio.
- As part of the Dementia Strategy there is an aim to improve the dementia diagnosis rates and the latest December target has been achieved by GP practices, NHS Wakefield CCG is on track to meet the 67% target by March 2015.

A full discussion took place on the following issues:

- The CCG is assured about the robustness of the clinical risk assessment process which is undertaken daily to manage bed utilisation and staffing. Bed capacity is reviewed as part of the daily system resilience call and MYHT are frequently reviewing the requirement for the additional bed capacity. MYHT
have continued to be proactive regarding the staffing levels and have sought extra resources including non-clinical staff supporting meal times.

- The CCG have been kept informed on a daily basis regarding the number of delayed discharges and the process has been supported by a joint working group made up of staff from MYHT and the CCG.
- Matt updated on YAS acknowledging that the survey undertaken by the Good Governance Institute will assist with informing of ways to improve performance. It was acknowledged that Jo Webster, Chief Officer, is in daily discussion with YAS regarding the immediate issues and a briefing will be presented at the March Governing Body regarding quality. Laura informed the Committee that following an increase in serious incidents reported in June 2014 and the delay in responses, it was acknowledged that the management of serious incidents has improved.
- Dr David Brown queried the 62 day pathway target and Matt advised that a root cause analysis is undertaken for each breach noting that there is not usually just one cause for a breach. Matt confirmed that the audit to be undertaken by Capita is currently being scoped, this will be used to improve the pathway.
- Sharon Fox requested an exception report in respect of Breast Feeding to be included as part of the report for the next meeting.
- Sharon Fox referred to the CQC inspection report for Stuart Road surgery and whether clinical supervision is provided for nursing staff. Laura Elliott agreed to clarify and report back.
- Stephen Hardy raised concerns regarding staffing levels at MYHT. Jo Webster advised that currently the staffing level is below the recommended one in eight, however she assured the Committee that this has been risk assessed by MYHT. It is anticipated that following recruitment MYHT should achieve the one in eight target by 30 April 2015.
- Sandra Cheseldine referred to the results of the Hip Fracture report and raised a concern regarding the mobility figures reported, noting that patients do not seem to be receiving the appropriate support to achieve mobility. Laura Elliott advised that MYHT colleagues have been invited to attend the Integrated Governance Committee in February to discuss the Hip Fracture Pathway, also the detailed plan is discussed at the MYHT Executive Quality Board meetings.
- Jo Pollard advised that a piece of work is being undertaken by Wakefield, Hull, Scarborough and York CCGs regarding the handover times between YAS and MYHT and how the process can be improved.

It was RESOLVED that:

i) the Committee noted the current performance against the CCG strategic objectives and Quality Premium;

ii) approve the actions being taken to address areas of poor performance.

15/07 Finance Report Month 9

Karen Parkin presented this report noting that the CCG has a year to date surplus of £4,879k and the forecast year end position is £7,611k which is an increase from month 8. All key performance targets are green with the exception of QIPP delivery and activity trends.
Karen highlighted the following from the report:

- The surplus position has increased due to the CCG element of the returned national underspend on the Continuing Health Care restitution claims risk pool as required by NHS England.
- Change to the prescribing position resulted in an overspend which is a shift from a small undertrade last month. The main cause of the overspend is in relation to category M drugs. NHS England had amended the payment regime which has resulted in a cost pressure to CCGs.
- Received allocated funds in respect of Quality Premium Awards 2013/14 and Mental Health Resilience 2014/15.
- MYHT current activity reconciliations show a net undertrade year to date. There are a number of potential emerging pressures associated with MYHT forecast outturn. An amendment to page 4 of the report was noted, under the ‘Overall position’ section, the first sentence should read quarter 2 not quarter 1.
- Key focus area is on Agreement of Balances and Annual Accounts preparation.
- The Co-commissioning bid has been approved subject to minor amendments which is excellent news.
- Andrew Pepper raised a number of potential risks with regard to MYHT forecast outturn discussions with NHS England regarding specialist commissioning and resolution of outstanding allocations.

A full discussion took place and the following issues were raised:

- Concerns were raised regarding QIPP and when a plan can be expected for 2015/16. Jo Webster responded confirming that the Governing Body Development Session to be held on Tuesday, 27 January 2015 will include a full discussion regarding QIPP plans for 2015/16 and 2016/17.
- Timely payment of invoices was raised and Karen Parkin advised that this relies on inter-dependencies between organisations and increased effort and pressure is actively managed to ensure payments are received, including with local partners such as WMDC.

It was RESOLVED that:

i) the Committee noted the Month 9 Finance Report

15/08 Community Specialist Contact Lens Service and Community Low Vision Aids Service

Simon Rowe attended the meeting to present this paper which seeks to gain approval from the Integrated Governance Committee for two procurement decisions in respect of Specialist Contact Lens Service and Low Vision Aids Service. It was noted that the current contracts both end on 31 March 2015. The Clinical Cabinet agreed the updated service specifications in December 2014.

Simon explained that with regard to the Community Specialist Contact Lens service, following market testing amongst optometrists this has identified that only the existing provider of this service, Pollards Opticians, wishes to provide this service. It was acknowledged that there are no concerns regarding the capacity and capability of Pollards to meet the demand for specialist contact lenses.
The low vision aids service in Wakefield and District is currently provided by Vision Express opticians. Market testing amongst local optometrists has indicated interest to provide this type of service. It is proposed that the provision of a low visions aids service would suit an Any Qualified Provider accreditation process.

A discussion followed and Jo Webster advised that with regard to the Community Specialist Contact Lens service she agreed in principle that it would not be necessary to go out to procurement when the existing provider has been identified as the only provider wishing to provide this service.

It was RESOLVED that:

i) the Committee approved in principle for the existing provider of the Community Specialist Contact Lens Service to continue to provide the service; and
ii) the Committee approved the commencement of an Any Qualified Provider accreditation process for the provision of Community Low Vision Aids Service.

15/09 Public Sector Equality Duty

Laura Elliott and Granville Thirwell attended the meeting to present this paper. The purpose of this report is to demonstrate compliance with the Equality Act General Equality Duty. Laura confirmed that it is a statutory duty to publish this report by 31 January 2015. The report will provide an insight into how evidence has been used in taking forward the quality objectives the CCG committed to in 2014. Acknowledging that this report is currently a work in progress.

A discussion followed and it was agreed that any information included in the previous report should not be included again in this report, noting that details of case studies are yet to be added. It was suggested that the report should include what has been achieved, what needs to be improved and what additional actions are required.

It was RESOLVED that:

i) the Committee approved the draft Public Sector Equality Duty report for publishing deadline 31 January 2015

15/10 Research and Development Update

Stella Johnson attended the meeting to present this paper providing a description of the work Yorkshire and Humber Commissioning Support has undertaken in delivering the research service on behalf of the CCG, ensuring that the CCG has met its statutory obligations with regards to research for the period 1 April 2014 to 30 September 2014.

Stella referred to Appendix 1 of the report regarding the future plans for Action to Support Practices Implementing Research Evidence (ASPIRE) seeking endorsement for an opt-out approach for practices from the CCG. Following discussion this was agreed and it was suggested that the communication to practices should be through the Network Development Unit and Stella was asked to contact Kerry Munday, Interim Head of Network Development.

Stella commented on the Applying Research in Commissioning decisions (ARC) Forum
and thanked the CCG for their support in attendance at these events. It was suggested that for future meetings linking the ARC forum with an existing clinical meeting could be a way forward.

It was RESOLVED that:

i) the Committee endorsed the ‘opt out’ approach for the next phase of the ASPIRE study;
ii) assist the YHCS in developing the research community for CCG member practices; and
iii) continue to attend the ARC forum events.

15/11 Intellectual Property Policy

Stella Johnson gave a verbal update on the Intellectual Property Policy advising that there are national changes in relation to the research governance framework quoted within the policy. These changes are currently being rewritten by the Health Research Authority (HRA). Following a review of these changes the policy will be revised and presented to the Integrated Governance Committee for approval.

It was RESOLVED that:

i) the Committee noted the verbal update

15/12 Minutes of meetings

The minutes of the following meetings were shared for information:

(i) Mid Yorkshire Hospitals NHS Trust Executive Quality Board – minutes of meeting held on 11 December 2014
(ii) Mid Yorkshire Hospitals NHS Trust Executive Contract Board – minutes of meeting held on 20 November 2014
(iii) South West Yorkshire Partnership Foundation Trust Quality Board – minutes of meeting held on 15 December 2014
(iv) NHS111 West Yorkshire Clinical Quality Group – minutes of meeting held on 9 December 2014
(v) Quality Intelligence Group – minutes of meeting held on 16 December 2014
(vi) System Resilience Group – minutes of meetings held on 23 October and 27 November 2014

Sandra raised a query in respect of the NHS111 West Yorkshire Clinical Quality Group minutes asking what is meant by the “Goldline Service” referred to in the minutes? This will be clarified and reported back to the Committee.

15/13 Consider future topics for Deep Dive

No further topics were suggested.

15/14 Any other business
No other business discussed.

15/15  Date and time of next meeting:

Thursday, 19 February 2015, 1.30 to 4.30 pm in the Seminar Room, White Rose House.
Title of meeting: Governing Body

Date of Meeting: 10 March 2015

Paper Title: Clinical Cabinet: presentation of minutes and items for approval by Governing Body

Purpose (this paper is for): Decision ✓ Discussion Assumption Information

Committee chair: Dr Adam Sheppard, Assistant Clinical Leader

Meeting minutes enclosed: 18 December 2014 and 22 January 2015

Recommendation:
It is recommended that the Governing Body receive and note the minutes of the Clinical Cabinet held on 18 December 2014 and 22 January 2015.

Executive Summary:

18 December 2014

The following was discussed at Clinical Cabinet in December:
- Presentation by MYHT on the Future Hospital;
- Presentation by MYHT on the Acute Service Reconfiguration and Connecting Care;
- Children’s new ASD/ADHD clinical pathway and MYHT recovery plan for the current backlog;
- Specialist contact lenses and low visual aid;  
- Star Bereavement;
- Mental Health clusters;  
- 24/7 Hospice admissions;  
- Development of 2015/16 CQUINs;  
- CCG strategy update;  
- QIPP update;  
- Clinical network update; and  
- Minutes from the Medicines Optimisation Group meeting.

22 January 2015

The following was discussed at Clinical Cabinet in January:
- Electronic Palliative Care Co-ordination Systems (EPaCCS)
- Urgent Care Strategy
- Health Inequalities Project
- Service Specification for non-urgent ophthalmology
- Crisis Care Concordat Joint Action Plan
- MSK update
- Planned Care Transformation
- First tranche of reviewed Commissioning Criteria Base Policies (sub policies)
- Update: Review of WSYBCSU Commissioning Guidelines for Specialist Plastic Surgery Procedures
- LSP Exit Plan
- MASH
- Specialised Commissioning Service Update
- Patient Experience report - General Practice
- Summary of s256 agreements with Local Authority and Future options.
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday, 18 December 2014
09.00 – 12.30 pm
Seminar Room, White Rose House

Present:
Dr Adam Sheppard (Chair) Asst. Clinical Chair, WCCG
Dr Phil Earnshaw Clinical Chair, WCCG
Jo Pollard Chief of Service Delivery and Quality, WCCG
Andrew Pepper Chief Financial Officer, WCCG
Dr Clive Harries GP, WCCG
Dr Ann Carroll GP, WCCG
Dr David Brown GP, WCCG
Sandra Greenwood Nurse, WCCG
Stephen Hardy Lay Member, WCCG

In Attendance:
Dr Andrew Furber Director of Public Health, WMDC
Dr Patrick Wynn GP, WCCG
Kerry Munday Interim Head of Network Development Unit
Michelle Ashbridge Senior Commissioning Manager, WCCG (Item 5)
Simon Rowe Senior Commissioning Manager, WCCG (Item 8)
Mike Forster Director, MYHT (Item 6)
Helen Childs Director (Item 6)
Tracey Sparkes Interim Senior Commissioning Manager (Item 7)
Mike Garnham Clinical Advisor/Project Manager, Mental Health Current Team (Item 10)
Michelle Ashbridge Senior Commissioning Manager (Item 11)
Luke Streeting Senior Commissioning Manager (Item 12)
Kate Trevelyan (KT) Senior Management Support, NHS WCCG (minutes)

1 APOLOGIES FOR ABSENCE

Apologies were received from Dr A Biswas, Dr P Dewhirst, Michele Ezro

2 DECLARATIONS OF INTEREST

1) Item 9 – ASD/ADHD: Dr Brown (involvement in a neurology development team)

3 A MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2014

Minutes of the last meeting were agreed as a correct record. Andrew Pepper referred to Item 6 Re-ablement Funds and asked for it to be noted that the report would go through due governance and be recommended for approval at Governing Body
4 ACTION LOG

The Action Log was reviewed and updated accordingly.

5 FUTURE HOSPITAL

The apologies of Dr Dinesh Nagi were noted due to sick leave. It was agreed that the presentation would be rescheduled to a Clinical Cabinet agenda as early as possible in the New Year in line with Dr Nagi’s availability.

6 ACUTE SERVICE RECONFIGURATION AND CONNECTING CARE

The apologies of Caroline Griffiths were noted due to sick leave. Helen Childs (Programme Lead for Connecting Care) and Mike Forster (Associate Director at MYHT) attended to update members on the community aspect of the presentation which highlighted:

- Bed day challenge with high risk to achieve;
- The new service to deliver the reductions over a two year period;
- Connective Care connects and aligns people to develop relationships;
- Stepped phase approach re transformation;
- Capita modelling to highlight issues and concerns re resources, future demands and gaps in capacity;
- Information around taking efficiencies out of the system being presented to the Provider Alliance

Dr Earnshaw was concerned about the negative impact of taking efficiencies out of the system before making the system work in the first place. Members noted that the Better Care Fund would protect funding and that it enables joint commissioning decisions which might lead to integrated models of care provision from the system. Funding was from non recurrent investment as agreed at Governing Body.

There was concern about gaps around social care and mental health. Dr Brown described a situation where extra care funding had been provided and it was noted that re-ablement funding does provide such support but that regular social care is ‘means’ tested.

Jo Pollard referred to Capita and the efficiencies which would enable a reduction of the investment in the community services which would need real transparency at EQB. Dr Wynn asked about the Capita report, in terms of understanding the variance to calculate and cope with capacity. It was noted that MYHT were sharing their CIP Programme and members discussed concerns with regard to the review of case records and risk stratification.

Mike Foster updated members on the various co-located hubs in place which highlighted the integration of System 1 and there were queries on how this would work with EMIS. Dr Harries highlighted that integration of the system and shared records which would need a lot of support to make it a reality. Members expressed concerns particularly around System 1 deployment and engagement.
Dr Sheppard recommended that the issues re IT and System 1/EMIS integration should be taken outside of the meeting and then to bring back to Informal Clinical Cabinet to provide assurance.

There were also issues around member practices feeling disengaged and Helen updated members on the background of the Provider Alliance which had been formed to deal with Primary Care and Community issues with GP Network Chairs being encouraged to lead and/or be involved in discussions.

The implementation assurance framework process was discussed and Jo Pollard indicated that it was part of the consultation process with check and balances in line with the quality assurance process. The document would then be taken to the stakeholder group and then to all partners to sign off.

Dr Sheppard thanked Helen Childs and Mike Foster indicating that the issue should be brought back to Informal Clinical Cabinet to progress discussions and provide the necessary assurances.

IT WAS RESOLVED:

i) to note the presentation;
ii) Helen Childs/Mike Foster to provide assurance e.g. EMIS/System 1 at an Informal Clinical Cabinet (February/March)

Action: Helen Childs/Mike Foster to provide assurance at Informal Clinical Cabinet (February/March) re EMIS/System1

7 ASD/ADHD NEW CLINICAL PATHWAY AND MYHT RECOVERY PLAN FOR CURRENT BACKLOG

Tracey Sparkes presented the ASD paper which recommended that the Clinical Cabinet considers the options for a new pathway for ASD assessment for autism and MYHT recovery plan. The outcome would be that those children and young people on the waiting list would be seen earlier with the backlog cleared in time for the new service in 1 June 2015. Members thought that the recovery plan was unrealistic and unlikely to succeed.

If the funding was approved, it was further recommended that Clinical Cabinet makes it clear that this will be on the condition that the block contract for community paediatric services is reviewed and that commissioners have more clarity about the funding of this service, why such a backlog can accrue and how this can be avoided in the future.

Members queried where the finance of £213K sat in the budget and Tracey responded that it related to another piece of work on the paediatrics. Members expressed particular concerns around the funding and community paediatrician resources. Tracey informed members that £300K had been identified within the community block contract.

Members recognised that there was a significant problem with children not being diagnosed in a timely manner around manpower and resource with the clinical risks involved. There were reconfiguration issues and members were concerned about how the risks could be managed.

Jo Pollard summarised the executive actions to escalate:
• Jo and Andrew will pick up issues re the recovery plan;
• Tracey to provide a list of the cluster of issues relating to childrens services to take back to Executive Team to agree how to handle strategy and report back to Clinical Cabinet

Action: Jo Pollard and Andrew Pepper to discuss issues re the recovery plan

Tracey Sparkes to provide a list of the cluster of issues to take back to Executive Team to agree how to handle strategy and report back to the Clinical Cabinet

IT WAS RESOLVED:

i) Note the report;
ii) Jo Pollard and Andrew Pepper to discuss issues re the recovery plan;
iii) Tracey Sparkes to provide a list of the cluster of issues to take back to Executive Team to agree how to handle strategy and report back to Clinical Cabinet

8 SPECIALIST CONTACT LENSES AND LOW VISUAL AID

Simon Rowe presented the paper which provides the service specifications for two essential ophthalmology services, a service providing low vision aids, and one providing specialist contact lenses, highlighting risk around using one service provider on a specialised service. Vision Express (Wakefield) provides the low vision aids service under a contract with the CCG that ends in March 2015. Pollards Opticians (Wakefield) provide the specialist contact lenses service under a contract with the CCG that ends in March 2015.

The recommendations were:

i) Detail what changes if any need to be made to the service specifications;
ii) Agree that the service specifications, with any agreed changes maybe used to re-procure the low vision and specialist contact lenses services.

Members queried the options in the specialist guidance. Dr Wynn commented that the Contact Lens service was needed noting that it was consultant referral. Members agreed to support the service as is.

Dr Wynn commented that low visual aid specification was different as there was risk about it and it members discussed the various factors involved.

Dr Earnshaw queried whether consultation with patients had been undertaken which Simon confirmed and Stephen Hardy commented that full engagement was required to ascertain patient views, whether they were happy etc. (if a service was not broken, why fix it).

Members agreed to the specification of the low visual aids should be subject to further market testing, scoping and identification of risks. Members also discussed possibilities of ‘smarter working’ between optometrists and suppliers to achieve better pricing.

Dr Sheppard summarised:
• Approved specialist contact lenses specification;
• Low vision aids specification agreed, but further work to be done and to bring back recommendations on how to proceed.

IT WAS RESOLVED:

i) Approved specialist contact lenses specification;
ii) Low vision aids specification agreed, but further work to be done and to bring back recommendations on how to proceed.

9 STAR BEREAVEMENT

Dr Carroll introduced the Star Bereavement paper and the proposal to not extend the contract beyond 31 March 2015 for the service which was originally joint funded. When the joint funding ceased in April 2014, the CCG agreed to carry on funding for a year to allow time for a commissioning decision.

Members noted the recommendations:

• To agree to not continue to fund the service from 2015;
• To meet with Star Bereavement to ensure an ongoing action plan;
• To undertake a further piece of work to ensure that current referrers are aware of how to support children who have been bereaved;
• Throughout the integration development process, any gaps in support for bereaved children will be identified and addressed.

It was noted that referrals do not come from GPs due to lack of knowledge of the service, although it was noted that CAHMS do refer into it. Quality assurance was also a concern due to a lack of specification and there was no mechanism in respect of safeguarding. Dr Carroll highlighted that a deep dive of the service by Sharon Wallis which had previously raised concerns.

Members were updated by Dr Carroll on discussions with CAMHS yesterday about options going forward if the service was not extended with a number of options and other services possible for bereaved and/or vulnerable children. The early intervention hubs would provide GPs with choice and give access to locality managers.

Stephen Hardy queried patient care involvement with concern re quality of service and the process undertaken if the service was not extended to ensure that there was sufficient capacity in the rest of the system. It was understood that CAHMS had the waiting list down to six weeks and Dr Carroll emphasised the need to understand the services available and communicate to GPs so that they are utilised.

Jo Pollard updated that there was no transparency around the quality of the service which raised concerns. There was a need to understand services and education needs being used and supported by LA to bring into the main stream portfolio rather than stand alone.

Members agreed to decommission the service, with a need to: 
• write to external agencies to update and provide assurance around where they go to refer;
• Action plan to ensure children receive continuing care;
• Review of referrals into the service going forward;

IT WAS RESOLVED:

i. Approval given to not extend the contract for the service after April 2015;
ii. Look at an action plan to ensure children receive continuing care;
iii. Review of referrals into the service going forward;
iv. Write to external agencies to update and advise where they can refer into to provide assurance into the system

10 MENTAL HEALTH CLUSTERS

Dr Harries updated members on the background to Mental Health Clusters and introduced Graham Garnham whose background was in occupational therapy. Graham informed that Monitor/ NHS England were leading and the proposed cluster model had been initiated by SWYPFT. Graham highlighted:

• A need for the model to address all gaps (Health & Well Being, Quality and Funding);
• Direction of Travel;
• Mental Health grievances;
• Historical issues around funding through the block contract;
• NHS England were looking for a payment system offering improvement and drive based on needs, resources and outcomes;
• By April 2016 all contracts will have a clear incentive to delivery, outcomes;
• A need to improve the quality of the data;
• Cluster model being rolled out and piloted in different parts of the country (details available on HCIC web site)
• Cluster currency model assessment tool and outcome measure with local tariffs being collated around the cluster to identify costs;
• Mental Health Clustering tool is patient needs related;

Mike tabled the Cluster description document which detailed cluster packages of care and gave a brief overview of the content. It was noted that there was no cluster for CAHMS as it had not yet been developed and patients would still need to be seen within CAHMS services.

Dr Harries queried assurance that the clustering process was accurate and Mike responded that these were monitored regularly to check the scores rating and any variances.

Dr Earnshaw expressed concern about how this would most help patients as to whether it gave them better care and the risks involved. Mike responded that as a pilot format it was still an evolving model in terms of packages of care; with ongoing assessments being done to identify what was needed. Members were concerned that there should be a more patient centred approach to needs (what happens if they don’t fit within the cluster model), with
perhaps structured questionnaires which should sit behind the scores and members discussed the possible complexities behind the assessments.

In response to members’ comments, Mike responded that the service would enable a level of health intelligence which has not been available before to structure services in a transparent way. Mike was unable to comment on the local tariff and Clive requested that this information be supplied as soon as possible. Jo Pollard expressed concerns around the quality of the service, patient experience, plus whether the data would enable an assessment of financial risks. Mike indicated that the information was presented by cluster or episode of care.

The transition period was not formalised and Andrew Pepper updated members on mental health currencies and the possibility of acute currencies. Andrew concurred that it had great value in terms of transparency, but at the same time there was an issue around sustainability.

**IT WAS RESOLVED:**

i) note the contents of the presentation

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**11 24/7 HOSPICE ADMISSIONS**

Michelle Ashbridge and Luke Streeting attended and informed members that a business case came to Clinical Cabinet in February 2014 which reviewed the Wakefield and Pontefract Rapid Intervention Service (a pilot from March 2012 to March 2014) in which the option to continue to commission 24/7 hospice admissions from a non recurrent uplift to the hospices via a grant allocation was approved with a requirement to re-evaluate the service and recommend whether this should become a routine service that is recurrently funded.

Michelle informed members that the pilot was started in April but there had been a number of issues in the system plus the recruitment of specialist staff to support a 24/7 service.

Recommendations were

i) recognise the current position in respect of the number of challenges in the system;

ii) going forward, understand some of the detail behind that and try to understand what it would have looked like if the challenges had not been there.

Michelle emphasised that the service would support everything including the patient experience but Dr Sheppard was concerned about the activity from the Trust and EOL patients being caught up in the system.

Members considered that there were service issues around contract management, costing, specialists not being in post and non-delivery. Members agreed that patients should have the opportunity to go into hospices if preferred and cases should be escalated appropriately. There was a query around the level of data and it was emphasised that all members should be registered which Michelle confirmed she would review.

Andrew Pepper expressed concern as the grant monies had not been deployed in the way that had been expected. Andrew commented that the investment was the right thing to do but thought that it was part of Connective Care and further review was required.
Dr Sheppard summarised the recommendations:

- agreement to support going forward;
- Need to bring back Clinical Specification (which could be approved by the Clinical Chair) to provide assurance around funding and the interface with Out of Hours (LCD);
- Additional work required around engagement, particularly in secondary care.

**Action:** Michelle Ashbridge to provide clinical specification to give assurance around funding and the interface with Out of Hours (LCD)

**IT WAS RESOLVED:**

i) Noted and agreed support going forward;
ii) Need to bring back clinical specification (which could be approved by the Clinical Chair) to provide assurance around funding and the interface with OOH (LCD)
iii) Additional work required around engagement, particularly in secondary care

12 **UPDATE: DEVELOPMENT OF 2015/16 CQUINS**

Members reviewed the CQUINS report which had been written following discussions at the November Clinical Cabinet. Members acknowledged the level of hard work achieved by the Quality Team. Andrew Pepper stated that negotiations had commenced with MYHT and SWYPFT using CQUINS particularly that some element is taken off and used to manage the risk (3.2%). Dr Earnshaw challenged around possible governance issues which Andrew confirmed he would investigate.

**Action:** Andrew Pepper to investigate governance issues around CQUINS and management of the risk

Dr Furber queried if smoking and pregnancy delivery were part of the quality premium/guidelines or held somewhere else in the contract. Dr Carroll indicated that she would query with Laura Elliott. Dr Harries updated members on issues which related to flu vaccinations during pregnancy and Dr Brown informed that it had been raised at EQB with assurance given. Jo Pollard confirmed that an action would be taken back to EQB in January.

**Action:** Flu Vaccine Issue to be discussed at EQB in January

Dr Carroll to query with Laura Elliott where smoking and pregnancy delivery sit in the contract

**IT WAS RESOLVED:**

i) To note the report
13 **CCG STRATEGY UPDATE: COMMISSIONING INTENTIONS**

Matt England introduced the paper which was based around discussions at the Planning and Delivery Group and summarised 2015/16 commissioning intentions to date. Members discussed issues and concerns around community, Walk in Centre strategy/NHS England.

Dr Furber raised a concern around IFR panels commissioning issues as to whether these had been included. Jo Pollard indicated that she would discuss with Matt England to ensure that IFR issues were taken into account in the commissioning intentions.

**Action:** Jo Pollard to discuss IFR issues with Matt England to ensure they are taken into account in the commissioning intentions

Members noted the paper and acknowledged that it was well written.

**IT WAS RESOLVED:**

i) to note the paper

14 **QIPP UPDATE**

No comments noted.

15 **CLINICAL NETWORK**

Members led Commissioning would be discussed at Informal Clinical Cabinet on the 8 January to be attended by Network Chairs where discussions would begin to develop planned care pathways. Members acknowledged the need to push to get everyone involved and to identify champions on the provider side of primary care.

16 **MINUTES FROM SUB GROUP**

No minutes to share.

18 **ANY OTHER BUSINESS**

18.1 **System Resilience Update**

Dr Sheppard gave an informal update on the system resilience issues and concerns. There was a requirement to communicate to GPs re capacity over the holiday period and Dr Earnshaw updated members further on this requirements. Members discussed concerns re activity, capacity and data quality.

**Action:** Kerry Munday to take data quality issues to Primary Care co-commissioning.
Date and time of the Next Meetings:

Informal Clinical Cabinet:
Thursday, 8 January 2015
11.30 am – 1.00 pm
Boardroom, WRH

Clinical Cabinet:
Thursday, 22 January 2015
09.00 – 12.30 pm
Seminar Room, WRH
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday, 22 January 2014
09.00 – 12.30 pm
Seminar Room, White Rose House

Present:
Stephen Hardy Lay Member, WCCG, (Chair)
Dr Phil Earnshaw Clinical Chair, WCCG
Jo Pollard Chief of Service Delivery and Quality, WCCG
Dr Clive Harries GP, WCCG
Dr Avijit Biswas GP, WCCG
Dr Ann Carroll GP, WCCG
Dr David Brown GP, WCCG
Sandra Greenwood Nurse, WCCG

In Attendance:
Dr Patrick Wynn GP, WCCG
Karen Parkin Associate Director, Finance and Governance, WCCG
Anna Middlemiss Public Health Consultant Service Manager, Strategy and Support Team
Linda Driver Head of Service Development & Transformation, WCCG (Item 16)
Michelle Ashbridge Senior Commissioning Manager, WCCG (Item 5)
Dr Kath Lambert Consultant in Palliative Medicine, DDH (Item 5)
Jenny Feeley Urgent Care Transformation Lead, WCCG (Item 6)
Gary Crellin Senior Transformation Associate, YHCSU (Item 12 and 13)
Sharon Cook Commissioning Manager, WCCG (Item 12 and 13)
Gill Day Commissioning Manager, Public Health (Item 7)
Alix Jeavons Senior Commissioning Manager, WCCG (Item 9)
Mandy Sheffield Head of Safeguarding, WCCG (Item 15)
Mary Kearney Specialist Nurse, Safeguarding Children (Item 15)
Laura Elliott Head of Quality and Engagement, WCCG (Item 17)
Ian Wightman Principal Associate, YHCSU (Item 14)
Fred Chambers Interim Project Accountant, WCCG (Item 18)
Richard Maine Business Manager, WMDC (Item 23)
Kate Trevelyan Senior Management Support, NHS WCCG (minutes)

1 APOLOGIES FOR ABSENCE

Apologies were received from Dr A Sheppard, Dr P Dewhirst, Michele Ezro, Dr A Furber, Andrew Pepper

2 DECLARATIONS OF INTEREST

1) Item 7 – all GP members Health Inequalities
MINUTES OF THE MEETING HELD ON 18 DECEMBER 2014

Minutes of the last meeting for 18 December 2014 were agreed as a true record - but it was agreed that Item 7 which would be amended and finalised by JoP /Dr D Brown so that it reflected more precisely the members concerns in respect of funding and unrealistic recovery plan.

ACTION LOG

The Action Log was reviewed and updated accordingly.

EPaCC

Dr Kath Lambert Mid Yorks DDH, North Kirklees presented EPaCCS which illustrated the current position, what had been achieved and the shared template (EOL care) diagnosis.

Funds for the research at £24K had allowed Dr Lambert to dedicate clinical time to EPaCCS which went live in April 2014. 38 out of 40 practices were signed up with trained community nurse/multi agency support, also working closely with CSU to develop a quarterly report.

The benefits were seen as

- Resource for information which was regularly updated
- Increase of patients on the QOF register
- Documents ACP discussions

Dr Lambert took members through the charts which compared QOF/EPaCCS data. Wakefield figures were seen as excellent and Dr Lambert indicated that it reflected the dedicated time and good team work.

A Wakefield Data sheet was shared which illustrated benefits. Dr Harries commented on the traffic light system to signpost people to where they need to go and share information giving the exact position. It was agreed that it enhanced GP mobile working in the community which had huge future potential:

- Good practices
- Help future service development
- ‘Flag’ patients in acute trust highlighting particular issues/requirements
- Prescription history

Dr Lambert reviewed the next steps indicating that it would be beneficial to continue to revisit practices, review flag definitions and admissions of patients on EPaCCs and was looking to the CCG for support.

Dr Carroll commented on the CCG support to nursing homes and the amount of work done on the CPR forms. Dr Lambert responded that training had not taken place in Care Homes
and it was thought to be good for this to be undertaken using the CPR form in an advanced care planning discussion.

Members noted that that the work would be communicated out via the Network Development Unit and Framework to escalate knowledge.

IT WAS RESOLVED:

i) To note the presentation

6 URGENT CARE STRATEGY

Jenny Feeley presented the paper which illustrated the background on how urgent care was delivered via the Urgent Care Working Group. The vision had been amended to reflect integration with patients being signposted to the most appropriate places.

Jo Pollard commented that it would be helpful to bring back the 5 year plan going forward with timeline and bring back to the Clinical Cabinet next month.

Action: Jenny Feeley to bring back a paper in February to reflect the 5 year plan with timeline.

Members indicated approval.

IT WAS RESOLVED:

i) To approve the report

Jo Pollard asked Jenny to give members a resume of the current position with the Gateway Review. Jenny indicated that it was part of the Meeting the Challenge with the idea to help and support to decide what is required, providing a briefing pack for interviews. Interviews would be conducted with senior colleagues within the WCCG, NKCCG, MYHT and YAS so that all organisations understand to ensure it is working as required.

Dr Carroll was not sure that Maternity and Children had been taken into account and there were concerns around bed occupancy. Members agreed that Childrens should be kept separate and it was agreed that Jenny would take back and investigate further.

Action: Jenny to investigate whether Maternity and Childrens had been taken in to account. Also Childrens bed occupancy should be recorded separately.

7 HEALTH INEQUALITIES PROJECT

Gill Day attended to present the paper which gave an update on the current position indicating that it had been presented at JSCB. Gill updated members on progress of networks against their timelines, indicating the success stories particularly the Care Home project which had had utilised collaborative working with a proactive approach.

An updated paper would be taken to JSCB in February about use of the remaining funding.
Dr Earnshaw declared interest for all GPs. There was concern about the appropriate utilisation of monies allocated to support GP Staff (2 year funding in LA budget). There was a need to agree where the funding would be coming from after the 2 years. Members agreed that this particular issue should be discussed outside of the meeting because of conflicts of interest and that such discussions should led by Karen Parkin. Members were concerned about the impact on QIPP on the potential funding streams as part of the consolidation of GP budgets. It was queried whether the monies would overlap with NDF. Members agreed that funding should be discussed outside of the meeting and brought back.

Action: Karen Parkin to report back on funding queries

IT WAS RESOLVED:

i) to note the paper;
ii) to discuss funding outside of the meeting

8 SERVICE SPECIFICATION FOR NON-URGENT OPHTHALMOLOGY

Stephen Hardy updated members that Simon Rowe was unable to attend and Dr Wynn had suggested that the service specification could be approved if members were in agreement. Members were asked if there were any objections or concerns and approval was noted.

IT WAS RESOLVED:

i. the ophthalmology paper was approved

9 CRISIS CARE CONCORDAT JOINT ACTION PLAN

Alix Jeavons attended indicating that the Crisis Care Concordat declaration had been agreed at the Health and Wellbeing Board in November. The action plan details how local agencies will work together and identifies work streams to achieve improved outcomes. It was brought to Clinical Cabinet for discussion in respect of the Primary Care/Mental Health aspects. Alix indicated that it would have wider consultation before the next Health & Well Being board meeting.

Jo Pollard thought that it was a good document with the primary care input example against a national initiative for people with mental health problems. Members agreed that there was a gap in Primary Care around Crisis. Dr Brown gave an example of a good story which did not actually fit the ‘crisis’ model. The bad story was around a patient with long standing issues who did not receive the relevant help. Alix responded that the example would be taken back to review.

Dr Carroll did not feel that the RAG rating was correct. Dr Earnshaw felt that there was a need to check in general practice about the appropriate handling of people in crisis and also that the Crisis service should keep GPs updated as it was difficult to get an urgent response back to GPs. Jo Pollard indicated that there was a need to process update back within 24 hours say be telephone call to indicate patient status. Members agreed that a review of referrals could be conducted through the contract and quality CQUINS. It was also noted
that a skills audit identification programme might also be a possibility. There was a query around specialties and whether it would be channelled through SWYPFT.

Jo Pollard reminded members that over the last 18 months mental health commissioning had fundamentally changed going from passive to pro-active, transforming local services working with SWYPFT. The issues raised today were for wider consultation in terms of CQUINS and these would be picked up outside of the meeting. It was noted that as Wakefield CCG were not the lead commissioner, it would need to be discussed with Matt England. It was agreed that Karen Parkin would follow this up.

Action: Karen Parkin to discuss commissioning issues raised with Matt England

Jo Pollard requested Alix to bring to bring a presentation at Informal Clinical Cabinet on Mental Health Strategy for Wakefield.

Action: Alix Jeavons to bring a presentation on Mental Health Strategy for Wakefield to Informal Clinical Cabinet.

10 MSK UPDATE

The MSK paper had been withdrawn and the redrafted Business Case will be brought back to Clinical Cabinet.

11 PLANNED CARE TRANSFORMATION

Members noted the contents of the report with the recommendation that Clinical Cabinet note/approve the principles and proposals to support transformation across the planned care for Wakefield CCG.

Due to the extensive agenda, it was agreed that this would be brought back to the February Clinical Cabinet.

Action: Planned Care Transformation to be on the February agenda

12 FIRST TRANCHE OF REWEVED COMMISSIONING CRITERIA BASE POLICIES (SUB POLICIES)

Sharon Cook presented the paper which presents the First Tranche review of the commissioning sub policies taken by CSU and explained that it was part of the annual review process evidence review that policies were up to date. Sharon referred to the table on page 2 which illustrated the policies against national guidance.

Dr Wynn queried that there was a standard score for hips which did not appear to apply to knees but assumed that it was included. Members agreed that Sharon should investigate this exception.

The recommendations were

i) Consider and approve the first tranche of reviewed commissioning criteria based policies (sub policies);
ii) Agree the incorporation of the sub policies into the Commissioning policy and communicate to key stakeholders;

iii) Note the content of the Equality Impact Assessment and Quality Impact Assessment

Members approved that the evidence base could be incorporated into the CCG policies subject to the exception being investigated and congratulated Sharon on the work done.

IT WAS RESOLVED:

i) To note and approve the recommendation subject to

ii) Sharon to investigate the exception

13 UPDATE: REVIEW OF WSYBCSU COMMISSIONING GUIDELINES FOR SPECIALIST PLASTIC SURGERY PROCEDURES

Sharon Cook referred to the presentation at the November Clinical Cabinet and it was requested for the report to be brought back with additional information. Sharon gave apologies from both Dr Claire Freeman and Alison Ball who were unable to attend due to sickness. Sharon asked if members could still consider the comments on the clinical evidence base or would prefer for the paper to be brought to another meeting.

Members agreed that the paper should be deferred pending the outcome of the queries which were being investigated by Gary Crellin. The outcomes should be incorporated into the amended paper which should also include patient engagement and clarity around the BMI rating which members discussed.

IT WAS RESOLVED:

i) to bring back an updated paper

14 LSP EXIT PLAN

Ian Wightman presented the paper explaining the background advising that it related to a national programme for IT, how it related to System 1 and highlighted main themes. The requirement now was for HSCSE Members practices to decide whether:

- To remain on system 1
- Or go to TPP EMIS

The recommendations were that the Clinical Cabinet

ii. understand and discuss the plan and financial impact of the LSP exit on the CCG’

iii. Provide the CCG intentions to continue to support Practices to remain on SystmOne.

Members had particular queries around funding sources, Licence Fees, GP system of choice (GPs can choose which system but migration costs and revenue running cost would incur extra costs. Dr Earnshaw queried what would happen if a SystmOne Practice decides to go to EMIS. GP contract says the GPs can choose what system. Ian indicated that there would be two costs
• Migration cost which the CCG would need to pick up from the GPIT;
• Revenue running cost

Members noted that it was not mandatory funding and practices had the option to say no. It was noted that there was also a risk around the LSP contract which enables secondary care providers to take the LSP free (albeit funded through the central fund) which would change in July 2016. After further discussion, members agreed that Karen Parkin would discuss this issue with Contracting.

Members also felt that the matter needed to be escalated through NHS England/Confederation. Dr Harries indicated that Mel Brown was in process of dealing with the issue but that he had to raise the matter several times with the CSU. Members were aware that it was not included within the paper and Ian reported that they were meeting with the CSE and that there was an initial survey review which would need to be undertaken by the end of January with MYHT and Locala. Jo Pollard indicated concern over the clinical risk.

Members agreed that there was to be no communication re changes until issues had been resolved. MYHT IT was also discussed and risks highlighted around E consultation

IT WAS RESOLVED:

i. Report noted;
ii. No immediate changes with the CCG response being Status Quo at the moment

Ian further highlighted the implication of the MY licence fee funding and SystmOne in hospices (palliative care). Dr Harries asked for Ian to make direct contact with Michelle Ashbridge (Cancer Lead at WCCG).

15 MASH

Mandy Sheffield and Mary Kearney attended to present the MASH paper and highlighted key themes. Mary indicated that they were trying to improve the analysis of the information and they covered 35 referrals per week. They have now central access to all systems to combine an analysis and referred to a Case Study. Mandy indicated that they were asking for recurrent funding rather than non recurrent funding.

Mary stated that from the clinical view point there were massive benefits and Dr Earnshaw asked if there was anything GPs could do better. Mary indicated that they get co-operation but there was an issue re quick turnaround of a response and Dr Earnshaw advised the GPs would not be able to respond in the middle of surgery. It was noted that it was beneficial when GPs were on SystemOne and had enabled shared access. Dr Harries commented that the issue of timely responses would be discussed further.

Mary Kearney left the room and members continued to discuss the funding implications.
Dr Earnshaw expressed concern about the allocation of funds going forward but did not want to impact the MASH service. Dr Carroll emphasised the point that all organisations should be paying (Jo Pollard indicated that this should be added to contract negotiations).

Members felt that the CCG were responsible to commission safeguarding services and Mandy indicated they were not under duty to commission but organisations themselves had a legal responsibility. Dr Earnshaw referred to the ICS budget and a need to challenge where the money had been spent. Jo Pollard indicated that there was a need to look at MYHT/SWFT through the contract negotiations and fund that way. Members agreed that Karen Parkin should meet with Mandy to understand the history in order to come to a solution that consolidates so that appropriate organisations fund through contract negotiations.

**Action:** Karen and Mandy to meeting to discuss funding options

Members agreed to the proposal in principle subject to the outcome of the discussions between Karen and Mandy re funding options

**IT WAS RESOLVED:**

i) Agreed to the proposal subject to the outcome of the discussions between Karen and Mandy re funding options

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**16 SPECIALISED COMMISSIONING SERVICE UPDATE**

Linda Driver introduced the work around the Specialised Commissioning Service update re issues within the system and action to mitigate risks. The services on the list highlighted core commissioning responsibilities which included renal dialysis and morbid obesity.

The recommendations were

i) Note the changes to commissioning responsibility from 1 April 2015;

ii) Note the potential changes to commissioning responsibility in relation to renal dialysis and morbid obesity surgery services and

iii) Note the issues, risks and preliminary actions to mitigate them.

Linda highlighted the service derogation of specialised commissioning and the core system which included financial responsibilities and corporate skills. It was noted that MYHT had to give assurance around ‘fit for service’. Members agreed that there was a need for more engagement to enable wider discussions and acknowledged that there was more work to be done.

**IT WAS RESOLVED:**

i) To note the paper

ii) More work to be done around engagement for wider discussions to be enabled
17 PATIENT EXPERIENCE REPORT – GENERAL PRACTICE

Dr Earnshaw and Dr Wynn declared conflict of interest.

Laura Elliott attended to present and update members on the background of the patient experience report relating to GP Practices in Primary Care. It was noted that this report included the most patient feedback with access to care being the item with the most comments.

Jo Pollard commented that the Patient Experience Reports were useful to inform commissioning and improve patient experience. The focus had been on the Quality team working alongside commissioners and contractors to ensure it happens. The report needed to be shared across the organisation but also with individual practices to inform on their own service improvement.

Members discussed this item at length recognising that there was a presentation and communication issue around the star ratings. Laura commented that the profile for each practice were examples which had not been used in the analysis.

Dr Earnshaw recommended that the report should be discussed at the annual visits which would allow context to be taken into account and members agreed that this was a good solution.

IT WAS RESOLVED:

i. Note the content of the report;
ii. Share the content with members practices via the annual visits

18 SUMMARY OF S256 AGREEMENTS WITH LOCAL AUTORITY AND FUTURE OPTIONS

It was queried whether this paper should still be considered as several clinical members had left Clinical Cabinet to attend another meeting.

It was acknowledged that the paper was for information only and therefore could still be discussed.

Fred Chambers presented the paper which gave a statement on the current position with S256 in respect of annual funding to the council and the monies being transferred to the Better Care Fund from April 2015 (£42m). It was noted that section 4 and 5 related to bi funding in respect of the Connective Care which will be subject to change from April 2015. Fred highlighted sub section 2 indicating that ReAbility funding would transfer to Better Care Fund next year (£42m).

It was noted that the review of the 256/75 would be going through JSCB to complete by end of March 2015 and that Mel Brown was leading for CCG.

Members agreed that there was a need to ensure that the review was ‘knitted’ into the QIPP challenge and members debated the possible resource e.g. Carers money in the five year forward plan (was there value for money), progress already made with the LD review etc. It was thought that a commissioning review could be undertaken and challenges made.
Dr Harries indicated that he had the same concerns about the Better Care Fund and did not feel that enough engagement had been undertaken within the decision making process going forward.

Karen Parkin responded that it was for information and discussion to give a position statement indicating that the whole governance around this is through Mel and JSCB and then into the new Integration Executive. Members were not in agreement with the approach taken because it was CCG money. Jo Pollard indicated that this needed to be discussed with Andrew Pepper and talked through at Executive Team about the resource. Karen and Fred indicated that it was not new monies but old but agreed that there was a need for more scrutiny over QIPP.

It was agreed that the report would be referred to Jo Pollard and Andrew Pepper for consideration and report back.

**Action:** The report to be referred to Jo Pollard and Andrew Pepper for consideration and report back

**IT WAS RESOLVED:**

i) The report was noted;

ii) The report would be referred to Jo Pollard and Andrew Pepper for further consideration and report back

19 **CCG STRATEGY AND ANNUAL DELIVERY PLAN**

Member noted the contents of the Paper.

20 **QIPP UPDATE**

QIPP discussed under Item 18.

21 **CLINICAL NETWORK**

Dr Earnshaw updated members around Clinical networks being developed for the PM Challenge Fund with the positive feedback and involvement, particularly Network 2 and 3. It was acknowledged that Practice Managers would get more out of it than GPs and referred to the joint meeting which was taking place on 3 February 2015.

22 **MINUTES FROM SUB GROUP**

No minutes to share.
ANY OTHER BUSINESS

Connecting for Health IGSoc Application

Richard Maine attended to update members on the Connecting for Health IGSoc Application and Stephen Hardy advised that no decisions could be made as the meeting was not quorant.

Richard indicated that he was a Business Manager for Wakefield Council on the Performance Improvement Team. One of the key aspects being worked on is how we can better share systems and data and work together particularly in adult health and social care and childrens integrated hubs. The IGSoc toolkit had been in place for two years with data sharing agreements in place. Now looking to identify a sponsor to support the application and were asking the CCG to technically sponsor a connection with no other requirements. Need CCG agreement indicating that they had submitted all the relevant documents Richard indicated that there was a key piece of work around NHS England without it the process cannot move forward. Also work being undertaken with Dr Furber’s team in Public Health around having direct access.

Jo Pollard stated that it was a step in the right direction and was really pleased to see it here and strongly support it.

Stephen Hardy indicated that Jo Pollard would recommend Chair’s Action to Dr Adam Sheppard re approval with the support of the members of the Clinical Cabinet who were still in attendance.

Richard advised that there were no financial implications as it was fully funded (monies agreed when CCG was a PCT). Stephen Hardy indicated that for audit purposes, Dr Sheppard’s chair action would need to be recorded through the appropriate channel and it was agreed that Jo Pollard /Karen Parkin would feed back to Mel Brown.

Action: Jo Pollard to recommend Chair’s action to Dr A Sheppard

Karen Parkin/Jo Pollard to feed back to Mel Brown re the outcome

Date and time of the Next Meetings:

Informal Clinical Cabinet:
Thursday, 12 February 2015
11.30 am – 1.00 pm
Boardroom, WRH

Clinical Cabinet:
Thursday, 26 February 2015
09.00 – 12.30 pm
Seminar Room, WRH
NHS Wakefield Clinical Commissioning Group

EXECUTIVE APPROVALS GROUP

Minutes of the Meeting held on 16 October 2014

Present:
- Rhod Mitchell (Chair) Lay Member
- Sandra Cheseldine Lay Member
- Sharon Fox Independent Nurse Member
- Jo Webster Chief Officer
- Andrew Pepper Chief Finance Officer
- Hany Lotfallah Secondary Care Consultant

In Attendance:
- Katherine Bryant Governance & Board Secretary
- Greg Connor Executive Clinical Advisor
- Angela Peatfield Minute Taker

1 Apologies

Apologies received from Stephen Hardy and Jo Pollard.

2 Minutes of the meeting held on 17 July 2014

The minutes of the meeting were agreed as a correct record.


Greg Connor attended the meeting to present this report and confirmed that the NDF Scrutiny Panel had met on 5 August 2014 to consider remedial action plans for the practices which had not achieved the 90% utilisation target required by the NDF. Two practices agreed they were unlikely to be able to claw back sufficient activity in future quarters and so received a reduced payment. One other practice received no payment. A further six practices negotiated remedial plans and these were approved by the Scrutiny Panel and are reflected in the new performance targets for Q2.

The Scrutiny Panel met again on 9 October to review the Q2 (July to September) performance of each practice and Greg highlighted the following:

- All practices have achieved five of the seven Key Performance Indicators (KPI) for Q2
- Two of the seven KPIs require review due to factors outside the control of practices
- 38 practices have met or exceeded the target for additional clinical activity in Q2
- One practice has underachieved but remedial action has been proposed and is recommended by the Scrutiny Panel
- One practice has a delayed submission

It was noted that excluding the delayed submission, the NDF has funded 36,400
additional patient contacts in Q2 which is an increase of 4,490 on Q1.

A discussion took place regarding the increase in additional patients and Hany Lotfallah queried how many of the additional patient contacts were new visits or patients returning for additional appointments? Greg Connor advised that this data was not collected but confirmed that the level of demand is rising and extra capacity is necessary to meet demand.

Greg advised that all practices have submitted proposals for a Network Health Improvement Plan detailing priorities for each network. Stage 2 will be taking place between October and December 2014 with a completed plan required for submission to the NDU by 19 December 2014.

Hospital activity and budget data is not yet available to networks due to delays in the implementation of the IT system which is currently being piloted.

It was noted that all practices have coded outpatient referrals and reports have been compiled on a monthly basis. Use of the recommended codes has improved from Q1, however not every practice is achieving 90% compliance with the formulary. It has been identified that codes submitted by some community staff are affecting the results from practices. Therefore, the formulary has been revised and the NDU is working with the practices under 90% compliance to review the specific codes. It was acknowledged that good progress has been made. Following discussion, Rhod Mitchell requested for a cumulative total to be included in future coding information.

Details of membership engagement were shared and Greg commented that it is important that a full complement of practices attend the network meetings to ensure full engagement from all networks. It was acknowledged that attendance can be related to practice size noting that small practices can sometimes find it difficult to attend all network meetings. If a network chair is unable to attend, another clinical lead can attend on their behalf. Jo Webster commented that consideration should be given to how single handed practices can be supported to ensure they are able to attend network meetings.

Rhod Mitchell asked if consideration has yet been given to how objectives may be delivered differently next year. Greg advised that this first year is testing the process and the networks will be involved in devising the draft plan for 2015/16.

Jo Webster commented that plans need to be aligned to future seven day access and as networks mature consideration should be given as to how resources could be used differently. Greg acknowledged that some funding streams are time limited and some monies are on a non-recurrent basis. Andrew Pepper suggested that the focus next year should be on the difference made to patients and to consider the outputs as well as inputs.

Jo Webster congratulated the NDU for their achievements acknowledging that the focus is now on developing the draft plans for January 2015. The Primary Care Strategy and the comments raised at the Governing Body Development Session held on 14 October need to be considered when developing future plans.
It was RESOLVED that

i  The EAG approved the report of the NDF Scrutiny Panel including the proposals for payments and remedial action required by the Network Development Framework.

4  Any other business

No other business was raised.

5  Date of next meeting

Thursday, 15 January 2015, 4.30 pm in the Seminar Room, White Rose House.
HEALTH AND WELLBEING BOARD

Thursday, 13 November 2014

Present: The Chair (Councillor Mrs P Garbutt)
The Deputy Chair (Dr P Earnshaw)
Councillor Mrs M Cummings
Councillor Mrs Rowley
Mr A Balchin Corporate Director WMDC
Mr J Wilson Corporate Director WMDC
Dr L Kamal CCG Representative
Mr S Hardy Non-Executive Member of CCG
Dr A Sheppard CCG Representative
Dr A Carroll CCG Representative
Mr S Michael SWYFT
Chief Superintendent Whitehead West Yorkshire Police
Mr S Eames Mid Yorkshire NHS Trust
Ms J Webster Mid Yorkshire NHS Trust
Ms P Bee Voluntary Sector Representative

34. ACCEPTANCE OF APOLOGIES FOR ABSENCE
Apologies for absence submitted prior to the meeting were accepted on behalf of Mr K Dodd, Ms J Roney OBE and Mr P Loosemore.

35. MINUTES - 18 SEPTEMBER 2014
Resolved – That the Minutes of the meeting of the Health and Wellbeing Board held on 18 September 2014 be approved as a correct record, subject to the following amendments:

- Item 27 – first sentence, second paragraph should read – The BCF had been developed in line with the transformation plans and integration plans for the Wakefield District, developing a vision and shared narrative around health and social care.
- Item 28 - second paragraph, second sentence should read – The Health and Wellbeing Board had welcomed the plans but acknowledged there was further work to be done.
- Item 28 – Resolved number 2 should read – That the Board agreed that the Delivery Plans were submitted to the Health and Wellbeing Board on the 13 November and would be submitted to the Local Services Board on the 21 January 2015.
- Item 30 – Resolved number 2 should read – That the Board feedback discussions on the report to the Adults and Health Overview and Scrutiny Committee in 6 months’ time.
- Item 31 – paragraph one sentence one should read – Jo Webster, the Accountable Officer Clinical Commissioning Group advised that Joyce Redfearn had created a draft paper entitled ‘Integration in Wakefield: A Reflection’ which highlighted successes, problems and challenges.
- Item 31 – paragraph 2 in addition (at the end) – This paper will be incorporated into the Government review and referenced.

36. MEMBERS DECLARATIONS OF INTEREST.
No Declarations of Interest were made.
37. CONNECTING CARE: BETTER CARE FUND/GOVERNANCE REVIEW - SIGNAL OF INTENT.
Consideration was given to a report of the Chief Accountable Officer, Wakefield CCG and the Corporate Director, Adults, Health and Communities, Wakefield Council.

The Better Care Fund Plan had been shared with NHS England and received notification that this had been ‘Approved with Support’ with the emphasis that it was a strong plan. The next couple of months would be spent refining the plan from the feedback received and strengthening the arrangements to be more effective and responsive. By April 2015 a section 75 agreement would need to be in place and signed by Wakefield Council and Wakefield Clinical Commissioning Group to outline the pooled budget arrangements.

The Board praised the Plan so far and asked that engagement with patients and colleagues be ongoing so that it captured their views and became more robust and inclusive. Any changes to the plan needed to fit within the timescale and then there would be an opportunity to change the constitution in January 2015. A Governance Review would take place and the outcomes would be brought back to the Board in due course.

Resolved – 1) The Board agreed that it would undertake a review of Governance arrangements through a phased approach outlined in the report.

2) The Board adopted the principles outlined in the report.

3) That the terms of reference for the Health and Wellbeing Board, the Integration executive and the joint Strategic Commissioning Group be reviewed as part of the Governance Review.

4) That the timetable outlined in the report be approved.

5) That Board members would commence consultation within their organisations to ascertain the demand for Governance arrangements and feedback at the January 2015 Board meeting.

6) That a paper concerning the progress of the review of governance arrangements for Integration of Adult Care in Wakefield District be reviewed at the January 2015 meeting.

38. DISTRICT OUTCOMES FRAMEWORK - DELIVERY PLANS
Consideration was given to a report of the Chair of the Health and Wellbeing Board and the Director of Public Health, Adults, Health and Communities about the Delivery Plans being developed to support the District Outcomes Framework 2014/15.

The Plans had proved difficult and challenging but were created to ultimately improve the provision of care in the Wakefield District. SWYFT were praised for their work around dementia and the links established.

It was noted that the data shown in the current Dementia Delivery Plan referred to 2012/13 and as updated information was received into the CCG the plan would be refreshed.

Smoking was also discussed and the fact that if a patient had given up with the help of SWYFT, then their progress could be tracked. There were some difficulties encountered
when trying to maintain a healthy workforce and productivity could be affected by smoke breaks.

**Resolved** - 1) That the content of the Delivery Plans be approved.

2) That Mrs Wilson refresh the data within the Dementia Delivery Plan when available.

3) That the Delivery Plans be submitted to the Local Services Board on the 1 January 2015 recognising some may still be work in progress.

39. **MENTAL HEALTH TRANSFORMATION UPDATE**

Consideration was given to a report of the Senior Commissioning Manager, NHS Wakefield CCG on the progress of the Mental Health Service Transformation in delivering the planned interventions outlined in NHS Wakefield CCG's Five Year Strategic Plan.

The interim team for the Psychiatric Liaison Service had been in place since December 2013 and seen over 1300 patients at Pinderfields and Pontefract. A small amount of data had been gathered showing an increase in admissions but this was expected, having only been gathered over a short period of time. Long range data would be likely to show a different picture and would be captured as an ongoing process. There had been a significant reduction in stay and also in the length of time patients waiting time for assessments, which was the intention of the strategic plans.

Wakefield had a very high level of 15-24 year olds admitted through self-harm and this would be analysed once further data had been received. Work had begun on intervention with young people, parents and adolescents. Various services were involved in the transformation of mental health services and SWYFT was at present reviewing the Child and Adolescent Mental Health (CAHMS) service specification and delivery model. Lower level intervention would be increased through the changes which were being made.

Engagement with members of the public, service users, carers, provider organisations and other stakeholders was a key focus on driving the changes and had resulted in underpinning principles which would be delivered by secondary mental health services. Clearer signposting to support services and more targeted services such as housing would be developed further.

A district wide agreement was required to be submitted to show commitment locally to the Crisis Care Concordat, which was a document published by the Government. A total of 22 national bodies had already signed up to the agreement which gave a responsibility towards people who needed help with their mental health.

**Resolved** – 1) That the progress made against each intervention was noted.

2) That the format of the Crisis Care Concordat declaration, included in the report, be agreed.

40. **INTEGRATED EARLY HELP OFFER - PRESENTATION AT THE MEETING.**

Carly Speechley, Service Director, Children and Young People’s Directorate gave a presentation on Better Services for Children, Young People and Families.

A case had been created for change in the services which had been brought about by
HEALTH AND WELLBEING BOARD - THURSDAY, 13 NOVEMBER 2014

financial challenges and system failures in terms of serious case reviews. The aim of the changes was to provide the best possible outcomes for children and their families through the work of co-ordinated services. Six outcomes had been created to drive the Children and Young Peoples Framework and was based around the needs of the community.

Seven Integrated Early Help Hubs had been created to service all areas of the District, each with an Integrated Team Manager and a Locality Service Manager who would oversee the Leadership Team. The Leadership Teams also contained representatives from other Services such as Street Scene, Schools and the Police.

More emphasis would be placed on identifying families where trouble may occur such as vulnerable and chaotic households where abuse, truancy and Anti-Social behaviour often took place. Data was being collected about troubled families which would make the process of intervention easier. A support system had been created with levels from one to five, five being the highest level of protection incorporating use of the criminal justice system.

Resolved – That the report be noted.

41. SERVICES FOR CHILDREN.
Dr Ann Carroll, CCG (Clinical Commissioning Group) gave a report on the changing services for children.

It was noted that there were an increasing number of children at risk or being looked after and the transformation of Integrated Children’s services took this into account. Health Visitors and School nurses would be moved from the Health Service to the Local Authority and this would be managed closely to ensure the new service matched the old one.

The Integrated Early Help Hubs would refer patients to GPs and children’s centres while hospitals and other agencies would be referred to the Hub. GPs would be referring cases to social care at an earlier stage than they did previously. The IT system would be improved so it could be used to a greater capacity including the development of IT links. Services would be made more easily accessible, especially to troubled families, who had encountered difficulties in the past with accessing them.

It was further explained that one in four children attended A & E each year and a quarter of these children were admitted to hospital. Pathways for urgent care, long term conditions and safeguarding had been rewritten and would improve the efficiency of the service. Much emphasis would be placed on partners working together over the next 6 months to develop the best possible plans for 2015/16.

Children and young people’s mental health had been selected as a pilot project to review how care was provided locally and this would be linked in with adult mental health.

Resolved – That the report be noted.

42. RECENT DEVELOPMENTS IN PRIMARY CARE COMMISSIONING - PRESENTATION AT THE MEETING.
Dr Greg Connor, Executive Clinical Advisor and Dr Phil Earnshaw, Chair of the Clinical Commissioning Group gave a verbal update on the recent developments in Primary
HEALTH AND WELLBEING BOARD - THURSDAY, 13 NOVEMBER 2014

Care Commissioning.

There would be a substantial change with the introduction of co-commissioning giving more local control and delivering integrated out of hospital services. An external review of primary care contracts had been commissioned working with NHS England. Most contracts were PMS (Personal Medical Services) which was a locally agreed alternative to the GMS (General Medical Services) contracts which some were. The review would look at value for money, how the service worked with others and whether the contract gave the best possible outcome.

Although there seemed to be some public anxiety around the NHS changes and plans, the CCG were proud of the network development and were working on sensitively delivering a common approach across the district. The changes were not just about more GPs but different ways of accessing services and a principal seven day working pattern. Engagement would continue into December and then transition arrangements would start in January and continue until March.

Resolved – That the report be noted.

43. CCG VERBAL UPDATE.
Jo Webster, the Accountable Officer Clinical Commissioning Group gave a verbal update on the five year plan and emphasised how the changes would be put into place.

Three facets were needed to sustain a high quality NHS, demand was one of them which included prevention; however, there were only so many resources available so careful planning was required to maximise the effect. Efficiency was the second and funding the last which was closely related to finance and was a huge challenge.

A CQC (Care Quality Commission) inspection of MYHT had recently taken place which showed that the Trust required considerable improvement although the CCG had been aware that changes needed to be made before the report had been received. The financial position had improved, however, and the Trust's deficit stood at £17 million rather than the previous figure of £50 million. The Trust acknowledged that the inspection had been the right way forward and that they needed to change for the better. Part of the report highlighted the safety of the hospitals and although this had been an issue for at least a decade, especially with outpatients, things were improving. The biggest message to take from the report was the fact that the staff were of a caring nature.

Resolved – That the update be noted.

44. GOOD NEWS UPDATE - HSJ AWARDS - VERBAL ITEM.
The Chair reported that the Wakefield CCG had been shortlisted for Clinical Commissioning Group of the year by HSJ (Health Service Journal). The HSJ Awards were the largest celebration of healthcare excellence in the country.

Mr Steven Michael Chief Executive, South West Yorkshire Partnership NHS Foundation Trust reported that they had won a Health Service Journal Award for 'Compassionate Patient Care'. The Trust’s Creative Minds Initiative encourages creative approaches and activities in healthcare helping to increase self-esteem, provide a sense of purpose, develop social skills, help community integration and improve quality of life. Since the launch of the initiative in 2011, Creative Minds has delivered more than 150 creative
products in partnership with over 50 community organisations – benefitting over 3000 people.

Resolved – That the report be noted.

45. DUE NORTH - REPORT ON HEALTH EQUITY FOR THE NORTH OF ENGLAND.
Resolved – That the report be noted.

46. LOOKED AFTER CHILDREN AND CARE LEAVERS STRATEGY 2014/17.
Resolved – That the report be noted.

47. NHS PRIORITIES FOR THE COMING MONTHS - TRIPARTITE LETTER 18 SEPTEMBER 2014.
Resolved – That the report be noted.

48. WEST YORKSHIRE FINDING INDEPENDENCE (WY-FI) PROJECT REPORT.
Resolved – That the report be noted.

49. GETTING READY FOR WINTER - LETTER FROM JANE ELLISON MP, PARLIAMENTARY UNDER SECRETARY FOR STATE FOR PUBLIC HEALTH.
Resolved – That the report be noted.

50. ANY OTHER BUSINESS.
Councillor Cummings advised that she was concerned about the sharp increase of drug and alcohol use in the district. Liver disease was also on the rise so there could possibly be a correlation between the two.

Ms Wilson advised that there was a gastroenterology steering group around the prevention of liver disease and feedback from the meeting could be brought to the next Health and Wellbeing Board meeting.

51. DATE AND TIME OF NEXT MEETING.
The next meeting of the Health and Wellbeing Board will be held 12.30 p.m. on Thursday 22 January 2015 in Committee Room A, County Hall, Wakefield.

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