BOARD MEETING OF THE GOVERNING BODY

TO BE HELD ON TUESDAY, 11 MARCH 2014
BOARDROOM, WHITE ROSE HOUSE
AT 1.00 PM

AGENDA

PART 1

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<tr>
<th>No.</th>
<th>Agenda Item</th>
<th>Lead officer</th>
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<td>1.</td>
<td>Welcome and Chair’s Opening Remarks</td>
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<td>2.</td>
<td>Apologies for Absence – Dr Andrew Furber and Sandra Cheseldine</td>
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<td>3.</td>
<td>Public Questions and Answers</td>
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<td>4.</td>
<td>Declarations of interest</td>
<td>All present</td>
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<tr>
<td>5.</td>
<td>a Minutes of the meeting held on 14 January 2014</td>
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<td>b Action sheet from the meeting held on 14 January 2014</td>
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<td>6.</td>
<td>Matters arising</td>
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<td>7.</td>
<td>Chief Officer Briefing</td>
<td>Jo Webster</td>
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<td>9.</td>
<td>Finance Report Month 10</td>
<td>Andrew Pepper</td>
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<td>10.</td>
<td>Process for sign off of NHS Wakefield CCG Final Accounts for 2013/14</td>
<td>Andrew Pepper</td>
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<td>11.</td>
<td>WSYB Commissioning Support Unit Service Level Agreement</td>
<td>Andrew Pepper</td>
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<td>12.</td>
<td>Safeguarding Annual Reports</td>
<td>Mandy Sheffield</td>
</tr>
</tbody>
</table>
13. Risk Register Report

14. Receipt of minutes and items for approval

a Audit Committee
   (i) Minutes of meeting held on 4 February 2014

b Integrated Governance Committee
   (i) Minutes of meeting held on 19 December 2013,
   (ii) Minutes of meeting held on 16 January 2014

c Clinical Cabinet
   (i) Minutes of meeting held on 19 December 2013
   (ii) Minutes of meeting held on 30 January 2014

d Health and Well Being Board
   (i) Minutes of meeting held on 16 January 2014

e Decisions of the Chief Officer – verbal update

15. Any other business

16. 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)”.

17. Date and time of next Public meeting:

   Tuesday, 27 March 2014, 1pm in the Boardroom, White Rose House
Welcome and Chair's Opening Remarks

Dr Earnshaw welcomed everyone to the first Governing Body meeting of 2014. In particular he welcomed Professor Moira Livingstone (observing the meeting as part of a board assessment) and Laura Elliott (standing in for Jo Pollard who had been called away at short notice). He explained that this was the Governing Body’s first paperless meeting.
14/2 **Apologies for Absence**

Apologies for absence were received from:

- Dr Avijit Biswas  
  GP, Pinfold Lane Surgery
- Stephen Hardy 
  Lay Member
- Jo Pollard 
  Chief of Service Delivery and Quality

14/3 **Declarations of Interest**

Dr Phil Earnshaw reminded members of the Governing Body that any conflicts of interest should be declared. There were no declarations of interest at this stage.

14/4 **Public Questions and Answers**

Following a question he raised on 12 November 2013 about changes to the MYHT continence service Mr Tony Howell from Spectrum People thanked members of the Governing Body for their response. Dr Earnshaw offered any further help to Governing Body could offer to facilitate a resolution to this issue.

Dr Earnshaw invited further questions from the public, but there were no additional questions.

14/5 **Minutes of meeting held on 12 November 2013**

It was **RESOLVED** that:

i) the minutes of the meeting of the NHS Wakefield Clinical Commissioning Group Governing Body Meeting held on 12 November 2013 were agreed as a correct record with no amendments.

14/6 **Action sheet from meeting held on 12 November 2013**

Katherine Bryant provided the governing body with an update on progress on outstanding actions from 12 November 2013. She noted that all were completed with the exception of:

- Minute 13/64 – the continuing healthcare system and processes report will be presented to the Governing Body in March 2014.
- Minute 13/151 – an update report would be provided to the Governing Body during the private section of the meeting.
- Minute 13/155 – an update was included within the Chief Officer’s briefing report.

14/7 **Matters arising**

There were no matters arising.

14/8 **Chief Officer Briefing**

Jo Webster presented the Chief Officer briefing report. She provided an update regarding the proposed development of Castleford Health Centre.

It was reported that the CCG’s Quality Intelligence Group will consider local implementation of the government’s response to the Francis Enquiry (titled ‘Hard Truths:
The CCG Assurance Framework balanced scorecard for quarter 2 showed a worsened position for domain three, which was now red. Jo confirmed that in response the CCG was supporting MYHT to implement health care acquired infection personal accountability agreements.

The Programme Executive approved The Mid Yorkshire Health and Social Care Partnership Transformation Programme Outline Business Case (referred to as the OBC) in principle in December 2013. The OBC is being further developed and finessed in light of recent NHS England guidance (for example the NHS England publication Everyone Counts: Planning for Patients 2014/15 to 2018/19). It is expected that the revised OBC will be presented to the Governing Body in March 2014, alongside the CCG’s strategic and operational plans. Jo confirmed that the Secretary of State decision is still awaited regarding review of the Acute Hospitals Reconfiguration Outline Business Case.

In March 2013 the Governing Body delegated authority to the ‘Executive Approvals Group’ to consider and approve the Primary Care Local Improvement Framework (PCLIF) for 2013/14. The Executive Approvals Group met in December 2013 to consider the interim evaluation of the PCLIF scheme. It was agreed that the PCLIF scheme should not be recommissioned for 2014/15 in its current form. It is proposed that successful aspects of the scheme are carried forward into a new scheme for 2014/15. Dr Ann Carroll emphasised the importance of circulating a timetable to practices to help them consider and manage the implications of a new scheme.

Sharon Fox asked for further information about the proposed development of Castleford and Normanton District Hospital. Dr Earnshaw outlined the history to the development plans and noted the complex nature of the situation. He expressed his commitment to facilitating a resolution to the development proposals.

It was **RESOLVED** that the Governing Body:

(i) note the contents of the report for information.
(ii) support on-going developments outlined in the report.
(iii) approve an extension to the membership of the Executive Approval Group to include the Chief Finance Officer and Chief Officer.
(iv) agree to delegate authority to the Executive Approval Group to consider and approve a new Primary Care Local Improvement scheme for 2014/15 which is focused on quality improvement and aligned to the CCG’s care closer to home transformation, within available financial resources.

**Presentation: Digital Strategy**

Dr Clive Harries provided members of the Governing Body with an update on the CCG’s digital strategy. He described his passion for technology and what it can do to help people work together. Recognising however that if people are not fully supported new technology can be difficult and daunting.

The strategy has four key strands; communications, collaboration, information, and finally knowledge and skills.

Clive described a range of potential applications for new technology within clinical systems (for example e-consultations) and across corporate functions (for example instant messaging to reduce the number of meetings).
Two short film clips were shown, which described the use of new technology in telemedicine and the Vertucare processing being developed in Bradford.

It was agreed that CCG’s goal will be to “create a digital health community that shares information and knowledge, communicates, plans and collaborates in ways that free people to provide and receive the highest quality care”.

Dr Earnshaw thanked Clive for his presentation and invited members of the Governing Body to ask questions. Dr Sheppard asked whether the introduction of e-consultations in Bradford had reduced the number of clinics. Dr Harries confirmed that e-consultations were being used by a range of specialities and had resulted in a reduced number of hospital clinics. Steve Bryan noted the importance of capturing what patients want, Dr Harries echoed this and drew attention to potential funding from the Prime Ministers Challenge Fund.

It was **RESOLVED** that the Governing Body:

(i) note and supported the Digital Strategy presentation.

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14/10 **Finance Report (month eight)**

Andrew Pepper introduced Karen Parkin, Head of Finance and Governance, who was in attendance to support presentation of the month eight finance report.

Year to date the CCG’s financial forecast year end position was on plan. It was noted that an additional allocation of £3,576,000 for winter pressures had been received [full details at minute 14/14].

Andrew noted three areas of cost pressure;

- an overtrade due to increased activity at Mid Yorkshire Hospitals Trust (MYHT).
- increased prescribing costs.
- increased costs within Continuing Healthcare claims.

A response had been received from NHS England following the CCG’s letter to Paul Baumann (Chief Financial Officer, NHS England) regarding the fundamental review of allocations policy.

Members of the Governing Body were invited to comment and ask questions.

With regard to the MYHT day case over trade Sandra Cheseldine noted recent issues with coding accuracy at MYHT. In light of this Sandra queried how sure the CCG was that there had been a change in the day case mix. Andrew assured the Governing Body that inappropriate coding is discussed with MYHT and challenged appropriately.

Rhod Mitchell asked whether MYHT were still experiencing difficulties as a result of the new Patient Administration System (PAS). Andrew said that the Trust had seen errors in the system and the way the system was being used. A programme of activity to resolve these issues was in place and would be completed by February 2014.

It was **RESOLVED** that the Governing Body:

(i) note the contents of the Finance Report (month 8).
Financial Plan 2014/15 and onwards

Andrew Pepper reported that the CCG had received confirmed allocations for the financial years 2014/15 and 2015/16. In addition NHS England had provided planning assumptions for a further three years. There had previously been concern that if the fundamental review of allocations had been adopted in full Wakefield CCG would have seen a significant reduction in funding. NHS England had not however decided to fully implement the review, and there would therefore be growth for the next two years.

The CCG programme allocation for 2014/15 will be £457,483k and the running costs allocation will be unchanged at £8,580 (£25 per head of population). In 2015/16 the running cost allocation will reduce by 10%. The Quality Innovation Productivity and Prevention (QIPP) target will need to be circa £14m for 2014/15.

A change in the business rules will require the CCG to invest circa £11.4million non-recurrently. Andrew reflected that this was a significant sum to invest non-recurrently and suggested that the Governing Body will need to consider whether it was wise to invest such a large sum in one year.

Work is underway to implement the Better Care Fund, a pooled fund which will be held jointly by the CCG and Wakefield Council. The minimum level for Wakefield will be £26.9million (including capital).

Finally Andrew noted the first draft of the CCG’s financial plan will be submitted on 14 February 2014. Jo Webster added that this will be developed ‘hand-in-glove’ with the strategic and operation plans.

Sandra Cheseldine drew attention to point 11 of the report (QIPP), and expressed concern about the proposed use of non-recurrent funds to resolve a recurrent issue. Andrew Pepper said the Governing Body will need to balance the use of non-recurrent funds against disruption to the underlying position.

It was RESOLVED that the Governing Body:
   (i) note the contents of the report.

Strategic Plan

Sally Bell explained that the mandate from government to NHS England requires CCGs to produce 2 year operational plans and a 5 year strategic plan. This was a new approach for the NHS. The report presented to the Governing Body summarised guidance issued to CCG by NHS England.

Plans are being built on the assumption that the MYHT Meeting the Challenge programme will progress as planned. The Secretary of State has not yet made a decision. Any further delay, or a decision that does not accept all the proposed changes in the programme, is a risk and will have a considerable impact on the whole MYHT health economy. Jo Webster said that work over the past year placed the CCG in a strong position to determine strategy in the absence of the Secretary of State’s decision, but nevertheless continued delay was a risk to the organisation.

Sally described a few key themes from the strategic plan, including technology, seven-day working, and out of hospital care. Quality will be integral to all parts of the plan. The development of primary care will underpin the strategy.
Members of the Governing Body will be invited to contribute to development of the strategic plan including at a development session on 11 February 2014. Jo Webster drew attention to the ways in which member practices will be engaged in the development of the strategic plan.

Work is underway at a regional level to integrate and align each CCG’s strategic and operational plans. Jo Webster provided additional detail and assured the Governing Body that the intention is to enhance regional cooperation and avoid duplication across strategic plans.

Dr Furber said that he welcomed the strategic planning process, and hoped that in the future a single plan for health and social care across Wakefield would be possible.

It was RESOLVED that the Governing Body:

(i) note the contents of the paper;
(ii) support the workshops that will be held in March and April in order to continue to develop strategic thinking; and
(iii) support the direction of travel.

14/13 Integrated Quality and Performance Summary Report

Andrew Pepper explained that the report showed a continuation of the themes presented in November 2013.

Andrew reported that YAS had failed to achieve the 75% target for Cat A Red 2 8 minute response times for the period, but remained on target for the year to date. Andrew noted that this was positive trajectory and a great deal of energy and resource had been expended to improve performance.

Although they are on an improving trajectory ambulance turnaround times remain significantly below the required standard at all three hospital sites. Dr Earnshaw reflected that during a recent patient safety walkabout he saw improvement at Dewsbury Hospital in how turnaround times were managed.

Laura Elliot reported that both MYHT and Wakefield CCG are breaching the MRSA target; 7 cases recorded against the CCG year-to-date. It is forecast that Wakefield CCG will fail to meet the Clostridium Difficile target. All reported cases are being mapped, but no pattern or trend has yet been identified. In addition the Medicines Management Team is undertaking work to lower the usage of Proton-pump inhibitors (PPIs).

Matt England reported an improvement has been seen across all 18 week referral to treatment pathways with non-admitted and incomplete pathways now meeting the required standard. He noted regular meetings are being held with MYHT to discuss resolution of issues following implementation of the PAS system.

Members of the Governing Body were informed that ‘Improving Access to Psychological Treatment’ (IAPT) remains a risk because it is below the target level of performance. A recovery plan has been agreed with the provider.

Laura Elliot said that MYHT received a highly commended award from Dr Foster for a reduction in weekend mortality. Furthermore the Friends and Family Test performance at MYHT continues to be positive.
A total of eight GP practices within Wakefield district had been reviewed by the CQC. Only three reports had been published; all show full compliance with the five outcomes assessed.

Jo Webster congratulated Matt England and Laura Elliot and their teams on the quality of the Integrated Quality and Performance report.

Mr Hany Lotfallah sought further details about the speciality within which the 52 week breach had taken place.

Dr Brown queried figures included within the South West Yorkshire Partnership Foundation Trust (SWYPFT) dashboard. In particular the “crisis referrals (2 hours) receiving a face to face contact within 2 hours for CAMHs” target. It was agreed this should be rated as ‘red’ (and not ‘green’);. In addition David reflected that in his experience routine referrals (excl. memory service) were not receiving a face to face contact within 14 days. It was agreed that a deep-dive analysis will be presented to the Integrated Governance Committee in February.

It was RESOLVED that the Governing Body:

(i) note the content of the report and actions;
(ii) note the information contained in the report related to NHS Wakefield CCG across all providers including Mid Yorkshire Hospitals NHS Trust for October 2013 (unless otherwise stated).

14/14 Update on Winter Plans 2013/14

Dr Adam Sheppard and Sally Bell provided an update on work undertaken since the Governing Body approved the Winter Plan in November 2013. The Urgent Care Strategic Group (formerly referred to as the Urgent Care Board) have considered all changes to the Winter Plan.

The plan now includes the process for a daily conference call to take place (7 days per week). Sally noted the need for these calls. In addition a ‘surge and escalation’ plan has been written to accompany the Winter Plan.

Additional non-recurrent monies have been allocated by NHS England to Wakefield CCG for use across the Mid Yorkshire area. £3,560k has been allocated to partners of the Mid Yorkshire Urgent Care Strategic Group. These monies were approved by the Chief Officer and Chief Financial Officer under the CCG’s Operating Scheme of Delegation. Sally noted that the monies must be spent by the end of March 2014.

It was RESOLVED that the Governing Body:

(i) note additional work undertaken to strengthen the winter plan and the development of the surge and escalation plan.
(ii) note the additional non recurrent funding and how funding has been allocated.

14/15 Local Clinical Network Reconfiguration

Dr Greg Connor explained that the CCG’s membership structure had developed organically. It had however become clear that the existing network structure did not effectively support practices to work closely together. It was therefore proposed that
practices are reconfigured in seven networks, broadly consistent with the local authority neighbourhood boundaries.

Greg explained that the criteria for deciding on a new network structure was:

- geographical contiguity;
- mirroring local authority boundaries where this is feasible;
- similar sized networks big enough to be efficient but small enough to be engaging;
- networks which fit with the integrated care teams required by the care closer to home programme.

A total of seven responses were received from practices. In addition to the comments included in the paper, a concern had been raised about the need to support development of the new networks.

The Governing Body were invited to comment on the proposals. Steve Bryan expressed his support and echoed the need to support the further development of the practice networks.

Dr Ivan Hanney suggested that in future a small commissioning budget should be devolved to each network.

Jo Webster welcomed the progress made in the CCG’s first 12 months. She confirmed that an organisational development expert would be engaged to support the further development of the CCG’s membership.

It was RESOLVED that the Governing Body:

(i) approve the proposed reconfiguration of local clinical networks with immediate effect.

14/16 Director of Public Health Annual Report

Dr Andrew Furber presented the Director of Public Health Annual Report. He explained that the report focused on long terms conditions and dementia; the back story to integration.

Recommendations are included in the Director of Public Health Annual Report; they focus on prevention and empowerment of people with long-term conditions. Furthermore the report outlines proposals to support patients with dementia and their families, for example increased awareness and the introduction of dementia friendly communities.

Dr Furber also explained that the report included information about progress against the recommendations made last year.

The Governing Body welcomed the report and thanked Dr Furber. It was agreed the copies would be re-circulated to member practices.

It was RESOLVED that the Governing Body:

(i) note the Director of Public Health Annual Report 2013.

14/17 S256 agreement re Social Care Funding by NHS England

Mr Andrew Balchin declared an interest in this paper.
It was proposed that £5.9m funds would be transferred from NHS England to Wakefield Council via a s256 agreement. This was subject to CCG support and evidence that the funds will benefit health.

The Governing Body noted that the report had previously been considered by the Joint Strategic Commissioning Board (JSCB) and Clinical Cabinet. And on 16 January 2014 the Health and Wellbeing Board will be asked to formerly approve the proposal so that the transfer of monies can be achieved prior to 31 March 2014.

It was **RESOLVED** that the Governing Body:

(i) note and agree the s256 agreement prior to progress to the Health and Wellbeing Board.

### 14/18 Better Care Fund Update

Helen Childs explained that report was written jointly between the CCG and Wakefield Council. This fund supports the strategic objectives of the CCG; it will help the CCG achieve transformation and integration in Wakefield, helping to ease the pressure of demographic changes.

The fund will be a single pooled budget held joint between the council and the CCG, with the needs of patients a central focus. The Health and Wellbeing Board will have responsibility for signing off the final plan, following formal support for the CCG Governing Body. In light of the very tight timetable for submission it was proposed that the Chair and Chief Officer (having consulted with at least two lay members) approve the final draft Better Care Fund plan on behalf of the Governing Body.

It was noted the Joint Strategic Commissioning Board (JSCB) would consider implementation of the Better Care Fund at a forthcoming development session.

Jo Webster drew attention to the need for the Better Care Fund plan to align with the strategic, operation and financial plans.

It was **RESOLVED** that the Governing Body:

(i) note the details of the Better Care Fund and its relevance to Wakefield District.

(ii) approve the Better Care Fund approval process.

### 14/19 Commissioning and Contracting Strategy

Andrew Pepper introduced the Commissioning and Contracting Strategy. He confirmed that the Integrated Governance Committee had considered and discussed the strategy.

The strategy described the eight stage commissioning cycle approach. Matt England and Debra Taylor-Tate explained that it brings together commissioning, contracting and finance aspects; all of which are equally important and need to be intrinsically linked.

It was agreed that there should be further development of the section of the strategy which outlines the CCG’s commercial strategy.

It was **RESOLVED** that the Governing Body:

(i) receive and approve the Commissioning and Contracting Strategy, subject to
one revision strengthening the description of the CCG’s commercial strategy.

14/20 Minutes of the Audit Committee held on 17 December 2013

Sandra Cheseldine presented minutes the minutes of the Audit Committee held on 17 December 2013, and invited the Governing Body to consider the headline discussions outlined in the cover sheet.

It was RESOLVED that the Governing Body:
   (i) the minutes of the Audit Committee held on 17 December 2013 be noted.

14/21 Minutes of the Integrated Governance Committee held on 21 November 2013

Rhod Mitchell presented minutes of the Integrated Governance Committee held on 21 November 2013, and invited the Governing Body to consider the headline discussions outlined in the cover sheet.

It was RESOLVED that the Governing Body:
   i) the minutes of the Integrated Governance Committee held on 21 November 2013 be noted.

14/22 Minutes of the Clinical Cabinet held on 24 October 2013 and 28 November 2013.

Dr Adam Sheppard presented minutes of the Clinical Cabinet held on 24 October 2013 and 28 November 2013, and invited the Governing Body to consider the headline discussions outlined in the cover sheet.

It was RESOLVED that the Governing Body:
   i) the minutes of the Clinical Cabinet held on 24 October 2013 and 28 November 2013 be noted.

14/23 Minutes of Health and Wellbeing Board held on 14 November 2013

Jo Webster presented the minutes from the Health and Wellbeing Board meeting held on 14 November 2013.

It was RESOLVED that the Governing Body:
   i) minutes of the Health and Wellbeing Board on 14 November 2013 be noted.

14/24 Any other business

There were no 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).

14/25 Date and time of next meeting
Tuesday, 11 March 2014, 1pm in the Boardroom, White Rose House
### Action Points from the Meeting held on Tuesday 14 January 2014

<table>
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<tr>
<th>Minute No</th>
<th>Topic</th>
<th>Action Required</th>
<th>Who</th>
<th>Date for Completion</th>
<th>Progress</th>
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<tr>
<td>13/64</td>
<td>Chief Officer Update – Continuing Care</td>
<td>• Final report from the independent organisation commissioned to undertake an audit of local Continuing Healthcare systems and processes to be presented at a future Board meeting</td>
<td>Jo Pollard</td>
<td>March 2014</td>
<td>Report will be presented to the Integrated Governance Committee in March 2014.</td>
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<tr>
<td>14/08</td>
<td>Chief Officer Update – OBC</td>
<td>• Revised OBC to be presented to the Governing Body for approval alongside the CCG’s strategic and operational plans</td>
<td>Jo Webster</td>
<td>March 2014</td>
<td>Meeting scheduled for 27 March 2014</td>
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<tr>
<td>14/08</td>
<td>Chief Officer Update – PCLIF</td>
<td>• Communication to practices regarding the timetable for a decision about a revised PCLIF scheme for 2014/15.</td>
<td>Dr Greg Connor</td>
<td>February 2014</td>
<td>Complete</td>
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<tr>
<td>14/12</td>
<td>Strategic Plan</td>
<td>• Link to the NHS England publication to be circulated to the Governing Body <em>Everyone Counts: Planning for Patients 2014/15 to 2018/19</em></td>
<td>Sally Bell / Katherine Bryant</td>
<td>February 2014</td>
<td>Complete</td>
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<td>14/13</td>
<td>Integrated Quality &amp; Performance Report</td>
<td>• Confirm further details about the 52 week breach (including the specialty).</td>
<td>Matt England</td>
<td>February 2014</td>
<td>Complete (confirmed that the patient was due for treatment within Trauma and Orthopedics department at MYHT. Treatment has been completed.)</td>
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<tr>
<td>Code</td>
<td>Subject</td>
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<td>14/15</td>
<td>Local Clinical Network Reconfiguration</td>
<td>• Practices to be informed that the proposed reconfiguration of local clinical networks had been approved by the Governing Body.</td>
<td>Dr Greg Connor / Dr Ivan Hanney</td>
<td>January 2014</td>
<td>Complete</td>
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<td>14/15</td>
<td>Director of Public Health Annual Report</td>
<td>• Recirculate the Director of Public Health Annual Report to member practices</td>
<td>Lee Beresford / Liz Blyth</td>
<td>January 2014</td>
<td>Complete</td>
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<td>14/18</td>
<td>Better Care Fund</td>
<td>• Chair and Chief Officer (having consulted with at least two lay members) to approve the final draft Better Care Fund plan on behalf of the Governing Body</td>
<td>Jo Webster / Andrew Pepper</td>
<td>February 2014</td>
<td>Complete</td>
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<td>Title of meeting:</td>
<td>Governing Body</td>
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<td>Date of Meeting:</td>
<td>11 March 2014</td>
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<tr>
<td>Paper Title:</td>
<td>Chief Officer Briefing</td>
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<tr>
<td>Purpose (this paper is for):</td>
<td>Decision</td>
<td>Discussion</td>
<td>Assurance</td>
<td>Information</td>
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<tr>
<td>Report Author and Job Title:</td>
<td>Jo Webster, Chief Officer</td>
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<td>Responsible Clinical Lead:</td>
<td>Dr Phillip Earnshaw, Chair</td>
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<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Webster, Chief Officer</td>
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<tr>
<td>Recommendation</td>
<td>To note the contents for information and support on-going developments outlined in the content of the report.</td>
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<td>Executive Summary:</td>
<td>To provide a brief update to members of the Governing Body on areas not covered on the main agenda.</td>
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<td>Link to overarching principles from the strategic plan:</td>
<td>Improve health equality across our population</td>
<td>Support for individual health and wellbeing</td>
<td>Care provided in the right setting and close to home</td>
<td>Appropriate access and choice for all</td>
<td>Understanding our population and putting patients at our centre</td>
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<td>Outcome of Equality Impact Assessment:</td>
<td>Not applicable</td>
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<td>Outline public engagement:</td>
<td>Not applicable</td>
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<tr>
<td>Assurance departments/organisations who will be affected have been consulted:</td>
<td>CCG Leadership Team</td>
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<tr>
<td>Previously presented at committee / governing body:</td>
<td>Presented to every meeting of the Governing Body; most recently in January 2014.</td>
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<td>Risk Assessment:</td>
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<td>Finance/ resource implications:</td>
<td>None identified.</td>
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Chief Officer Briefing

11 March 2014

Excellence in Participation Awards

NHS Wakefield Clinical Commissioning Group, in partnership with NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit, and our member practices, has been shortlisted for the Excellence in Participation to Achieve Insight and Feedback: Commissioner Award at the forthcoming NHS England Excellence in Participation Awards 2014.

Putting patients first is the initiative which aims to deliver our vision of ensuring that quality and patient experience are at the heart of the CCG. We gather insight from local people from many sources: surveys, direct feedback, consultation, social media, personal comments and statements, letters, and feedback from our member practices and partners alongside the standard channels of PALS and complaints. The uniqueness of our work is how we join up this feedback and use it to take collective action around future commissioning decisions.

Putting patients first helps us understand and use the experience of a wide variety of patients reflecting the diversity of our local population to influence every stage of the commissioning cycle through:

- Quarterly patient experience reports to inform service transformation;
- Comprehensive engagement to inform strategic planning and service reviews;
- Quality Intelligence Group to inform the monitoring of current providers; and
- Public Involvement and Patient Experience Committee (PIPEC) and Patient Participation Group (PPG) Network involvement to hold us to account as commissioners.

Putting patients first is living the NHS values by using feedback as insight to make improvements in the delivery of care. Our approach ensures that everyone counts, not basing our decisions on the views of one group or a few individuals. We make sure that those who are often not represented have a way of sharing their views either directly or via their representatives. Putting patients first encourages and welcomes feedback from everyone to improve the quality of commissioned services.

We would like to recognise the involvement and contribution of our PIPEC and PPG Network members for their contribution in this initiative.

The winners will be announced on 3 March 2014 at the Health Innovation EXPO 2014 in Manchester.

‘What matters to you?’ - Engagement on commissioning priorities

In 2012/13 we held two public events to support the development of the commissioning priorities for 2013/14. However this year, our approach and the development of the strategic plan was more inclusive and comprehensive aimed to find out what matters to patients and the public. Engagement took place through roadshows asking the local population for their priorities and thoughts on health services. A report has been produced outlining the outcomes and also including information gathered by the CSU engagement team as part of the Call to Action initiative and a summary of themes arising from the Patient Participation DES carried out by member practices and their Patient Participation Groups.

Feedback from the Governing Body informed the work and we targeted communities where engagement needed to increase – namely young people. The initiative was tailored to gain the views
of the public across the nine protected equality characteristics and took place in the form of street interviews, engagement with students and local groups, market stalls and using information from current engagement initiatives we were conducting. New relationships within the community were developed during the process and these will be explored in future engagement initiatives, diversifying the profile of respondents in future work.

The main findings from the three chapters of the report include:

- Access to services – hospital appointments, access to GPs and 24/7 access to services
- Staffing – public wanting to see increase in front line staffing levels, the need to invest in staff (training) and reduction in bureaucracy.
- Health promotion - messages in schools and to parents were seen as a way of improving health and wellbeing, together with better and affordable access to leisure facilities.
- Suggestions for improving services included more community based services and better access to GPs.
- Prevention – feedback noted more screening and earlier diagnosis and treatment, training and education programmes and investment in services for older people.
- When considering what good NHS would look like, the feedback included adequate front line staffing levels, patients being treated with dignity and respect, access to services (GP and hospital appointments and reduction of waiting times), and reducing bureaucracy, unnecessary administrative tasks and targets.

The report was shared with Clinical Cabinet on 27 February and a full presentation of the findings will be given to the group in March. Extracts from the report have been used to support Clinical Network applications for the Prime Ministers Challenge Fund, and to inform the King Street Walk-in Centre Service Review. The full report is available at http://www.wakefieldccg.nhs.uk/commissioning-priorities-engagement-report

**Q3 Delivery Dashboard (Balanced Scorecard)**

As previously reported to the Governing Body, the CCG Assurance Framework for 2013/14 is designed to give assurance that CCGs are delivering quality and outcomes for patients, both locally and as part of the national standards, as well as being the basis for assessing that CCGs are continuously improving from the start point of authorisation.

A core component of the interim framework for Quarters 1 and 2 was the Balanced Scorecard. From Quarter 3 this has been replaced by a Delivery Dashboard, refocused to become a source of intelligence which informs assurance conversations about the operational delivery of all CCGs. The dashboard no longer gives an overall RAG status for each Domain. The content of the dashboard continues to be largely generated centrally, drawing on existing published data, with a small part of the information produced by each CCG through self-certification.

NHS Wakefield CCG received the final Quarter 3 Delivery Dashboard on 18 February 2014. Below is a summary for each section of the Dashboard.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Q3 Exceptions</th>
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<tr>
<td>Quality</td>
<td>Populated by CCG self-certification submitted on 24.01.14</td>
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<tr>
<td></td>
<td>CQC enforcement action, MRSA bacteraemia cases, Never Events at MYHT.</td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>Individual items are RAG rated.</td>
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<tr>
<td></td>
<td>Red – Response to Category A calls within 8 minutes (Red 2)</td>
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<tr>
<td>Outcome</td>
<td></td>
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<td>---</td>
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<tr>
<td>Finance</td>
<td></td>
</tr>
<tr>
<td>Authorisation</td>
<td>Fully authorised</td>
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</table>

The Integrated Quality & Performance and Finance reports further on in the agenda give the current performance information and exception reports for each of these areas.

The Q3 Assurance meeting will be held with NHS England (West Yorkshire) on Wednesday 12 March. The meeting will focus on co-producing a report focused on achievements/good practice, exceptions and agreeing further actions.

**Public Sector Equality Duty Report and the Equality Delivery System**

Equality and diversity is about our commitment to be inclusive, fair and equitable to all our patients, carers, communities and staff. It is about listening to and responding to all including minority voices not just those who ‘shout loudest’. Equality and diversity is about how and what we procure and commission, how we engage with our patients, carers and communities, how we listen to, treat and engage with our staff and how we hold our providers to account to ensure services are personal, fair and address the needs of all groups in our community.

As a CCG we are required under the Equality Act 2010, to demonstrate that we are meeting our legal duties when it comes to equality and diversity. This means that we have to publish information annually, on 31 January and that we have to agree and publish equality objectives. We have used the national Equality Delivery System (EDS) as a framework to support the publication duty and to inform our equality objectives for 2014/15.

In order to establish a baseline of equality performance against the EDS goals and outcomes and develop new 4 year equality objectives we have undertaken:-

- Public and patient engagement on the 24 September 2013.
- Staff consultation via staff survey during October 2013.
- Member practice consultation via survey during November 2013. Unfortunately the response to this was disappointing and we were unable to include this in the assessment process.
- Public Sector Equality Duty (PSED) workshop held on 25 November 2013 to identify PSED evidence and assess progress against all four EDS goals.
- Board development session on 10 December 2013 to review and agree combined draft grades from the above engagement and use this to identify areas for development.
- Final agreement of the grades was delegated to the Integrated Governance Committee (IGC), who approved the grades on 19 December 2013. The Committee also requested that a smaller working group be convened to use the grades to identify development areas to inform draft equality objectives.
- The Taking forward the Equality Delivery System (EDS) and developing our Equality Objectives report shows how we are using the EDS as a framework to review and revise our current

- The IGC delegated authority to our Equality & Diversity leads (lay and executive) to sign-off the final PSED evidence for publication on 31 January 2014, supported by our E&D lead in the Commissioning Support Unit.
- On 11 February 2014, a subgroup of the IGC met with E&D experts to review all the information from the PSED and EDS reports to identify and draft equality objective aligned to our strategic objectives, and the outcomes of the EDS report. These will be presented to IGC in March with final sign off from the Board at the next meeting.

Multi-agency Safeguarding Hub

The CCG has continued to support the development of the MASH, which went live on the 6th January 2014. The recruitment of the 2 specialist Nurses and the administrative assistant have been successful, with two staff currently in post, and the third will commence in post in April.

During the first 7 weeks of operation the Local Authority have indicated that the quality of health information provided to assist them with their investigations has been of a very high standard, and has been significantly beneficial in ensuring the appropriate outcome to investigations. The transition into the new way of working has not been without challenges, the CCG continues to work through these challenges with partners in the NHS and in the MASH. Examples of where the NHS has enhanced the investigation process include:

- Identifying the existence of another child within a family unit that had not been considered in the investigation as parents had not given this child’s name to referrer.
- Identifying the complexity in a family where substance misuse was thought to be under control, but was actually increasingly chaotic.
- Finding a 2 year old child had had no contact with universal services, no GP registration, and no health input.

The CCG sponsored training for GP practices to provide information regarding the MASH, and the information governance implications of the unit. Four sessions have been undertaken, with around 150 staff from primary and secondary care attending.

CCG Organisational Change

A review of the way we have been working has been carried out and as a result a number of changes are being put in place. These changes will ensure that the CCG is fit to respond to the national NHS agenda, local health needs and future partnership working. The headline changes are as follows:

a) Strengthening the executive portfolio; creation of a new post the Associate Director of Commissioning and Quality. A change to job title; the Head of Finance and Governance will become the Associate Director of Finance, Governance and Contracting. The Associate Director of Strategy and Reform – will lead the strategy team who will become part of the new Strategy and Innovation Unit.

b) Changes to our SLA with CSU; it is our intention to strengthen our commitment to continuing our partnership working with the CSU. There will be some changes made to what we
purchase from our commissioning support service. Things are still being finalised and all the staff who will be affected have been informed. In addition, we are currently consulting with staff who work in the continuing health care team on our intention to buy this service in the future from the CSU.

c) Working with partners. The Public Health department at Wakefield Council have carried out a review of their own structure, as part of this process they have consulted with us and we are in support of the proposed changes. We are also continuing to explore ways of working more effectively in collaboration with our neighbouring CCGs across a range of commissioning functions.

The national/local direction of travel is to integrate services across health and social care. In view of this we will be working with our local authority partners to review both children and adult commissioning functions. We anticipate that the children’s review will be completed by June 2014 and the estimated date of completion for adults is by the end of this calendar year.

It is hoped that these changes will enable us to work differently so that we are more flexible and as an organisation are able to react quickly to the constantly changing health agenda. We also need to be able to respond to the challenge of our 10% reduction in running costs and we believe that the principles of how we intend to work with our partners and others will enable us to do this without making wide scale redundancies.
Title of meeting: Governing Body  
Date of Meeting: 11 March 2014  
Paper Title: Integrated Quality and Performance Report (Board Summary)  
Purpose (this paper is for): Decision, Discussion, Assurance, Information  
Report Author and Job Title: Andrew Singleton, Quality Co-ordinator, Luke Streeting, Performance and Planning Manager  
Responsible Clinical Lead: Dr David Brown, Quality lead  
Responsible Governing Board Executive Lead: Jo Pollard, Director of Commissioning and Quality Improvement, Andrew Pepper, Chief Finance Officer  

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 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, with an exception report to highlight the key issues and actions being taken to improve performance, as well as flags key quality issues including recently published CQC reports.

Key Areas of Achievement

- Wakefield CCG Ambulance response time CAT A (Red 1 and 2) 19 mins has seen a significant improvement in comparison to last months actual and YTD performance.
- There were no 52 week referral to treatments breaches reported in January 2014.
- The CQC has lifted the warning notice against MYHT.
- VTE risk assessment target met in December following recent deterioration.
- First Maternity Friends and Family results published
- MYHT performed well in the CQC Maternity Services patient survey

Key areas for improvement

- Wakefield CCG Ambulance response time CAT A (Red1) and CAT A (Red 2) 8 mins response times is below target and worsening in comparison to last month although YTD performance is above target.
- Ambulance turnaround at MYHT has continued to be below target.
- Cancer waits 62 days referral to definitive treatment has continued to be below target and worsened in two consecutive months.
- Cancer waits 31 days wait where treatment is a course of radiotherapy - performance is below target.
- Although C. Diff actual performance is below target for both Wakefield CCG and MYHT current month performance has improved from last month.
- A Patient Safety Walkabout in Dewsbury identified concerns about care provided on Ward 4.
- The CQC identified minor concerns at two GP practices
At the Governing Body meeting in January members requested a deep dive to review the length of time patients have to wait for mental health services in SWYPFT’s Wakefield Business Delivery Unit, as information presented appeared inconsistent with soft intelligence from GPs and patients. The report includes the outcome of this review.

<table>
<thead>
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<th>Link to overarching principles from the strategic plan:</th>
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<tbody>
<tr>
<td>Improve health equality across our population</td>
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<tr>
<td>Support for individual health and wellbeing</td>
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<tr>
<td>Care provided in the right setting and close to home</td>
</tr>
<tr>
<td>Appropriate access and choice for all</td>
</tr>
<tr>
<td>Understanding our population and putting patients at our centre</td>
</tr>
<tr>
<td>Safe and high quality experiences and clinical outcomes</td>
</tr>
<tr>
<td>Transparent clinically-led commissioning</td>
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<tr>
<td>Service transformation through redesign</td>
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<tr>
<td>Improvement through collaboration and integration</td>
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<td>Financial efficiency, probity and balance</td>
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<th>Outcome of Equality Impact Assessment:</th>
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<td>Integrated Governance Committee – 16 January and 20 February 2014</td>
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<th>Risk Assessment:</th>
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</thead>
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<tr>
<td>The Board Assurance Framework reflects the key controls and assurances against overarching principles from the strategic plan listed above.</td>
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<tr>
<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>
<th>Finance/ resource implications:</th>
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</thead>
<tbody>
<tr>
<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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NHS Wakefield Clinical Commissioning Group
Integrated Quality and Performance Report (Board Summary)
March 2014
# Key Messages

## Key Success Stories
- Wakefield CCG and MYHT Ambulance times response time CAT A (Red 1 and 2) 19 mins has seen a significant improvement in comparison to last months actual and YTD performance.
- No 52 week referral to treatments have been reported for the current month.
- CQC has lifted the warning notice against MYHT.
- VTE risk assessment target met in December following recent deterioration.
- Four separate Patient Safety Walkabouts at MYHT in January identified good leadership on most wards.
- First MYHT Friends and Family results published nationally for Maternity.
- MYHT performed well in the CQC Maternity Care Survey.
- Star House Care Home received an excellent CQC report.

## Areas for Improvement
- Wakefield CCG Ambulance targets CAT A (Red1) and CAT A (Red 2) 8 mins response times actual Dec 2013 performance is below target although YTD performance is above target.
- Ambulance turnaround at MYHT has continued to be below target.
- MYHT reported 1 MRSA bacteraemia case in December 2013.
- Cancer waits 62 days referral to definitive treatment has continued to be below target and worsened in two consecutive months.
- Cancer waits 31 days wait where treatment is a course of radiotherapy actual performance for the current month is below target.
- Although C. Diff actual performance is below target for Wakefield CCG in December performance has improved from last month.
- A Patient Safety Walkabout in Dewsbury identified significant concerns about care provided on Ward 4.
- CQC identified minor concerns at 2 GP practices.

---

**Recommendations:**
- To note the current performance against the CCG strategic objectives and Quality Premium; and
- Approve the actions being taken to address areas of underperformance.
Wakefield CCG performance against CCG Strategic Objectives

**Source** – CCG Outcomes Framework, Everyone Counts, NHS Constitution

**Data** – December 2013 (Year to date position)

**Wakefield CCG Strategic Objectives Balanced Scorecard**

**Level 2a: Key Performance Indicators**

**PREVENTION OF ILL-HEALTH AND ILLNESS**
- Cancer - max 2 week wait urgent GP referral
- Cancer - max 2 week wait breast symptoms
- 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 surgery
- Cancer - max 31 days for treatment where that treatment is an anti-cancer drug regime
- Cancer - max 31 days for treatment where that treatment is a course of radiotherapy

**CARE CLOSER TO HOME AND OUT OF HOSPITAL**
- Cancer - max 62 day wait from urgent GP referral to first definitive treatment for cancer
- Cancer - max 62 days wait from referral from a NHS Screening Service to first definitive treatment
- Cancer - max 62 days wait for first definitive treatment following a consultant decision to upgrade priority of patient (NHS Constitution 2004)
- MRSA / CDIFF Breaches

**RESPONSIVE URGENT CARE**
- RTT 18 weeks - Admitted pathways
- RTT 18 weeks - Non Admitted 18 weeks
- RTT 18 weeks - Incomplete pathways
- RTT - 52 weeks wait from referral to treatment

**SAFE EARLY YEARS AND HEALTHY TRANSITION TO ADULTHOOD**
- Smoking in pregnancy

**Changes from previous month**
1. RTT 18 Weeks Admitted has turned green
2. Cancer - 62 day wait from GP referral has turned Red
# Level 2a: Key Performance Indicators

**Key Performance Indicators – Exceptions**

Source – CCG Outcomes Framework, Everyone Counts, NHS Constitution

**Data – December 2013**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Wakefield CCG Strategic Objective</th>
<th>Data Availability</th>
<th>Reporting Period</th>
<th>Period Target/2013/14 Plan</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Direction of travel</th>
<th>Provider</th>
<th>Direction of travel</th>
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<td>Cat A (Red 1) 8 min response time</td>
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<td>75%</td>
<td>72.1%</td>
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<tr>
<td><strong>Ambulance - Turnaround Time</strong></td>
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<td>Not reported at CCG Level</td>
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<td><strong>Acute Trust – Turnaround Time</strong></td>
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<td>All handovers between ambulance and A&amp;E should take place within 15 mins</td>
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<td>95%</td>
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<td>Max 62 day wait from urgent GP referral to first definitive treatment for cancer</td>
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<tr>
<td><strong>Care closer to home and out of hospital care</strong></td>
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<tr>
<td>4</td>
<td>18 Week RTT Waiting Time Standard</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>RTT Admitted pathways</td>
<td>monthly Dec</td>
<td>90.0%</td>
<td>91.1%</td>
<td>90.1%</td>
<td></td>
<td></td>
<td>↔</td>
<td></td>
<td>90.1%</td>
<td>90.4%</td>
<td>91.1%</td>
</tr>
<tr>
<td></td>
<td>RTT Non-admitted pathways</td>
<td>monthly Dec</td>
<td>95.0%</td>
<td>94.4%</td>
<td>95.5%</td>
<td></td>
<td></td>
<td>↓</td>
<td>↑</td>
<td>95.5%</td>
<td>95.6%</td>
<td>94.4%</td>
</tr>
<tr>
<td>5</td>
<td>Improving Access to Psychological Therapies</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>People entering psychological therapies</td>
<td>1/4y</td>
<td>2.6%</td>
<td>2.4%</td>
<td>4.5%</td>
<td></td>
<td></td>
<td>↑</td>
<td>↑</td>
<td>4.5%</td>
<td>8.0%</td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- ↑: Above target and improving
- ↓: Below target and improving
- ↔: No change
-Dot: Nationally published validated data
- -: Not yet fully validated

---

**NHS Constitution**

- Ambulance response times
- Turnaround Time
- Handovers between ambulance and A&E
- Cancer Waits - 62 Days
- Healthcare Associated Infections
- Improving Access to Psychological Therapies

---

**Wakefield CCG**

- Ambulance response times
- Turnaround Time
- Healthcare Associated Infections
- Cancer Waits - 62 Days
- Improving Access to Psychological Therapies

---

**Clinical Lead**

- Adam Sheppard
- Abdul Mustafa
- Andrew Furber
- Patrick Wynn
- Claire Haines
Strategic Monitoring

Performance is above target this month on the following indicators however, they continue to be monitored.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Wakefield CCG Objective</th>
<th>Data Availability</th>
<th>Reporting Period</th>
<th>Period Target</th>
<th>Actual</th>
<th>YTD</th>
<th>FOT</th>
<th>Provider</th>
<th>Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive Urgent Care</td>
<td>% Patients who spent 4 hours or less in A&amp;E</td>
<td>Weekly</td>
<td>Dec</td>
<td>95%</td>
<td>Not reported at CCG Level</td>
<td>95.4%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>Adam Sheppard</td>
</tr>
<tr>
<td>1 Ambulance Response Times</td>
<td>Cal A (Bed 1 and 2) 10 min response time</td>
<td>monthly</td>
<td>Dec</td>
<td>75%</td>
<td>↑</td>
<td>↑</td>
<td>▼</td>
<td>↑</td>
<td>↓</td>
</tr>
<tr>
<td>4 Trolley Waits in A&amp;E</td>
<td>No wait from a decision to admit to admission of more than 12 hours</td>
<td>Weekly</td>
<td>Dec</td>
<td>0</td>
<td>Not reported at CCG Level</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Adam Sheppard</td>
</tr>
<tr>
<td>Prevention of all health and illness</td>
<td>Minimise breaches</td>
<td>Monthly</td>
<td>Dec</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>↔</td>
<td>↔</td>
</tr>
<tr>
<td>4 Mixed-sex accommodation breaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↔</td>
<td>↔</td>
</tr>
<tr>
<td>Cancer Waits - 2 Weeks</td>
<td>NSA 2 week wait from GP referral to first outpatient appointment - all cancers</td>
<td>Monthly</td>
<td>Dec</td>
<td>98%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer Waits - 31 Days</td>
<td>NSA 2 week wait for patients referred with IBD symptoms - cancer not suspected</td>
<td>Monthly</td>
<td>Dec</td>
<td>98%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>1 Cancer Waits - 31 Days</td>
<td>NSA 31 day wait from diagnosis to first definitive treatment - all cancers</td>
<td>Monthly</td>
<td>Dec</td>
<td>98%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer - 62 Days</td>
<td>NSA 31 day wait for subsequent treatment where treatment is surgery</td>
<td>Monthly</td>
<td>Dec</td>
<td>98%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer - 62 Days</td>
<td>NSA 31 day wait for subsequent treatment where treatment is an anti-cancer drug regime</td>
<td>Monthly</td>
<td>Dec</td>
<td>98%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer - 62 Days</td>
<td>NSA 62 day wait from NHS screening service to first definitive treatment for cancer</td>
<td>Monthly</td>
<td>Dec</td>
<td>98%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Cancer - 62 Days</td>
<td>NSA 62 day wait for first definitive treatment following a consultant decision to upgrade priority of patient</td>
<td>Monthly</td>
<td>Dec</td>
<td>18%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
</tr>
</tbody>
</table>

| Care closer to home and out of hospital care | The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days | 1/4ly Q2          | 95%             | 99.0% | 97.0% | 97.0% | ↑      | ↑      | ↑      | ↑      | ↑      | ↑      | No data | Patrick Wynn |
| 4 Diagnostic test waiting times            | Patients waiting for a diagnostic test should be waiting for less than 6 weeks        | Monthly           | Dec              | 1%            | ↑      | ↑   | ↑   | ↑        | ↑        | Patrick Wynn |
| 4 18 Week RTT Waiting Time Standard       | RTT - Incomplete pathways                                                             | Monthly           | Dec              | 92.0% | 93.0% | 92.3% | ↓      | ↑      | ↓      | ↑      | ↑      | ↑      | Patrick Wynn |
| 4 18 Week RTT Waiting Time Standard       | Number of patients on incomplete pathways over 12 weeks                               | Monthly           | Dec              | 0             | 0%    | 0%  | 0%  | ↔        | ↔        | Patrick Wynn |
Level 2a: Strategic Plan – Quality Premium Performance Scorecard

Performance against Strategic Plan Quality Premium Objectives (Year to date)

Data set:
1. The data represents the YTD position for the CCG, and colour coded against the national target threshold.
2. If data is not available for the current period it is reflected by a grey box.

Quality Premium financial value calculations:
1. The total QP is calculated on a £5 per head population for the CCG.
2. The current population baseline for Wakefield CCG is 356,679.
3. The estimated current QP for Wakefield CCG is £1,783,395.
4. Each measure is worth 12.5% (223k) of the total QP value, with the exception of the combined Domain 2 and 3 which is worth 25% (446k).
The following Quality Dashboard has been constructed to allow the Integrated Governance Committee to note the performance of the Mid Yorkshire Hospitals NHS Trust against key quality indicators. The indicators selected are those most likely to impact on the Trust’s regulatory, contractual or reputational status. The latest data available at the time of writing will be used, and may be subject to change due to validation between deadline for papers and Integrated Governance Committee meeting.

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Mid Yorkshire HT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Period Target/ 2013/14 Plan</td>
<td>Actual</td>
</tr>
<tr>
<td><strong>Patient Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>December 0</td>
<td>0</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>December &lt;49</td>
<td>4</td>
</tr>
<tr>
<td>VTE - Risk Assessment</td>
<td>December 95%</td>
<td>95.50%</td>
</tr>
<tr>
<td>Harm Free Care (new VTE, falls, pressure ulcers &amp; urinary tract infections)</td>
<td>December -</td>
<td>90.29%</td>
</tr>
<tr>
<td>Never Events</td>
<td>January 0</td>
<td>0</td>
</tr>
<tr>
<td>Sts Number Open</td>
<td>January n/a</td>
<td>31</td>
</tr>
<tr>
<td>Sts New for month</td>
<td>January n/a</td>
<td>4</td>
</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SJHR - Latest Data</td>
<td>Apr 12 - Mar 13</td>
<td>&lt;100</td>
</tr>
<tr>
<td>IJSRM 2012/13 rebased - latest data</td>
<td>April - Oct 2013</td>
<td>&lt;100</td>
</tr>
<tr>
<td>Amenable Mortality</td>
<td>July 2013</td>
<td>-</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single sex Accommodation Breaths</td>
<td>December 0</td>
<td>0</td>
</tr>
<tr>
<td>Complaints handled within timescales</td>
<td>November 95%</td>
<td>98.00%</td>
</tr>
<tr>
<td>Friends and Family Test response rates</td>
<td>December Q1 15%</td>
<td>26.20%</td>
</tr>
<tr>
<td>Friends and Family Test net promoter score</td>
<td>December 0-100</td>
<td>68</td>
</tr>
<tr>
<td><strong>Improvement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse to bed ratio</td>
<td>December -</td>
<td>2.04</td>
</tr>
<tr>
<td>Doctor to patient ratio</td>
<td>August -</td>
<td>0.13</td>
</tr>
<tr>
<td>Staff sickness rate (with Balfour Betty Workforce) Rolling 12 months</td>
<td>November 4.00%</td>
<td>4.05%</td>
</tr>
<tr>
<td><strong>External Assurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Acute Quality Dashboard undesirable alerts</td>
<td>December 0</td>
<td>0</td>
</tr>
<tr>
<td>CQC Conditions or Warning Notice</td>
<td>January 0</td>
<td>0</td>
</tr>
</tbody>
</table>
# Level 2b: Quality Dashboard – YAS

<table>
<thead>
<tr>
<th></th>
<th>Reporting Period</th>
<th>Period Target/2013/14 Plan</th>
<th>Actual</th>
<th>YTD</th>
<th>Direction of travel Month</th>
<th>Previous months score card</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of patient related incidents (ops and A&amp;E)</td>
<td>December</td>
<td>N/A</td>
<td>0.03%</td>
<td>0.026%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff related incidents (ops and A&amp;E all staff)</td>
<td>December</td>
<td>N/A</td>
<td>3.72%</td>
<td>2.43%</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>Medication related incidents</td>
<td>December</td>
<td>N/A</td>
<td>50</td>
<td>272</td>
<td>↑</td>
<td></td>
</tr>
<tr>
<td>SI’s number open (Wakefield)</td>
<td>January</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SI’s new for the month (Wakefield)</td>
<td>January</td>
<td>N/A</td>
<td>0</td>
<td>2</td>
<td></td>
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</tbody>
</table>

**Clinical Effectiveness – Ambulance Quality Indicators**

<table>
<thead>
<tr>
<th></th>
<th>England average: August</th>
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</thead>
<tbody>
<tr>
<td>Stemi: Proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle</td>
<td>August</td>
<td>79.9%</td>
<td>87.1%</td>
<td>83.9%</td>
<td></td>
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</tr>
<tr>
<td>Cardiac arrest: Proportion of patients who were discharged from hospital alive following resuscitation by ambulance service following a cardiac arrest</td>
<td>August</td>
<td>9.0%</td>
<td>11.3%</td>
<td>10.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke: Proportion of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes of the call being received</td>
<td>August</td>
<td>66.9%</td>
<td>60.7%</td>
<td>65.9%</td>
<td></td>
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</tr>
</tbody>
</table>

**Patient Experience (Calderdale, Kirklees and Wakefield cluster)**

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Friends Test Score</td>
<td>November</td>
<td>75-100%</td>
<td>77.4%</td>
<td>79.36%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns, complaints, comments: Response within 24 working days</td>
<td>November</td>
<td>90%</td>
<td>41.1%</td>
<td>50.0%</td>
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<td></td>
</tr>
</tbody>
</table>

**Operational**

<p>| | | | | | | |</p>
<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff sickness rate (West Yorkshire A&amp;E)</td>
<td>December</td>
<td>5.4%</td>
<td>6.67%</td>
<td>5.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDRs for all of workforce within the last 12 months (all staff)</td>
<td>December</td>
<td>95%</td>
<td>75%</td>
<td>66.6%</td>
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</tr>
</tbody>
</table>

**External Assurance**

<p>| | | | | | | |</p>
<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor Governance Rating</td>
<td>Q3</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Conditions or Warning Notice</td>
<td>December</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Green circle indicates YAS performance is better than national average for relevant month, red circle indicates performance is worse for relevant month.
The Friends and Family Test (FFT) asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The FFT score is calculated using the proportion of patients who are extremely likely to recommend minus those who would not recommend or indifferent.

### A&E (patients discharged from A&E only)

<table>
<thead>
<tr>
<th>Date</th>
<th>MYHT response rate %</th>
<th>National response rate %</th>
<th>MYHT FFT Score</th>
<th>National FFT Score</th>
<th>MYHT extremely likely and likely responses %</th>
<th>National extremely likely and likely responses %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-13</td>
<td>75</td>
<td>70</td>
<td>60</td>
<td>55</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Jul-13</td>
<td>70</td>
<td>65</td>
<td>55</td>
<td>50</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>Aug-13</td>
<td>65</td>
<td>60</td>
<td>50</td>
<td>45</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>Sep-13</td>
<td>60</td>
<td>55</td>
<td>45</td>
<td>40</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Oct-13</td>
<td>55</td>
<td>50</td>
<td>40</td>
<td>35</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>Nov-13</td>
<td>50</td>
<td>45</td>
<td>35</td>
<td>30</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Dec-13</td>
<td>45</td>
<td>40</td>
<td>30</td>
<td>25</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

### Inpatient

<table>
<thead>
<tr>
<th>Date</th>
<th>MYHT response rate %</th>
<th>National response rate %</th>
<th>MYHT FFT Score</th>
<th>National FFT Score</th>
<th>MYHT extremely likely and likely responses %</th>
<th>National extremely likely and likely responses %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-13</td>
<td>80</td>
<td>75</td>
<td>70</td>
<td>65</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Jul-13</td>
<td>75</td>
<td>70</td>
<td>65</td>
<td>60</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Aug-13</td>
<td>70</td>
<td>65</td>
<td>60</td>
<td>55</td>
<td>55</td>
<td>50</td>
</tr>
<tr>
<td>Sep-13</td>
<td>65</td>
<td>60</td>
<td>55</td>
<td>50</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Oct-13</td>
<td>60</td>
<td>55</td>
<td>50</td>
<td>45</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>Nov-13</td>
<td>55</td>
<td>50</td>
<td>45</td>
<td>40</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>Dec-13</td>
<td>50</td>
<td>45</td>
<td>40</td>
<td>35</td>
<td>35</td>
<td>30</td>
</tr>
</tbody>
</table>

### Key Messages
- A&E at Pinderfields has only achieved a response of greater than 20% in August 2013. Dewsbury and Pontefract A&E response rates have been above 30% since September 2013.
- The Patient Safety Walkabout team which visited Dewsbury A&E in January spoke with staff who really valued seeing the comments made by patients and saw improvements made to the ward environment following suggestions made by patients.
- The majority of elderly wards have consistently struggled to achieve response rates of greater than 20%.
- 94.77% of patients in the December FFT would recommend MYHT. This figure has remained consistent since the introduction of FFT
- The top three areas of improvement suggested by patients in recent months are: staffing levels; wait for treatment; food
- 8 inpatient wards at MYHT all had response rates of below 20% and at least 10 eligible patients in December 2013.
- PGH G4 – 13.95%  PGH G41 – 15.63%  DDH W2 – 14.55%  PGH G34 – 8.50%  PGH G43 - 6.33%  DDH W5 – 9.86%  DDH W14 – 15.33%  PGH G20 – 19.75%

### FFT Scores by site and ward (minimum 10 responses and response rate >20%)

The wards with the highest FFT scores were:
- PGH G21: 100 (3)
- PGH G29: 100 (1)

The wards with the lowest FFT scores were:
- DDH W8: 38 (0)
- DDH W6: 54 (2)

Number inside brackets indicates number of occasions the ward has featured in the same category in the previous reports for which the same analysis was undertaken.
NHS England published maternity Friends and Family Test data for the first time on 30 January 2013. Each woman is asked up to four FFT questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>MYHT Response Rate</th>
<th>National Response Rate</th>
<th>MYHT Score</th>
<th>National score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How likely are you to recommend our antenatal service to friends and family if they needed similar care or treatment?</td>
<td>11.30%</td>
<td>10.49%</td>
<td>50</td>
<td>63</td>
</tr>
<tr>
<td>How likely are you to recommend our labour ward/birthing unit/homebirth service to friends and family if they needed similar care or treatment?</td>
<td>12.70%</td>
<td>19.10%</td>
<td>93</td>
<td>75</td>
</tr>
<tr>
<td>How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment?</td>
<td>21.70%</td>
<td>20.70%</td>
<td>62</td>
<td>66</td>
</tr>
<tr>
<td>How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment?</td>
<td>3.6%</td>
<td>9.76%</td>
<td>70</td>
<td>74</td>
</tr>
</tbody>
</table>

**Key messages**
- Trusts are expected to achieve an overall response rate of >15%, MYHT are failing to do this.
- 100% of women would recommend MYHT labour wards/birthing unit/homebirth service.
- Just one woman was unlikely or extremely unlikely to recommend a postnatal ward at MYHT.
- The national FFT should be interpreted with caution. Since this data was published University College Hospital, London notified NHS England that its maternity data for December was incorrect. No revised data has since been published.

**Future FFT developments:**
FFT will be rolled out to the following services within the next 18 months:

<table>
<thead>
<tr>
<th>Deadline for implementation</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014 (FFT for staff)</td>
<td>Hospital trusts</td>
</tr>
<tr>
<td>December 2014</td>
<td>GP practices, community health services, mental health services</td>
</tr>
<tr>
<td>March 2015</td>
<td>All NHS services including day cases and outpatients</td>
</tr>
</tbody>
</table>
## Level 3: Exceptions & Narrative

<table>
<thead>
<tr>
<th>Area</th>
<th>New Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Response Times – YAS Cat A (Red 1), (Red 2) and (Red 1&amp;2)</td>
<td>• Performance action plan is being reviewed and monitored by the CSU and through the Contract management board. The contract Lead Commissioner is engaging with YAS regarding contract penalties.</td>
</tr>
</tbody>
</table>
| Ambulance Turnaround Times and Ambulance Handover                    | • The quality team are leading discussions regarding the improvement trajectories required to meet CQUIN improvement plan for the remaining quarter.  
• Turnaround specific winter plan to be submitted.                   
• Achievements and best practice examples in the last six months to be documented and shared. |
| Cancer Waits – 62 Days from referral from a GP Referral              | • A detailed review of Wakefield CCG patients has been undertaken which is being discussed with MYHT (who in aggregate achieved the 62 day GP referral standard of 85%) to ensure the transfer deadlines are met and the root cause analysis of breaches is effective.  
• The months performance has been notified to the CCG Lead Commissioner who will discuss at the next Cancer Network meeting to identify any wider inter-provider issues. |
| 31 Days from referral from a GP Referral                            | • MIHT are implementing a personal accountability agreement to ensure staff understand their personal responsibility and accountability in relation to HCAI.  
• Further analysis of the mapping processes for CDI and MRSA against GP post codes is to be undertaken to identify the rate of these alert organisms against the practice population size.  
• The lead IPC Nurse is meeting with the Independent Liaison Group Coordinator to discuss further the attendance of care home staff at catheter training sessions |
| MRSA                                                                | • These concerns have been shared with the Medicines Management Team. The Medicines Management Team is undertaking work to lower the usage of PPIs.  
• Prescribing of cephalosporins and quinolones is included as a prescribing indicator in the Improvement in Prescribing Plan (IMPP) and will be for 2014/15 |
| Clostridium Difficile                                                | • Demand – the CCG is reviewing the data provided, a plan to engage with practices has been developed, correlation of demand increases with commissioning intentions is being completed.  
• The impact of winter pressures on the 18 week position is being monitored and a co-ordinated approach being delivered within the CCG.  
• The trust has implemented measures to enhance data quality.          |
| 18 week RTT waiting Time Standard Admitted and non admitted pathways |                                                                                                                                            |
Quality Intelligence Group
The Group represents every team within the CCG, plus colleagues from Public Health 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.

December 2013 – 32 pieces of ‘soft’ intelligence mapped

<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>
</table>
| Appointments               | Incidents          | 5                    | 18 week wait referral to treatment performance | MYHT             | HIGH             | 1. Add to risk register  
2. Check on MYHT register. (In addition to others) |
| - getting through to appt contact centre | PALS/Complaints | 5                    |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| - obtaining appointment     | Other              |                      |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| - cancelled repeatedly      |                    |                      |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| - reductions in frequency   |                    |                      |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| - PAS upgrade               |                    |                      |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| Capacity                   | PSU                | 3                    | MYHT 2ww data SWYPFT CQUINs | MYHT SWYPFT      | HIGH             | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
2. Oral surgery – refer to contracting |
| - Oral surgery             | Other              | 3                    |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| - CAMHS                    |                    |                      |                    |                  |                  | 1. Autism – Develop CQUIN for 2014/15 with SWYPFT  
2. Oral surgery – refer to contracting |
| Information Governance     | Incidents          | 3                    | GP practices SWYPFT |                  | Medium           | 1. Ensure practices reporting as incidents in line with IG toolkit requirements.  
2. MASH training will cover information governance requirements  
3. Discuss with Caldicott Guardian |
| - PSU                      | Other              | 3                    |                    |                  |                  | 1. Ensure practices reporting as incidents in line with IG toolkit requirements.  
2. MASH training will cover information governance requirements  
3. Discuss with Caldicott Guardian |


## January 2014 – 31 pieces of ‘soft’ intelligence mapped

<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>
</table>
| **Access** | Engagement, PALS / Complaints / Patient opinion, Other | 🌟🌟🌟🌟🌟🌟🌟 | Referral to treatment data | MYHT, SWYPFT, GP practices | HIGH | 1. SPOC – refer to contracting  
              2. CAMHS – addressed through Serious Case Review |
| Privacy + dignity SWYPFT and MYHT including Queen Elizabeth House (QEH) | Engagement, PALS / Complaints / Patient opinion, Other | 🌟🌟🌟🌟🌟 | CQC provider reports | MYHT, SWYPFT | HIGH | 1. Patient Safety Walkabout on Gate 6  
              2. Patient Opinion – addressed through EQB  
              3. QEH – raised through safeguarding and EQB |
| Care Homes | Other | 🌟🌟🌟🌟🌟 | CQC provider reports | Various care home providers | HIGH | 1. Actions taken through safeguarding and large scale investigation. |
| Communication | Engagement, Incidents, PALS / Complaints / Patient opinion, PSU, Other | 🌟🌟🌟🌟🌟🌟🌟 | CQC provider reports | MYHT, GP practices, Sheffield Hallamshire Neurosurgery | HIGH | 1. Raise through contracting |
| Continuing Care | Incidents | ✓ | | MYHT | HIGH | 1. To be raised through Continuing Care team |

**Legend:**  
- 🌟: Moderate  
- 🌟🌟: High  
- 🌟🌟🌟: Very high  
- 🌟🌟🌟🌟: Maximum
The Quality Premium is £5 per head of running cost population and will be payable to CCGs in 2014/15 based on the quality of health services commissioned during 2013/14. This will be based on 4 national measures and 3 locally-determined measures. The initial value will be reduced if providers, from which the CCG commissions services, are unable to meet the 4 key areas of the NHS Constitution and pledges for its population.

As well as achieving above there are 2 prerequisites for the Quality Premium to be payable. They are:

- Quality premium payments will not be made if a serious quality failure has occurred, i.e. CQC finds that a provider is in serious breach of its registration requirements.
- CCGs must meet its financial duties.

### National and Local Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Threshold</th>
<th>Percentage of Quality Premium</th>
<th>Value for CCG</th>
<th>OP Achievement on current performance</th>
<th>Funding</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Reducing potential years of lives lost through amendable mortality</td>
<td>The potential years of life lost from amenable mortality for a CCG population will need to reduce by at least 3.2% between 2013 and 2014</td>
<td>12.5%</td>
<td>£ 222,924</td>
<td>N/A</td>
<td>N/A</td>
<td>Outcome data for 2013 will not be available until Autumn 2014</td>
</tr>
<tr>
<td>Domains 2 and 3</td>
<td>Reducing avoidable emergency admissions</td>
<td>A reduction or zero per cent change in emergency admissions for the identified conditions for a CCG population between 2012/13 and 2013/14, or the Indirect Standardised Rate of admissions in 2013/14 is less than 1,000 per 100,000 population.</td>
<td>25.0%</td>
<td>£ 445,849</td>
<td>N/A</td>
<td>N/A</td>
<td>Outcome data for 2013/14 will not be available until summer 2014</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring roll out of the Family and Friends Test and improving patient experience of hospital services</td>
<td>1. Assurance that all relevant local providers of services commissioned by a CCG have delivered the nationally agreed roll out plan to the national timetable. 2. An improvement in average FFT scores for acute inpatient care and A&amp;E services between Q1 2013/14 and Q1 2014/15 for acute hospitals that</td>
<td>12.5%</td>
<td>£ 222,924</td>
<td>Y</td>
<td>£ 222,924</td>
<td>Specific dates when baseline and outcome data will be published is not yet available</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Preventing Healthcare associated infections</td>
<td>1. There are no cases of MRSA baterium assigned to the CCG and 2. C. Difficile cases are at or below defined thresholds for the CCG.</td>
<td>12.5%</td>
<td>£ 222,924</td>
<td>N</td>
<td>£ -</td>
<td>YTD there have been 7 MRSA and 58 C.Diff cases for the CCG, which is above the threshold</td>
</tr>
<tr>
<td>Local Measure 1</td>
<td>Reducing Smoking in pregnancy</td>
<td>Reduce smoking at time of delivery from baseline of 24.1% to 23%.</td>
<td>12.5%</td>
<td>£ 222,924</td>
<td>Y</td>
<td>£ 222,924</td>
<td></td>
</tr>
<tr>
<td>Local Measure 2</td>
<td>Improving Access to Talking Therapies</td>
<td>Increase people entering psychological therapies from baseline 9.6% to 11.4%</td>
<td>12.5%</td>
<td>£ 222,924</td>
<td>N</td>
<td>£ -</td>
<td>Q2 performance is 9% against a target of 11.4%. A recovery plan</td>
</tr>
<tr>
<td>Local Measure 3</td>
<td>Improving Recovery from Stroke</td>
<td>People with a new diagnosis of stroke who have a follow-up assessment within 4-8 months of initial assessment 70%.</td>
<td>12.5%</td>
<td>£ 222,924</td>
<td>N</td>
<td>£ -</td>
<td>Q2 performance is 40% against a target of 70%</td>
</tr>
</tbody>
</table>

Total £1,783,395 £ 445,849
Key Issues

- There are delays in the publishing of Domain 1 data that means an indicative assessment of the CCG’s current performance against this area is not possible, CSU have been engaged, and at present all CCG’s are in the same position and no proxy measure is currently being developed.

- The data for Domains 2 and 3 is currently being worked on for the CCG, at the present time an indication of performance cannot be provided, therefore a financial value cannot be attributed.

- All aspects of the Friends and Family Test have been delivered.

- The CCG targets relating to Healthcare associated infections are zero for MRSA.

- The current performance relating to reducing smoking in pregnancy is above the required standard, therefore, a positive approach towards this premium being delivered should be maintained.

- The current performance in the remaining two Local Measures remains a significant risk for the CCG, recovery plans for performance are in place.
**Background:** Wakefield CCG Board members requested a deep dive to review the length of time patients have to wait for mental health services in Wakefield Business Delivery Unit. They specifically wanted further analysis for the Memory Service and Psychological Therapies as information presented appeared inconsistent with soft intelligence from GP and patient experience. Access data is routinely reported to the Integrated Governance Committee in the form of the SWYPFT Quality Dashboard. This data is derived from the SWYPFT 2013-14 CQUIN scheme.

**Derived from Quarter 3 CQUIN data:**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis referrals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 hours receiving a face to face contact within 4 hours</td>
<td>85% Q1</td>
<td>89.8% (254/283)</td>
<td>90.4% (206/228)</td>
</tr>
<tr>
<td><strong>Routine referrals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(working age adults)</td>
<td>80%</td>
<td>80%</td>
<td>76.8%</td>
</tr>
<tr>
<td>receiving a face to face contact within 14 days of referral</td>
<td>(230/291)</td>
<td>(357/466)</td>
<td>(369/463)</td>
</tr>
<tr>
<td><strong>Routine referrals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(working age adults)</td>
<td>90% Q1</td>
<td>97%</td>
<td>98.1%</td>
</tr>
<tr>
<td>commencing treatment within 6 weeks of face to face contact</td>
<td>(421/436)</td>
<td>(334/362)</td>
<td>(454/468)</td>
</tr>
<tr>
<td><strong>New referrals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(working age adults)</td>
<td>93% Q2.2</td>
<td>97.8%</td>
<td>99.5%</td>
</tr>
<tr>
<td>for psychological therapies assessed within 14 days</td>
<td>(265/275)</td>
<td>(261/264)</td>
<td>(214/215)</td>
</tr>
<tr>
<td><strong>New referrals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(working age adults)</td>
<td>93% Q3.2</td>
<td>91.2%</td>
<td>96.2%</td>
</tr>
<tr>
<td>for psychological therapies starting within 16 weeks</td>
<td>(151/162)</td>
<td>(128/138)</td>
<td>(153/159)</td>
</tr>
</tbody>
</table>

**Key Issues: Psychological Therapies**

CQUIN data for Q3 shows that the large majority of patients are assessed and start treatment within timescales. However, when this is broken down to working age adults;

- 78.8% of routine referrals are assessed within 14 days (98 patients were not assessed within 14 days in the quarter).
- 98.1% of routine referrals start treatment within 6 weeks.

However, soft intelligence suggests that this is inconsistent with GP and patient experience. It would be difficult to validate this data at this time and it should be noted that this data is provider specific and does not include Turning Point who provide the Right Steps IAPT service. Proposed actions are to raise this at SWYPFT Quality Board and to explore how the patient pathway currently operates with Wakefield Business Delivery Unit. Quality indicators for routine referrals for working age adults will continue in the 2014/15 CQUIN scheme as the performance in older people’s services was potentially masking the working age adult achievement.

**Key Issues: Memory Service**

Access to memory services has been recognised as a challenge across all Business Delivery Units. The current waiting time for Wakefield is reported as 6 weeks by the Trust.

Responsible Clinical Lead: Dr Clive Harries  Commissioning Lead: Philip Smedley  CCG Assurance: SWYPFT Quality Board
This summarises findings from a Walkabout that took place at Dewsbury District Hospital on 8 January 2014. Walkabouts involve a small team of clinical and non-clinical staff walking onto ward areas to note their first impressions and talk to patients and staff to identify areas of good practice and areas for improvement. This visit included the Director of NHS England (West Yorkshire Area Team).

The walkabout took place on A&E, Ambulatory Care, Ward 4 (Neurology / Stroke), Ward 7 (Paediatrics) and Ward 14 (Surgery). The Ward 4 visit identified a number of concerns, which are detailed on the following page with the actions taken. The visits to the other areas identified predominantly good practice.

Areas of good practice

- **Friends and Family Test**: Comments from the Family and Friends Test were displayed on the Ward 14 notice board, both positive and negative. In A&E staff felt pleased when the Charge Nurse showed them positive comments from the Family and Friends Test. The Ward Manager described improvements made to the patient environment following patient feedback.
- **Staffing**: Families on Ward 7 reported that staff were ‘fantastic’ and really happy with the care provided. They were especially complimentary re the staff in A/E in particular the student nurse and Doctor “they always explain everything to me despite me coming in every month.” “They always explain what they are going to do to my little girl”
- **Cleanliness**: All wards were felt to be clean. A patient on Ward 14 said that “staff never stop cleaning.”
- **Well-led**: All areas appeared to have effective leadership. Staff on Ward 14 felt supported and involved in the ward and the PSW which visited A&E felt the Charge Nurse was knowledgeable and passionate about delivering excellent patient care.
- **Responsive**: Patients spoken to in A&E praised the department. One patient said that he “was impressed how quickly he had been attended to.”

Areas for improvement

- **Nutrition**: One patient on Ward 14 felt the choice of food was limited as some of their preferred choices had often gone before the food reached them. The PSW team on Ward 7 felt there should be a menu for children after a number of families stated that there was nothing on the menu that their child liked.
- **Caring**: One patient felt they were “not listened to” on Ward 14, and felt nurses were “too specialised in gynaecology” and were not able to answer questions about the bowel surgery they had had.
- **Medical records**: Some standard sized folders used to file documentation on Ward 7 were not large enough, this created a risk of documentation going missing.
- **Admission**: Staff described how when it was exceptionally busy due to a bed shortage in the hospital, consultants enabled a number of patients to be discharged who otherwise would have been admitted. Staff also stated that they often have difficulties getting doctors from other specialities to attend the department to assess patients, there can be long wait.
- **Ambulatory care**: No patients were in the Ambulatory Care unit when the PSW team visited, although one patient was waiting to be transferred from A&E.

Key Actions

- Verbal feedback was given to the senior manager once the walkabout was completed. Feedback is fed to the MYHT Chief Nurse and discussed at MYHT monthly Quality & Clinical Governance Committee. The report will be shared at MYHT Executive Quality Board meeting on 20 March 2014.
- The usage of the Ambulatory Care Unit was raised at the Wakefield and North Kirklees Urgent Care Group.
The visit to Ward 4 identified a number of concerns in relation to call bells, nursing assessment, staffing, and standards of care - which prompted MYHT to take immediate action.

**Key Actions:** A number of actions have been implemented to address these concerns.
- Documentation is being reviewed frequently to ensure that observations are reviewed frequently and within the appropriate timescales.
- Staff have been reminded to ensure that patients have access to their call-buzzers and that they provide prompt, courteous and safe care to patients when they request it.
- Joint Patient Safety Walkabouts have taken place on 5 elderly care wards in the Trust to determine if the problems identified on Ward 4 are more widespread or contained to Ward 4. Ward 4 has also been re-visited to assess if the improvements have been made. Visits to all other medicine and elderly care wards will take place during February and March 2014.
- A local Quality Summit was held on 10 February 2014. Staff from MYHT, Wakefield CCG, North Kirklees CCG, Area Team colleagues, the CQC, the Trust Development Authority and local Healthwatch organisations attended. MYHT presented on the actions taken with regards to Ward 4, and to discuss the three main areas of concern for commissioners – staffing, leadership and culture, and service transformation.
It has been identified in previous months that CCG is unlikely to achieve the Improving Access to Treatment target for the 13/14 Quality Premium. As a consequence there has been an increased engagement with the provider who have produced a service recovery and improvement plan aimed at increasing the access capacity within the service.

As of the 12th February the total number of clients entering treatment has risen to 3474, and increase of 595 since the beginning of January leaving a total of 1290 clients that need to enter treatment prior to 31/03/14, the target still remains at risk. As part of the action plan the following additional capacity has been created:

- Provision of 5 Welcome to Rightsteps Workshops since the 6th January, 96 clients chose this option after their assessment with 50 attending, 31 DNA’s and 15 cancelling prior to the workshop.
- Recovery has also been utilised well by clients, we have offered 51 sessions with 40 of these attended, an attendance rate of 78.43%, 25% higher than Welcome to Rightsteps.
- 7 clients have used the cCBT mood gym in January with 1 DNA

The provider has conducted a service and capacity reviewed analysing service efficiency and clients attrition at the various stages of the pathway from referral to treatment between 1st April 2013 and 18th January 2014. The highlights are identified below:

**Activity**

<table>
<thead>
<tr>
<th>KPI 3 – The number of referrals</th>
<th>6071</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI 4 – The number entering treatment</td>
<td>2996</td>
</tr>
</tbody>
</table>

- Averaging 144 referrals per week
- On average 71 clients enter treatment per week
- The Moving to Recovery rate stands at 54.58%, 7.7% higher than the national average (46.8)
- 60% of referrals attend an assessment
- Of those who attended an assessment 82% entered treatment
- 62% of referrals were Female, 38% Male
- Booked 16,794 treatment sessions of which 12,756 were attended – that’s an average of 304 attended treatment sessions per week.

**Inappropriate referrals:**

In the period 987 referrals were deemed inappropriate for our service – this equates to 16.25% of all referrals.

- 475 of these referrals were from GP’s
- 407 were self referrals
- 105 were from other sources such as Health Visitors, CMHT etc
Inappropriate Referral Neurological Difficulties 4
Inappropriate Referral specific Anger Management required as presenting problem 57
Inappropriate Referral Bereavement 8
Inappropriate Referral Gambling 5
Inappropriate Referral Out Of Area 18
Inappropriate Referral Physical Health Intervention 5
Inappropriate Referral Primary Problem Drug/Alcohol 115
Inappropriate Referral Already In Secondary Care Mental Health 55
Inappropriate Referral Specific Eating Disorder 11
Inappropriate Referral Suitable For Specialist Agency 54
Inappropriate Referral Under 18 24
Referred On 116
Inappropriate Referral - Needs Secondary Care due to presenting problem 515

52% of all inappropriate referrals needed secondary care.

Not opting in
In the period 825 referrals chose not to opt in to our service before attending an assessment. These clients will have been contacted via both telephone and a letter requesting them to contact the service if they wished to engage.

Assessments
A key area to increase our entered treatment figure is to improve our attendance of assessments, as 83% of attended assessments go on to enter treatment. In the period we have offered 5534 assessment slots with a detailed breakdown below -

<table>
<thead>
<tr>
<th>Assessment Attendance</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment cancelled by the Client</td>
<td>756</td>
</tr>
<tr>
<td>Assessment Did not attend - no advance warning given</td>
<td>982</td>
</tr>
<tr>
<td>Assessment cancelled by the Service</td>
<td>159</td>
</tr>
<tr>
<td>Assessment Attended</td>
<td>3573</td>
</tr>
<tr>
<td>Assessment Arrived late, but seen</td>
<td>60</td>
</tr>
<tr>
<td>Assessment client arrived late and could not be seen</td>
<td>4</td>
</tr>
</tbody>
</table>

As can seen there were **982 assessments were the client simply did not attend** with no advanced warning given. It is hoped that the new text message reminders now been sent to all clients will improve the DNA and cancelled appointment rate especially at assessment.
The table above shows:
- 70.74% of self referrals attended an assessment that’s 17% higher than GP referrals.
- Entered treatment figures are 10% higher for self referrals.
- Coincidently nearly 90% of GP referrals that attended an assessment went on to enter treatment.

**Conclusion**
The above report has shown the below outcomes:

- DNA rate for assessments is high, it is hoped the SMS text reminders generated via IAPTUS will reduce this. They are also asking each client where contact can be made their preferences for assessments availability.
- The provider is further looking at the inappropriate referral rate per GP and target these GP’s to attend their practice meetings and develop closer links. The provider can also send out a referral criteria to all GPs as a reminder which may reduce the likelihood of clients been referred who are under 18, already actively in secondary care or out of area for instance.
- There is a large number of GP referrals who never opt in to the service, this take up time due to trying to contact each client on three separate occasions and then send a opt in letter. The provider is currently looking at they could improve this system.
- Self referral has a higher attendance rate at assessments and statistic show that once a client is assessed they are very likely to enter treatment, a further option is to continue to encourage GPs and professionals to use self referral rather than making a referral for the client. Self referrals also ensure that the client ends up in the right service at the right time and reduces repeat referrals and assessments for the client to go through.

**Further actions**
Commissioners and the Contracting team continue to monitor progress with weekly updates now being received. Discussion needs to take place regarding the greater utilisation of the self referral mechanism given the higher level of success in the referral resulting in an entering treatment outcome and the subsequent removal of barriers to operational capacity improvement.
Joint Patient Safety Walkabouts took place on 28 January at Dewsbury, 29 January at Pinderfields and 31 January at Pontefract in response to the concerns identified on Ward 4. Representatives from MYHT, North Kirklees CCG and Wakefield CCG visited elderly care and medical wards at each site to determine if the problems identified on Ward 4 were confined to this ward or were more widespread.

**Dewsbury PSW**

**Ward 4**
- The ward was tidier, staff interacted with patients in an appropriate manner and many patients reported a positive patient experience.
- The standard of care planning was not adequate.

**Ward 5**
- The patients, carers and staff the PSW team spoke with all praised the ward. Patients also praised the quality of the food.
- The standard of documentation was generally good, with the dementia care planning better compared to that seen on previous patient safety walkabouts.
- The medical and nursing staff identified staffing levels as a concern, although they felt staffing levels have improved in recent weeks.

**Pinderfields PSW**

**Gate 41**
- Patients were complimentary about the ward and one patient felt this experience was better than previous stays.
- Staffing ratios were perceived to be too high. This was not helped by high absence rates and a high turnover of staff.
- It was felt the lack of senior medical decision makers at weekends and consultant ward rounds being undertaken twice a week has implications for discharge.

**Gate 42**
- When the ward coordinator is not present discharge planning is not undertaken
- Documentation was comprehensive and up to date. The ward was felt to have good leadership.
- 3 registered nurses were on duty caring for 41 patients, the majority who had dementia.

**Gate 43**
- Staff reported that the new ward management team had helped improve standards and morale.
- All patients were happy with the care they were receiving.
- Senior management have responded positively when serious concerns about staffing levels have been escalated by the Matron and Ward Manager.

**Pontefract PSW**

**Stroke Rehabilitation Unit**
- Patients and relatives confirmed that staff were very exceptionally caring and felt involved in the care planning process.
- All patients spoken with were pleased with how they were recovering from their stroke.
- Patients were not receiving 45 minutes of direct therapy 5 days a week in line with NICE guidance, for each therapy.
In the Spotlight: National Survey of Women’s Experiences of Maternity Care

During the summer of 2013, a questionnaire was sent to all women who gave birth in February 2013 (and January 2013 at smaller trusts). Responses were received from 195 people who used services at MYHT. The questions were scored on a scale from 0 to 10. A score of 0 was assigned to all responses that reflect considerable scope for improvement, whereas a response that was assigned a score of 10 referred to the most positive possible reported service user experience. There were a number of new questions added to the 2013 survey. For the 2013 survey the CQC has grouped the questions into 1 of 7 categories and compared responses against other trusts.

### Performance overview - 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Section score</th>
<th>2013 Rating</th>
<th>Performance by individual question</th>
<th>2010</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>The start of your care in pregnancy</td>
<td>6.1</td>
<td>Better (top 20% of trusts)</td>
<td>Number of responses</td>
<td>176</td>
<td>195</td>
</tr>
<tr>
<td>Antental check ups</td>
<td>8.3</td>
<td>Better (top 20% of trusts)</td>
<td>Number of questions</td>
<td>19</td>
<td>42</td>
</tr>
<tr>
<td>Labour and birth</td>
<td>8.8</td>
<td>About the same as most other trusts</td>
<td>Highest scoring 20% of trusts</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Staff</td>
<td>8.6</td>
<td>About the same as most other trusts</td>
<td>Amber (same as most other Trusts)</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>8.3</td>
<td>Better (top 20% of trusts)</td>
<td>Lowest scoring 20% of trusts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feeding (Postnatal Care)</td>
<td>8.1</td>
<td>Better (top 20% of trusts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care at home after the birth</td>
<td>8.6</td>
<td>About the same as most other trusts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MYHT is listed as performing better than other trusts in 4 categories, despite being rated as one of the best performing trusts for 3 questions in the entire survey. These questions are:

- Thinking about your antenatal care, were you involved enough in decisions about your care? – Score 9.0
- Did the midwife or midwives that you saw take your personal circumstances into account when giving you advice? - Score 8.9
- Did a midwife or health visitor ask you how you were feeling emotionally? – Score 9.8

### Areas for improvement

- Offering women a choice of where to have their baby – Score 4.9
- Offering women a choice about where antenatal checks will take place – Score 3.1
- Not being left alone by midwives or doctors at a time when it worried them – Score 7.2
- Giving women the information and explanations they needed after the birth in hospital – Score 7.7
- Providing women with consistent feeding advice after their birth – Score 7.2
- Giving women active support and encouragement about feeding their baby – Score 7.7

### Changes over time

- There was a significant deterioration in performance for the following question:
  - Not being left alone by midwives or doctors at a time when it worried them

### Limitations

- The survey was distributed in the summer of 2013 to women who gave birth in February 2013. It should be noted that this is a limitation as women’s recollection of her experience may differ if the same questions were asked within a month of giving birth.
Background: When the CQC inspected in May 2013 they found evidence that in some areas of the hospital the service was failing to ensure people were protected against the risks of receiving inappropriate or unsafe care or treatment. The CQC judged this had a moderate impact on people who used the service. MYHT were issued with a formal warning telling the provider they must improve by 27 August 2013. The CQC received an action plan from the Trust which showed the improvements they were putting in place. The CQC also received information concerning the care provided on Gate 43 and Gate 12.

Dementia: This visit also formed part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital. This included consideration of the care experienced by patients with dementia on Gates 41 and 42.

Staffing: Staffing was not assessed on this visit. A further inspection is planned to review staffing. Concerns were raised to the CQC about staffing levels on Gate 41 and how this impacts on the care of patients with dementia. The CQC has shared this with the Trust and requested that they investigate and address the issues raised.

Reasons for non-compliance:

Records

Gate 41 (Elderly): The CQC reviewed the records of 2 patients with dementia. For one patient an assessment of need had been completed and they had a number of generic care plans. However the care plans had not been updated and did not correspond with the care which had been delivered as written in the daily evaluation. The other patient’s care plans had not been completed on admission to the ward. However, it had not been reviewed or updated in the two weeks following admission. A dementia care plan was in place for both patients with dementia. However, one of these care plans had not been completed until a month after admission. There was insufficient detail relating to dementia care in the care plans. For example, there was no explanation of why patients had been admitted to the ward rather than receiving support at home or in their care home. Staff told the CQC they did not attempt to obtain information regarding the patient’s life history unless this had been made available on admission.

Gate 43 (Elderly): Care plans had not been reviewed or updated to reflect the individual’s needs. Inspectors saw omissions in one patient’s fluid balance chart. Records were disorganised and it was difficult to find information about the patient’s current care needs.
In the Spotlight: CQC Reviews – Care Homes

### The Beeches
The Beeches provides accommodation and care for up to 23 older people.

<table>
<thead>
<tr>
<th>Provider</th>
<th>The Beeches, Castleford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>25 November 2013</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced routine inspection.</td>
</tr>
<tr>
<td>Link to Report</td>
<td>The Beeches</td>
</tr>
<tr>
<td>CQC history:</td>
<td>15 July 2013 – routine inspection to check if improvements made</td>
</tr>
<tr>
<td></td>
<td>30 November 2012 – routine inspection</td>
</tr>
</tbody>
</table>

#### Outcomes

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>09</td>
<td>Management of medicine</td>
<td>Enforcement action taken, moderate impact</td>
</tr>
<tr>
<td>16</td>
<td>Assessing and monitoring the quality of service provision</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

### Riverside Court
Riverside Court provides accommodation, personal care and nursing care for up to 61 people some of who may also have physical disabilities or suffer with dementia.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Riverside Court, Knottingley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>26 November 2013</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced routine inspection.</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Riverside Court</td>
</tr>
<tr>
<td>CQC history:</td>
<td>13 April 2012 – routine inspection</td>
</tr>
</tbody>
</table>

#### Outcomes

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Respecting and involving people who use services</td>
<td>Compliant</td>
</tr>
<tr>
<td>04</td>
<td>Care and welfare of people who use services</td>
<td>Compliant</td>
</tr>
<tr>
<td>11</td>
<td>Safety, availability and suitability of equipment</td>
<td>Compliant</td>
</tr>
<tr>
<td>14</td>
<td>Supporting workers</td>
<td>Compliant</td>
</tr>
<tr>
<td>16</td>
<td>Assessing and monitoring the quality of service provision</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

### Warde Aldam
Warde Aldam is a care home with nursing. It provides care for a maximum of 60 people

<table>
<thead>
<tr>
<th>Provider</th>
<th>Warde Aldam, South Elmsall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>13 December 2013</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced inspection</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Warde Aldam</td>
</tr>
<tr>
<td>CQC history:</td>
<td>02 October 2013 – routine inspection</td>
</tr>
<tr>
<td></td>
<td>14 August 2012 – routine inspection</td>
</tr>
</tbody>
</table>

#### Outcomes

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>04</td>
<td>Care and welfare of people who use services</td>
<td>Action needed, moderate impact</td>
</tr>
</tbody>
</table>

### Earls Lodge
Earls Lodge, Wakefield

<table>
<thead>
<tr>
<th>Provider</th>
<th>Earls Lodge, Wakefield</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>16 December 2013</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced routine inspection</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Earls Lodge</td>
</tr>
<tr>
<td>CQC history:</td>
<td>13 June 2013 – routine inspection</td>
</tr>
<tr>
<td></td>
<td>12 December 2012 – routine inspection</td>
</tr>
</tbody>
</table>

#### Outcomes

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>04</td>
<td>Care and welfare of people who use services</td>
<td>Action needed, moderate impact</td>
</tr>
<tr>
<td>08</td>
<td>Cleanliness and infection control</td>
<td>Compliant</td>
</tr>
<tr>
<td>09</td>
<td>Management of medicines</td>
<td>Action needed, minor impact</td>
</tr>
</tbody>
</table>
**In the Spotlight: CQC Reviews**

Star House is a specialist respite care unit which provides nursing care for children with disabilities and life limiting illnesses. It is provided by Wakefield Metropolitan District Council (WMDC). An unannounced inspection of the unit was carried out in November 2013 and the report was published on 24 December 2013.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Date of Inspection</th>
<th>Review Type</th>
<th>Link to Report</th>
<th>CQC history:</th>
</tr>
</thead>
</table>

**Outcomes**
- Compliant

**CQC history:**
- No previous inspections

**In the Spotlight: CQC Reviews – GP Practices**

Riverside Court provides accommodation, personal care and nursing care for up to 61 people some of who may also have physical disabilities or suffer with dementia.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Date of Inspection</th>
<th>Review Type</th>
<th>Link to Report</th>
<th>CQC history:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverside Court</td>
<td>26 November 2013</td>
<td>Unannounced routine inspection.</td>
<td>Riverside Court</td>
<td>13 April 2012 – routine inspection</td>
</tr>
</tbody>
</table>

**Outcomes**
- Compliant

**CQC history:**
- No previous inspections

**In the Spotlight: CQC Reviews – GP Practices**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Date of Inspection</th>
<th>Review Type</th>
<th>Link to Report</th>
<th>CQC history:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospect Surgery</td>
<td>17 October 2013</td>
<td>Announced inspection.</td>
<td>Prospect Surgery</td>
<td>No previous inspections</td>
</tr>
</tbody>
</table>

**Outcomes**
- Compliant

**CQC history:**
- No previous inspections

<table>
<thead>
<tr>
<th>Provider</th>
<th>Date of Inspection</th>
<th>Review Type</th>
<th>Link to Report</th>
<th>CQC history:</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Thomas Road,</td>
<td>05 November 2013</td>
<td>Announced inspection.</td>
<td>St Thomas</td>
<td>No previous inspections</td>
</tr>
</tbody>
</table>

**Outcomes**
- Compliant

**CQC history:**
- No previous inspections
In the Spotlight: CQC Reviews – Northgate Endoscopy Unit

Northgate Endoscopy Unit provides diagnostic endoscopic services in a community health centre setting.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Northgate Endoscopy Unit, Pontefract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>10 December 2013</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced routine inspection.</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Northgate</td>
</tr>
<tr>
<td>CQC history:</td>
<td>15 January 2013 – routine inspection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>04 – Care and welfare of people who use services</td>
<td>Compliant</td>
</tr>
<tr>
<td>05 – Meeting nutritional needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>09 – Management of medicines</td>
<td>Compliant</td>
</tr>
<tr>
<td>10 – Safety and suitability of premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>11 – Safety, availability and suitability of equipment</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
Title of meeting: Governing Body
Date of Meeting: 11 March 2014
Paper Title: Finance Report Month 10 2013/14
Purpose (this paper is for): Decision

Report Author and Job Title: Karen Parkin, Head of Finance & Governance
Responsible Clinical Lead: Not applicable
Responsible Governing Board Executive Lead: Andrew Pepper, Chief Finance Officer
Recommendation:
It is recommended that the Governing Body note the contents of the report.

Executive Summary:
The Month 10 Finance Report provides a year to date and year end forecast position as at 31st January 2014. Overall the CCG has a year to date surplus of £4,585k against a planned surplus of £4,585k and year-end forecast of £5,502k which is equal to plan. There are 12 key financial performance indicators:

- 7 indicators are green: underlying recurrent surplus, surplus year to date, surplus forecast, 2% NR funds, running costs, risk management and timeliness & quality of returns.
- 2 indicators are amber/green: QIPP year to date and QIPP full year forecast.
- 0 indicators are amber/red.
- 2 indicators are red: Activity trends – year to date and full year forecast.
- 1 indicator is not yet scored: Balance sheet indicators have yet to be defined by NHS England.

The report highlights any significant adverse variances, including a forecast MYHT overtrade of £6.4m. The brought forward surplus reserve have now been fully utilised to offset the overtrade position.

Link to overarching principles from the strategic plan:

| 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 |
| Understanding our population and putting patients at our centre |
| Safe and high quality experiences and clinical outcomes |
| Transparent clinically-led commissioning |
| Service transformation through redesign |
| Improvement through collaboration and integration |
| Financial efficiency, probity and balance |

Outcome of Equality Impact Assessment: Not applicable
Outline public engagement: Not applicable
Assurance departments/organisations who will be affected have been consulted: Not applicable
Previously presented at committee / governing body: Month 8 Finance Report was presented at Governing Body meeting on 14 January 2014. The Month 10 Finance Report was presented at Integrated Governance Committee on 20 February 2014.
| Reference document(s) / enclosures: | Month 10 Finance Report  
3 Appendices are included to provide further detail on specific issues:  
- Appendix 1: Prescribing Information  
- Appendix 2: QIPP – updated position statement on the 13/14 programme  
- Appendix 3: Summary of 2% Non-recurrent sources and application of funds |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment:</td>
<td>Section 6 of the paper gives details of the financial risks including mitigation.</td>
</tr>
<tr>
<td>Finance/ resource implications:</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
### NHS WAKEFIELD CCG

**Finance Report – Month 10 2013/14**

1. **Introduction**

   This report shows the financial position at 31st January 2014.

2. **Key Financial Performance Indicators**

   NHS Wakefield CCG key financial performance indicators are detailed below:

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>Indicator</th>
<th>RAG Measure</th>
<th>RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Underlying recurrent surplus</td>
<td>Green: &gt;= 2% Amber/Green: 1-1.99% Amber Red: 0-0.99% Red: &lt;0%</td>
<td>Green</td>
<td>£9.4m (2.1%) calculated after impact of non-recurrent and QIPP savings</td>
</tr>
<tr>
<td>2</td>
<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%</td>
<td>Green</td>
<td>Variance is 0.0% against plan</td>
</tr>
<tr>
<td>3</td>
<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%</td>
<td>Green</td>
<td>£0k full year forecast to plan = 0%</td>
</tr>
<tr>
<td>4</td>
<td>Management of 2% NR funds within agreed processes</td>
<td>Green=Yes Red=No</td>
<td>Green</td>
<td>Plans submitted to WYAT within agreed process and timescales. WYAT fully informed of all CCG intentions</td>
</tr>
<tr>
<td>5</td>
<td>QIPP - year to date delivery</td>
<td>&gt;=80% of plan Amber/Red: &gt;=50% of plan Red: &lt;50% of plan</td>
<td>Amber/Green</td>
<td>£6.7m delivered against YTD plan of £7.9m = 85%.</td>
</tr>
<tr>
<td>6</td>
<td>QIPP - full year forecast</td>
<td>&gt;=80% of plan Amber/Red: &gt;=50% of plan Red: &lt;50% of plan</td>
<td>Amber/Green</td>
<td>£8.2m forecast delivery against plan of £10m = 82%.</td>
</tr>
<tr>
<td>7</td>
<td>Activity trends - year to date</td>
<td>&lt;101% of plan Amber/Red: &lt;102% of plan Red: &lt;103% of plan</td>
<td>Red</td>
<td>YTD Month 8 activity received for MYHT with an overtrade of 4% against YTD month 8 plan.</td>
</tr>
<tr>
<td>8</td>
<td>Activity trends - full year forecast</td>
<td>&lt;101% of plan Amber/Red: &lt;102% of plan Red: &lt;103% of plan</td>
<td>Red</td>
<td>Forecast activity received for MYHT with an overtrade of 4% against YTD month 8 plan.</td>
</tr>
<tr>
<td>9</td>
<td>Running costs</td>
<td>Green: &lt;= RCA Red: &gt;RCA</td>
<td>Green</td>
<td>£109k underspend at M10</td>
</tr>
<tr>
<td>10</td>
<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 not met</td>
<td>Green</td>
<td>All risks identified with value and mitigation (see section 6)</td>
</tr>
<tr>
<td>11</td>
<td>Assessment of internal and external audit opinion and on timeliness and</td>
<td>Based on assessment of returns</td>
<td>Green</td>
<td>Self assessed green based on timeliness and accuracy of returns to WYAT</td>
</tr>
<tr>
<td></td>
<td>quality of returns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Balance sheet indicators including performance against planned cash limit</td>
<td>to be defined</td>
<td>TBC</td>
<td>Cash: £159k held at 31st January. BPPC: 88% of invoices paid by number and 97% paid by value.</td>
</tr>
</tbody>
</table>
3. **Overall Financial Performance**

There were four allocation adjustments during January. Total Allocations for 13/14 are presented below:

<table>
<thead>
<tr>
<th>Description</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/14 Opening Programme Allocation</td>
<td>450,210</td>
</tr>
<tr>
<td>13/14 Running Cost Allocation</td>
<td>8,580</td>
</tr>
<tr>
<td>Specialist Commissioning transfer to NHSE</td>
<td>(7,624)</td>
</tr>
<tr>
<td>Offender Health</td>
<td>544</td>
</tr>
<tr>
<td>Angel Lodge</td>
<td>295</td>
</tr>
<tr>
<td>B/F surplus</td>
<td>4,231</td>
</tr>
<tr>
<td>Cervical Cytology Screening</td>
<td>(302)</td>
</tr>
<tr>
<td>Specialist Commissioning Service Cross Boundary</td>
<td>(598)</td>
</tr>
<tr>
<td>Mid Yorkshire Critical Care/Rehab</td>
<td>6,212</td>
</tr>
<tr>
<td>Movement to surplus per final accounts</td>
<td>1</td>
</tr>
<tr>
<td>Winter Pressures Tranche 2</td>
<td>3,576</td>
</tr>
<tr>
<td><strong>Total Allocation at 31st December 2013</strong></td>
<td>465,125</td>
</tr>
<tr>
<td>NHS England re: Property Services</td>
<td>968</td>
</tr>
<tr>
<td>NHS England Transformation costs</td>
<td>1,080</td>
</tr>
<tr>
<td>Winter Pressures – NK CCG</td>
<td>(720)</td>
</tr>
<tr>
<td>Winter Pressures – SY &amp; B AT</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total Allocation at 31st January 2014</strong></td>
<td>466,485</td>
</tr>
</tbody>
</table>

An analysis of budget headings and financial performance is provided in the table below:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Annual Budget £'000</th>
<th>Budget to Date £'000</th>
<th>Expenditure to Date £'000</th>
<th>Variance to Date £'000</th>
<th>Forecast year end Variance £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>40,132</td>
<td>33,443</td>
<td>33,297</td>
<td>-146</td>
<td>-170</td>
</tr>
<tr>
<td>Acute - Mid Yorkshire Hospitals Trust</td>
<td>204,157</td>
<td>170,131</td>
<td>175,143</td>
<td>5,012</td>
<td>6,029</td>
</tr>
<tr>
<td>Acute - Leeds</td>
<td>12,866</td>
<td>10,722</td>
<td>10,723</td>
<td>1</td>
<td>-104</td>
</tr>
<tr>
<td>Acute - YAS</td>
<td>15,213</td>
<td>12,677</td>
<td>12,664</td>
<td>-13</td>
<td>53</td>
</tr>
<tr>
<td>Other Acute - NHS</td>
<td>12,993</td>
<td>10,828</td>
<td>10,212</td>
<td>-615</td>
<td>-1,251</td>
</tr>
<tr>
<td>Other Acute</td>
<td>19,706</td>
<td>16,422</td>
<td>17,243</td>
<td>822</td>
<td>1,131</td>
</tr>
<tr>
<td>Prescribing</td>
<td>60,486</td>
<td>51,132</td>
<td>50,688</td>
<td>-444</td>
<td>-494</td>
</tr>
<tr>
<td>Primary Care and Out of Hours</td>
<td>6,404</td>
<td>5,337</td>
<td>5,233</td>
<td>-103</td>
<td>-101</td>
</tr>
<tr>
<td>Continuing Care &amp; Free Nursing Care</td>
<td>25,613</td>
<td>21,344</td>
<td>23,064</td>
<td>1,720</td>
<td>2,276</td>
</tr>
<tr>
<td>Community Services</td>
<td>29,563</td>
<td>24,636</td>
<td>24,535</td>
<td>-101</td>
<td>-46</td>
</tr>
<tr>
<td>Other Contracts</td>
<td>8,485</td>
<td>7,071</td>
<td>7,098</td>
<td>27</td>
<td>20</td>
</tr>
<tr>
<td>QIPP</td>
<td>-2,839</td>
<td>-2,366</td>
<td>-333</td>
<td>2,033</td>
<td>2,440</td>
</tr>
<tr>
<td>Winter Pressures</td>
<td>3,576</td>
<td>2,980</td>
<td>2,147</td>
<td>-833</td>
<td>-1,000</td>
</tr>
<tr>
<td>Reserve-Contingency</td>
<td>2,251</td>
<td>1,876</td>
<td>0</td>
<td>-1,876</td>
<td>-2,251</td>
</tr>
<tr>
<td>Reserve-Emerg. Readmissions</td>
<td>2,426</td>
<td>2,022</td>
<td>2,022</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reserve-Committed reserve</td>
<td>300</td>
<td>250</td>
<td>250</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reserve - Other</td>
<td>1,877</td>
<td>1,564</td>
<td>1,298</td>
<td>-266</td>
<td>-320</td>
</tr>
<tr>
<td>Non Recurrent Reserve</td>
<td>4,964</td>
<td>4,137</td>
<td>2,553</td>
<td>-1,584</td>
<td>-1,901</td>
</tr>
<tr>
<td>Bfwd Surplus</td>
<td>4,230</td>
<td>3,525</td>
<td>0</td>
<td>-3,525</td>
<td>-4,230</td>
</tr>
<tr>
<td><strong>Programme Allocation (exc planned surplus)</strong></td>
<td>452,403</td>
<td>377,730</td>
<td>377,838</td>
<td>109</td>
<td>83</td>
</tr>
<tr>
<td>Running Costs</td>
<td>8,580</td>
<td>7,153</td>
<td>7,045</td>
<td>-109</td>
<td>-83</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>460,983</td>
<td>384,884</td>
<td>384,883</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

13 / 14 Surplus                                                          | 5,502               | 4,585                | 0                        | -4,585                | -5,502                          |

**Total Allocation**                                                     | 466,485             | 389,469              | 384,883                  | -4,585                | -5,502                          |
The variance on QIPP is offset by underspends on Prescribing, The Practice (Ophthalmology), Assura (Dermatology) and other reserves.

Year to Date expenditure on NHS contracts reflects activity information received for April to November for some acute providers. However there remain some validations outstanding which are being progressed by the CSU.

The brought forward surplus reserve and contingency reserve have been fully utilised to offset the overtrade position.

Running costs are under budget which is a combination of vacancies and organisational development training costs.

4. Programme Budgets

A year end reconciliation exercise has now been concluded with MYHT. A forecast year end position has been agreed and this is reflected on the month 10 position. This includes finalising the position with regard to net overtrade on activity, application of maternity pathway tariff, penalties, cquins and excluded drugs.

- Other NHS Acute includes £1.0m undertake on Barnsley and Doncaster relating to non-elective procedures, an overtrade of £0.4m on Sheffield relating to 2 Critical Care patients and an overtrade on other Non-Acute.

- Other Acute is showing £1.1m overspend. This includes overspends on Audiology AQP (£490k) and an overspend on Patient Choice (£500k).

- Prescribing is showing a YTD and FOT underspend of circa £500k. The QIPP target was £2m. Although the year end position shows less than target, a financial analysis of the work undertaken by the Medicines Management team shows that savings of £1.5m have been made to date but this is hindered by cost pressures and the increase in other areas such as “no cheaper stock obtainable” (NCSO) products. Prescribing trends and month 8 actual spend by practice is presented at appendix 1.

- The Continuing Health Care overspend has been highlighted in some detail in previous reports. The overspend position has increased to £2.3m.

5. QIPP and Non-Recurrent Reserve

- In the table above, the QIPP annual budget has reduced from the original £10m target as some agreed QIPP schemes have now been transacted. It is presented here as an overspend to offset the saving on prescribing and the undertake positions relating to ophthalmology and dermatology as these are all QIPP schemes.

- There remain £0.4m QIPP scheme to transact which relates to mental health PICU beds. This has now been agreed by the relevant CCGs.

- An updated position on the QIPP programme is shown in appendix 2.

- Non-Recurrent plans include 3 reserves: 2% non-recurrent, non-elective readmissions and winter plan funds.
6. **Risks & Opportunities**

Key risks are outlined in the table below:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Expenditure Risks £m</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Contract over-trade - MHHT (including underachievement of PCLIF)</td>
<td>6.4</td>
<td>This risk has now been crystallised via the year end reconciliation agreement with MHHT</td>
</tr>
<tr>
<td>Net other cost pressures relating to acute provider (NHS and non NHS) activity and prescribing cost pressures</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Continuing Health care</td>
<td>2.3</td>
<td>On-going review of cases and cost pressures presents potential risk. Unlikely to mitigate through review of CHC brought forward provision due to the change in accounting arrangements</td>
</tr>
</tbody>
</table>

12.5

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Expenditure Opportunity £m</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency Held</td>
<td>2.3</td>
<td>These have now materialised and are included in the month 10 position to offset the forecast risks above</td>
</tr>
<tr>
<td>Non Recurrent Measures - Slippage on 2% NR reserve + emergency re-admissions reserve + Winter Pressures</td>
<td>2.9</td>
<td>As above</td>
</tr>
<tr>
<td>Non Payment of remaining balance of PCLIF due to non-achievement of target reductions</td>
<td>0.8</td>
<td>As above</td>
</tr>
<tr>
<td>Non Recurrent Measures - brought forward surplus reserve</td>
<td>4.2</td>
<td>As above</td>
</tr>
<tr>
<td>Share of National Transformational Fund</td>
<td>0.2</td>
<td>Awaiting confirmation from NHS England</td>
</tr>
<tr>
<td>NHS Property Services cost risk - not materialised</td>
<td>1.0</td>
<td>As above</td>
</tr>
<tr>
<td>National Support for local costs of transformation</td>
<td>1.1</td>
<td>As above</td>
</tr>
</tbody>
</table>

12.5

7. **Better Payment Practice Code**

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. Section 251 data validation issues relating to patient confidentiality are still resulting in some invoices not being paid within the 30 days. This issue is being addressed together with the CSU and the Continuing Care Team.

<table>
<thead>
<tr>
<th>Month 10 2013/14 - 31st January 2014</th>
<th>Number</th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non NHS Creditors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bills at the end of the month</td>
<td>1,030</td>
<td>8,342</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>889</td>
<td>7,083</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>86%</td>
<td>85%</td>
</tr>
<tr>
<td>NHS Creditors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bills at the end of the month</td>
<td>201</td>
<td>31,430</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>191</td>
<td>31,356</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>95%</td>
<td>100%</td>
</tr>
</tbody>
</table>
8. **Cash**

Cash held at 31st December was £159k, which is within the 5% tolerance target.

The Central Support Directorate of NHS England has been endeavouring to ensure that the cash requirement identified by each CCG will be the same as the Maximum Cash Drawdown (MCD). Through the process of reviewing the total NHS England Group cash requirement and negotiation with DH the estimated difference between cash requirement and available cash is an overall shortfall of circa £190m or (0.3%) nationally. The CCG has now been informed of its MCD for 2013/14, as a percentage of FOT is 96.5%. This will be managed through our levels of creditors at the year end.

9. **Statement of Financial Position**

Following confirmed guidance from NHS England, the only legacy balances being brought into CCG 2013/14 opening Statement of Financial Positions (Balance Sheets) are fixed assets, inventories and financial leases. The PCT had no inventories or financial leases, and all its fixed assets were transferred to NHS Property Services, Department of Health or NHS England. Hence there are no adjustments to make for opening balances in the current year. Other relevant balances, including the 2012/13 CHC provision, may be transferred to CCGs as from 1st April 2014.

10. **Other Legacy Issues**

Any payments made by CCGs in the current financial year in relation to legacy balances will be reimbursed by NHS England in February and again before the year end where appropriate.

11. **GP IT budgets**

It was reported last month that discussions were taking place to agree a way forward for the agreement of GP IT budgets. It is proposed that providing the Wakefield CCG 13/14 revenue allocation is £748k (excluding capital) then the CCG is in a position to agree this with the CSU. It is now clear that the depreciation charge in 2013/14 relating to legacy GP IT assets as well any purchased in 2013/14 will be financed by NHS England. The allocations for GP IT for 2014/15 are still being developed/agreed upon within NHS England and we will be advised once the position becomes clearer.

12. **Recommendations**

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

Karen Parkin,
Head of Finance & Governance
04/03/2014
Appendix 1: Prescribing Spend

Prescribing 2012/13 actual Vs 2013/14 actual expenditure

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>4,495,600</td>
<td>5,101,584</td>
<td>4,488,513</td>
<td>4,706,726</td>
<td>4,902,111</td>
<td>4,514,977</td>
<td>5,083,815</td>
<td>4,829,363</td>
<td>4,641,562</td>
<td>4,833,413</td>
<td>4,413,227</td>
<td>4,799,381</td>
</tr>
<tr>
<td>Actual 2013/14</td>
<td>4,854,513</td>
<td>4,975,755</td>
<td>4,571,425</td>
<td>5,053,967</td>
<td>4,736,002</td>
<td>4,728,303</td>
<td>5,152,036</td>
<td>4,814,816</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: 13/14 QIPP Schemes – Update as at 11/02/14

<table>
<thead>
<tr>
<th>QIPP Number</th>
<th>Programme</th>
<th>Scheme Name</th>
<th>Clinical Lead</th>
<th>HoS</th>
<th>Lead</th>
<th>Savings Start Date</th>
<th>PYE 13/14</th>
<th>PYE 14/15</th>
<th>RAG (ASSESSED DELIVERY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC001</td>
<td>Other Services</td>
<td>Childrens Complex &amp; Continuign Care Packages</td>
<td>Ann Carroll</td>
<td>Ian Carr</td>
<td>Ian Carr</td>
<td>1st Apr 13</td>
<td>75</td>
<td>101</td>
<td>amber</td>
</tr>
<tr>
<td>MC002</td>
<td>Other Services</td>
<td>PCLIF: Unplanned Care for Paediatrics and LT conditions: rotavirus immunisation; public health programme including accident prevention; epilepsy nurse specialist service; respiratory nurse specialist service; family centric primary care</td>
<td>Ann Carroll</td>
<td>Ian Carr</td>
<td>Morna Cooke</td>
<td>1st Apr 13</td>
<td>360</td>
<td>387</td>
<td>green</td>
</tr>
<tr>
<td>MH001</td>
<td>Mental Health</td>
<td>Psychiatric Intensive Care Unit (PICU)</td>
<td>Clive Harries</td>
<td>Michelle Ezro</td>
<td>Phil Smedley</td>
<td>1st Apr 13</td>
<td>398</td>
<td>398</td>
<td>green</td>
</tr>
<tr>
<td>MH002</td>
<td>Mental Health</td>
<td>Community Unit for the Elderly (CUE)</td>
<td>Clive Harries</td>
<td>Michelle Ezro</td>
<td>Phil Smedley</td>
<td>1st Apr 13</td>
<td>250</td>
<td>250</td>
<td>green</td>
</tr>
<tr>
<td>PC003</td>
<td>Planned Care</td>
<td>Criteria Based Commissioning</td>
<td>Patrick Wynn</td>
<td>Linda Driver</td>
<td>Jenny Feeley</td>
<td>1st Dec 13</td>
<td>0</td>
<td>132</td>
<td>red</td>
</tr>
<tr>
<td>PC004</td>
<td>Planned Care</td>
<td>Dermatology</td>
<td>Patrick Wynn</td>
<td>Linda Driver</td>
<td>Debra Taylor Tate</td>
<td>1st Apr 13</td>
<td>1,013</td>
<td>632</td>
<td>green</td>
</tr>
<tr>
<td>PC005</td>
<td>Planned Care</td>
<td>Ophthalmology Transformation (including all providers)</td>
<td>Patrick Wynn</td>
<td>Linda Driver</td>
<td>Debra Taylor Tate</td>
<td>1st Apr 13</td>
<td>1,442</td>
<td>1,198</td>
<td>green</td>
</tr>
<tr>
<td>PH004</td>
<td>Urgent Care</td>
<td>Community Respiratory Service</td>
<td>Avijit Biswas</td>
<td>Jo Hanlon</td>
<td>Lisa Chandler</td>
<td>1st Dec 13</td>
<td>0</td>
<td>156</td>
<td>red</td>
</tr>
<tr>
<td>PR001</td>
<td>Prescribing</td>
<td>Nutrition redesign</td>
<td>Paul Dewhirst</td>
<td>Jo Fitzpatrick</td>
<td>Corrine McDonald</td>
<td>1st Nov 13</td>
<td>0</td>
<td>180</td>
<td>red</td>
</tr>
<tr>
<td>PR002</td>
<td>Prescribing</td>
<td>Prescribing QIPP (inc. repeat prescriptions)</td>
<td>Paul Dewhirst</td>
<td>Jo Fitzpatrick</td>
<td>Lyndsey Clayton</td>
<td>1st Apr 13</td>
<td>1,500</td>
<td>2,000</td>
<td>green</td>
</tr>
<tr>
<td>UC001</td>
<td>Urgent Care</td>
<td>Urgent Care PCLIF</td>
<td>Adam Sheppard</td>
<td>Matt England</td>
<td>Sandy Smith (CSU)</td>
<td>1st July 13</td>
<td>1,471</td>
<td>3,032</td>
<td>amber</td>
</tr>
<tr>
<td>UP002</td>
<td>Primary Care</td>
<td>Primary care Streaming</td>
<td>Adam Sheppard</td>
<td>Linda Driver</td>
<td>Simon Rowe</td>
<td>1st Apr 13</td>
<td>78</td>
<td>78</td>
<td>green</td>
</tr>
<tr>
<td>PH005</td>
<td>Community Services</td>
<td>Nephrology</td>
<td>Avijit Biswas</td>
<td>Jo Hanlon</td>
<td>Janet Wilson</td>
<td>1st Apr 14</td>
<td>0</td>
<td>35</td>
<td>green</td>
</tr>
<tr>
<td>Planned Care</td>
<td>Contract Challenges: Including a review of Pathology Tests, Intra Vitreal Injections, Review of local tariffs.</td>
<td>Maciej / Andy Mobbs</td>
<td>1st Sept 13</td>
<td>0</td>
<td>0</td>
<td>200</td>
<td>200</td>
<td>1,384</td>
<td>green</td>
</tr>
<tr>
<td>All</td>
<td>Surplus budget review</td>
<td>Andrew Pepper</td>
<td>Karen Parkin</td>
<td>1st April 13</td>
<td>1st April 13</td>
<td>8,171</td>
<td>8,779</td>
<td>8,344</td>
<td>green</td>
</tr>
</tbody>
</table>

Forecast Savings: 8,171/8,779
## Appendix 3: 2% Non-Recurrent Reserve

### SUMMARY OF NON-RECURRENT SOURCES AND APPLICATION OF FUNDS

<table>
<thead>
<tr>
<th>Sources</th>
<th>Ref</th>
<th>Description</th>
<th>Date Approved by WYAT</th>
<th>Winter Pressures Value (k£)</th>
<th>Winter Pressures Value (k£) as % of non-recurrent reserve</th>
<th>2% non-recurrent reserve Value (k£)</th>
<th>non-elective readmissions Value (k£)</th>
<th>Total Value (k£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td>2% non-recurrent reserve</td>
<td></td>
<td>9,004</td>
<td></td>
<td></td>
<td></td>
<td>9,004</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td>non-elective readmissions</td>
<td></td>
<td></td>
<td>2,426</td>
<td></td>
<td></td>
<td>2,426</td>
</tr>
<tr>
<td>A</td>
<td></td>
<td>Sub Total</td>
<td></td>
<td>9,004</td>
<td>2,426</td>
<td>9,004</td>
<td></td>
<td>11,430</td>
</tr>
<tr>
<td>c</td>
<td></td>
<td>Brought forward PCT reserve</td>
<td></td>
<td>3,576</td>
<td>9,004</td>
<td>2,426</td>
<td></td>
<td>15,006</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td>£256 resources with WMDC</td>
<td></td>
<td>3,576</td>
<td></td>
<td></td>
<td></td>
<td>2,426</td>
</tr>
</tbody>
</table>

### Potential Applications

#### Matt England PCLIF
- a | Primary Care Local Improvement Framework | 18/09/2013 | 0 | 2,700 | 0 | 2,700 |
- b | Performance Management of PCLIF | 18/09/2013 | 0 | 80 | 0 | 80 |

#### Helen Childs Care Close to Home
- c | Single Point of Access | | 0 | 0 | 200 | 200 |
- d | Existing Virtual Wards | 30/08/2013 | 0 | 174 | 0 | 174 |
- e | Roll out of Integrated Care Teams (at same time) | | | | | |
- f | Network 2 (by individual networks) | | 0 | 0 | 816 | 816 |
- g | Networks 16,3 | | 0 | 0 | 0 | 0 |

#### Helen Childs CC2H Additional Resources
- f | ESD (Early Supported Discharge) - Toronto Module/LACE Tool | | 0 | 0 | 100 | 100 |
- g | ESD - Pharmacists x2 | | 0 | 0 | 28 | 28 |
- h | ESD - Drug and Alcohol Workers x3 | | 0 | 0 | 30 | 30 |
- i | ESD - Data Analyst | | 0 | 0 | 12 | 12 |
- j | Integrated Care Team development (ICT) - Organisational Development | 05/11/2013 | 0 | 69 | 0 | 69 |
- k | Mobile Working - Assisted technologies/mobile working | | 0 | 0 | 244 | 244 |
- l | GP Network events | 30/08/2013 | 0 | 39 | 0 | 39 |
- m | GP Network events | 05/11/2013 | 0 | 13 | 0 | 13 |
- n | CC2H Evaluation - Patient Evaluation | | 0 | 24 | 0 | 24 |

#### Gaynor Connor Urgent Care
- i | Admissions Avoidance team | | 0 | 0 | 0 | 0 |
- j | Pump priming of the diagnostics business case at MYHT | | 0 | 0 | 0 | 0 |
- k | Increased health care capacity to reduce delayed discharges | 30/08/2013 | 0 | 50 | 0 | 50 |
- l | Increased MY Therapy services | 30/08/2013 | 0 | 63 | 0 | 63 |
- m | Spot purchasing / winter bed capacity | 30/08/2013 | 0 | 285 | 0 | 285 |
- n | Primary Care Foundation | 30/08/2013 | 0 | 0 | 0 | 0 |
- o | Winter Plan | 05/11/2013 | 0 | 646 | 0 | 646 |
- p | Remaining Winter Pressures allocations | | 0 | 2,564 | 0 | 2,564 |
- q | Emergency Care Practitioners | | 0 | 0 | 0 | 0 |

#### Michele Ezro Mental Health
- o | Mental Health transformation | | 0 | 350 | 0 | 350 |

#### Andrew Pepper Acute Trust
- p | MYHT reserve for non-recurrent costs | | 0 | 2,638 | 0 | 2,638 |
- q | MYHT reserve for former SCG share of non-recurrent costs | | 0 | 200 | 0 | 200 |

### Other
- r | Health Inequalities GSM support | | 0 | 76 | 0 | 76 |
- s | QIPP invest to save reserve (includes £125k prescribing support) | 30/08/2013 | 0 | 125 | 0 | 125 |
- t | PMO in-year additional costs | 30/08/2013 | 0 | 500 | 0 | 500 |
- u | Qualitative Interview Tool | 30/08/2013 | 0 | 0 | 0 | 0 |

#### Gill Day
- w | Podiatry MYHT Contract | | 0 | 50 | 0 | 50 |
- x | Continuing Care: Promoting Efficient Discharges from MYHT | 30/08/2013 | 0 | 35 | 0 | 35 |

#### Rosemary Davison
- y | Continuing Care: Short Term Clinical Support | 30/08/2013 | 0 | 0 | 0 | 0 |

#### Michelle Ashbridge
- a | Community Respiratory Service | | 0 | 33 | 0 | 33 |
- b | MPET end of Life Care Training | 05/11/2013 | 0 | 84 | 0 | 84 |

#### Mandy Sheffield
- c | Multi Agency Safeguarding Hub (MASH) | 05/11/2013 | 0 | 19 | 0 | 19 |
- d | Urinary Catheter Training (Care Homes) | 05/11/2013 | 0 | 25 | 0 | 25 |
- e | Care Pathways & Packages Project | | 0 | 9 | 0 | 9 |

#### M Ashbridge
- a | Wakefield Electronic Palliative Care Coordination System (EPaCCS) | | 0 | 26 | 0 | 26 |

#### Becky Gunn
- g | Patient Engagement - CC2H Evaluation | | 0 | 47 | 0 | 47 |
- h | Primary Care Investment | | 0 | 0 | 0 | 0 |

### B
- Sub Total | | | 3,608 | 7,046 | 1,430 | 12,084 |

### C
- Difference | 32 | -1,958 | -996 | -2,922 |

### D
- Proposed reconciliation | 0 | 0 | 0 | 0 |

### E
- TOTAL | 3,608 | 7,046 | 1,430 | 12,084 |
- DIFFERENCE | 32 | -1,958 | -996 | -2,922 |
**Title of meeting:** Governing Body  
**Date of Meeting:** 11 March 2014  
**Public/Private Section:**  
<table>
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<th>Private</th>
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<tbody>
<tr>
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</tbody>
</table>

**Paper Title:** Process for sign off of final accounts for 2013/14

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

<table>
<thead>
<tr>
<th>Decision</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Information</th>
</tr>
</thead>
</table>

**Report Author and Job Title:** Karen Parkin, Head of Finance & Governance

**Responsible Clinical Lead:** Not applicable

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

**Recommendation:**
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:**

To enable DH Group Accounts to be produced, NHS England has agreed that CCGs will be required to comply with the Manual for Accounts and the CCG Annual Reporting Guidance 2013/14.

The annual report and accounts will be prepared in line with the strict timetable determined by NHS England. By 12.00 noon on Wednesday 23 April 2014 the CCG must submit full draft accounts. The deadline for the full audited and signed accounts and the annual report is Friday 6 June 2014 and the CCG must hold a public meeting at which the Annual Report & Accounts should be presented no later the 30 September 2014.

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

<table>
<thead>
<tr>
<th>Improve health equality across our population</th>
<th>Support for individual health and wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Appropriate access and choice for all</td>
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<td>Transparent clinically-led commissioning</td>
<td>Service transformation through redesign</td>
</tr>
<tr>
<td>Improvement through collaboration and integration</td>
<td>Financial efficiency, probity and balance</td>
</tr>
</tbody>
</table>

**Outcome of Equality Impact Assessment:** Not applicable

**Outline public engagement:** Not applicable

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

**Previously presented at committee/governing body:** On 4 February 2014, the Audit Committee received a series of reports outlining the processes for delivering accounts from a CCG and Audit perspective.
<table>
<thead>
<tr>
<th>Reference document(s) / encls</th>
<th>None.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Assessment:</strong></td>
<td>The risk that CCG fails to deliver a set of unqualified accounts has been recognised on the CCG’s risk register (ref 33, score of 6).</td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
<td>None identified.</td>
</tr>
</tbody>
</table>
NHS Wakefield Clinical Commissioning Group

Board Meeting of the Governing Body

11th March 2014

Process for sign off of final accounts for 2013/14

1 Introduction

To enable DH Group Accounts to be produced, NHS England has agreed that CCGs will be required to comply with the Manual for Accounts.

The draft CCG Annual Reporting Guidance 2013/14 has recently been published and forms the overall guide for CCGs.

On 4 February 2014, the Audit Committee received a series of reports outlining the processes for delivering accounts from a CCG and Audit perspective.

2. Statement of Accountable Officers Responsibilities

The Clinical Commissioning Group Accountable Officer (The Chief Officer) must explain their responsibility for preparing the Financial Statements in a Statement of Accountable Officer’s Responsibilities.

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.

3 Chief Executive and Chief Financial Officers consistency statements

To provide assurance to NHS England, its auditors, the Department of Health and the group auditors 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:

The first will confirm that ISFE (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 will confirm that the data contained in the supplementary data collection templates is an accurate reflection of the data in the signed Financial Statements.

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

4 CCG Annual Reporting Guidance 2013-14

The key dates relating to the submission of draft and final accounts and annual reports are provided below.
By 12.00 noon, Wednesday 23 April 2014: Full draft accounts, ISFE consistent data collection and statement, signed by the CE and CFO

By 12.00 noon, Friday 6 June 2014: Full audited and signed accounts, ISFE consistent data collection and statement, signed by the CE and CFO

By 17.00 on Friday 6 June 2014: Auditors to submit one original signed copy of the full Annual Report & Accounts to NHS England.

No later than 17.00 on Friday 6 June 2014: Publish Annual Report & Accounts in full on the public website.

No later the 30 September 2014: Hold a public meeting at which the Annual Report & Accounts should be presented.

The following is a hyperlink to the full guidance, which appears under the heading of CCG Finance

http://www.england.nhs.uk/resources/resources-for-ccgs/

The Governing Body meeting on 13 May 2014 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 8 May and 22 May 2014.

Given the timing of Governing Body meetings, it is proposed that the Governing Body delegates 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.

3 Action Required

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
04 March 2014
**Title of meeting:** Governing Body  
**Agenda Item:** 11  
**Date of Meeting:** 11 March 2014  
**Public/Private Section:**  
Public ✔ Private N/A  
**Paper Title:** Service Level Agreement (SLA) negotiations with West and South Yorkshire and Bassetlaw Commissioning Support Unit: Progress Update Report  
**Purpose (this paper is for):** Decision ✔ Discussion Assurance Information  
**Report Author and Job Title:** Karen Parkin, Head of Finance and Governance  
**Responsible Clinical Lead:** Not applicable  
**Responsible Governing Board Executive Lead:** Andrew Pepper, Chief Finance Officer  

**Recommendation:**

The Governing Body are asked to note the current progress and to delegate authority to the Chief Officer (CO) and Chief Financial Officer (CFO) to agree the final contract and to ensure delivery of sustainable 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 West and South Yorkshire and Bassetlaw Commissioning Support Unit (CSU) for 14/15 and 15/16.

The current 13/14 service level agreement provides for a range of services at a cost of £2,820,283.

On the 22 August 2013, a letter was issued to all CCGs from Rosamond Roughton, National Director, commissioning development at NHS England. It recognises the desire that CCGs have to commission support through greater transparency of information, simple and cost effective mechanisms and concluded that where CCGs wish to do so, they can extend their SLAs with CSUs until no later than April 2016.

Contract negotiations have been lead at a CFO level for both CCG and CSU organisations. Regular weekly meetings are ongoing and a number of principles have been established. Iterations of the draft pricing schedules have been shared and discussed between CFOs. The final offer will be agreed over the forthcoming week.

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

<table>
<thead>
<tr>
<th>Principle</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health equality across our population</td>
<td></td>
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<tr>
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<tr>
<td>Safe and high quality experiences and clinical outcomes</td>
<td></td>
</tr>
<tr>
<td>Transparent clinically-led commissioning ✔</td>
<td></td>
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<tr>
<td>Service transformation through redesign</td>
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<tr>
<td>Improvement through collaboration and integration ✔</td>
<td></td>
</tr>
<tr>
<td>Financial efficiency, probity and balance ✔</td>
<td></td>
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</tbody>
</table>

**Outcome of Equality Impact Assessment:** Not applicable
<table>
<thead>
<tr>
<th>Outline public engagement:</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance departments/ organisations who will be affected have been consulted:</td>
<td>The CSU have liaised with CCGs on any relevant strategy</td>
</tr>
</tbody>
</table>
| Previously presented at committee / governing body: | A progress report on SLA negotiations with the CSU was last presented to Integrated Governance Committee on 20th February 2014. The Committee noted the paper and requested that:  
• KPI related payment mechanisms be considered.  
• Flexibility for any service change to be maintained for those services contracted over two years within the overall cost envelope.  
• To ensure 10% reduction by 15/16 in line with running costs allocations. |
| Reference document(s) / enclosures:               | Report on “2014/15 SLA Negotiations with WSYBCSU” |
| Risk Assessment:                                  | There is a risk that the Commissioning Support Unit (CSU) fails develop appropriately. Due to inability to secure and retain the required capacity and capability. Resulting in loss or reduction of the delivery of agreed support services at the levels of efficiency and effectiveness that the CCG requires. |
| Finance/ resource implications:                   | Total Cost £2.8m with ongoing negotiation. Likely to be a cost reduction in 14/15 and 15/16 on current contract value. |
2014/15 SLA Negotiations with West and South Yorkshire and Bassetlaw Commissioning Support Unit

Progress Update Report for Governing Body Tuesday, 11 March 2014

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 Commissioning Support Unit (CSU) for 14/15 and 15/16 and seek delegated authority to agree a final contract which delivers sustainable support services to the CCG.

2 Context

The current 13/14 service level agreement provides for a range of services at a cost of £2,820,283:

<table>
<thead>
<tr>
<th>Service</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Intelligence</td>
<td>£ 646,809</td>
</tr>
<tr>
<td>Transformation</td>
<td>£ 630,060</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>£ 68,658</td>
</tr>
<tr>
<td>Provider Management</td>
<td>£ 162,015</td>
</tr>
<tr>
<td>Governance</td>
<td>£ 340,455</td>
</tr>
<tr>
<td>Information Technology</td>
<td>£ 359,599</td>
</tr>
<tr>
<td>Communications and Engagement</td>
<td>£ 412,501</td>
</tr>
<tr>
<td>Workforce and Organisational Development</td>
<td>£ 200,186</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£2,820,283</strong></td>
</tr>
</tbody>
</table>

In addition, the CCG agreed to enter into a contract variation with the CSU to manage legacy continuing healthcare claims.

Performance monitoring systems against the current 13/14 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 specifications have been developed and improvements to these are currently being made for 14/15.
- Weekly meetings between the CCG contract lead and the CSU Client Relations Manager
- Completion of monthly satisfaction scores which form one element of the overall performance report submitted by CSU.
- Monthly contract monitoring meetings between the CCG and CSU at Director level. The CSU performance report is presented and any concerns are discussed.

3 National Guidance

On the 22 August 2013, a letter was issued to all CCGs from Rosamond Roughton, National Director, commissioning development at NHS England. It recognises the desire that CCGs have to commission support through greater transparency of information, simple and cost effective mechanisms, but that
any timetable for procurement shall be sensible so as not to divert focus away from the contracting round and strategic challenges as set out in ‘A Call to Action’. The conclusion therefore was that where CCGs wish to do so, they can extend their SLAs with CSUs until no later than April 2016. Within this however, CCGs should use the opportunity to review their needs and renegotiate the arrangements with the CSU.

4 Current SLA Progress for 14/15 & 15/16

A progress report on SLA negotiations with the CSU was last presented to Integrated Governance Committee on 20th February 2014. The Committee noted the paper and requested that:

- KPI management be strengthened
- Flexibility for any service change to be maintained (for those services contracted for two years)
- To ensure 10% reduction by 15/16 in line with running costs allocations

Contract negotiations have been led at a CFO level for both CCG and CSU organisations. Regular weekly meetings are ongoing. Principles established to date are:

- Overall health economy stability to be maintained – significant decommissioning of CSU services to be avoided unless there is a whole health economy reason for doing so.
- Baseline contract value to be no more than the 13/14 contract value.
- For those service lines which have been performing well and are robust, a two year contract to be established.
- A required reduction for 14/15 then a further reduction in 15/16 equating to a 10% reduction over 2 years (for relevant services).
- Changes to some services in 14/15 – Communications & Engagement, Governance, Continuing Health Care.
- Development of service specifications and work plans to be drafted by CSU/CCG leads for each service and incorporated into the final contract.

A number of iterations of the draft pricing schedules have been shared and discussed between CFOs. The final offer will be agreed over the forthcoming week.

5 Governance

NHS England guidance (as described above) allows for CCGs to enter into contracts up to April 2016 with CSUs. The CCG scheme of delegation requires Governing Body approval for commitment of non-healthcare expenditure over £1M.

As necessary, a tender waiver will be submitted and recorded in the report to audit committee.

6 Recommendations

The Governing Body are asked to note the current progress and to delegate authority to the CO and CFO to agree the final contract and to ensure delivery of sustainable support services in line with NHS England guidance.

Karen Parkin,
Head of Finance
28 February 2014
### Executive Summary:

**PCT Safeguarding Children Annual Report 2012/13**

The Board is required to receive a number of annual Safeguarding reports this includes the Annual report indicating the position of the NHS in relation to safeguarding children, this is a statutory obligation under the Children Act 2004. This is the Annual Report for Safeguarding Children for the Wakefield District relating to the year ending 31st March 2013. Essentially this is the closedown report for the PCT.

The report identifies:
- the trends for child protection planning over the last 4 years;
- longitudinal study of the categories of abuse to which Wakefield children are subjected;
- Performance of the main Health providers within the district in relation to training and supervision;
- Serious Case Reviews

The report makes recommendations in relation to the findings above. It can be found at Appendix 1.

**Wakefield and District Safeguarding Children Annual Report 2012/13**

The Board is asked to consider the annual report presented by the Wakefield and District Safeguarding Children Board (2012/13).

This annual report covers the period 1st April 2012 to 31st March 2013. It is the multi-agency Local Safeguarding Children Board annual report which was approved by the LSACB in January 2014. The report details the progress of the SLCB over the 12 months to the 31st March 2013, and outlines how the Board aims to meet its vision of "Children and young people in the Wakefield district will be safe and will feel safe within their homes, schools and communities".

The report outlines the position for NHS Wakefield District as this was the commissioning organisation on the LSCB until it’s closedown at the end of March 2013.


<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>CCG Governing Body</th>
<th>Agenda Item:</th>
<th>12</th>
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<tbody>
<tr>
<td>Date of Meeting:</td>
<td>11th March 2014</td>
<td>Public/Private Section:</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>Mandy Sheffield, Head of Safeguarding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Ann Carroll, Governing Body Member and Children’s Lead Sharon Fox, Governing Body Member – Nurse Representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Jo Pollard, Chief of Service Delivery and Quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation(s):</td>
<td>It is recommended that the Committee note the content of the reports</td>
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</tr>
<tr>
<td>Link to overarching principles from the strategic plan:</td>
<td>Improve health equality across our population</td>
<td>Support for individual health and wellbeing ✓</td>
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</table>

| Outcome of Equality Impact Assessment: | Not applicable |
| Outline public engagement: | Not applicable |
| Assurance departments/organisations who will be affected have been consulted: | Not applicable |
| Previously presented at committee / governing body: | Not applicable |
| Reference document(s) / enclosures: | Appendix One: PCT Safeguarding Children Annual Report 2012/13 |
| | Appendix Two: Wakefield and District Safeguarding Children Annual Report 2012/13  
| Risk Assessment: | Not applicable |
| Finance/ resource implications: | The LSCB report highlights that the Board receives comparatively less funding than comparator authority LSCBs. The Board cannot sustain its current level of provision with the resources available, and I likely to continue to request additional financial support from the NHS and other Board partners.  

The financial commitment to the 2 safeguarding Boards currently stands at £67kpa. |
SAFEGUARDING CHILDREN
ANNUAL REPORT

April 2012 – March 2013
NHS Wakefield District
## Appendix One

**SAFEGUARDING CHILDREN ANNUAL REPORT 2012/13**

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<td>Safeguarding Statistics</td>
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<td>4.</td>
<td>Training</td>
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<td>5.</td>
<td>Supervision</td>
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<td>6.</td>
<td>Integrated Inspection of Safeguarding Children and Looked after Children 2010</td>
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<td>7.</td>
<td>Serious Case Reviews</td>
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<td>8.</td>
<td>Plans and Developments</td>
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<td>9.</td>
<td>Conclusion</td>
<td>11</td>
</tr>
<tr>
<td>10.</td>
<td>Recommendations</td>
<td>11</td>
</tr>
</tbody>
</table>
1. **Introduction**

This annual report represents the final position in relation to safeguarding children and the NHS prior to the closedown of NHS Wakefield CCG. The responsibilities of NHS Wakefield CCG as the successor organisation will be covered in section 8.

Under section 11 of the Children Act 2004, NHS Wakefield District (NHSWD) as the Primary Care Trust (PCT) had a number of responsibilities. NHSWD had to ensure that:

- All services it commissions provide their services with due regard to safeguarding and promoting the welfare of children
- Staff and those in services contracted by NHSWD are trained and competent to be alert to potential indicators of abuse or neglect in children
- Staff know how to act on their concerns and fulfil their responsibilities in line with the Local Safeguarding Children Board procedures
- They have in place a designated nurse and a designated doctor who have an over-arching responsibility across NHSWD area, which includes all providers
- The NHSWD Chief Executives’ responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively
- All health agencies with whom they have commissioning arrangements are linked into all Local Safeguarding Children Boards, and that there is appropriate representation at an appropriate level of seniority. Also ensuring that health services and health care workers contribute to multi-agency working

This report summarises the assurances NHSWD has received that indicate all the above have been met within the last year. In addition, this report details safeguarding children and child protection activity within the Wakefield district to provide the context for the provision of services.

The report has been prepared by Mandy Sheffield, Head of Safeguarding for NHS Wakefield Clinical Commissioning Group, with oversight from Dr Paul Glover, Named GP for Safeguarding Children and Dr Andrea Nussbaumer, Designated Doctor for Safeguarding Children. In preparing this report, the annual safeguarding children reports from the provider trusts have been scrutinised, alongside discussions with the safeguarding teams in the organisations. Wakefield Metropolitan District Council have provided the statistics included in the report.

2. **Background**

The 2011/12 annual report presented to the Governance Committee of the PCT Cluster Board in February 2013, and the Clinical Commissioning Executive in March 2013 examined the performance of Mid Yorkshire
Hospitals NHS Trust (MYHT), South West Yorkshire Partnership Foundation Trust (SWYPFT) and Spectrum Community Interest Company in safeguarding children. It concluded that:

- The safeguarding children performance of the services commissions for the residents of Wakefield and District had largely not improved, and there had mostly been a decrease in training and supervision performance during 2011/12;
- Whilst organisations considered they had continued to prioritise safeguarding children following Transforming Community Services (TCS), there was limited assurance that this was the case;
- Systems and processes had not been maintained in SWYPFT for on-going monitoring, particularly in relation to supervision and training.

This report will analyse progress in relation to these areas. This annual report for 2012/13 will examine the position in the following organisations:

- Mid Yorkshire Hospitals NHS Trust (MYHT)
- South West Yorkshire Partnership Foundation NHS Trust (SWYPFT)
- Spectrum Community Interest Company (Spectrum)
- Primary Care

3. Safeguarding Children Statistics

The following statistical information has been provided by Wakefield Metropolitan District Council (WMDC). Table 1 below builds the longitudinal picture of the number of children subject to a child protection plan from April 2009 to March 2013.

![Graph showing children subject to Protection Plans 2009-2013](image)

**Table 1** Children subject to Protection Plans 2009-2013
The number of children subject to child protection plans fell through the first part of 2012/13, although the last two quarters saw a sustained rise in numbers, so that, for the third year in succession, numbers at the year end (March) has remained relatively static.

The category of registration has continued to fluctuate (see chart 2 below). It is significant that in the year 2011/12, Neglect and Emotional 79% of children subject to child protection plans, a statistic that had remained largely static over the last 4 years. in 2012/13, the percentage of children categorised as at risk of Emotional Abuse or Neglect has increased to 90%. This indicates that only 4% of children are at risk from Sexual abuse, and 6% of children from physical abuse.

There is a recognition that Wakefield has a significantly higher number (per thousand) of children subject to Child in Need (CiN) plans. This is highly suggestive that the 'Early Help Offer' for families is not sufficiently robust to provide support to families early enough to prevent statutory intervention. The statistics provided in this paragraph would echo this, as both Emotional Abuse and Neglect are pervasive forms of abuse, requiring significant changes in parenting capacity to reduce the risk, compared to the disclosure and action nature of physical abuse.

From April 2013 the commissioning of the Universal Health Services for children will not be the responsibility of the Clinical Commissioning Group, with Health Visiting and Family Nurse Partnership resting with the West Yorkshire Area Team of NHS England, and School Nursing with Wakefield Metropolitan District Council. These services are predominantly the ones working with families on the 'Early Help Offer', and low capacity in these services may have an impact both on the high number of children managed at CiN plan level, and those subject to child protection plans due to Emotional Abuse and Neglect.
Chart 1 - Changes in Category of Child Protection Plan 2010-2013
4. Training

Safeguarding children training is mandatory for all staff in the NHS. During 2012/13 the levels of training continued to be defined in the 2010 statutory guidance “Working Together to Safeguard Children”. This guidance was replaced in March 2013, but for the purposes of this report, the 2010 criteria are the guide used. This report covers level 2 and 3 training statistics.

The report submitted covering 2011/12 identified that the collation of statistics for mandatory safeguarding children training was not consistent across the NHS, and levels of training were not at an acceptable level. The following recommendations were made:

1. Poor compliance with Level 2 Training in MYHT will be raised at the Quality Board.
2. Poor compliance with Level 2 and Level 3 Training in SWYPFT will be raised at the Quality Board.

Both these actions were undertaken by the PCT, and regular monitoring of training compliance took place. The position at the end of 2012/13 is reported below:

**MYHT**

MYHT has adapted the reporting of statistical information regarding mandatory safeguarding children training, the statistic now reflects the Trust as a whole, rather than separating the acute and community sectors. In March 2012, MYHT reported 52% of community staff and 55% of acute staff had received safeguarding children training to level 2. The position for the period 2012/13 has increased marginally to 59% of all staff. The position in relation to level 3 training has fallen, from 87% of Acute staff, and 98.4% of community staff compliant to a total of 84% of all level 3 practitioners during the current year. Table 2 below provides the statistical information for MYHT for levels 2 and 3.

<table>
<thead>
<tr>
<th>Level</th>
<th>% Staff compliant with mandatory safeguarding Training 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>59%</td>
</tr>
<tr>
<td>Level 3</td>
<td>84%</td>
</tr>
</tbody>
</table>

*Table 2 MYHT Training statistics*

**SWYPFT**

SWYPFT report statistical information in relation to all employees – Wakefield, Kirklees, Barnsley and Calderdale, however they have presented the following statistic for staff employed in Wakefield District.

<table>
<thead>
<tr>
<th>Level</th>
<th>% Staff compliant with mandatory safeguarding Training 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>80.1%</td>
</tr>
<tr>
<td>Level 3</td>
<td>59.7%</td>
</tr>
</tbody>
</table>
Level 2 training demonstrates an improvement from 73% in 2011/12, and although the statistic for level 3 training is poor, no data was collected during the previous year, so comparison cannot be drawn.

Spectrum

The services by Spectrum Community Interest Company includes services provided to children and their carers. Spectrum has continued to prioritise the provision of safeguarding training to all staff in the organisation.

<table>
<thead>
<tr>
<th>Level</th>
<th>% Staff compliant with mandatory safeguarding Training 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>80%</td>
</tr>
<tr>
<td>Level 3</td>
<td>100%</td>
</tr>
</tbody>
</table>

The level 2 statistic is a fall from 100% in the previous year, largely due to the acquisition of new services where safeguarding training has not been mandatory prior to management by Spectrum.

Primary Care

The Head of Safeguarding has continued to promoted the use of ‘e-learning’ for all services within primary care, and continued to provide regular level 2 sessions which were promoted for staff in general practice, dental practices, community pharmacies and optician practices. The taught courses continued to be well attended, with 234 attendees during the year.

Primary care continue to access e-learning provided by the Local Safeguarding Children Board (LSCB) although due to personnel changes in the LSCB administration team it has not been possible to obtain statistics for completion by Primary Care staff.

The registration of Dentists with the CQC prompted significant increases in the demand for level 2 training, and it is anticipated that the same will occur in General Practice.

To meet the demand for Level 3 safeguarding children training for GPs and Nurse Practitioners, two Target sessions were undertaken in 2012/13. A total of 420 people attended these sessions, which included a summary of learning for Primary care from the four Serious Case Reviews undertaken in Wakefield in 2012, a session from a senior manager in Children's Social Care, and an informative session detailing how level 3 competency could be maintained.

Analysis

There has been little significant improvement in the compliance with mandatory safeguarding children training in Health Trusts over the year 2012/13, although the recording of information is more comprehensive and streamlined this year. This is a very worrying situation: Level 2 training will
Appendix One

equip staff in contact with children and their parents to recognise the indicators of abuse and neglect and have the knowledge of what to do if they suspect a child may be at risk. Level 3 training equips a practitioner to manage the risk, and provides additional competency to assess families where children may be at risk of abuse or neglect.

The levels of training continues to be below an acceptable level in the NHS, and will need continued monitoring by the CCG in 2013/14.

5. Supervision

Safeguarding supervision has been closely monitored by the PCT since 2010, when the processes for assuring the performance of practitioners involved with children requiring safeguarding was commented on by the CQC.

MYHT

Through 2012/13, MYHT safeguarding supervision was a CQuIN scheme, this scheme was very successful in ensuring that the organisation prioritised sessions for all staff working significantly with children and young people. MYHT report that the reason for the lower than expected performance in relation to Paediatric Therapists was Supervisor sickness.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Percentage undertaken</th>
<th>Target percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Practitioners</td>
<td>96.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Community Midwives</td>
<td>92%</td>
<td>85%</td>
</tr>
<tr>
<td>Paediatric Therapists</td>
<td>45%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table 3 MYHT Supervision statistics as at 31.03.2013

In light of the changes to the commission of some of the services covered in this data from 1st April 2013, recommendation was made to the Director of Nursing in the West Yorkshire Area Team of NHS England to continue a CQuIN scheme for Health Visitor safeguarding supervision in the year 2013/14.

SWYPFT

Statistics for the level of supervision amongst staff as at 31st March 2013 has not been made available. SWYPFT have reported that, as at 30th November 2013, 96% of staff working in the Children and Adolescent Mental Health Services have had supervision addressing issues of safeguarding. They further report that:

- All staff now have monthly (this is a minimum and is significantly more for some staff groups) clinical supervision with an appropriate trained and qualified supervisor at the core of this is the safeguarding and promoting the welfare of the child.
- All staff have monthly management supervision where the broader impact of learning and development, case load size and complexity
Appendix One

and other operational matters is considered safeguarding and promoting the child is at the core of this.

- All staff are encouraged to attend fortnightly Safe Space safeguarding peer supervision groups facilitated by the CAMHS safeguarding lead and the Nurse Advisor safeguarding children.

- All staff have access to the CAMHS safeguarding lead or if preferred a NSPPC trained supervisor of which the Wakefield CAMHS where 1:1 safeguarding supervision is identified either by the

- All staff receive 1:1 supervision with the a (sic) member of safeguarding team as requested.

Spectrum

Spectrum have continued to provide supervision in accordance with their policy, and have achieved 100% for all relevant staff.

6. Inspections for Safeguarding and Looked after Children

The Care Quality Commission inspection framework for the NHS is scheduled to change in 2013/14. The NHS was not subject to any formal safeguarding inspections during 2012/13, although Health Services were involved in the Unannounced Inspection of Wakefield Council undertaken by OFSTED in October 2012, and were involved in the OFSTED Thematic Inspection of safeguarding Children with Disabilities. There were no recommendations for the NHS from these inspections.

6. Serious Case Reviews

The four Serious Case Reviews within Wakefield District reported in the last annual report were all completed in 2012. There were recommendations within all four reviews for the Mid Yorkshire Hospitals NHS Trust, recommendations to General Practices in three reviews, and for the PCT, South West Yorkshire Partnership Foundation Trust and Spectrum CIC in one review. These recommendations will be performance managed by the Local Safeguarding Children Board.

The following paragraph summarises the outcome of the cases, all of which have been given pseudonyms:

- Abigail: a 9 week old baby who sustained a fatal head injury. Her father was convicted of murder in 2012, and sentenced to life with a minimum term of 8 years. The Serious Case Review was published by the LSCB, with minimal publicity.

- Benjamin: a five year old child who died as a result of multiple non-accidental injuries. His father (sole carer) was convicted of murder in 2012, and sentenced to life with a minimum term of 28 years. This review is not published, as the LSCB has been advised against publication for legal reasons.

- Christine: a 17 year old young lady who was murdered, along with her 18 year old friend, by Christine’s sister's ex-partner (pseudonym...
David). Christine had been 'Looked after' by the Local Authority, and was supported by services as a 'Care Leaver' at the time of her death. David was convicted of two counts of murder, and received 2 life sentences, with a minimum term of 34 years. This SCR was published following the conclusion of the trial, and was received with some press interest.

- Emma: a 7 week old baby who received fatal head injuries. At the time of her death, Emma was being managed as a 'Child in Need'. Emma's father was convicted of her murder in 2012, and sentenced to life, with a minimum term of 13 years. The review has not yet been published.

Key learning for the NHS from these four reviews has included:

- The quality of communication within, and between health services, and between the NHS and other partner agencies has not been adequate. This included face to face, electronic and written communications (all cases);

- The knowledge of staff in the NHS in relation to domestic abuse has not been sufficient to ensure victims and their children can be supported (3 cases);

- Knowledge of child sexual exploitation was limited (one case);

8. Plans and Developments for 2013/14

The roles of the designated professionals for safeguarding children are included in the structure of the NHS Wakefield Clinical Commissioning Group. These roles, with that of the named GP, will ensure that the NHS continues to commit to safeguarding children in the future.

The CCG will continue to support the work of the Local Safeguarding Children Board with the identification of the Chief Officer as the LSCB member for the CCG. This commitment will include support to the Local Authority and West Yorkshire Police in the development of the Multi-Agency Safeguarding Hub (MASH), and commitment to commissioning a health resource to work within the Hub.

Continued concerns relating to the uptake of level 2 safeguarding children training in MYHT and level 3 in SWYPFT will continue to be raised with the organisations, and will monitored through the Executive Quality Boards.

NHS Wakefield CCG will ensure that learning and recommendations from SCRs are performance monitored, and audited over the coming year. This will be undertaken through the Executive Quality Boards.

The CCG will lead the NHS in preparing for the CQC Children Looked After and Safeguarding Inspection following publication of the framework.

9. Conclusion
Appendix One

The CCG Governing Body has limited assurance that services the PCT commissioned were equipped to safeguard and promote the welfare of children during the year 2012/13

- The safeguarding children supervision performance of MYHT has continued to improve through the year.
- The performance of MYHT in ensuring that level 3 staff receive mandatory training has improved, although level 2 training is still below acceptable levels;
- SWYPFT has established the systems for monitoring training requested by the PCT, and statistical information for the Wakefield Business Unit are not collated. This was a recommendation from the PCT in 2012. Training for practitioners in SWYPFT who have significant contact with children and young people is however falling short of the target set by the organisation.
- NHS Wakefield CCG has maintained the consistency of safeguarding children oversight across health providers in Wakefield by incorporating the Designated Professionals into the organisational structure.

10. Recommendations

1. Poor compliance with Level 2 Training in MYHT will continue be raised at the Executive Quality Board.

2. Poor compliance with Level 3 Training in SWYPFT will be raised at the Executive Quality Board

3. The Clinical Commissioning Group should continue to support the work of the Local Safeguarding Children Board, including the development of the Multi-Agency Safeguarding Hub

Mandy Sheffield
Head of Safeguarding
November 2013
Appendix Two:

Wakefield and District Safeguarding Children Annual Report 2012/13

<table>
<thead>
<tr>
<th>Title of meeting:</th>
<th>Governing Body</th>
<th>Agenda Item:</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Meeting:</td>
<td>11 March 2014</td>
<td>Public/Private Section:</td>
<td></td>
</tr>
<tr>
<td>Paper Title:</td>
<td>NHS Wakefield Clinical Commissioning Group Risk Register</td>
<td>Public</td>
<td>✓</td>
</tr>
<tr>
<td>Purpose (this paper is for):</td>
<td>Decision Discussion Assurance Information ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Author and Job Title:</td>
<td>Adam Bassett, Senior Associate Governance and Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Clinical Lead:</td>
<td>Dr Phil Earnshaw, Chair of the CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible Governing Board Executive Lead:</td>
<td>Andrew Pepper, Chief Financial Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation:</td>
<td>It is recommended that the Governing Body:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>i notes the risk register for NHS Wakefield Clinical Commissioning Group as a correct reflection of the current position, following the Integrated Governance Committee on 20 February 2014.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Summary:</td>
<td>The Risk Register was considered by the Integrated Governance Committee on 20 February 2014 following a new review cycle. It was agreed at that meeting that it would be presented to the Governing Body on 11 March 2014.</td>
<td></td>
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<tr>
<td></td>
<td>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.</td>
<td></td>
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<tr>
<td></td>
<td>During this review cycle 5 risks have been identified for closure and 4 new risks have been added.</td>
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<tr>
<td></td>
<td>As of 11 February there are 57 risks on the risk register as follows;</td>
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<tr>
<td></td>
<td>Critical Risks (scoring 25-20) – None</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Serious Risks (scoring 16-15) – Eight as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 348 Scoring 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is a risk that the CCG will exceed its allocations in 14/15 and future years due to high levels of demand and price increases outstripping allocation increases resulting high levels of QIPP and QIPP risk and resulting in a failure to meet its statutory duty.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 323 Scoring 16</td>
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<td></td>
<td>There is a risk the out-of-hours service will experience significantly higher activity than is contractually planned for 2014-15. This will therefore effect the ability of the service provider to provide a service to these patients which meets the contractual KPIs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 37 Scoring 16</td>
<td></td>
<td></td>
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</tbody>
</table>
There is a risk that MYHT will have further cases of MRSA bacteraemia and exceed the annual objective of 49 Clostridium difficile cases in 2013/14. Due to the incidence of health care associated infections in hospital. Resulting in contractual, reputational and patient safety consequences.

- 28 Scoring 16

There is a risk that the CCG will have further cases of MRSA bacteraemia and exceed the annual objective of 86 Clostridium difficile cases in 2013/14. Due to the incidence of health care associated infections in community and hospital settings. Resulting in financial (loss of proportion of quality premium), reputational and patient safety consequences.

- 22 Scoring 16

There is a risk of a delay in MYHT implementing the clinical services strategy following the Meeting the Challenge consultation (and the decision taken by the CCG’s Board in July). Due to the Joint Overview & Scrutiny Committee referring the consultation to the Secretary of State for Health. This referral was made in October 2013. Resulting in a lengthy delay in receiving a decision, or a decision that meant changes to the proposals.

- 17 Scoring 16

There is a risk of failure to deliver the planned improvements and savings within our QIPP programme for 2013/14 due insufficiently robust assessment and planning and insufficiently resilient implementation resulting in increased challenge to the delivery of required organisational financial balance.

- 324 Scoring 15

There is a risk to the functioning of the Multi-agency Safeguarding Hub due to the Health resource being insufficient to meet the information research requirements of the Hub. This could result in damage to the reputation of the CCG.

- 45 Scoring 15

There is a risk to ophthalmology patients experiencing delays in first outpatient and follow up appointments due to increasing demand for services at Mid Yorkshire resulting in delayed diagnosis and treatment.

Those risks scoring 15 and above are outlined in appendix 1 to the report.

High Risks (scoring 12-8) – 22
Other risks (scoring 6 or below) – 27

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.

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

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 20 February 2013.

Reference document(s) / enclosures:
A full copy of the risk register is available upon request from the West and South Yorkshire and Bassetlaw Commissioning Support Unit Governance and Risk Team (adam.bassett@wsybcсу.nhs.uk)

Risk Assessment:
This is the risk assessment mechanism for NHS Wakefield CCG.

Finance/ resource implications:
None identified.
Title of meeting: Governing Body

Date of Meeting: 11 March 2014

Paper Title: Audit Committee: presentation of minutes and items for approval by Governing Body

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

Committee chair: Sandra Cheseldine – Lay Member

Meeting minutes enclosed: 4 February 2014

Recommendation:
It is recommended that the Governing Body receive and note the minutes of the Audit Committee held on 4 February 2014.

Executive Summary:

Headline discussions included:

4 February 2014
- Received a progress update from the Clinical Cabinet, and noted that a work-plan for 2014/15 is being developed to support future agenda planning.
- A full timetable for the production and publication of the 2013/14 CCG Annual Report and Accounts was considered, this included preparation for the Annual Governance Statement. A draft of the Annual Report will be available on 23 April for submission to External Audit and will be published on 6 June 2014. In view of the tight timetable delegated authority from the Governing Body will need to be sought for approval of the final accounts by the Audit Committee in association with the CFO and CO.
- Update on the Transfer Scheme for the assets and liabilities of the former PCT. The documentation still contains numerous errors although these have been advised to the Legacy team several times. It was agreed that the CCG could only sign the document if it was accurate.
- Wakefield PCT closedown; the Finance Team continue to liaise with the West Yorkshire Area Team to maintain open communication of the legacy matters.
- Service Auditor Reports will be provided by one external, independent auditor for each service provider such as the CSU. They are required as part of the annual governance statement.

Policies approved: None; the Audit Committee does not have the delegated power to approve policies.
Welcome and Chair’s opening remarks

Sandra Cheseldine welcomed Clare Partridge to her first Audit Committee meeting at NHS Wakefield CCG.

Apologies for absence

Apologies for absence were received from:

- Dr Clive Harries – Nominated Clinical member; and
- Jo Pollard – Chief of Service Delivery and Quality

Minutes of the meeting held on 17 December 2013

The minutes were approved as a true record of the meeting held on 17 December 2013.

Action sheet from the meeting held on 17 December 2013

Internal Audit Report – assurance mapping

Michelle Marsden advised that this work was ongoing and a report would be presented at the next Audit Committee meeting.
13/81  Reports prepared by Capita

Andrew Pepper shared the Capita publication entitled “Review of activity classification at Mid Yorkshire Hospitals NHS Trust” for information.

It was noted that this report replaces the Payment by Results information that the Audit Commission previously reported on. Following discussion it was agreed that a report detailing actions to be taken based on the recommendations would be presented at the next Audit Committee meeting with a further progress report in six months including comments from MYHT.

13/100  Internal Audit and Counter Fraud Progress Report

Nigel Bell confirmed that the next West Yorkshire Audit Consortium event is being held on Monday, 10 February 2014. Sandra Cheseldine and Rhod Mitchell confirmed that they would be attending.

14/5  Declarations of interest

Sandra Cheseldine invited members to declare conflicts of interest. No interests were declared.

Governance and Systems of Internal Control

14/6  Insurance Arrangements 2014/15

Adam Bassett attended the meeting to present this paper detailing the agreed insurance arrangements between the CCG and the NHS Litigation Authority for 2014/15.

No issues were raised.

It was RESOLVED that:

i. the Committee noted the Insurance Arrangements for 2014/15

14/7  Governance Controls Exception Report

Katherine Bryant presented this report outlining the activity in the period since the December Audit Committee meeting, noting there has been:

- One declaration under the CCG’s Standards of Business Conduct, relating to external remunerated activity
- CCG seal has not been used to execute any documents
- No suspension of Standing Orders
- Two tender waivers have been approved

Sandra Cheseldine queried whether any sponsorship had been received through the Target Event days, it was agreed that this will be followed up with the Practice Support Unit. Katherine advised that the Medicines Management team are currently developing a sponsorship and partnership policy and this would be presented at the March Integrated
Governance Committee meeting together with the Standard of Business Conduct policy.

**It was RESOLVED that:**

i. the Committee noted the paper and the governance control exceptions detailed in relation to Standards of Business Conduct declarations, Use of the CCG’s seal, Waiver of the Standing Orders exception report and Quotation and Tender Waiver exceptions.

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**Clinical Cabinet Progress Report**

Katherine Bryant presented this report detailing the items considered by members of the Clinical Cabinet. It was noted that two items included in the Clinical Cabinet Terms of Reference have not been considered by the committee. These items are equality and diversity and research governance, both of which have instead been considered by the Integrated Governance Committee. Clinical Cabinet has adopted responsibility for consideration of information technology and these changes will be reflected when the terms of reference for both Committees are reviewed and updated in spring 2014.

Katherine advised that a work-plan for 2014/15 is currently being developed. A discussion followed noting that as the issues discussed at the Clinical Cabinet are not cyclical the development of a work-plan may look ahead to a longer time horizon.

Rhod Mitchell queried whether there was potential to miss anything and Sandra Cheseldine responded that close links with the commissioning plans need to be incorporated in the work-plan to ensure this does not happen. Teams need to be considering the work they are involved in and ensuring that this forms part of the work-plan.

The nature of the items discussed can impact on primary care and therefore conflicts of interest can arise. These are managed in the meeting appropriately, either by delegation to another group or via the Deputy Chair (Lay Member).

**It was RESOLVED that:**

i. the Committee noted the content of the report; and

ii. agreed that the next update report is presented to the Audit Committee in September 2014.

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**Annual Governance Statement**

**a) Outline of Annual Governance Statement 2013/14**

Katherine Bryant presented this paper providing a detailed assessment of the content of the Governance Statement. Discussions will take place with key stakeholders and a first draft will be presented to the Integrated Governance Committee in March and Audit Committee in April, noting that the final Governance Statement will be published on 5 June 2014 as part of the Annual Report and Accounts.

A discussion followed and Linda Wild commented that through a ‘compare and contrast’ with other CCGs any advice and tips will be shared. Nigel Bell commented that the
inclusion of audit opinions in the report would be useful.

Rhod Mitchell suggested that a timeline of the organisational journey is included in the report. The draft document will be shared with Rhod Mitchell and Sandra Cheseldine for their comments.

It was RESOLVED that:

i. the Committee noted the report and plans to prepare the Governance Statement for inclusion in the Annual Report and Accounts.

b) Consistency Statements – Chief Finance Officer and Accountable Officer

Eamonn May presented this paper advising that the CCG Accountable Officer (the Chief Officer) must explain their responsibility for preparing the Financial Statements in a Statement of Accountable Officer’s Responsibilities. It was noted that the Chief Officer and the Chief Financial Officer will be required to sign and submit two consistency statements. This documentation will be positioned after the Annual Report and before the Governance Statement.

It was RESOLVED that:

i. the Committee noted the process outlined

14/10 Losses and Special Payments Update

Eamonn May and Susan Allan-Kirk presented this update providing details of a current situation regarding the continued usage of a business mobile phone after the last registered user left the PCT. It was noted that the local counter fraud officer has been heavily involved in the investigation. This is ongoing.

A review is being progressed by the West Yorkshire Audit Consortium involving finance, governance and facilities to reduce the risk of such an incident happening in the future. Sandra Cheseldine suggested an audit of mobile devices should be undertaken on a regular basis.

It was RESOLVED that:

i. the Committee noted the content of the report.

14/11 Review of Continuing Health Care Provision

Eamonn May presented this report advising that following the provisions set up at 31 March 2013 for Restitution Claims and LD Resettlement Patients present indications are that the number of cases and the average cost per claim is lower than originally provided for.

New draft guidance on provisions has been received that states that provisions may not count against Resource Limits at the point at which a provision is raised. Further guidance is awaited.
Following a discussion it was agreed that the provisions should remain unchanged for the time being until further guidance is received.

It was RESOLVED that:

i. the Committee noted the processes outlined and agreed to leave the provisions assessment unchanged at present

14/12 2013/14 Accounts Planning Update

Eamonn May presented this report advising that the CCG Annual Reporting Guidance 2013-14 has recently been published. Appendix 1 to the report detailed the timetable for the production and publication of the Annual Report and Accounts.

A full exercise to agree balances took place for period 9, including income and expenditure figures as well as debtor and creditor balances. The CCG is awaiting the formal results from this exercise, but no major variances were found during the completion of the work. A further full exercise will be completed at the year end.

It was noted that the draft accounts will be presented to the Audit Committee on 8 May 2014 and the Governing Body on 13 May 2014. At the Governing Body meeting on 11 March 2014 approval will be sought to delegate authority to the Audit Committee members to approve the final accounts at their meeting on 22 May 2014. The meeting invitation will be extended to those members of the Governing Body not on the Audit Committee membership. The final accounts will then be published on the web site on 6 June 2014.

It was RESOLVED that:

i. the Committee noted the processes outlined

14/13 Wakefield District PCT Closedown

Eamonn May presented this paper advising that any payments made by CCGs in the current financial year in relation to legacy balances will be reimbursed by NHS England after month 9 closedown and again before the year end, where appropriate.

The Finance Team continue to liaise with the West Yorkshire Area Team to maintain open communication of the legacy matters.

The team were congratulated for their hard work with regard to the closedown of the PCT.

It was RESOLVED that:

i. the Committee noted the processes outlined

14/14 CSU and Service Auditor Statements

Eamonn May presented this paper advising that Service Auditor Reports will need to be obtained from the Commissioning Support Unit, ESR (McKessons), Shared Business
Services and Business Service Authority. Service Auditor Reports will be provided by an external, independent auditor for each provider and this negates the need for each user to send their own auditors to do this work. A summary position statement was received for the CSU on 29 January and was attached at Appendix 1.

A discussion followed and it was noted that the CSU have to complete numerous action points before a Service Auditor report can be prepared. Andrew Pepper confirmed that he continues to hold discussions with the senior management of the CSU. A decision regarding the future provision of provider management has yet to be made.

The completed reports will be required as part of the annual governance statement.

**It was RESOLVED that:**

i. the Committee noted the content of the report

**14/15 Contract Award Update**

Matt England presented this update advising that one contract has been awarded through the formal procurement process since the last Audit Committee meeting. A contract has been awarded to Nova for the provision of the Bereavement Service and the contract will take effect from 1 April 2014.

**It was RESOLVED that:**

i. the Committee noted the content of the report.

**14/16 Transfer Scheme Update**

Matt England presented this update on the assets and liabilities transfer and the clinical services transfer documents detailing the progress towards sign off of the legal documentation. It is noted that there are a number of errors in the document and these have been communicated to the legacy team several times. Although there has been on-going dialogue the CCG is now unable to gain agreement on any further amendments, noting that the outstanding errors have been identified by the CCG and flagged from as early as April 2013.

The contracting team are unable to recommend signature of the legal document given the amount of mis-statements in the draft Transfer Scheme. From the Legacy Team guidance it appears unlikely that an accurate transfer scheme documentation can be achieved and signed off as the matter appears to have been drawn to a close by the Department of Health.

A discussion followed and it was agreed that the CCG could only sign the document if exceptions are included. Andrew Pepper agreed to formally write to the Legacy Team indicating that the CCG will not be able to sign the Transfer Order in its current form.

**It was RESOLVED that:**

i. the Committee noted the content of the report and the proposed approach
**14/17 Contracting and Commercial Strategy Team Update**

Matt England presented this update outlining the key developments, challenges, risks and opportunities for the Contracting and Commercial Strategy department. 2013/14 has been a challenging year in particular managing the transition from the old commissioning landscape to the new arrangements. Further developments and opportunities have been identified which were discussed.

Sandra Cheseldine congratulated the team on their hard work over the past year.

**It was RESOLVED that:**

i. the Committee noted the ongoing self review of the department

**14/18 Annual Report Plan**

Tony Rider attended the meeting to provide a verbal update advising that a draft Annual Report will be available on 23 April for submission to External Audit. The Annual Report will be published on 6 June 2014. Discussions are taking place with the design team at the CSU with regard to the design of the Annual Report. Linda Wild requested that the draft document submitted on 23 April is as near to the final document as it can be and populated with the majority of information.

**It was RESOLVED that:**

i. the Committee noted the verbal update

**Internal Audit and Counter Fraud**

**14/19 Internal Audit and Counter Fraud Progress Report**

Michelle Marsden presented this progress report. Since the last Audit Committee meeting a final report has been issued for W05/2014 – Opening Balances with an opinion of Significant Assurance.

Work on the following audits has been completed and the reports are currently in draft:

- WD06/2014 – Learning from Events
- WD07/2014 – Transaction Testing

It was noted that the audit of Healthcare Contracts is part of a wider piece of work on Contracts Management and a further update will be provided at the next meeting.

Appendix B of the report detailed the Counter Fraud Plan performance. Sandra Cheseldine queried why there was no investigation days recorded in respect of the issue discussed earlier in the meeting. Michelle agreed to clarify this and ensure the report was amended for the next meeting.
It was RESOLVED that:

i. the Committee noted the content of the report.

**External Audit**

**14/20 External Audit Technical Update**

Linda Wild presented this update advising of two Audit Committee Institute events taking place:

- Spring Technical Update Event – 10 March and 20 March 2014
- Audit Committee Institute Spring Seminars – 7 April and 9 April 2014

A brief description of the events was included in the update.

It was RESOLVED that:

i. the Committee noted the content of the report.

**14/21 External Audit Plan 2013/14**

Clare Partridge introduced the plan advising that the plan assists in highlighting risks for the CCG as a new emerging organisation.

Although no high risk areas have been identified at this stage, it is noted that the following areas require audit focus at the interim audit visit to enable better understanding to any related risks for 2013/14:

- CCG opening balances; and
- CSU assurance

A timeline was included in the plan indicating when each component of the audit would be delivered and how this will be aligned to the Audit Committee dates.

It was RESOLVED that:

i. the Committee noted the content of the report.

**14/22 Any Other Business**

None

**14/23 Date and time of next meeting**

The Committee noted the date and time of the next meeting as Thursday, 24 April 2014, from 1.00 to 3.00 pm in the Boardroom, White Rose House.
Title of meeting: Governing Body  
**Agenda Item:** 14b (i) & (ii)  
**Date of Meeting:** 11 March 2014  
**Public/Private Section:** Public  
**Paper Title:** Integrated Governance Committee: presentation of minutes and items for approval by Governing Body  
**Committee chair:** Rhod Mitchell – Lay Member  
**Meeting minutes enclosed:** 19 December 2013 and 16 January 2014  

**Recommendation:**  
It is recommended that the Governing Body receive and note the minutes of the Integrated Governance Committee held on 19 December 2013 and 16 January 2014.

**Executive Summary:**  
Aside from standing items - including the finance report, quality & performance report, complaints update and information governance report - headline discussions included:

**19 December 2013**
- **Quality & Performance Report** - YAS achieved the performance targets for Cat A (Red 1) and Cat A (Red 1 and 2 combined) for the period and year to date. Ambulance Turnaround Time had improved, but performance was still below target level which was being monitored through the West Yorkshire CSU. Cancer 52 day wait target missed and a root cause analysis detailed the reasons. Mid Yorkshire had been issued with a performance notice and would be fined accordingly. No cases of MRSA reported in October, although there was one for the CCG in November which takes the CCG cumulative target to 8. There was one Never Event for MYHT in November (third for 2013) in respect of a retained instrument which had been resolved by the removal of the instrument.
- **Strategic plan 2014/15** update, outlining the key themes. First submission is to be in by 14 February for the 2 year plan and 20 June for the 5 year strategy
- Approved the Committee’s **work-plan** for 2014.
- Considered the CCG’s **risk register**. It was agreed that the score assigned to the risk of failure to deliver the planned improvements and savings within our QIPP programme for 2013/14 should be increased.
- Update regarding **research activity**; covering the research assurance aspect and research development work regarding case findings by the Primary Care Closer to Home Team.
- Approval of the Primary Care funding scheme is part of the **Winter Funding** arrangements.
- **Finance Report** – CCG is still on target to achieve and reporting green on the financial position, amber/green on QIPP and still reporting red against contracts in terms of year to date activity and forecast activity.
- **Workforce report** – the committee noted that the sickness rate was above the target level and was 6.1% in November 2013.
- **Contract Governance and Assurance** – noted new Monitor guidance regarding procurement. The guidance does not mandate going out to procurement, but requires a set of behaviours around competition and choice.

**16 January 2014**
- **Quality & Performance Report** – slight deterioration in **Ambulance Response Times** target in month, still achieving the operating standard year to date. No **MRSA** cases reported in November by MYHT, cumulative total eight, five assigned to CCG and three assigned to MYHT. Improvement from previous months on **18 Weeks RTT Waiting Time** standard, operating standing requirements across all three pathways both month
and year to date have been met. Contract management meeting taking place today regarding **Improving Access to Psychological Therapies** service, further deep dive of this service to be presented at next meeting in February 2014

- Quarter 3 **Health and Safety** report presented including Fire Rise Assessment for White Rose House
- Quarter 3 **Infection, Prevention and Control Report** presented noting there had been low uptake of the catheter training offered by MYHT to staff in care homes, additional dates to be offered and alternative training methods to be considered
- Agreed delegated authority to Jo Pollard, Sandra Cheseldine and Laura Elliott to sign off the final **Public Sector Equality Duty** evidence for publication on 31 January 2014
- **Finance Report** – as at 31 December 2013 CCG has a year to date surplus of £4,127k against a planned surplus of £4,127k and year –end forecast of £5,502k. Brought forward surplus reserve has been fully utilised to offset the overtrade position
- Report outlining three modelling scenarios of a **Long Term Financial Plan** aiming to strike a balance between level of contingency and non recurrent reserve and the challenge to deliver the right level of QIPP
- Agreement to enhance the current CCG arrangements in respect of the **Individual Funding Requests** panel process and the terms of reference to be amended

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<td>Confidentiality and Data Protection Policy</td>
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NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 19 December 2013

Present:  
Rhod Mitchell (Chair)  Lay Member  
Andrew Pepper  Chief Financial Officer  
Jo Pollard  Chief of Service Delivery and Quality  
Dr Phillip Earnshaw  Nominated Clinical Member  
Dr David Brown  Nominated Clinical Member  
Stephen Hardy  Lay Member  

In Attendance:  
Sandra Cheseldine  Lay Member  
Sharon Fox  Governing Body Nurse  
Karen Parkin  Head of Finance and Governance  
Katherine Bryant  Governance and Board Secretary  
Matt England  Head of Contracting and Commercial Strategy  
Jenny Feeley (items 5, 9vi)  Service Development and Transformation Manager  
Karen Marsh (item 7)  Strategic Planning Systems Support, WSYBCSU  
Laura Elliott (item 9i)  Head of Quality and Engagement  
Adam Bassett (items 9ii, 9iii)  Senior Associate Governance and Risk, WSYBCSU  
Satbir Saggu (item 9iv)  Senior Associate Research, WSYBCSU  
Stella Johnson (item 9iv)  Associate Research, WSYBCSU  
Pia Bruhn (item 9v)  Senior Associate Quality and Inclusion, WSYBCSU  
Simon Rowe (item 9vi)  Commissioning Manager  
Sam Byrnes (items 11i, 11ii)  Senior Associate Information, WSYBCSU  
Michael Vournas (item 11i)  Senior Associate Information, WSYBCSU  
Heather Prest (item 12i)  Senior Associate Learning and Development, WSYBCSU  
Mandy Sheffield (item 14)  Head of Safeguarding  
Kate Trevelyan  Minute taker

13/222  Apologies for Absence

Apologies for absence were received from Jo Webster and Dr Avijit Biswas

13/223  Declarations of Interest

Dr David Brown declared an interest in respect of agenda item 9iv - Primary Care Winter Funding.
Minutes of the Meeting held on 21 November 2013

The minutes of the meeting held on the 21 November 2013 were agreed as an accurate record.

Action Sheet from the Meeting held on 21 November 2013

13/199 – Patient Survey Overall Score

The scores relate to the GP Patient Survey overall score which is displayed on NHS Choices.

13/200 – Enhancing the Partnership with the CSU – IFR

Discussions had taken place between Sandra Cheseldine and Jo Pollard. There was a meeting scheduled in January and many of the actions were ongoing. The backlog of patients were being dealt with by additional staff training, revising the Terms of Reference and determining whether the responsibility stays with the CCG or moves to the CSU. It was agreed that Jo and Sandra would bring back a formal response in January.

13/205 – Finance Report Month 7

It was confirmed that the QIPP table had been amended in respect of Urgent care PCLIF.

13/214 – Minutes of the Meetings – appropriate attendance

This response was deferred to January 2014.

Integrated Quality and Performance Report

Matt England and Laura Elliott presented this report providing updates against the CCG strategic objectives, quality premium and details of key exceptions and successes.

Matt presented performance highlights from the report which covered the period up to October 2013:

- YAS achieved the performance targets for Cat A (Red 1) and Cat A (Red 1 and 2 combined) for the period and year to date;
- Wakefield CCG continue to meet the category 2 red target although in October, YAS missed targets due to changes in sub-contracting arrangements. It was noted that this would improve
- Ambulance Turnaround Time had improved, but performance was still below target level which was being monitored through the West Yorkshire CSU;
- Cancer 52 day wait – target missed and a root cause analysis detailed the reasons. Mid Yorkshire had been issued with a performance notice and would be fined accordingly.
- 18 week RTT deep dive - it was noted that the Trust are providing a recovery
plan with assurance about how it was being monitored internally. The Committee noted that it could be at risk due to time constraints ie. one quarter left to achieve. A recovery trajectory with milestones had been requested with the Trust providing assurance on the achievement of specialties with the exception of Plastics;

- 52 week Breaches - one in October was the last of the 8 breaches which had been notified (there were none in November);

Rhod Mitchell queried the impact on demand planning and Matt confirmed that it was significant but that the PAS system user error was being dealt with through validation of records and training of staff. It was acknowledged that the impact on the position of the waiting list could pose risks.

Laura Elliott presented highlights from the quality sections of the report:

- No cases of MRSA reported in October, although there was one for the CCG in November which takes the CCG cumulative target to 8 with Mid Yorks remaining at 5 (4 assigned to CCG and the rest assigned to the Acute Trust).
- CDiff – Mid Yorks still on target to be on green with CCG moving toward exceeding the target;
- There was one Never Event for MYHT in November (third for 2013) in respect of a retained instrument which had been resolved by the removal of the instrument;
- The CQC reports for GP practices issued so far reflected compliance but there were issues around Prospect Road and St Thomas Road which had moderate issues;
- Patient Safety Walkabouts pathway pilot had been commissioned with the Childrens’ commissioner in Public Health;
- Good News: The Quality report indicated that 66% of complaints were handled within timescales in September which had increased to 78% for October and they are on track to deliver the 90% target. Concern was noted around the surgery division which was at 72%.

Steve Hardy commented that there was soft intelligence around the Palliative Care at Home Team which related to the travel distance being too far for the patient. Laura indicated that the Continuing Care Team had intervened with no further issues.

Sharon Fox queried the continuing problem with CDiff. Laura responded that it was part of the improvement process around prescribing e.g. antibiotics which Phil Earnshaw elaborated on.

Sandra Cheseldine referred to the CQC reports and the possibility of introducing unannounced visits to Care Homes. Laura indicated that the quality and assessment of Care Homes was already being discussed.

Rhod expressed concern about the Serious Incidents and the need for assurance from SWYPFT around their contingency plans for service users. Laura responded that it was a very specific service incident rather than an organisation issue and referred to the root cause analysis which indicated that the patient did not have a clear crisis or contingency plan. Therefore the
incidents were more of a reminder to staff to make sure that every patient had a plan.

Phil queried the Quality Premium (QP) and generation of finance. Andrew responded that nationally it was not anticipated that everyone would get the full percentage of QP but it was something which would need to be reviewed.

It was RESOLVED that:

i) the Committee noted the report

13/227 Yorkshire Ambulance Service Foundation Trust Application Progress

Jenny Feeley attended the meeting to report on the presentation which had been shared at the West Yorkshire CBU meeting. Jenny indicated that YAS were going through national requirements to become a Foundation Trust and YAS felt that putting all efforts into their application process would enhance control over their finances, objectives and how they move forward in the future.

Jo Pollard asked a question from the Executive Summary around the impact on quality and the influence which could be placed to strengthen YAS. Jenny responded that the contract contained financial and activity implications which would be monitored through national indicators. Jo referred to the learning from Mid Staffordshire and requested that within the Integrated Quality and Performance report, greater focus should be placed on quality and outcomes indicators for YAS.

Rhod queried the 13/14 position re what YAS believe they are going to achieve versus actual. Matt advised that the growth over the last three years was 3% which was in line with the activity reported but the position was reviewed on a regular basis.

It was RESOLVED that:

i) the Committee noted the presentation and requested that within the Integrated Quality and Performance Report, greater focus should be placed on quality and the outcome indicators for YAS

13/228 Transformation Outline Business Case

The Committee reviewed the report and there were no comments made.

It was RESOLVED that:

i) the Committee noted the report

13/229 Strategic Plan 2014/15 Update

Karen Marsh attended the meeting to provide an update on the Strategic Plan 2014/15 and to highlight the key themes
• Outcome from workshops with Governing Body and and Clinical Cabinet; how important it was to engage with the membership;
• Enablers such as workforce and IT would be needed to support the 2 and 5 year plans;
• It was a challenge to produce an achievable plan (penalties could be incurred if not achieved);
• First submission in by 14 February for the 2 year plan and 20 June for the 5 year strategy with a requirement for strategic planning in-between.

It was RESOLVED that:

i) the Committee noted the contents of the report and update provided

13/230 Integrated Governance Committee Workplan Progress Report

Katherine Bryant presented this paper which provided an update on the work-plan and presented proposals for 2014 work-plan.

Andrew Pepper commented that it was a good work-plan which covered all aspects of the Terms of Reference which it was noted would be reviewed in February, with recommendations being made to the Governing Body in March.

It was RESOLVED that:

i) the Committee noted the progress report; and
ii) approved the workplan for 2014/15

13/231 Review of the NHS Hospitals Complaints System

Adam Bassett attended the meeting to present the report of the NHS Hospitals Complaints System and highlighted the action plan and recommendations therein:

• Commissioners;
• CCG complaints process.

Rhod commented that the report was very detailed.

It was RESOLVED that:

i) the Committee noted the content of the report

13/232 Risk Register

Adam Bassett attended the meeting to present the Risk Register as at 9 December, indicating that there were 57 risks, 10 were noted as serious but non as critical. Adam referred to the four appendices which noted high level risks, closed risks and any new issues.
Sandra Cheseldine expressed concern around the QIPP score of 16 and the challenge involved to meet the target which would present the biggest risk going forward. It was agreed that the importance of QIPP would be reflected in the Register.

It was RESOLVED that:

i) the Committee noted the report and agreed that the importance of QIPP needed to be reflected in the Risk Register

13/233 Update on Research Activity October 2013

Saggu Satbir and Stella Johnson attended the meeting to present on the Research Activity to October 2013. Covering the research assurance aspect and research development work regarding case findings by the Primary Care Closer to Home Team. The key areas were:

- Research Management and Governance
- Research Development
- Research Engagement
- Knowledge Transfer

With two recommendations:

- Assist the WSYBCUS in securing time at CCG wide meetings to increase awareness and engagement in research;
- Help to develop practice engagement in the UK Diabetes study by disseminating study information through the Practice Support Unit.

Saggu commented that they were looking for ideas to take forward to support the initiatives.

Phil Earnshaw commented that he would be willing to advise them re contacts and that it would be a good idea to contact Janet Wilson re diabetes.

Jo Pollard thought it reflected a positive profile and indicated that a meeting should be scheduled in January to review the way forward and ways of promoting it through Primary Care.

It was RESOLVED that:

i) the Committee noted the report

13/234 Primary Care Winter Funding

Jenny Feeley and Simon Rowe attended the meeting to present the paper for approval of the Primary Care funding scheme which was part of the Winter Funding arrangements.

It was noted that the Local Area Team had made funding available across the region to help improve Primary Care capacity during the winter period. It had
been delegated to respective CCGs to develop the scheme to meet the needs of the local population. The scheme which had been agreed was for Saturday opening which would provide three hours during January, February and March. Due to the time constraints work had already started around engagement with practices to gain interest and sign up in readiness. Nine practices had confirmed (total of 12 allowed).

An associated risk was noted as a conflict of interest (Primary Care is commissioned by the Area Team) but it was determined by the Area Team that the funding was coming outside of the CCG.

Jenny reported that a letter from Jo Webster had been sent to the Area Team for feedback on the issues encountered regarding Local Enhanced Services.

Dr Phil Earnshaw updated the Committee on the background and commented that Jenny and Simon had worked extremely hard on a very difficult project.

It was RESOLVED that:

i) the Committee approved the immediate implementation of the framework with those practices which have agreed to the declaration;

ii) noted and supported the next steps which are: gain practices final confirmation of wishing to undertake the scheme and move to implementation; Finance to arrange payment mechanism through WYCSA and update DoS entries with appropriate opening times

It was noted that Dr Brown did not participate in the approval vote

13/235 Finance Report Month 8

Karen Parkin reported that they were still on target to achieve and were reporting green on the Financial position, amber/green on QIPP and still reporting red against contracts in terms of year to date activity and forecast activity. It was noted that

- Non recurrent allocation at £3.6m to support winter pressures;
- Further allocations to be made this year re an addition colposcopy allocation where services have moved from CCG back to NHS England;
- GP IT allocation from West Yorkshire Area Team to CCG will be received in January;
- Overtrade against Mid Yorkshire NHS Hospital Trust (MYHT) had not changed with an end of the year position at £5.6m;
- Other significant variances with year end overspends noted as Continuing Care (£1.8m) and QIPP;
- As reported at Audit Committee, a letter from NHS England had been received on legacy balances from the PCT (Appendix 6) will remain in NHS England accounts and will not transfer to CCG. CCG balances will be returned on 1 April 2015;
- Capital planning return report provided an high level overview on predicted spend which is separate from the IG budgets and GP IT budgets. The committee discussed the elements of core and non core
spending and the impact which IT spending had on the total business noting that the additional strategy spend was previously turned down by the Area Team on the basis that it was not considered best value for money;

- MYHT overtrade included an element re excluded drugs. It was noted that assurance on this had been requested via Contract Management Group/Equality Contract Board and subsequently discovered that the charge to NHS England was not correct and should have been charged to the CCG. As a result a detailed validation review was being conducted by Medicines Management;
- Two further appendices related to:
  - Letter from NHS England regarding guidance on property costs (£1.3m) and noted that the CCG will be charged the full amount set aside. Karen advised that NHS England have advised that there would be a further review in the future and further guidance will follow
  - Response from NHS England regarding the CCG concerns raised on the impact of the fundamental review of allocation policy;

Rhod referred to Page 10 and the £80K fee for the performance management of PCLIF and queried whether this should be bought based on the cost level of provision made. Andrew clarified that this was a cost to the CSU for the additional business intelligence resource which had been agreed.

Andrew updated the Committee on the Contracts Summit which had been organised with MYHT to discuss issues such as overtrade and excluded drugs issues in order to achieve validations which would carry forward to the year end.

**It was RESOLVED that:**

i) the Committee noted the report

13/236  **Financial Strategy**

Andrew Pepper updated members around expectations which had been agreed at the NHS England Board Meeting on Tuesday re allocations.

- Outcome would be growth next year and the year after with inflation
- Confirmation of allocation for WCCG with reconciliation on the overall position
- Growth in 14/15 was £9.5m
- Growth in 15/16 was £7.8m
- The Transformation Integration fund (now called Better Care Fund) which would be part implemented next year. Plans to redirect the funding and top up with central NHS funding which would increase the WCCG allocation by £7.5m to provide a Better Care Fund of £24.3m;

Phil reported that West Yorkshire Public Health allocation had been increased by 7.2% and the Local Authority had just received their central grant allocations for next year which are minus 2.7%. Andrew commented on the public health increased resource could possibly (if included) be allocated to the Better Care
It was RESOLVED that:

i) the Committee noted the report

**13/237 Information Governance Update and Policies for approval**

Sam Byrnes and Michael Vournas attended the meeting to present on the highlights and recommendations from the report including:

- Confidentiality and Data Protection;
- Freedom of Information Policy;
- Merging of the Confidentiality statement and Data Protection Policy to reflect CCG arrangements;
- Also recommendation around appointing a Deputy Caldicott Guardian and Dr Harries had been nominated for approval by the Committee

Dr Phil Earnshaw expressed concern that this had not been advised in advance and Katherine Bryant explained the background to the nomination which had been proposed by Dr Brown and herself. It was noted that Dr Harries had undertaken the necessary training and was happy to assist.

**Registration Authority Arrangements**

Michael Vournas provided the Committee with background information about the Registration Authority system and smart cards. Michael requested that a standard letter be drawn up addressed to the RA Lead at the Information Centre to nominate two individuals to become the RA Managers on behalf of the CCG as an interim arrangement.

Jo Pollard expressed concern about how the staff would be engaged in terms of the policies and updates ie. Deputy Caldicott Guardian. Katherine confirmed that this would be done via an update at the staff briefing and followed up by inclusion in the staff Newsletter.

Matt England asked in respect of the RA process would there still be a need for sponsors within the CCG which Michael confirmed.

Andrew Pepper commented that RAs were a specialist technical area which was on the Risk Register and would be reliant on CSU expertise to move forward. Michael responded that a standard letter would be required from the CCG (as previously noted) to the RA Lead at the Information Centre.

It was RESOLVED that:

i) the Committee noted the report;
ii) approved the Confidentiality and Data Protection Policy and Freedom of Information policy; and
iii) approved the appointment of the Deputy Caldicott Guardian and the appointment of the RA sponsor and lead RA agents.
13/238 Freedom of Information update

Sam Byrnes presented this report providing an update on the Freedom of Information activities and compliance during November 2013. Eleven requests were received during November with 107 having been received year to date as at 12 December 2013.

A discussion followed and Dr Phil Earnshaw commented that information should come to the CCG to understand the issues around the FOI requests. Katherine indicated that she was the link person for FOIs and as such could facilitate the information into the Executive Team and also highlight any reputational issues to Communications colleagues.

It was RESOLVED that:

i) the Committee noted the report and agreed that Katherine Bryant should facilitate updates to the Executive Team

13/239 SIRO/Caldicott Guardian Update

Katherine Bryant referred to the regular SIRO/Caldicott Log updates received every month and requested any comments, commenting that there were no particular issues to raise.

Rhod commented that there had been a lot of updates. Katherine responded that there had been a high level of printing incidents and steps had been put in place to resolve the problem.

It was RESOLVED that:

i) the Committee noted the update

13/240 Contract, Governance and Assurance

Matt England attended the meeting and presented an update on the contract development update noting:

- changes in procurement re revised EU directives and rules for corporation, competition and choice in respect of the Monitor guidance;
- The Monitor guidance does not mandate going out to procurement it mandates a set of behaviours around competition and choice which will be used re procurement challenges;
- Do not need to go out to tender but if done there needs to be a governance route of transparency which is accountable following the CCG scheme of delegation;
- Policy and Procedures must be compliant with these principles;
- Further development of the Commissioning Strategy and hope to take the final version to the Board in January along with update on process;
- Major work undertaken on the prioritisation process with a summary of
the outcome is appended, highlighting where tender waiver or contract extensions may be needed;

- The three year procurement schedule shows updated position of services with the requirement to re-advertise only once in the three year cycle;
- Contract governance element – just one contract outstanding which is independent vascular. Their issue is not with the CCG but with PBr so this has been taken up with Monitor (issue around pricing change which CCG(s) refused);
- New contract signed with Conica re business printing services;
- National AQP Team support withdrawn at the end of November and WSYBCSU providing the resource with no problems anticipated;
- Slight dispute on a contract variation on 13/14 Ophthalmology service around pricing and interpretation of how inflated would be applied.

Dr Phil Earnshaw queried how the King Street contract extension negotiations were going. Matt responded that there were no issues on the walk in centre element but there were financial issues between West Yorkshire Area Team (WYAT) and Local Care Direct on funding of the registered risk. Phil expressed concern that the Walk in Centre’s future was potentially put in jeopardy by a relatively small amount of money and asked that this be resolved. Matt indicated that Simon Rowe was in regular dialogue with WYAT and the committee asked for an update to be brought to the next meeting.

**It was RESOLVED that:**

i) the Committee noted the content of the report;
ii) agreed the approach to resolving the pricing issue with The Practice Service Ltd;
iii) agreed the proposal in regard to managing contract expiries; and
iv) requested an update on the King Street Contract Extension to be brought to the January meeting.

### 13/241 Business Continuity Update

Mandy Sheffield attended to present an update on how the departments and services within the CCG would react if taken into a full business continuity plan activation which had not previously been undertaken. The challenge was around sustainability after 24 hours as detailed in the report and the Heads of Service had been asked to consider possible other ways of working.

Rhod Mitchell asked where the server was based and Mandy confirmed that it was based at White Rose House but that staff could work remotely through the VPN, including Oracle.

Following a detailed discussion around the possible outsourcing solutions of the server and limited desk allocation to cover a prolonged situation, Andrew believed that there was a need for a CCG co-ordinated response against the series of contingencies which had been identified. Mandy further advised that a table top test would be conducted in January and after querying, was advised that ultimate responsibility in business continuity would sit with Jo Webster.
Jo Pollard commented that the matter should be discussed outside the meeting which was agreed.

It was RESOLVED that:

i) the Committee noted the content of the report;
ii) that a table top test would be taken in January;
iii) that the matter should be further discussed outside of the meeting

13/242 Equality Delivery System

Pia Bruhn attended the meeting to present this paper. Pia commented that the Equality Delivery System was presented at the Board Development Session on the progress of the Quality Board assumptions and delivery system outcomes which had been combined into a rag rated document (tabled). It was noted that at the Board Delivery session, there was no decision on 2.1 which was required so that it could be shown on the web site.

Pia commented that the consistent methodology throughout was that if the green and amber were greater than the red it would become an amber and this was the recommendation.

Members of the Committee confirmed that they were comfortable with the methodology outline. The decision was made to accept the grading scheme tabled and 2.1 should be confirmed as red.

It was RESOLVED that:

i) the Committee noted the content of the document tabled and agreed to the recommendation of the grading scheme and that 2.1 should be confirmed as red

13/243 Workforce report

Heather Prest presented the Workforce update and highlighted issues re

- Sickness rates at 6.1% in November
- Review being undertaken around the recording of sickness

Rhod Mitchell queried whether there were 100% return to work forms received which Heather confirmed but was unsure about the level of detail which was recorded. There was requirement to work with managers on how this should be done to understand the underlying issues.

Andrew Pepper and Jo Pollard commented that HR should work with line managers to educate them to ask the right questions to ensure this process was dealt with correctly.

Dr Phil Earnshaw sought further information about mandatory training requirements for the Governing Body. Heather confirmed that an Action Plan had been developed and it was a requirement for GPs and the Governing Body
to prove that training had been undertaken. Katherine Bryant reported that she was liaising with Joanne Stevenson in Organisational Development to set up some mandatory training sessions in the New Year for members of the Governing Body.

Jo Pollard commented that it would be of benefit to see how sick rates are managed around targets and responsibility. Mandatory training should also be covered in the same way to demonstrate what the organisation is doing. It was agreed that there should be discussions outside the meeting around more interactive recordings being undertaken.

It was RESOLVED that:

i) the Committee noted the Workforce Services Update

13/244 Minutes of meetings

The minutes of the following meetings were shared for information:

i) Mid Yorkshire Hospitals NHS Trust Executive Quality Board – meeting held on 21 November 2013
ii) Mid Yorkshire Hospitals NHS Trust Executive Contract Board – meeting held on 21 November 2013
iii) NHS11 Wakefield and North Kirklees Clinical Quality Group – meetings held on 05 November 2013
iv) 999 YAS Clinical Quality Development Review Group - meeting held on 19 November 2013
v) Quality Intelligence Group – meeting held on 7 November 2013
vi) Calderdale, South West Yorkshire Partnership Foundation Trust Board – meeting held on 25 November 2013

Members noted the minutes and there were no issues recorded.

It was RESOLVED that:

i) the Committee noted the minutes

13/245 For Information

(i) YAS 999 Commissioning News – November 2013

The above publication was shared for information and there were no issues.

13/246 Any other business

None

13/247 Date and time of next meeting:

NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 16 January 2014

Present: Rhod Mitchell (Chair) Lay Member
Andrew Pepper Chief Financial Officer
Jo Pollard Chief of Service Delivery and Quality
Dr Phillip Earnshaw Nominated Clinical Member
Dr David Brown Nominated Clinical Member
Dr Avijit Biswas Nominated Clinical Member
Stephen Hardy Lay Member

In Attendance: Sandra Cheseldine Lay Member
Sharon Fox Governing Body Nurse Representative
Katherine Bryant Governance and Board Secretary
Liz Goodson Commissioning Accountant
Laura Elliott (item 5i) Head of Quality and Engagement
Luke Streeting (item 5i) Performance and Planning Manager
Andrew Singleton (item 5i) Quality Co-ordinator
Adam Bassett (item 5ii) Senior Associate Governance and Risk, WSYBCSU
Sue Ross (item 5iii) Lead Infection, Prevention and Control Nurse
Pia Bruhn (item 5iv) Senior Associate Quality and Inclusion, WSYBCSU
Sam Byrnes (items 7i, 7ii) Senior Associate Information, WSYBCSU
Stephen Rose (item 7i) Senior Information Governance Officer (The Health Informatics Service)
Heather Prest (item 8i) Senior Associate Learning and Development, WSYBCSU
Sarah Hudson (item 9i) Contracts Manager
Carol Bell (item 9i) Contracts Support Manager
Angela Peatfield Minute taker

14/1 Apologies for Absence

Apologies for absence were received from Jo Webster

14/2 Declarations of Interest

Sandra Cheseldine declared an interest in respect of Paper 9ii – Individual Funding Requests (IFR) Panel Options Paper advising that she chairs a considerable number of the IFR Panels.
Minutes of the Meeting held on 19 December 2013

The minutes of the meeting held on the 19 December 2013 were agreed as an accurate record.

Action Sheet from the Meeting held on 19 December 2013

13/201 – Winterbourne Review Joint Action Plan

The quarterly updated rag rated action plan will be presented at the March IGC meeting.

13/207 – Commissioning and Contracting Strategy

Andrew Pepper advised members that the Commissioning and Contracting Strategy had been presented at the Governing Body meeting held on 14 January 2014.

13/232 – Risk Register

It was noted that for the next risk register review cycle the new updated Risk Register system will be in operation.

Integrated Quality and Performance Report

Laura Elliott, Luke Streeting and Andrew Singleton attended the meeting to present this report providing updates against the CCG strategic objectives, quality premium and details of key exceptions and successes.

Luke and Laura highlighted the following from the exception report:

- Slight deterioration in Ambulance Response Times targets within in month for Red 2 and Red 1 and 2 combined measures. YAS are still achieving the operating standard year to date but are just below the standard in month. This does represent a slight risk and this will be raised at the Contract Management Board
- Ambulance Turnaround times for MYHT - there has been a month on month improvement but it is still significantly below the required standard
- No MRSA cases reported by MYHT in November, but there was a pre-48 hour case reported by Leeds Teaching Hospitals which increased our cumulative total to eight. It was noted that these are now split following the review being completed and the CCG now only receive those that are assigned to the CGG, therefore this makes the CCG total five rather than eight as three are assigned to MYHT
- Non recurrent funding was provided to MYHT to deliver catheter care training to care home staff and it was noted that the take up from care homes has been limited
- MYHT clostridium difficile (Cdiff) year to date position is within the annual target noting that actions are being taken around Medicines Management, Prescribing Antibiotics and PPI usage but there does not
seem to be any specific areas where these cases are coming from

- Cancer Targets – all targets except the 62 day urgent GP referrals have been achieved. With regard to the GP referrals there have been 15 breaches this month, nine of which related to split pathways and have been highlighted to the commissioner, discussions will take place at the locality meetings
- Significant improvement from previous months on 18 Weeks RTT Waiting Time Standard. The CCG have met the operating standard requirements across all three pathways both month and year to date position. The issue for MYHT in terms of operating standard is the year to date position on admitted but it is improving. With regard to the latest intelligence from MYHT in relation to the validated December position it is currently looking like an improvement on the November position. The number of actual specialities that have failed has reduced.
- One 52 week breach for the CCG, the CSU will be undertaking a root cause analysis
- Improving Access to Psychological Therapies, based on the latest published information we are not meeting the required access levels. There is a contract management meeting taking place today. The recovery plan has been received from Right Steps and more information is available around the volume of patients and the approach we are going to take through January, February and March to close the gap between current performance and target.

Luke gave an update on the Quality Premium noting that there are a total of seven areas within the Quality Premium, four are nationally determined and three are local measures. The key issues were highlighted, based on the issues identified the current assessment of likely financial value is:

1. The minimum value expected would be £334,387
2. The maximum possible would be £835,967

A discussion followed and Dr Phil Earnshaw commented that reward mechanisms need to be built in but queried whether there were any contractual penalty mechanisms for when key providers do not achieve. Laura advised that for the smoking target there is a local quality indicator in the MYHT contract. The IAPT is linked to the recovery plan. For the stroke target, Public Health were asked to provide a CQUIN as it is the Health and Well Being Board that deal with this area. Laura advised that next year the CCG only need to have one local measure and it has to be one already measured in the CCG outcome set.

Stephen Hardy queried when Right Steps took over providing the IAPT service it was assumed that they would pick up most of the work carried out by the previous organisation, but this has not yet happened. Initially it was thought to be a recruitment issue. Laura responded stating that it was understood this was part of the service transformation programme for mental health noting that a contract waiver took place for this year and a procurement process will take place in January 2015.
Luke advised that there are a number of issues nationally regarding Improving Access to Psychological Therapies. Through the recovery plan it is noted that resources are being brought in from other areas of the business to meet requirements in Wakefield and this needs to be part of the contract management process over the next twelve months.

Following discussion it was agreed that a deep dive of the IAPT service will be included in the next report.

It was RESOLVED that:

i) the Committee noted the report

14/6 Health and Safety Report

Adam Bassett attended the meeting to present an overview of the operational health and safety activity and identified risks during quarter 3. The report provides assurance that health and safety risks are identified and are being managed. It was noted that a Fire Risk Assessment was completed for White Rose House and was shared for information.

It was RESOLVED that:

i) the Committee noted the actions taken in quarter 3 to ensure compliance with relevant Health and Safety Executive national priorities and guidance

14/7 Q3 Infection, Prevention and Control Report

Sue Ross attended the meeting to present this report providing an overview of the activity during the period 1 October to 31 December 2013. It was noted that there have been nine MRSA cases, following the Post Infection Review (PIR) process five of those cases have been assigned to NHS Wakefield CCG and three to MYHT with one awaiting assignment following the result of the PIR.

Benchmarking information is detailed on page 5 of the report, however Sue Ross added a word of caution, as some of these figures are not correct and NHS England are currently working to rectify the errors.

Sue reported that there are no common links between cases so no themes can be identified. Staff from the Infection, Prevention and Control team join teleconferences with MYHT to help identify any learning for community services.

Sue advised that there had been low uptake of the catheter training offered by MYHT to staff in Care Homes. Further dates will be offered in April, May and June. A discussion followed and it was suggested that consideration should be given to alternative ways of providing this training.

Stephen Hardy asked whether as part of CQC inspections attendance at training sessions is considered, Sue confirmed that it is. Sue also confirmed that catheter management is included as part of the audit process of care homes.
Dr Phil Earnshaw suggested that using council contracts could be considered as a way to release staff to attend training sessions.

**It was RESOLVED that:**

i) the Committee noted the information within the report

### 14/8 Equality and Diversity Update

Pia Bruhn attended the meeting to present this paper providing an update on work undertaken in taking forward the Equality Delivery System (EDS) and in progressing the collection and collation of evidence for publication by 31 January 2014 to meet the Public Sector Equality Duty (PSED).

Pia asked the Committee to delegate authority to Sandra Cheseldine, Governing Body lead on Equality and Diversity, Jo Pollard and Laura Elliott to sign off the final PSED evidence for publication on 31 January 2014.

**It was RESOLVED that:**

i) the Committee noted the contents of the paper; and

ii) agreed to delegate authority to Sandra Cheseldine, Jo Pollard and Laura Elliott to sign off the final PSED

### 14/9 Finance Report Month 9

Andrew Pepper introduced Liz Goodson, Commissioning Accountant who was attending in place of Karen Parkin, Head of Finance and Governance. Andrew presented the Finance Report for Month 9 detailing a year to date and year end forecast position as at 31 December 2013. Overall the CCG has a year to date surplus of £4,127k against a planned surplus of £4,127k and year-end forecast of £5,502k which is equal to plan. The 12 key financial performance indicators were detailed in the report.

The report highlights any significant adverse variances, including a forecast MYHT overtrade of £6.7m, this figure now includes cost of excluded drugs. The brought forward surplus reserve has now been fully utilised to offset the overtrade position. Andrew advised that he is now in discussions with MYHT to agree the year end position based on all the data the CCG have.

Andrew gave an overview of risks and opportunities noting that the table presented has been slimmed down to make it easier to digest. It was noted that three new lines have been added to the opportunities:

- National Transformation Fund
- NHS Property Services
- National support for local costs of consultation/ transformation

Work is still ongoing regarding legacy issues. Any payments made by CCGs in the current financial year in relation to legacy balances will be reimbursed by NHS England after month 9 closedown and again before the year end where
Discussions were ongoing to agree a way forward for the agreement of GP IT budgets.

It was RESOLVED that:

i) the Committee noted the contents of the report

14/10 Long Term Financial Plan Update

Andrew Pepper presented this report on the current long term financial plan noting that the current QIPP challenge is £14m for 2014/15 and £12m thereafter. Three modelling scenarios have been prepared to illustrate potential approaches to delivering a sustainable financial process.

A full discussion took place considering the three scenarios and it was agreed that there is a balance to strike between the right level of contingency and non recurrent reserve and the challenge to the organisation to deliver the right level of QIPP.

Andrew commented that he would work on the next scenario and discuss the issues with interested parties, noting that the submission to NHS England takes place on 14 February. Emphasis was placed on making sure QIPP is a reality for staff and staff are held accountable for QIPP targets.

It was RESOLVED that:

i) the Committee noted the contents of the report and considered the use of funds according to the scenarios presented

14/11 Information Governance Update

Sam Byrnes and Stephen Rose attended the meeting to provide an update on Information Governance issues which included:

- Dissemination of the IG User Handbook and declaration to all staff
- Letter of confirmation of the CCG’s Registration Authority arrangements have been sent to Regional Registration Authority lead at Health & Social Care Information Centre
- Continued rolling review of IG related policies and procedures
- Classroom based IG training has been delivered
- Information asset assurance work has begun

The Committee were also invited to approve the Information Security Policy and Access to Records Procedure. Sam Byrnes advised that an amendment was being suggested to Section 5 – “Charging Fees for Access” of the Access to Records Procedure to clarify the charges, noting that Caldicott advice states it is free and the Data Protection Act states an organisation is entitled to charge. Following discussion it was suggested that should an individual request records the fee could be waived. It was agreed that a paragraph will be prepared
clarifying the charging fees and this will be signed off by the Caldicott Guardian and included in the procedure.

Sam advised that a further Information Governance training session is being arranged for February to capture all staff who have not yet had an opportunity to undertake the IG training.

It was RESOLVED that:

i) the Committee noted the progress of information governance activities during December 2013;
ii) approved the Information Security Policy; and
iii) approved the Access to Records Procedure subject to the agreed additional paragraph regarding charges. Authority was delegated to the Caldicott Guardian and SIRO to approve the amendment on behalf of the Committee.

14/12 Freedom of Information Update

Sam Byrnes presented the FOI update providing details of requests received and how these requests have been dealt with. It was noted that the CCG has achieved 100% compliance against the statutory time deadline for responses to FOI requests in the months of October, November and December.

It was noted that there has been significant improvement in compliance and it is proposed that future reporting is on a bi-monthly basis. Following discussion it was agreed that reporting should take place on a quarterly basis.

It was RESOLVED that:

i) the Committee noted the FOI activity and performance data for the month of December 2013; and
ii) the Committee agreed future updates will be reported on a quarterly basis.

14/13 SIRO/Caldicott Guardian Update

Katherine Bryant presented the Senior Information Risk Owner (SIRO)/Caldicott Guardian update which detailed requests received up to 6 January 2014.

The report provides assurance that appropriate systems and processes are in place.

Katherine advised that with regard to reference 4 on the register, this issue is now closed as the MASH training session for the governing body and the first training session for health professionals has taken place.

Katherine highlighted reference 65 regarding electronic personnel files concerned payroll having one shared folder and updating it and HR having another which was also being updated. Ending up with two sets of incomplete data. A project is now in place to create a new shared folder and update all personal files.
It was noted that members of the Governing Body attended an Information Governance training session on 10 December 2013. The trainer Dilys Jones recommended that a “properly trained expert staff and committee/group” should consider information governance matters. Following discussion by the Committee as to whether an additional sub group of the Integrated Governance Committee was required, it was agreed that due to the attendance of both the SIRO and Caldicott Guardian, the Integrated Governance Committee, fulfilled this requirement and provided significant assurance.

It was RESOLVED that:

i) the Committee noted the report

14/14 Workforce Update

Heather Prest attended the meeting to present this report on workforce information and intelligence relating to the directly employed Wakefield CCG workforce.

Heather highlighted the following:

- Sickness absence - there is a proposed new policy for recording sickness absence which will enable HR to work more proactively with managers, offer more timely support to individuals and offer greater clarity to the organisation from a business perspective. The new policy has yet to be recommended by the Social Partnership Forum before it can be presented to the Integrated Governance Committee.
- Mandatory Training – Heather reported that as of 16 January the CCG were 90% compliant in respect of Fire Safety training. It was noted that the compliancy figure shown in respect of Governing Body members mandatory training was incorrect and is higher than stated. It is intended that for GP members of the Governing Body, Practice Managers will be contacted regarding training already undertaken in the GP practice.
- Social Partnership Forum – first meeting was held on 25 November 2013 as this was not quorate the policies to be presented were referred to the next meeting on 17 February 2014.
- Appraisal – 70% of appraisals already completed and the remainder are already scheduled.
- Staff Survey – Following the results of the local staff survey a draft action plan will be presented to the Executive Team.

A full discussion took place. Heather advised that HR will code the reason for sickness absence which is intended to provide a more accurate picture overall. It was suggested that further training for line managers would be helpful to re-enforce the correct use of the policy.

It was RESOLVED that:

i) the Committee noted the report
Sarah Hudson and Carol Bell attended the meeting to present this update.

Sarah highlighted the following:

- A vast majority of healthcare contracts have been signed and returned by providers. Only one remains outstanding which is the Independent Vascular Services. The provider has been written to advising that if the contract is not signed by 10 January 2014 the contract offer will be withdrawn. The Provider has not commenced activity.
- One new contract has been awarded in December 2013. Niche Health and Social Care Consulting Limited, the contract was awarded for the provision of the Care Closer to Home Patient Engagement and is a non-healthcare contract.
- There are currently two contracts which provide community endoscopy services and through a contract variation it has been agreed that the two providers will extend provision of the service until 31 March 2014. The service is to be advertised on a one year Any Qualified Provider in early January for commencement from 1 April 2014.

It was RESOLVED that:

i) the Committee noted the update regarding contract governance and assurance

14/16 Individual Funding Requests Panel Options Paper

Jo Pollard presented this paper outlining the current risk related to the IFR Panel decision making process and the mitigating actions taken to reduce that risk. Jo informed the Committee that an additional GP member volunteered to become a panel member and was trained on 10 December 2013. The paper also included proposed options for the future management of IFRs to improve the timeliness of funding decisions. It was noted that the number of panel members has now increased and the backlog of cases has reduced.

The three options for the future management of the IFR Panel process were as follows:

Option One – Do nothing – remain with current arrangements
Option Two – Enhance the current CCG arrangements
Option Three – West and South Yorkshire and Bassetlaw CSU operates the whole IFR process

Following discussion Option Two, which is locally retaining the IFR Panels and association decision making, was agreed as the best way forward.

It was RESOLVED that:

i) the Committee approved Option 2 to enhance the current CCG arrangements for locally retaining the IFR Panels and associated decision
making;
ii) receive the amended Terms of Reference at the February Integrated Governance Committee; and
iii) noted that a training session for new members – Heads of Service and Clinical Cabinet will be held in January 2014.

14/17 Minutes of meetings

i) Mid Yorkshire Hospitals NHS Trust Executive Quality Board – meeting held on 19 December 2013

The minutes were shared for information. Jo Pollard advised that a time out will take place in February to work through issues and take forward proposals and recommendations that have come out of the Niche reports.

ii) Quality Intelligence Group – minutes of meeting held on 3 December 2013

The minutes were shared for information. No issues were raised.

It was RESOLVED that:

i) the Committee noted the minutes

14/18 For Information

i) YAS 999 Commissioning News – December 2013

The above publications were shared for information.

14/19 Any other business

None

14/20 Date and time of next meeting:

Thursday, 20 February 2014, 2.30 to 5.00 pm, Seminar Room, White Rose House.
Title of meeting: Governing Body

Date of Meeting: 11 March 2014

Paper Title: Clinical Cabinet: presentation of minutes and items for approval by Governing Body

Purpose (this paper is for): Decision

Committee chair: Dr Adam Sheppard – Assistant Clinical Leader

Meeting minutes enclosed: 19 December 2013 and 30 January 2014

Recommendation:

It is recommended that the Governing Body receive and note the minutes of Clinical Cabinet held on 19 December 2013 and 30 January 2014.

Executive Summary:

Aside from standing items - including QIPP update, network updates - headline discussions included:

19 December 2013
- Final review of the implementation of the Care Home Liaison and Support Service
- Approved non recurrent business case for the Care Closer to Home programme organisational change programme.
- A project board to be formed for the MSK Programme with engagement with public stakeholders on a consultation and assurance exercise by June 2014 and service provision by April 2015.
- Draft service specification for Maternity Services was presented with the aim to be ready for contract negotiation and implementation from 1 April 2014.
- Update on the Outline Business Case – secretary of state approval awaited.
- Update on the Primary Care Local Improvement (PCLIF) scheme. Despite good activity from practices it is not on track to deliver the projected savings. Proposals for a new scheme will be considered at Governing Body development day on 7 January 2014 with the potential for a new scheme to start in April 2014.

30 January 2014
- Presentation and discussion of the Strategic Plan.
- Better Care Fund Update it was agreed this would become a standing item on the agenda.
- Workshops to take place with MYHT, SWYPFT and YAS to develop the CQUIN scheme, final schemes to be completed for each provider by 28 February 2014.
- Six measures this year for Quality Premium, discussions to take place with Public Health colleagues working on the measures re follow up after stroke and engagement with GPs.
- Update from the Medicines Management Optimisation Group including a summary of the past year’s performance and plans for 2014/15.

Policies approved: No policies were approved at the meetings held on 19 December 2013 and 30 January 2014.
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday 19 December 2013
09.00 – 12.30
Seminar Room, White Rose House

Present:
Adam Sheppard (Chair) (AS) Asst. Clinical Chair, NHS WCCG
Dr Philip Earnshaw (PE) Chair, NHS WCCG
Jo Pollard (JP) Chief of Service Delivery and Quality, NHS WCCG
Andrew Pepper (AP) Chief Financial Officer, NHS WCCG
Lee Beresford (LB) Associate Director of
Dr Clive Harries (CH) GP, NHS WCCG
Dr Ivan Hanney (IH) GP, NHS WCCG
Dr Ann Carroll (AC) GP, NHS WCCG
Sandra Greenwood (SG) Nurse, NHS WCCG
Andrew Hardy (SH) Lay Member

In Attendance:
Andrew Furber (AF) Director of Public Health
Julie Owen (JO) Older Peoples Programme Manager, Wakefield Council (Item 5)
Dr Rosemarie Jones (RJ) Care Home Primary Care Lead (Item 5)
Helen Childs (HC) Interim Programme Manager, PMO (Item 6)
Maciek Gwozdziewicz (MG) Senior Project Manager – Transformation, WSYBCSU (Item 7)
Heiko Kausch (HK) Senior Project Manager – Transformation, WSYBCSU (Item 7)
Sally Bell (SB) System Support, WSYBCSU (Item 8)
Tracey Sparkes (TS) Interim Programme Manager, PMO, WCCG (Item 9)
Andy Mobbs (AM) Programme Manager, Transformation, WSYBCSU (Item 11)
Ian Wightman (IW) Principle Associate, WSYCSU (Item 14)
Michelle Ashbridge (MA) Senior Commissioning Manager, Service Development and Transformation, WCCG (Item 15)
Dr Greg Connor (GC) Executive Clinical Advisor for Commissioning and Quality Improvement, WCCG (AOB)
Tara Trayler (TT) Senior Management Support, NHS WCCG

1 APOLOGIES FOR ABSENCE

Apologies were received from Dr Avijit Biswas, Dr David Brown and Dr Paul Dewhirst.

2 DECLARATIONS OF INTEREST

ITEM 14 – GP IT - All GP members declared an interest.

AOB – PCLIF All GP members declared an interest.

3 A MINUTES OF THE MEETING HELD ON 28 NOVEMBER 2013

The minutes were agreed as a true record.
B MATTERS ARISING

Members noted update.

4 ACTION LOG

The Action Log was reviewed and updated noted.

CLINICAL BUSINESS:

5 FINAL REVIEW OF THE IMPLEMENTATION OF THE CARE HOME LIAISON AND SUPPORT

JO and RD presented the paper, the aims of the Care Home Liaison and Support Service (CLASS) were:

- To develop equitable access to primary and secondary health care for Care Home residents
- To develop effective health care support for specified Care Homes in the Wakefield District that will contribute to improved outcomes for patients.

Through the provision of proactive health care support to specified Care Homes in the Wakefield District. JO stated that the final review has demonstrated the potential impact of the interventions delivered by the Care Home Liaison and Support Service to deliver agreed outcomes and to influence patient care and improve the outcomes for residents.

JO informed members that whatever input is put into CLASS makes a huge difference and the course of action needs to be a long term commitment. JO stated that 7 practices over the district now support CLASS and currently Wakefield Council are looking at a Sheffield Model to see how they are looking at LES to improve Quality to consider a similar model in Wakefield.

Following discussion PE stated the need to budget for networks to support mainstream design for Care Closer to Home and the need for training of staff to ensure similar guidelines over locality working to ensure stable functional homes. RD stated the need for a streamline approach for Care Homes and General Practices to ensure alignment of practices.

HC stated that networks need to be informed in Phase 1 regarding the alignment proposal as this is not linked to Emergency Bed Days. JP stated this should be part of the Care Closer to Home mandate and consideration for a separate work stream regarding alignment to consider where it sits. JP stated it is a joint commissioning reasonability with the Local Authority, and education must be done in terms of Quality.

Action: It was agreed for JP and HC to pick this up with Kim Curry and an update around alignment would be brought to the meeting in February.

Members agreed to note the contents of the report and approve the associated recommendation of these proposals presented in the paper for an opportunity to improve the quality of care and patient outcomes through the provision of support for Care Homes to strengthen clinical skills and leadership in the management of resident’s healthcare. These proposals also represent a means to provide closer working links between Care Homes and the local health economy to support the reduction of unnecessary hospital attendances and
admission;

**SUBJECT TO:** impact on the larger transformation agenda, a model regarding alignment needs agreeing ensuring all financial implications to ensure practices agree via a network discussion.

**Action:** Need for a separate work stream around alignment, Helen Childs agreed to lead.

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**6 NON RECURRENT BUSINESS CASE – ORGANISATIONAL / DEVELOPMENT AND ENGAGEMENT**

HC presented the paper; stating the aim of Care Closer to Home Programme is to oversee the identification and delivery of appropriate services, models and associated pathways which will support the provision of safe and effective care closer to home, and avoid hospital admission or attendance where alternative approaches are appropriate. Where individuals need hospital treatment a service model will also be developed to ensure they are discharged from hospital as soon as they are medically stable, preferably to their own home. HC stated in order for this to be successful, all service providers need to be signed up to the changes required to realise this vision and to be fully engaged with the interventions required to enable them to develop and implement the necessary pathways and an important first step is to fully engage with member practices and community health and social care provider services to help everyone understand the case for change and enable that change to be made over a defined period of time.

HC informed members the business case brought for decision is for non-recurrent monies outlining a draft proposal from CSU to deliver a robust organisational change programme supporting the delivery of Integrated Care Teams in Wakefield district. HC stated the issue is for a staffing requirement for a specialist Organisational Development (OD) post 8d to develop strategy and plan for OD and engagement. AP informed members that the funding is part of the Care Closer to Home allocation.

Members agreed to approve the release of non-recurrent funds to enable the delivery of a robust organisational development approach supporting the delivery of Integrated Care Teams in Wakefield district.

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**7 MSK PROGRAMME EXECUTIVE SUMMARY**

MG and HK presented the paper, stating following presenting to members a service specification and business case in March 2013, based on the recommendations of the Clinical Cabinet, an MSK workshop was held on 26 November 2013 with key stakeholders, full list of stakeholders highlighted in Appendix A of the paper. Stakeholders agreed to refresh the existing IMAT service specification and business case to form part of the procurement documents and use a prime contractor model to commission services for MSK. The outcome of the workshop was subsequently presented to the QIPP Programme on 27 November 2013, who endorsed its recommendations.

MG stated the MSK programme is looking to form a Project Board to progress the idea by further developing the good IMAT work with final aim to procure a service Prime Contractor in line to the following indicative plan:

- Refresh the IMAT service specification and business case by February 2014 and present to Clinical Cabinet;
• On approval of the revised business case, give existing MSK service Notice of Termination by April 2014;
• Engage with public stakeholders on a consultation and assurance exercise by June 2014;
• Prepare tender and proceed with a service Prime Contractor procurement for completion by December 2014;
• Award a Prime Contractor and enable to commence service provision by April 2015.

MG informed members the objective is to deliver an improved MSK service (as indicated above) that will encompass specialist advice regarding treatment, further management and the negotiation of possible treatment pathways with the patient taking into consideration biological, psychological and social complexities. Therefore, the MSK Prime Contractor’s objectives are to develop a system that is driven and informed by patient outcomes is allied to a commercial contractual mechanism linked directly to those outcomes and is a sustainable system.

Following discussion members raised concern around:
• MSK becoming privatised, therefore out of WCCG control;
• Bespoke model for Wakefield not rest of Cluster;
• Big contractual implications – what’s included in and out of scope
• Specification needs to be properly engaged with members and
• Why has WCCG considered a “private prime contractor model”.

**Action:** MG/HK to produce a recommendation paper to February meeting with other options and a risk assessment around if WCCG did agree to a Private prime contractor model.

Members agreed to support the formal formation of a project board and empower it to direct and make project-level decisions within its governed Terms of Reference. **SUBJECT to:** MG to seek advice from Dr Patrick Wynn around who members of the project board should involve.

### 8 STRATEGIC PLANNING 14/15 UPDATE

SB presented the paper to members stating it has been brought to make members aware of the plan and the process that is taking place. SB indicated the Strategic Planning team are still awaiting the NHS England dates and allocations and she is attending a meeting on the 20th December with NHS England where information may be shared. SB shared a presentation with members which outlined:
• the planning process for the strategic plan 14/15;
• the national and local context;
• a summary of the financial outlook; and
• each of the five priority areas outlining its service priorities.

SB stated that these were discussed at a workshop at the Governing Body development session on 10th December and key themes from that discussion were highlighted, these being:
• Workforce
• Technology
• Integration with Local Authority
Following discussion SH stated the need for the final document to be in “the people’s language”. SB agreed that this was critical. AF stated the need for the 5 year plan to be focused on self-care and self-management and what the population of the Wakefield district are expected to do themselves. PE also wanted to ensure the need for urgent care to be linked with planned care in the 5 year strategy. SB agreed to take all these comments back to the Strategic Planning Team.

Action: CH stated that SB need to meet with Dr David Brown around Workforce issues, SB to set up and SB agreed to bring and update to the January meeting.

Members agreed to note the contents of the paper.

9 DRAFT SERVICE SPECIFICATION FOR MATERNITY SERVICES

TS presented the paper and a detailed presentation to members stating this is a draft version of a new service specification that has been developed for maternity services. The specification is one of the outputs from the Maternity, Children and Young People’s Transformation Programme. The specification has been developed by the Safe and Healthy Pregnancy Design group, whose members include clinicians and managers from MYHT, commissioning leads and public health colleagues from both Wakefield and NK CCGs.

TS stated that this is work in progress were the transformation team are currently fine tuning the key performance measures and to identify baselines. We are also in discussion with contracting and quality team colleagues re: performance management of the new specification. It is aimed that the specification will be completed by the end of December 2013 – ready for contract negotiation and implementation from 1st April 2014.

Members welcomed the presentation and following discussion it was agreed to:

- Take the specification to the contracting team to look at the negotiation ratios with MYHT;
- Consider an external review of the specification
- TS to contact Laura Elliott regarding the ratio of midwives, due to members concerns around quality. JP agreed she would pick this up at the Executive Quality Board also.
- TS to speak to Ruth Twiggins around the Tender for 2015.

Members agreed to note the contents of the report;

SUBJECT TO: further discussion at the Executive Quality Board (around ratio of midwives and patient quality of care) and Integrated Governance Committee.

10 MULTI-AGENCY SAFEGUARDING HUB ADDENDUM TO PREVIOUS REPORT

JP presented this paper for information, informing members of the changes on how families are assessed through Single Point of Access and the concerns that have been raised around the Health staffing element and the need for additional recruitment of staff. The addendum highlighted to members the financial implications of the MASH to the CCG per annum.

JP stated a letter will be sent to AF re the future commitment of Safeguarding in the long term.
Members agreed to note the approval of the additional expenditure associated with additional staff recruitment for the MASH through the SFI's and the non-recurrent budget holder.

PE wanted to state to members the issue around the commissioner and providers on this occasion and that WCCG do not want to commit to this on a longer term but got involved due to partnership working and the need for the service to continue.

**STANDING ITEMS**

**11 QIPP**

AM presented the paper to members stating that due to short timescales there is not much of an update from the last meeting put:

- To date the QIPP programme 13/14 consists of 13 active projects.
- All projects and programmes are reviewed and monitored on a regular basis by the QIPP group.
- Based on the submitted information planned savings estimated at £8m PYE.
- Identification of risk to delivery remains a priority for 13/14 QIPP Programme
- Planning for the 14/15 QIPP Programme is well under way.

**Action:** Following discussion members asked AM to present in January a firmer paper on combined list and indications on programmes going forward for 2014/15.

AP also agreed to do a short briefing on Capita via email prior to the next meeting in January.

Members agreed to note and approve the update.

**12 NETWORK UPDATES**

Nothing to report.

PE shared with members that himself and GC will be writing a consultation letter in January around the decision of reconfiguration and this will be discussed further at the Governing Board meeting on the 14th February 2014 regarding the redesign of Care Closer to Home at practices.

**CLINICAL DISCUSSION / DEBATE**

**13 OUTLINED BUSINESS CASE UPDATE**

AP presented this paper on behalf of Michele Ezro, stating that the Programme Executive Team meet and recognised the OBC document was a well worked up document on the 13th December and signed up in terms of finance and commissioning intentions working forwards on how transformation works and takes place.

JP informed members that the implementation plan has been shared to Heads of Service and Commissioning Leads and contractual and CQUN issues have to be included in the plan to ensure WCCG have got assurance in place.
PE stated that WCCG are still waiting for secretary of state approval.

Members noted progress with the current status of the OBC.

**PAPERS FOR INFORMATION ONLY**

**14 GP – IT UPDATE**

CH gave background to members around the issues of GP-IT from PCT to WCCG. IW presented the paper providing an update of the GP-IT provision for practices in Wakefield CCG.

IW highlighted to members that allocations have now been agreed and the core capital items have been agreed for 2013 and a bid is underway for 2014/15 to ensure all GPs get the technology needed.

IW informed that WCCG have been receiving legacy requests that are non-core by GP practices. These non-core are in the value of £129,000 available and it is WCCG decision how this is spent by March 2015.

Following discussion members agreed the following actions.

**Actions:**

1. JP and PE to discuss at the Executive Team around ICT Vision for Practices and communication to practices and;
2. AP to consider under the SFI and agree on behalf of Clinical Cabinet as Chief Financial Officer ensuring it’s equitable and prioritised adequately.

Members agreed to consider the recommendation on GP-IT capital requests and agreed to the consumables SUBJECT to: further consideration on the best use of the NON –core GP –IT funds outside the meeting.

**15 WAKEFIELD ELECTRONIC PALLIATIVE CARE CO-ORDINATION SYSTEM (EPaCCS)**

MA presented the paper; stating that The End of Life Care Strategy (2008) identified the need to improve coordination of care between care providers. The development of locality registers or Electronic Palliative Care Coordination Systems (EPaCCS) were identified as a mechanism to improve coordination of care.

MS stated that the implementation of a local EPaCCS utilising a single template within SystmOne, based on developments on Leeds and Bradford, will allow the information about patients at the end of life (the national Information Standard) to be recorded consistently. It is estimated that the implementation of an EPaCCS will increase quality of patient care and the number of patients dying in their usual place of residence; and reduce average length of stay.

Three options were presented to members, but MA stated that Option 2 was the preferred and most cost effective option and will deliver the following benefits:

- Improve coordination of care for patients at the end of life
- Increased use of a locality register of patients at the end of life with agreed multi agency protocols for consent and information sharing.
- Allow early identification and intervention of patients at end of life, to reduce unwanted admissions and length of stay and improve discharge planning.
- Enable reliable data for strategic and transformational planning
- Improve the consistency of recording of EOL QOF indicators and CQUINs measures
- Improve the quality and efficiency of existing Gold Standards Framework meetings
- Improve synergy with other projects (AMBER Care Bundle, MPET project and wider IT strategy)

This time limited project could start immediately and would run for 12 months. The non-recurrent funds for 2013/14 required to deliver the project are £25,700. The project will result in cost savings of approximately £39,910 p.a. per 200,000 population (a potential saving of £70,000 pa)

Members agreed to approves £25,700 of non-recurrent monies (for 2013/14) to support the provision of a virtual team working across the local health community to embed the use of an electronic care coordination system (EPaCCS) from the SystmOne platform

**SUBJECT to:** the need for engagement with all practices.

16 ANY OTHER BUSINESS

1. PCLIF

GC attended the meeting to provide member an update on PCLIF following the Executive Approval Group.

GC stated that the scheme has a number of learning points but unfortunately the PCLIF scheme is not on track to deliver savings though there is good activity from practices being delivered i.e. on Primary Care alternatives. GC stated that is clear that the scheme will certainly not achieve the savings in A&E attendance and emergency admissions across the district.

Following discussion it was agreed that the scheme in its current form could not be commissioned due to the current situation and a new scheme to ensure quality improvement and links to Care Closer to Home.

GC stated there is a Governing Board development day on the 7th January 2014 for members to discuss proposals regarding the future of PCLIF and this will be worked up for practices to start in April 2014.

**Action:** PE and JW to send out a letter to all practices regarding the proposals on PCLIF before Christmas.

Members noted the update.

19 DATE AND TIME OF NEXT MEETING

Thursday 30 January 2014
09.00 – 12.30
Seminar Room, White Rose House
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday 30 January 2014
09.00 – 12.30
Seminar Room, White Rose House

Present:
Adam Sheppard (Chair) (AS) Asst. Clinical Chair, NHS WCCG
Jo Pollard (JP) Chief of Service Delivery and Quality, NHS WCCG
Andrew Pepper (AP) Chief Financial Officer, NHS WCCG
Laura Elliott (LE) Head of Quality, NHS WCCG (part meeting)
Lee Beresford (LB) Associate Director of Strategy & System Development, NHS WCCG
Dr Clive Harries (CH) GP, NHS WCCG
Dr Ivan Hanney (IH) GP, NHS WCCG
Dr Ann Carroll (AC) GP, NHS WCCG
Dr Avijit Biswas (AB) GP, NHS WCCG
Dr David Brown (DB) GP, NHS WCCG
Dr Paul Dewhirst (PD) GP, NHS WCCG
Sandra Greenwood (SG) Nurse, NHS WCCG
Laura Elliott (LE) Head of Quality, NHS WCCG (part meeting)

In Attendance:
Andrew Furber (AF) Director of Public Health
Helen Childs (HC) Interim Programme Manager, PMO (Item 6)
Linda Driver (LD) Head of Service Development & Transformation, WCCG
Sally Bell (SB) System Support, WSYBCSU (Item 8)
Joanne Fitzpatrick (JF) Head of Medicine Management, WCCG
Lyndsey Clayton (LC) Chief Technician, WCCG
Michele Ezro (MEz) Programme Lead, WCCG
Becky Gunn (BG) WCCG
Jo Hanlon (JH) Head of Public Health (Health & Social Care), LA
Dr S Da Silva (SDS) GP, NHS WCCG
Tara Trayler (TT) Interim Strategy & Reform Manager, NHS WCCG
Kate Trevelyan (KT) Senior Management Support, NHS WCCG

1 APOLOGIES FOR ABSENCE

Apologies were received from Dr Phil Earnshaw

2 DECLARATIONS OF INTEREST

No issues were raised.

3 A MINUTES OF THE MEETING HELD ON 28 NOVEMBER 2013

The minutes were agreed as a true record.
B MATTERS ARISING

Members noted update.

4 ACTION LOG

The Action Log was reviewed and updated noted.

PRESENTATIONS

5 Strategic Plan

ME provided a brief update on the Strategic Operational Plan which covered a 2-5 year period forecast with key priorities such as

- Primary Care
- QIPP
- Better Care Funding
- Quality

The timeline was noted as

14 February Draft 2 year Operational Plan submission
4 April Final 2 year Operational Plan submission Draft 5 Strategic Plan submission
20 June Final 5 year Strategic Plan submission

LB updated members on the strategic objectives with emphasis on the profile of mental Health and Well Being re the transformation agenda and the ongoing work in respect of the strategic objectives:

- Prevention of ill health
- Care closer to home and Out of Hospital Care (AB leading)
- Responsive Healthcare
- Safe early years and transition
- Improving mental health

It was also noted that increased emphasis would be placed on the integration of children services with workstreams being identified to support. Members discussed the integration of mental health into the Plan which should also cover elderly care in hospital.

Members agreed that the work programme should be brought back to the February meeting with particular emphasis on elderly and dementia care.

Members unanimously agreed to support the Strategic and Operational Plan.

The break out sessions were then held to develop two patient stories and the outcome of which would be written up and shared.
AS closed by stating that a Strategic Plan follow up would be discussed at the February meeting.

**Action. Strategic Plan follow up to be added to February agenda**

### Better Care Fund Update

HC gave a verbal update indicating that the Better Care Fund has to be submitted to the Area Team by the 14 February 2014. The fund would then go to the Health & Well Being Board and then through CCG Governance with Jo W and Phil having delegated powers to sign off the draft before it was submitted to the Governing Body.

Members noted that the fund would support:

- Adult Community Nursing
- Intermediate Care service
- Speciality services
- Public Health services
- Health and Well Being services

The paper had been discussed at HWB/JSCB and AF updated members around the governance arrangements re Terms of Reference, joint membership strategy with particular emphasis on the inclusion of childrens’ commissioning. It was noted that the Health & Well Being Board was a sub committee of the Local Authority.

CH expressed concern around the process being used to get consensus from Practices and there was a risk around non achievement. After a detailed debate, it was agreed that the risk would need to be shared appropriately with a process being implemented to cover.

Members noted that the strategic implications of the Better Care Fund with joint commissioning of services affected the core business of the CCG and there was a need to track the governance, commissioning and health outcomes. It was agreed that the Better Care Fund was a mainstream cabinet discussion and as such would remain on the agenda as a standing item for monthly updates to be provided.

Members noted the contents of the report and approved the Better Care fund approval process.

**Action: Better Care Fund update to be a standing item on the agenda**

### CQUINS

It was noted that the paper provided information associated with the development of 2014/15 CQUIN scheme. There have been a number of changes to the national indicators, and the prequalification criteria has been removed. Innovation will now be negotiated as part of the contracting round. The financial value of the scheme remains at 2.5%.
The 4 national CQUIN goals for 2014/15 were noted as

- Friends & Family Test
- NHS Safety Thermometer
- Dementia & Delirium Care
- Diagnosis in Mental Health
- National VTE goals removed and will now be a contractual requirement

It was noted that development of the CQUIN scheme was being covered by a number of workshops involving MYHT, SWYPT and YAS. Further consultation will take place with commissioners, GPs and the providers with the aim of finalising schemes for each provider by 28 February 2014.

JoP commented that the strategic objective workplan underpins everything beneath it AC queried the inclusion of the 1:1 maternity case load (such as same midwife during delivery, antenatal care with same midwife). It was agreed that LE would contact Morna Cooke on this point.

**Action:** LE to pick up 1:1 ratio midwife with Morna Cooke

Members noted that contents of the report.

**7B Quality Premium**

LE presented the paper and highlighted the changes:

- This year measures from seven to six;
- Financial gateway to qualify—clearer circumstances where the CCG would not receive the Quality Premium;
- Change in cancer indicator from 62 days referral to treatment to 14 day from urgent GP referral to first appointment;
- Quality gateway – more explicit circumstances where the CCG would not receive the quality premium;
- Domain 2 measure – achieve improving access to IAPT access to 15% by 31 March 2015;
- Domain 4 measure – supporting roll out of Friends and Family Test and improvement in a selected indicator from Domain 4 of the CCG Outcome Indicator Set;
- Domain 5 (new indicator) – improved reporting of medication related safety incidents at a local provider;
- Local measure to be based on an indicator from the 2014/15 CCG Outcome indicator set re local issues and priorities. The level of improvement should be agreed between the CCG, the Health and Wellbeing Board and the NHS England area team

LE updated members on the detail behind the measures which were being proposed to take to the Health and Well Being Board next week.

**Measure 1** 3.2% reduction in potential year of life lost;
Measure 4  Proposed patient experience indicators average score

Members agreed to take forward measures 1 and 4.

Measure 5  GP Practices: increase reporting of in medication incidences

The method of incident reporting was discussed and after debate it was thought that a more efficient method could be achieved for example via SystemOne or the use of on site Pharmacy Technicians who could report incidences. Members agreed that LE/JF should work on a detailed solution.

Action:  LE/JF to work on a detailed solution and bring back

Local Measure  Continue with reducing smoking at time of delivery measure for the following reason.

Members agreed to support the action and to share the locally defined measures with Health and Well Being Board.

There was concern around the IAPT and Smoking indicator risk but ME reported that these were presently being worked on and it was noted that the Well Womens Service should be taken in consideration within the Transformation Programme. JoP commented that Public Health colleagues were working on the measures re follow up after stroke and engagement with Gps and members agreed that it was a discussion to be held outside of the meeting.

8  QIPP

AS reminded members that QIPP was a significant risk to the organisation and stressed that it was the responsibility of the Cabinet to achieve QIPP. AP updated members on the proposed QIPP target of £14m (£12m 2015) and associated issues. JoP tabled Appendix 1: Proposed QIPP Schemes which members reviewed. Members noted that one of the changes was moving Planned Care responsibility to Primary Care which would need clinical engagement with Heads of Service to work on the detail.

It was noted that there needed to be themed areas for QIPP not just financial but a redefined focus on quality of service and innovation. The challenges around QIPP were noted as tariff negotiations, audit findings and contract negotiations re agreements with MYHT/SWYPT and also a need to consider gaps, together with ideas from GPs.

It was agreed that an extraordinary Clinical Cabinet (including other network colleagues) meeting should be scheduled to discuss the issues in depth around

- How QIPP should be managed
- How the risks should be spread
- Engagement with the GP network
- QIPP GP Leadership
- Use the Medicine Management model for the Planned Care Programme
- Planned Care Incentive
- QIPP GP Leadership
Members agreed that a summary of the outcome of the Extraordinary Clinical Cabinet meeting should be brought back to the next meeting and that this issue should remain as a standing item.

**Action:** Summary of the outcome of the Extraordinary Clinical Cabinet to be brought back to the next meeting.

**9 Medicines Management Optimization Group**

PD introduced this item indicating that massive savings were being achieved as a result of direct interventions by Technicians.

JoF then gave a verbal update advising that the Medicines Management Optimisation Group was a sub group of the Clinical Cabinet (Prescribing CCU). The paper provided an update on the performance of Medicines Management through reporting to the Medicines Optimisation Group. It included sections on primary care prescribing/QIPP; high cost tariff excluded secondary care drugs, and oxygen. It concludes with a summary on the past year’s performance and looks forward to plans for 2014/15. Jo F highlighted and provided detail around key points which included:

- Technicians work plan;
- Medicines Technicians Pharmacy in Practices;
- Query Log kept to enable a track of savings;
- Team work with GPs;
- Brand generic production;
- Prescribing level workshops with GPs incentive to attend;
- Investigating possibility of doing a webinar;
- Regular communications, via visits, Prescribing bulletin etc;
- Improving on the prescribing plan via 10 indicators;
- Script switch prescribing software very successful but would be taken to tender for better prices;
- Secondary care high cost drugs charging issues between CCG and NHS England;
- Eye drops cost issues at MYHT raised via CMG/ECB (JoF escalating);
- Prescribing framework through Medicines Optimisation Group and not Clinical Cabinet. Members noted that appropriate governance had been checked with Katherine Bryant;
- Oxygen: Public Health working on this re inappropriate costs;
- Looking at Primary Care QIPP;
- Effectiveness of Prescribing Lead GP re prioritisation in busy Practices;
- Policy for approving primary care prescribing rebate scheme (will form part of QIPP) going to Integrated Governance;
- Rebranding of Medicines Management to new a name of Medicines Optimisation Team (MOT) to support a modern multi disciplinary approach about getting the right medicines, in the right time to the right patient.

Members noted the report and congratulated JF on excellent work.

**10 Any other Business**

No items were discussed
Date of the next meeting

Thursday, 27 February 2014
09.00 – 12.30 pm
Seminar Room, White Rose House
Agenda item: 14d (i)

Health and Well Being Board

Minutes of meeting held on 16 January 2014

http://mg.wakefield.gov.uk/documents/g11217/Printed%20minutes%20Thursday%2016-Jan-2014%20%20Health%20and%20Wellbeing%20Board.pdf?T=1
Agenda item: 14e (i)

Decisions of the Chief Officer

Verbal Update