# BOARD MEETING OF THE GOVERNING BODY

TO BE HELD ON TUESDAY, 13 MAY 2014
BOARDROOM, WHITE ROSE HOUSE
AT 1.00 PM

## AGENDA

### PART 1

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13. Building Health Partnerships (Presentation)  
   - Ageing Better  
   - Social Prescribing  
   - Carers  

Liz Howarth/Helen Childs

14. Receipt of minutes and items for approval
   
   a **Integrated Governance Committee**  
      (i) Minutes of meeting held on 20 February 2014,  
      (ii) Minutes of meeting held on 20 March 2014
   
   b **Clinical Cabinet**  
      (i) Minutes of meeting held on 27 February 2014  
      (ii) Minutes of meeting held on 27 March 2014
   
   c **Executive Approvals Group**  
      (i) Minutes of meeting held on 18 March 2014
   
   d **Health and Well Being Board**  
      (i) Minutes of meeting held on 13 February 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, 8 July 2014, 1pm in the Boardroom, White Rose House
Welcome and Chair’s Opening Remarks

Dr Earnshaw opened the meeting by welcoming recent correspondence from the Secretary of State for Health which confirmed that the Independent Review Panel (IRP) has considered the referral by Cllr Betty Rhodes (chair of the Joint Overview and Scrutiny Panel) and concluded that it is not suitable for full review. The Secretary of State has written to Cllr Rhodes and indicated that reconfiguration of health services as outlined in the Mid Yorkshire Hospital Trust (MYHT) Clinical Services Strategy should proceed quickly. Dr Earnshaw said that steps would now be taken to ready community services to support the reconfiguration.

Two bids have been made for the Prime Ministers Challenge Fund to support innovative ways of delivering care. Dr Earnshaw said it was expected news of whether the bids have been successful would be received within two weeks.
Dr Avijit Biswas    GP, Pinfold Lane Surgery
Stephen Bryan    Practice Manager, Stuart Road Surgery
Sandra Cheseldine    Lay Member
Dr Andrew Furber    Director of Public Health, Wakefield Council
Dr Clive Harries    GP, Chapelthorpe Surgery

14/37 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.

14/38 Public Questions and Answers

A member of the public, Mr Tony Howell, confirmed that he was in attendance at the meeting as a representative of NOVA (formerly attended as a representative of Spectrum People).

Two questions were received from the public in attendance:

Reflecting on recent comments by Michael Meacher MP, Mr Coates asked whether NHS Wakefield CCG has sufficient skills available in-house or are advisory agencies being employed? Jo Webster confirmed that the CCG does have sufficient organisational capacity, which was assessed during the CCG authorisation process. Jo noted support engaged from external organisations such as the West South Yorkshire and Bassetlaw Commissioning Support Unit. She noted that this was all achieved within the £25 per head of population running costs allowance.

Mr Drurick expressed his concern about item 16 on the Governing Body agenda. He said that as a public organisation he felt it was inappropriate for any section of the meeting to be held in private. Jo Webster said that as a public organisation following governance principles there were limited occasions when the Governing Body need to meet in private to discuss confidential items, for example if the discussion items relate to a named individual or to litigation. Dr Earnshaw provided assurance that wherever possible discussions and decisions take place in public, and private items are kept to an absolute minimum.

14/39 Minutes of meeting held on 14 January 2014

Sharon Fox confirmed that at minute 14/08 she referred to Castleford Health Centre, and not Castleford and Normanton District Hospital.

It was RESOLVED that:

i) the minutes of the meeting of the NHS Wakefield Clinical Commissioning Group Governing Body Meeting held on 14 January 2014 were agreed as a correct record with one amendment.

14/40 Action sheet from meeting held on 14 January 2014

Katherine Bryant provided the governing body with an update on progress on outstanding actions from 14 January 2014. She noted that three items were outstanding:

- Minute 13/64 – Continuing Healthcare Audit, this report will be presented to the Integrated Governance Committee.
- Minute 14/08 – The Outline Business Case will be presented to the Governing
There were no matters arising.

**Chief Officer Briefing**

Jo Webster presented the Chief Officer briefing report.

The CCG had been shortlisted (one of four finalists) for the *Excellence in Participation to Achieve Insight and Feedback: Commissioner Award* at the NHS England Excellence in Participation Awards 2014. Although the CCG was not awarded first prize it was important that the CCG had been recognised nationally for the ways in which the CCG engages patients and the public. The Governing Body congratulated the engagement team. Stephen Hardy echoed these sentiments and paid credit to Laura Elliot and her team. However he added that the award winner was a magnificent project and he paid tribute to everyone involved.

Jo noted the new format quarter three Delivery Dashboard for the CCG Assurance Framework. A meeting to discuss the dashboard with NHS England was scheduled to take place the next day. Jo explained that the dashboard highlighted any areas of concern.

It was confirmed that the CCG equality duty statement was published on 31 January 2014.

The Multi-Agency Safeguarding Hub (MASH) went live in January 2014. The CCG believe that this will be instrumental in improving safeguarding in the Wakefield District.

Finally the Governing Body were updated about a series of organisational changes which were implemented. Jo explained that these changes were the result of a review of the way the CCG has been working. These changes will ensure that the CCG is fit to respond to the national NHS agenda, local health needs and future partnership working.

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.

**Integrated Quality and Performance Summary Report**

Jo Pollard introduced the report. She flagged a number of areas including the CQC have lifted the warning notice against MYHT. Friends and Family data for maternity services at MYHT has been published. Following a request from the Governing Body in January 2014, the report contains details of a deep dive review into the length of time patients have to wait for mental health services in SWYPFT’s Wakefield Business Delivery Unit.

Matt England and Laura Elliot highlighted issues from the exceptions performance report:

- Wakefield CCG Ambulance response time CAT A (Red 1 and 2) 19 minutes has seen a significant improvement in comparison to last month actual and year to date (YTD)
performance. NHS Wakefield CCG are the lead commissioner for West Yorkshire. It is proposed that a CQUIN for individual CCG level performance is introduced during 2014/15.

- Ambulance turnaround at MYHT has continued to be below target. It is expected that performance in January and February 2014 will show improvements.
- Cancer waits 62 days referral to definitive treatment has continued to be below target and worsened in two consecutive months. A deep dive report will be presented to the Governing Body meeting in May 2014 following consideration by the Integrated Governance Committee.
- Year to date there have been seven MRSA healthcare acquired infections (HCAIs). In addition to the actions discussed previously at the Governing Body additional catheter care training has been delivered. The CCG has already exceeded the C-Difficile target for 2013/14.
- The CCG has achieved the 18 week Referral to Treatment target (RTT), but MYHT’s performance year to date is below the target level. The impact of winter pressures on the 18 week position is being monitored and a co-ordinated approach being delivered within the CCG.
- The Improving Access to Psychological Therapies (IAPT) data to quarter two shows performance of 2.4% against a target of 2.6% people entering psychological therapies. The provider has recognised that do not attends (DNAs) are a problem and have launched a text service in response.

Sharon Fox said she was heartened to hear that the uptake of catheter care training had improved. Laura said that in part this improvement is the result of targeted training requests.

Dr Adam Sheppard noted that despite concern a few weeks ago, the A&E four-hour standard waiting time target had been achieved.

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

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

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

**14/44 Finance Report (month 10)**

Karen Parkin presented the report. She confirmed that there were no material changes to the month eight finance report. The CCG is still on track to achieve the planned year-end surplus of £5,502k. QIPP achievement is forecast to be 85% of the target of £8,200k.

Forecast activity received for MYHT shows a 4% over-trade on the contract with MYHT.

There were allocations adjustments during month ten, these related to NHS Property Services and help for the CCG with transformation costs.

The CCG has settled on a year-end position with the main provider MYHT. Karen said that this reduced risk to the CCG.

Andrew Pepper provided additional information about the published running cost allowance for 2014/15; this will reduce by £20k in 2014/15 to £24.73 per head. He explained that this reduction is the result of NHS England holding the same level of national funding, but redistributing to reflect population changes. It was noted that this level of funding was significantly less than the administration funding received by the Primary Care Trust (£31.88 per head) in their last year of operation.
It was noted that nationally the NHS was in surplus, but some CCGs are in deficit.

Andrew confirmed that the finance team are on the path to manage year-end and produce the CCG’s annual accounts for 2013/14. Cash is being tightly managed to deliver the expected target as closely as possible.

It was noted that the GP IT allocation would not be received by the CCG during 2013/14.

Dr Ann Carroll sought further information about the under-spend on ophthalmology and dermatology community contracts. Andrew confirmed that initiatives were in place to resolve the situation. Jo Webster added that both these services were community services. In light of the transformation programme she had asked for both these services to be reviewed.

Rhod Mitchell congratulated the team for agreeing a year-end position with MYHT as this ensured a stable position for the CCG. Rhod noted delays in the CCG paying creditors. Andrew said that this is being monitored on a day-to-day basis but it reflected a national difficulty which resulted from s.251 changes (CCGs are not permitted to view patient confidential data to validate invoices). The CSU is supporting the CCG with invoice validation, and in order to expedite the delays a backlog of low value invoices have been approved.

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

(i) note the contents of the Finance Report (month 10).

**14/45 Process for sign off of final accounts for 2013/14**

Andrew Pepper explained that this paper describes the key activities in order for the CCG to prepare annual accounts for 2013/14. It was considered in detail by the Audit Committee in February 2014.

The CCG is required to comply with the national manual for accounts which is based on International Financial Reporting standards (IFRs). The accounts will be in a fixed format and to strict timescales in order for them to be consolidated at a national level.

The CCG has a new team of auditors and a good relationship has been developed with them.

Andrew detailed key dates for the Governing Body to be aware of:

- 23 April – submission of full draft annual report and accounts to the auditors
- 6 June – submission of full audited and signed accounts
- 30 September – an AGM must have been held by this date

The scheduled sequence of Governing Body meetings does not fit with this timetable and therefore delegated authority is being sought for the CCG Chair, Chief Officer and Audit Committee Chair to approve and submit the final audited accounts, annual report and supplementary information.

On behalf of Sandra Cheseldine, Rhod Mitchell invited all members of the Governing Body to the Audit Committee ‘page turn’ meeting on 8th May 2014.
It was **RESOLVED** that the Governing Body:

(i) note the processes outlined and give approval to the proposals outlined therein.

(ii) 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.

**14/46 Service Level Agreement negotiations with West and South Yorkshire and Bassetlaw Commissioning Support Unit: Progress Update Report**

Andrew Pepper explained that the paper summarised progress to agree a Service Level Agreement (SLA) with West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU). He noted that the WSYBCSU are a key stakeholder for the CCG. Although there are service areas which require further development, overall the service provided to the CCG by WSYBCSU is very good.

Discussions have been ongoing at director level about how the CCG and WSYBCSU can support each other. Andrew reflected that in order to develop services WSYBCSU needed a two-year commitment from the CCG. The CCG had proposed and it was understood that WSYBCSU had accepted the need for a share of the 10% cut in CCG running costs to be passed onto WSYBCSU in 2014/15.

Detailed contract schedules and service specifications were being developed for each service line. These would be completed in advance of 31 March 2014.

Finally Andrew noted that due to the value of the contract with WSYBCSU approval from the Governing Body was required before the contract could be approved. The Governing Body were therefore invited to delegate authority to the Chief Officer and Chief Finance Officer to agree the final contract and to ensure delivery of sustainable support services in line with NHS England guidance.

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

Dr Ann Carroll sought assurance that following concerns about the IT service provided to the CCG there would be sufficient investment in IT support. She highlighted the critical importance of IT in the integration of services. Jo Webster said that this was a point which had been reflected on. The technology agenda requires investment in order to see the full benefits. Andrew Pepper said that due to the specialist nature of this service area it was appropriate to engage support from the CSU.

Rhod Mitchell asked whether the SLA would include a break-clause? Andrew confirmed that the SLA would follow standard form and it was important for a break-clause to be included if a service to the CCG fails to deliver appropriately.

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

(i) note the current progress.

(ii) delegate authority to the Chief Officer and Chief Finance Officer to agree the final contract and to ensure delivery of sustainable support services in line with NHS England guidance.
Jo Pollard reminded the Governing Body of their statutory duties with regard to safeguarding.

Two reports were presented. The first was in effect a ‘close-down’ report for the Primary Care Trust. Jo noted that this report was out of date and presented the situation twelve months ago. The second report was prepared by Wakefield Council; the Wakefield and District Safeguarding Children Annual Report 2012/13.

Jo confirmed that in collaboration with other partners, arrangements were being put in place to ensure that the annual reports were prepared in a timelier manner in future years. Andrew Balchin agreed and supported this move to improve processes to ensure information is shared in sufficient time to learn emerging lessons.

Dr Ann Carroll echoed the sentiment that time has moved on since the time referred to in these reports. She noted that a number of recommendations, including the establishment of the Multi-Agency Safeguarding Hub (MASH) had been implemented.

Jo Pollard noted that because it contained third party information about individuals the Safeguarding Adult Board Annual Report will be considered by the Governing Body in the private section of the meeting. Andrew Balchin confirmed that the report would be made public at a future date.

Dr Earnshaw sought further information about progress to improve compliance with training. Jo Pollard confirmed that MYHT had improved compliance by 20% and SWYPFT were also meeting their target.

It was RESOLVED that the Governing Body:
   (i) note the content of the reports.

Andrew Pepper explained that the report presented a summary of the risks identified by the CCG. Full details of those risks with a score of or exceeding 15 were included.

Details of all identified risks are held on a live system and reviewed on an eight-week cycle.

Dr Earnshaw asked all clinician members of the Governing Body to review and consider whether the risks identified reflected the key risks faced by the CCG. Jo Webster noted that only risks with a residual score of 15 or over are listed in the paper. The risk register includes other risks (including those of a clinical nature) which have a score below 15. In a number of cases this will be the result of actions taken to mitigate the impact or likelihood of a risk, which will reduce risk score.

It was RESOLVED that the Governing Body:
   (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
Minutes of the Audit Committee held on 4 February 2014

Rhod Mitchell, on behalf of Sandra Cheseldine presented the minutes of the Audit Committee held on 4 February 2014, and invited the Governing Body to consider the headline discussions outlined in the cover sheet.

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

(i) noted the minutes of the Audit Committee held on 4 February 2014.

Minutes of the Integrated Governance Committee held on 19 December 2013 and 16 January 2014

Rhod Mitchell presented minutes of the Integrated Governance Committee held on 19 December 2013 and 16 January 2014, and invited the Governing Body to consider the headline discussions outlined in the cover sheet.

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

i) noted the minutes of the Integrated Governance Committee held on 19 December 2013 and 16 January 2014.

Minutes of the Clinical Cabinet held on 19 December 2013 and 30 January 2014

Dr Adam Sheppard presented minutes of the Clinical Cabinet held on 19 December 2013 and 30 January 2014, and invited the Governing Body to consider the headline discussions outlined in the cover sheet.

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

i) noted the minutes of the Clinical Cabinet held on 19 December 2013 and 30 January 2014.

Minutes of Health and Wellbeing Board held on 16 January 2014

Jo Webster presented the minutes from the Health and Wellbeing Board meeting held on 16 January 2014.

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

i) noted minutes of the Health and Wellbeing Board on 16 January 2014.

Decisions of the Chief Officer

Jo Webster explained that on rare occasions she makes decisions under powers delegated to her by the CCGs operating scheme of delegation. Jo confirmed to members of the Governing Body that she had approved the Improvement in Prescribing Plan (ImPP) for 2014/15. This followed consultation with a Lay Member.
14/54 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).

14/55 Date and time of next meeting

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

Dr Earnshaw welcomed everyone to the meeting. This was an exciting time for the NHS as changes are introduced to help the NHS modernise and deal with an ageing population. He noted the recent approval from the Secretary of State for Health for implementation of the MYHT Clinical Services Strategy to proceed. However this is only one part of the changes required. During the meeting the Governing Body will be invited to approve work across a number of related areas.

Apologies for Absence

Apologies for absence were received from:

Dr David Brown  
Sandra Cheseldine  
Dr Paul Dewhirst  
Sharon Fox  
Dr Ivan Hanney  
GP, Kings Medical Centre  
Lay Member  
GP, Queen Street Surgery  
Independent Nurse Member  
GP, College Lane Surgery
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.

Public Questions and Answers

There was one question from a member of the public regarding the CCG’s policy on faecal calprotectin testing. Dr Earnshaw outlined to the member of the public the CCG commissioned policy in advance of the start of the meeting.

Matters arising

There were no matters arising.

Chief Officer Update – verbal

Jo Webster provided an update on three areas. First the CCG await the results of the Prime Minister’s Challenge Fund; feedback received so far has been encouraging. Secondly, the CCG was part of a successful bid with WSYBCSU to be involved in a project called Working Voices. The funding will support work with local business who have staff that are resident in Wakefield. This project will support the CCG’s public engagement work. Finally Jo informed that Governing Body that she had received an email from Andy Buck the West Yorkshire Area Team Director, confirming that he will be moving on to a new role as Chief Executive of a voluntary sector organisation. It is not yet clear how and when he will be replaced.

It was RESOLVED that the Governing Body:

(i) note the Chief Officer’s verbal update

Developing a sustainable health and social care system for Wakefield

Jo Webster said that she would act as narrator for the paper which explains activities and initiatives included within the emerging NHS Wakefield Strategic Plan. Jo explained that initially she would outline the journey to date and then move on to describe how the strategy fits with the MYHT Clinical Services Strategy Full Business Case (FBC) and the Meeting the Challenge Outline Business Case (OBC).

The Governing Body considered an illustrative diagram showing alignment of the NHS Wakefield CCG Strategic Plan with the Wakefield Health and Wellbeing Strategy. Jo explained that the process started in 2010; a Health and Wellbeing Strategy was developed as a response to the Joint Strategic Needs Assessment (JSNA). The strategy included recognition that the focus for transformation should be guided by the need to ensure that:

- Patients are practically managed at or close to their homes;
- Only those patients who need to be in hospital are admitted; and
- Once admitted into hospital patients only stay for as long as is clinically necessary.

Jo outlined the seven principles and strategic approaches underlying the emerging CCG Strategic Plan:
1) Meeting the Challenge - Acute Services Strategy  
2) Productive Planned Care  
3) Mental Health  
4) Integrated Care  
5) Urgent Care and Emergency Care  
6) Citizen Participation and Empowerment  
7) Maternity, Children and Young People  
8) Primary Care at Scale.

Section 2.3 of the report outlined key milestones, including the public meeting on 25 July 2013 of the NHS Wakefield CCG and the North Kirklees CCG Governing Bodies. At this meeting it was agreed, subject to additional recommendations, to proceed to commission services that meet the future needs of the population as described in the MYHT clinical service strategy. Jo drew attention to appendix two; an update for the Governing Body on the ways implementation will proceed with quality and safety being paramount.

Jo invited Caroline Griffiths, Director of Corporate Planning and Projects to present further information about the FBC. Caroline also introduced Dr Simon Enright the lead clinician for the Clinical Services Strategy. Caroline explained that the FBC was a statutory requirement for all applications for funding to the Trust Development Agency. The MYHT Board will consider the FBC in April 2014.

Caroline described the headline changes proposed within the FBC. These included centralisation of a 24/7 inpatient Consultant led Obstetric Care at Pinderfields with Midwife Led Units on all three sites. In line with the Keogh review, the development of an emergency care network across the three hospitals with emergency care units at Pontefract and Dewsbury and a specialist emergency care unit at Pinderfields. Caroline noted the importance of developing care outside of hospital to support this change. The centralisation of specialist acute services and intensive care at Pinderfields. The separation of elective and non-elective surgery with centralisation of emergency and complex surgery at Pinderfields. Finally the centralisation of inpatient paediatric beds at Pinderfields with a Paediatric Assessment Unit at Dewsbury.

The FBC reflects assumed annual overall growth of 1% per annum based on evidence of 3% average annual growth reduced by 2% per annum to reflect Quality Innovation Productivity and Prevention (QIPP) and admission avoidance initiatives.

Capacity modelling shows a requirement for 88 additional staffed beds at Pinderfields and a reduction of 254 beds at Dewsbury (net reduction of 171 beds across the Trust). There are no proposed changes to bed configuration at Pontefract. Caroline explained that the proposed reduction in capacity will result in a total staff reduction of 328.14 FTE.

It was acknowledged that the public and patients have expressed concern that the Pinderfields site cannot cope with this increased demand. Caroline explained that non-clinical accommodation will be developed to create additional beds. The FBC supports an application for capital to support these necessary changes.

Finally Caroline explained that the capacity model assumptions aligned to assumptions in the OBC for Care Outside Hospital. Members of the Governing Body thanked Caroline and Simon for their contribution to the meeting.

Jo Webster explained that in Autumn 2013 NHS England published ‘Call to Action’ which outlined the seven year £30 billion challenge facing the NHS. This fed into the ‘Everyone
Counts’ planning guidance for CCGs published by NHS England in December 2013. The two year Operational Plan and the draft five year Strategic Plan outline how the CCG will respond to the Call to Action and contribute to the £30 billion saving.

Jo explained that she believes Wakefield is in a strong place to respond to the challenge because the district has already started on the journey of transformation.

Section seven of the report outlines the ways in which the CCG will work in partnership with the local authority. This includes aligning and pooling resources in the Better Care Fund, which will support the integration of health and social care.

The draft strategic plan described eight priority areas in the organisation’s response to the Everyone Counts guidance. The lead for each strand was invited to describe the ‘plan on a page’ for their priority area.

Dr Philip Earnshaw, on behalf of Dr Greg Connor, noted the planned interventions to deliver wider primary care at scale. This includes improved access to GP services, enhanced services within the community, network development, integrated care, quality development, and service reviews with hospital consultants.

Dr Biswas the clinical lead for integrated care explained that three pilot integrated care teams will be implemented over the coming months. Each pilot will test a different model of integration. Other planned interventions include social prescribing, gateway to care, a review of intermediate care beds and a review of the equipment service, development of a frailty unit and also implementation of a ‘Toronto’ model of supported discharge. Helen Childs added that the focus throughout will be on evidence based interventions. She also sought to reinforce the use of the voluntary and third sector, which will be critical to developing a sustainable model.

Dr Adam Sheppard reflected the importance of getting changes to urgent care right because it will impact on all strands of the strategy. The vision is of integrated quality care 24/7. The planned interventions were supported by the conclusions of the Keogh review of emergency and urgent care which was published in November 2013. Urgent non-life threatening situations should be treated close to home, not in hospital whilst serious or life threatening cases should be treated at centres of expertise. Dr Sheppard then described the seven interventions planned, including integrated emergency department service models, emergency ambulatory care units, development of a hospital admissions avoidance team, a review of the role GPs play in delivering urgent care, a review of the current mixed economy of urgent care provision, support for Yorkshire Ambulance Service to treat patients closer to home, and finally seven day urgent and emergency care services.

Linda Driver the CCG lead for improving productivity of elective care said all reviews would be evidence based and would focus on improving outcomes. The vision is for the CCG to commission services which provide patients with a choice of accessible care. Planned interventions include contract and service reviews (in line with a three year procurement plan), maximising technology, maximising contract levers and incentives, reducing unwarranted variation in diagnostic services to improve quality and increasing value for money.

Jo Webster explained that because the CCG felt mental health was so important, in an addition to the standard NHS England template, mental health service transformation will be included as a separate strand within the strategy. Clinical Lead Dr Clive Harries
described the prevalence of mental illness; one in four people will have a problem during their life. However, mental health often sits in ‘silos’ and does not have parity of esteem; i.e. equal status with physical health. Work undertaken during 2013/14, including the business case for a new psychiatric liaison service has already begun to improve the quality of services available. Dr Harries outlined a number of planned interventions, including a review of patient pathways and services for children, young people and adults, early and preventative interventions in mental health and improving awareness of mental health. He described the importance of utilising technology to cut across all planned interventions.

Dr Ann Carroll clinical lead for maternity, children and young people transformation described progress to develop integrated children’s commissioning and service provision, including development of a single strategy for children services and seven integrated early help hubs. Other planned interventions include redesign of behaviour pathways, review of transition to adulthood arrangements, and a review of mental health services for children and young people.

Jo Webster explained that specialised commissioning is led by NHS England, and will be incorporated into the CCG’s plan.

Finally Jo Webster outlined planned interventions to support and facilitate citizen participation and empowerment. This includes personal health budgets, personalised care plans, strengthening engagement mechanisms, strengthening use of patient insight and experience through ‘putting patients first’ work stream and finally development of the CCG’s IT strategy.

Andrew Pepper explained that continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21. In this context the CCG have a responsibility to deliver a balanced plan. Non-recurrent investment will focus on the CCG’s key themes including care closer to home, integrated care, urgent care, primary care and mental health.

Andrew drew attention to the size of the Quality Innovation Productivity and Prevention (QIPP) target with £3.5m unidentified for 2014/15 and £2.5m unidentified for 2015/16. On behalf of the Governing Body Clinical Cabinet will provide oversight and scrutiny of progress to achieve the QIPP target.

Andrew outlined a number of local strategic and technical risks which need to be mitigated. In particular he drew attention to Continuing Healthcare risk pool arrangements and unidentified and under-achievement of the QIPP.

In conclusion Andrew provided assurance that this is a clear, credible and balanced plan, which is bold and ambitious but not without risk.

The Better Care Fund (BCF) is a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities. Andrew explained that the Fund will enable the integration of health and social care at scale and pace. In Wakefield £42m of resources will be held in the BCF. This exceeds the minimum investment requirement. Wakefield’s BCF plan is stretching and ambitious, that has set Wakefield apart from other areas.
Jo Webster said that the two year operational plan has been embedded within all contracts for 2014/15.

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

Dr Sheppard commented that it was striking the CCG initiatives have repeatedly been ahead of national guidance. Jo Webster agreed, but reflected that it would now be important to implement efficiently, maintain safe delivery and live within allocated resources. If the CCG works in collaboration with others this will be achieved, but this is not without risk.

Andrew Balchin welcomed the draft plan. He contemplated where the ambitions within Wakefield will take the district next, and said he hopes Wakefield will continue to be reasonably bold. He expressed a view that in two years there should be one single plan for Wakefield. Dr Andrew Furber echoed these sentiments.

Andrew Pepper noted the hard work of the team who produced the paper. Jo Webster said work would continue and a further update will be brought back to the Governing Body in May 2014.

It was RESOLVED that the Governing Body taking into account all the information that has been presented;

a) Note that the contents of this paper are a formal record of the journey undertaken in Wakefield over the last four years to work towards achieving a clinically and financially sustainable health and social care system.

b) Agree that the direction of travel being undertaken as part of the strategic plan development is right and is supportive of the vision previously agreed by the Governing Body as how we wish Wakefield to develop its health and social care system.

c) Note and approve the two year Operational Plan and financial strategy prior to final submission to NHS England on the 4th April 2014.

d) Note and approve the Better Care Fund prior to final submission to NHS England on the 4th April 2014 and to be assured that it follows the principles set out to achieve the vision for the commissioning of integrated care in Wakefield.

e) Support the Meeting the Challenge Full Business Case, confirm that it continues to meet the direction of travel of Wakefield CCG’s commissioning intentions, and approve the activity and financial assumptions contained in the business case.

It was noted that this resolution e) is different to the resolution proposed within the paper circulated to the Governing Body in advance of the meeting.

f) Note the Transformation Programme Outline Business Case approved at the Programme Executive of the Mid Yorkshire Health and Social Care Partnership Programme and agree the investment necessary to support change as provided in the non-recurrent plans.
g) Note the significant progress made against the ambitions and conditions set out in the paper brought to the Governing Body on the 25th July 2013.

14/72 Board Assurance Framework Update

Andrew Pepper presented the Board Assurance Framework update report. He explained that each principle has an allocated lead clinician and a lead director who have jointly reviewed and update the Board Assurance Framework. Andrew explained that during this review period, as an addition level of scrutiny, Jo Webster and Sandra Cheseldine undertook a review of the Board Assurance Framework.

The Board Assurance Framework will be reviewed by the Governing Body in June 2014, and aligned to the new five year strategic plan.

Dr Earnshaw reminded all members of the Governing Body that they are responsible for getting underneath and testing the gaps and assurances recorded within the Board Assurance Framework. Assistance is available if required.

It was RESOLVED that the Governing Body:
   (i) note the contents of the Board Assurance Framework Update.

14/73 Governing Body elections and succession planning

Liz Howarth explained that the paper has two main purposes. First to set out arrangements for the CCG’s election process; the term of office for two GP members of the Governing Body will end soon. Furthermore the paper outlines plans to support Governing Body succession planning.

The election process will be the same as last year, the LMC are still willing to support the process. Two information events will be held for prospective GP Board Members.

In addition to the two GPs whose terms of office will expire in 2014, Dr Ivan Hanney will retire from the Governing Body in June 2014. Dr Ann Carroll added that she is also willing to retire as a member of the Governing Body (but continue as a Clinical Lead) if there are sufficient potential candidates.

Steve Bryan expressed concern about the diversity balance on the Governance Body, for example the majority are male. Succession plan should target individuals from under-represented groups.

It was noted that the term of office for both Dr Carroll and Dr Hanney was incorrectly stated within the paper, and is 2016 not 2018.

It was RESOLVED that the Governing Body:
   (i) approve the proposed process and timescale for elections to the Governing Body.

14/74 Any other business

On 1st April 2014 it would be the CCG’s first anniversary. Dr Earnshaw invited all members of the Governing Body to attend a birthday celebration event with CCG staff from 12.30pm at White Rose House.
There were no other items of additional business.

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

14/75 Date and time of next meeting

Tuesday, 13 May 2014, 1pm in the Boardroom, White Rose House
### Action Points from the Meetings held on Tuesday 11 March 2014 and Thursday 27 March 2014

<table>
<thead>
<tr>
<th>Minute No</th>
<th>Topic</th>
<th>Action Required</th>
<th>Who</th>
<th>Date for Completion</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>Complete Presented to the Integrated Governance Committee in April 2014</td>
</tr>
<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>Complete Presented to the Governing Body on 27 March 2014</td>
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<tr>
<td>14/19</td>
<td>Commissioning &amp; Contract Strategy</td>
<td>• Section regarding Commercial Strategy to be revised.</td>
<td>Andrew Pepper</td>
<td>March 2014</td>
<td>Will be presented to the Governing Body once it has been considered by the Integration Board</td>
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<tr>
<td>Title of meeting:</td>
<td>Governing Body</td>
<td>Agenda Item:</td>
<td>7</td>
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<tr>
<td>Date of Meeting:</td>
<td>13 May 2014</td>
<td>Public/Private Section:</td>
<td></td>
<td></td>
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<tr>
<td>Paper Title:</td>
<td>Chief Officer Briefing</td>
<td>Public</td>
<td>✓</td>
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<tr>
<td>Purpose (this paper is for):</td>
<td></td>
<td>Discussion</td>
<td>Asssurance</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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<tr>
<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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<tr>
<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>
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<td>Support for individual health and wellbeing</td>
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<td>Appropriate access and choice for all</td>
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<td>Understanding our population and putting patients at our centre</td>
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<td></td>
<td>Safe and high quality experiences and clinical outcomes</td>
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<td>Transparent clinically-led commissioning</td>
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<td>Service transformation through redesign</td>
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<td>Improvement through collaboration and integration</td>
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<td></td>
<td>Financial efficiency, probity and balance</td>
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<td>Outline public engagement:</td>
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<td>CCG Leadership Team</td>
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<td>Previously presented at committee / governing body:</td>
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<td>Reference document(s) / enclosures:</td>
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<tr>
<td>Risk Assessment:</td>
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<tr>
<td>Finance/ resource implications:</td>
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Chief Officer Briefing

13 May 2014

MYHT Full Business Case (FBC)

The CCG has written to confirm its support for the FBC as agreed at the Governing Body meeting on the 27 March 2014. A copy of the letter is attached (Appendix 1).

Senior Information Risk Owner (SIRO) Annual Report for 2013/14

The draft Senior Information Risk Owner (SIRO) Annual Report for 2013/14 was presented to the Integrated Governance Committee on Thursday, 24 April 2014. This report documents organisational compliance with legislative and regulatory requirements relating to the handling of information, including compliance with the Data Protection Act (1998) and Freedom of Information Act (2000). It was noted that the CCG had achieved Level 2 compliance on the Information Governance Toolkit and has put in place systems and processes with regards to Information Governance. A request for the number of Freedom of Information breaches to be included in the report was made (which totalled 37 in the year and non since 6 December 2013) and this was actioned by the Information Governance team. Following discussion by members of the Integrated Governance Committee it was agreed that it is appropriate to both receive and approve the annual report at the Committee. A final version of the document has been circulated to committee members.

Working Voices

As verbally reported to the Board in March, NHS Wakefield Clinical Commissioning Group is one of three CCGs in the North of England successful in being picked to benefit from support as part of NHS England’s Patient and Public Voice Commissioning Support programme. Support will be provided via Clinical Support Units to: pioneer new approaches, share good practice, enrich commissioning support through promoting strong community connections, create expertise and network effectively.

The aim of Working Voices is to tap into the working population to improve engagement with local people and build partnerships for mutual benefits with local organisations. Working people are often the “silent majority”, making up 70% of the population that are traditionally not involved in engagement. The benefits include:

- Giving us an insight into the views of the workforce so that we can design appropriate services
- Helping us to develop a deeper relationship with their local communities
- Allowing our communities to have their say
- Helping the public to understand how services operate
- Giving people the opportunity to become Workplace Ambassadors
- Allowing employers to create a happier, healthier and more empowered workforce
- Ensuring major decisions are transparent and the process for reaching them understood.

The pilot programme is for one year, and we will be working with NHS England and the West and South Yorkshire and Bassetlaw CSU Engagement Team (who are delivering this
To Board from proposed consultation.

Equality

In the comment, All organisations gathering initiatives to improve and ensure the delivery of services to support

@Working_Voices<https://twitter.com/Working_Voices> A Pioneers4Participation – Training (change, equality and diversity and personalisation)

MyNHS – This is a membership service to support engagement activity and relationships, for example the ability to send text reminders for events.

Year of Care – support and tools for work on long term conditions.

Patient in Control of their Own Care – support for personalised care standards and planning.

Equality Objectives

In January the CCG published two reports to discharge our statutory duty as enshrined within the Equality Act 2010:


A key aim contained within the PSED report is to agree and publish Equality Objectives (EO) for the period of 2013-17. In February 2014 a group of Governing Body members in consultation with the CSU Equality and Diversity leads, reviewed the documents and proposed the following four Equality Objectives:-

- Equality Objective 1: Increasing screening rates to tackle cervical and prostrate inequality;
- Equality Objective 2: Ensure access to local health provision for EU communities and improve the experience and confidence of the transgender community;
- Equality Objective 3: Enhancing member practice engagement;
- Equality Objective 4: Improving data quality and intelligence gathering and analysis, that informs evidence based commissioning and service improvement. Year one focus – mental health.

All four objectives were presented to the Integrated Governance Committee in March for comment, critique and approval.

The objectives are interlinked, and aim to provide a framework for future equality delivery. The development of an implementation plan is now underway, including an intelligence gathering exercise for the first two objectives. Objective 3 will be delivered based on the
intelligence collated through the delivery of objectives 1 and 2. Objective 4 aims to agree a data quality framework that builds on the (current) excellent internal practices, and further enhances intelligence gathering processes that can be used to track how ‘local public voices’ have influenced commissioning and strategic decisions made by the CCG.

**National Cancer Peer Review Programme 2014**

National Cancer Peer Review (NCPR) is a national quality assurance programme for NHS cancer services. The programme involves both self-assessment by cancer service teams and external reviews of teams conducted by professional peers, against nationally agreed “quality measures”. From March 2014, the programme has been revised to ensure that it meets the requirements of the new health care environment. The revisions to the programme aim to address the following key issues:

- Changes to governance and leadership of networking groups;
- Improving responsiveness of the programme;
- Ensuring the programme is sustainable;
- Ensuring the focus on outcomes;
- Patient choice.

The programme was formally hosted by NHS Improving Quality but from the 1st March 2014 will be hosted by NHS England under the leadership of the Clinical Director of Specialised Services

As part of the agreement between NHS Wakefield Clinical Commissioning Group and West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU), the WSYBCSU will oversee the Cancer Peer Review process on behalf of the CCG.

The schedule for network groups that are required to undertake a validated self assessment in 2014 is set out below. Validated self assessments (VSA) have to be completed by **31st July 2014**.

<table>
<thead>
<tr>
<th>2014</th>
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<tbody>
<tr>
<td>Gynaecology</td>
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<td>Children’s</td>
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<td>TYA</td>
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<td>Brain</td>
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<td>Sarcoma</td>
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<td>Chemotherapy</td>
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<td>Haematology</td>
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<tr>
<td>Colorectal</td>
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<td>Lung</td>
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</table>
There are no external visits taking place for any of the cancer services within MYHT.

Organisational Developments

The CCG has completed the staff consultation on the TUPE transfer of the CCG’s continuing health care function to the West and South Yorkshire Bassetlaw Commissioning Support Unit. Staff have transferred to the CSU on 1 May 2014. The CCG remains statutory accountable for the continuing health care function and have put in place commissioning and contracting structure and will retain a continuing health care quality assurance function.

Changes to the Better Care Fund Metrics

The CCG has continued dialogue with NHS England regarding the appropriate metrics against which to measure success of the Better Care Fund. As part of the initial submission, the Health and Wellbeing Board and Governing Body agreed a locally decided metric for the BCF which was “proportion of adults who get as much social care support as they want.” This was felt to be an appropriate choice due to it being focused on patient and service user experience. Subsequent engagement and feedback from NHS England suggests that as this measure can only be collected on an annual basis a more timely measure may be requested. There are a number of potential metrics which may be appropriate such as “satisfaction of domiciliary care users”, which will enable measurement of the impact on service users quality and experience of the health and social care system. Discussions are ongoing. As a principle, the selected metrics, would need to adhere to the overall direction set by the HWB and GB of focusing on quality of life and also meet a number of NHSE requirements on data quality.

Urgent and Integrated Care Symposium

16 April 2014 saw 120 delegates attend our Urgent and Integrated Care Symposium. The event was co-hosted with NHS North Kirklees CCG and The Mid Yorkshire Hospitals NHS Trust. It was a half day (twilight) session, and was attended by clinicians and other staff from both CCGs, the Trust, Locala, the voluntary sector, neighbouring CCGs and Trusts, CSU and other local organisations. The key objectives were:

- to motivate and energise by helping attendees to see and understand their role in a changing environment,
- to help attendees see how their role fits into the bigger picture and the contribution they can make,
- to share information about changes that are already taking place and explain their impact on how clinicians and other patient-facing staff work.

The key note speaker was Professor Keith Willett, NHS England’s director of acute care. He fulfilled our objectives exactly, providing encouragement, inspiration and challenge in equal measure.

Encouragement: over the last 15 years the NHS has become significantly more efficient at the same time as improving patients’ recovery and survival rates.
**Inspiration:** the national guidance on future services could have been written with our area in mind – we are ahead of the game. Keep going – do more and do it faster.

**Challenge:** build trust across the entire system, don’t allow relationships to become adversarial and be Ambassadors for Change.

Delegate feedback was very positive and is being channelled through the Urgent Care Board.

**Area Team Update**

The West Yorkshire Area Team Director Andy Buck will shortly be leaving the NHS to take up a post in the Voluntary and Community Sector in Sheffield. I would personally like to wish Andy all the best in his new career and to thank him for his guidance and support through this first year as a CCG. Our new interim Director will be Moira Dumma who is currently Director for Cheshire, Warrington and the Wirral. Moira will be in post at the beginning of July and I look forward to working with her in the future.

**360 Stakeholder Survey**

As part of the annual assurance process for CCG’s, Ipsos Mori have been commissioned to carry out a 360 Stakeholder Survey for each CCG across a predefined list of stakeholder categories. The survey serves two purposes:

1. To feed into assurance conversations between NHS England area teams and CCGs, as one source of evidence for the process. It will assess whether the stakeholder relationships, forged during the transition through authorisation, continue to be central to the effective commissioning of services by CCGs, and in so doing improve quality and outcomes for patients.

2. It will also provide a wealth of data for CCGs to help with their ongoing organisational development, enabling them to continue to build strong and productive relationships with stakeholders. The findings can feed into CCGs’ organisational development plans, providing a valuable tool for all CCGs to be able to evaluate their progress and inform development.

The process began on the 10th March and completed on the 8th April and in Wakefield we had the best overall response rate across Yorkshire and the Humber achieving 76.7%. The response rates for each category of stakeholder were:

- GP Member Practices -75%
- Local Authority - 60%
- Healthwatch and other patient groups - 100%
- Health and Wellbeing Boards - 66.2%
- Other CCG’s with which we have relationships - 100%
- Providers - 80%

The report highlighting feedback for Wakefield CCG will be available on the 9th May and a brief verbal update will be provided at the governing body.
NHS Clinical Commissioners CCG Manifesto

As the membership body for clinical commissioning groups NHS Clinical Commissioners has produced a manifesto for national and local government, system leaders, policymakers and politicians to give confidence that local commissioning works. It outlines the key asks from the system to ensure CCG’s are supported to realise their potential and create a truly transformational NHS.

The manifesto for change identifies eight critical asks to enable the potential of CCGs:

- Free clinical commissioners to act in the best interests of patients
- Make local system leadership a priority
- Health and wellbeing boards as the focus of joined-up commissioning
- CCGs must not be a risk pool for the NHS
- Support to deliver large-scale transformation at pace
- Connecting national and local commissioning
- Better alignment of local commissioning to healthcare quality and the new inspection regime
- Competition in the NHS in the best interests of patients

Prime Minister’s Challenge Fund

West Wakefield wins bid for Prime Minister’s Challenge Fund! The 6 Network practices: Chapelthorpe, Church Street, Lupset, Middlestown, Orchard Croft and Prospect Surgery have been chosen, as one of just a few winners out of over 250 that applied to the fund.

Jeremy Hunt, the Secretary of State for Health and Simon Stevens the new Chief Executive of the NHS visited Wakefield to discuss the vision, plans and ambitions expressed in what has been described, as one of the most innovative of all the bids received. Key elements of the pilot include:

- Increased hours of availability, 7 days a week 8am – 8pm
- A bigger virtual team to support faster decisions and new ways of accessing services, developing digital healthcare including web based care navigation, unified communications, social networks and Apps.
- Better support for self-care with co-ordinated and integrated social care, nursing, hospitals, community and mental health, GP and voluntary services.
- Help to access and navigate the system including care navigators, health and wellbeing workers, voluntary services, social prescribing and a local directory of services.
- Mobile outreach service in the community.
- Focus on vulnerable elderly in care homes and housebound as well as acutely ill children and hard to reach groups.
23 April 2014

Stephen Eames
Chief Executive
Mid Yorkshire Hospitals NHS Trust
Via email: Stephen.Eames@midyorks.nhs.uk

Dear Stephen

Meeting the Challenge: Full Business Case (FBC) for the Reconfiguration of Acute Services in Mid Yorkshire

Further to the letter provided by the CCGs on 17 March 2014, we thought it would be useful to confirm the position of our CCGs now that both organisations’ Governing Bodies have had opportunity to consider your FBC.

In Wakefield, on 25 March 2014, you kindly presented to the Governing Body informal session a detailed analysis of the model of care, workforce and finance assumptions contained within the case. This was followed on 27 March 2014, with a further presentation to the public meeting of the Governing Body. Following this, the CCG considered its operational plans and draft strategic plans including the strategies for primary care, integrated care, urgent care, elective care, mental health and maternity and children’s commissioning. In addition, the CCG considered the two year financial plan, the approach to strengthen engagement and the Better Care Fund.

The CCG then resolved to “Support the Meeting the Challenge Full Business Case, confirm that it continues to meet the direction of travel of Wakefield CCG’s commissioning intentions, and approve the activity and financial assumptions contained in the business case.”
In North Kirklees, you and your team attended our Clinical Strategy Group on 19 March to talk through the FBC in much the same way as with Wakefield CCG. We were keen to be assured that projected demand, activity and finance levels incorporated into the FBC were consistent with those we have used in our own work for our Care At or Closer to Home programme – an integrated programme across Kirklees in partnership with Kirklees Council. We discussed the FBC at our Governing Body meeting on 2 April where the debate led us to conclude that we supported the FBC with the following two caveats that:

- MYHT continues to work with us to enable NKCCG to commission 24/7 primary care to be delivered from the Dewsbury District Hospital site; and

- NKCCG will work with MYHT to ensure the Dewsbury Midwife Lead Unit satisfies both trust and commissioner that the services are both good quality and cost effective as well as meet the needs of our local population. This point is emphasised more generally in a later paragraph.

We concluded that we welcomed the delivery of local services in North Kirklees, consistent with the FBC including those caveats we set out in our Board to Board meeting on 25 July 2013.

These resolutions formalise the CCGs’ support for the important and necessary changes proposed in the FBC which are required to maintain and improve health services for the population served by Mid Yorkshire Hospitals NHS Trust.

In recognising the assumptions in the FBC, this acknowledges:

1) The activity and income projections in the FBC are consistent with the activity projections in the 5-year strategic plans produced by each CCG and are reflected in the supplementary business cases for care outside of hospital which have been approved by the Programme Executive.

2) That MYHT has estimated £7.9m of transitional support over the period 2014-15 to 2016-17 and – as noted previously in our letter of 17 March 2014 – we recognise that the current NHS England policy is that the costs of transformation should be met from local resources by utilising the local call to action reserve held non-recurrently. The funding for 2014-15 of £1.4m has been agreed with the Trust and the future funding will form part of the 5-year strategic plans. However, the CCGs will work with the Trust to minimise the transitional costs and risks as far as possible to ensure best value for money, whilst ensuring that quality services continue to be delivered which are safe and sustainable both in current and future years.

3) That MYHT have included the requirement for £3.9m of legacy support for the period 2014-15 to 2015-16 which is included in CCG financial plans; and that the FBC includes an estimated local tariff premiums from 2016/17 in respect to the proposed A&E configuration and the Midwife-Led unit. The CCGs and MYHT
have agreed to work together to ensure that the service model is safe and sustainable and represents best value. At present, the proposed service reconfiguration would require local tariff to be developed.

In summary, these resolutions formalise the CCG support for the important and necessary changes proposed in the FBC which are required to maintain and improve health services for the population served by Mid Yorkshire Hospitals NHS Trust.

Yours sincerely

Andrew Pepper
Deputy Chief Officer, Wakefield CCG

Chris Dowse
Chief Officer, North Kirklees CCG

Copy: Andy Buck (andy.buck@nhs.net)
Stephen Downs (stephen.downs1@nhs.net)
Title of meeting: Integrated Quality and Performance Report (Board Summary)  
Date of Meeting: 13 May 2014  
Public/Private Section:  
Public  
Private  
N/A  
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 content of the report and actions; and  
ii. note the information contained in this report relates to NHS Wakefield CCG across all providers including Mid Yorkshire Hospitals NHS Trust (MYHT) for January and February 2014 (unless otherwise stated).

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 March and April 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 a summary 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

- The CCG has met the required 18 week pathway targets year to date  
- MYHT responded to 96.6% of complaints within timescales in January 2014  
- The Summary Hospital Mortality Index (SHMI) for the CCG and MYHT is significantly lower than the national average  
- Dewsbury and Pontefract Emergency Departments both achieved some of the best Friends and Family Test response rate nationally in February 2014  
- The CCG’s soft intelligence reporting template has been listed as an example of good practice in the West Yorkshire Audit Consortium Good Practice Briefing on Learning to Improve

Key areas for improvement

- Ambulance response times for CAT A (Red 2) 8 minutes for YAS and the CCG is below target  
- Ambulance turnaround targets at MYHT and YAS have continued to be below target  
- Cancer waits - 62 days referral to definitive treatment has continued to be below target  
- The CCG had one 52 week breach in February  
- The CCG will breach the C.difficle target for 2013/14  
- The CQC issued a warning notice for Langtree Park Nursing Home  
- The Staff Survey results for MYHT have not improved on the previous year
<table>
<thead>
<tr>
<th>Link to overarching principles from the strategic plan:</th>
<th>Improve health equality across our population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support for individual health and wellbeing</td>
</tr>
<tr>
<td></td>
<td>Care provided in the right setting and close to home</td>
</tr>
<tr>
<td></td>
<td>Appropriate access and choice for all ✔</td>
</tr>
<tr>
<td></td>
<td>Understanding our population and putting patients at our centre</td>
</tr>
<tr>
<td></td>
<td>Safe and high quality experiences and clinical outcomes ✔</td>
</tr>
<tr>
<td></td>
<td>Transparent clinically-led commissioning ✔</td>
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<td></td>
<td>Service transformation through redesign</td>
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<td></td>
<td>Improvement through collaboration and integration</td>
</tr>
<tr>
<td></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: | Not applicable                                    |
| Previously presented at committee / governing body: | Integrated Governance Committee – 20 March and 17 April 2014 |
| Reference document(s) / enclosures:              | Not applicable                                    |
| Risk Assessment:                                 | The Board Assurance Framework reflects the key controls and assurances against overarching principles from the strategic plan listed above. Mitigating actions have been included within the report and risks are captured as appropriate in the Board Assurance Framework and Corporate Risk Register. |
| Finance/ resource implications:                  | Mitigating actions required to improve performance or quality are assessed on an individual basis for any finance or resource implications |
NHS Wakefield Clinical Commissioning Group
Integrated Quality and Performance Report
May 2014 (Board Summary)
### Recommendations:
- To note the content of the report and actions
- To note the information contained in this report relates to NHS Wakefield CCG across all providers including Mid Yorkshire Hospitals NHS Trust (MYHT) for January and February 2014 (unless otherwise stated).

### Key Messages

#### Key Success Stories
- Wakefield CCG achieved all three referral to treatment operating standards for the period and the YTD.
- MYHT has achieved the A&E 4 hour waiting time for the period and the YTD cumulative position.
- Wakefield CCG and YAS have achieved the required operating standards across all Cat A (Red 1, 2 and combined 1&2) for the YTD position.
- There were no incidents of MRSA for the CCG during the period.
- MYHT achieved the current complaints response target for the first time in January 2014.
- The Summary Hospital Mortality Index (SHMI) for WCCG patients is significantly lower than the national average – placing the CCG in the top 20% of CCG’s nationally.
- Pontefract A&E and Dewsbury A&E ranked 14th and 15th respectively of all 200 A&E sites in England during February 2014.

#### Areas for Improvement
- YAS have failed the operating standard for Cat A Red 1 and Red 2 for the period (February 2014).
- MYHT failed the required standards for the period with regarding to the Cancer 31 day wait for surgery and 62 day wait from Urgent GP referral for the period.
- Wakefield CCG failed the required standard for the period and YTD for Cancer 62 day wait from Urgent GP referral.
- There was 1 incidence of MRSA at MYHT during the period.
- The CQC issued a warning notice for Langtree Park Nursing Home.
- Ambulance Turnaround times continue to be below the required standard for both YAS and MYHT.
- Diagnostic Waiting Times have not achieved the required standard for both WCCG and MYHT for the period, but are within the target for the YTD position.
- IAPT performance remains below the target performance level.
- There was one 52 week Breach (ENT) for WCCG during February and six for MYHT (one in ENT and five in Trauma and Orthopaedics).

### Items also included in the January and February IGC Reports
- Serious Incident summary
- CQC Intelligent Monitoring and Quality Risk Profiles
- Performance Exceptions and Narrative
- Sentinel Stroke National Audit
- PROMs
- Q3 CQUIN achievement
- Leeds Childreens Heart Surgery Services Review
- Complaints and Compliments
Wakefield CCG performance against CCG Strategic Objectives

Source – CCG Outcomes Framework, Everyone Counts, NHS Constitution
Data – February 2014 (Year to date position)
### Level 2a: Key Performance Indicators

#### Strategic Monitoring
Performance is above target this month on the green indicators however, they continue to be monitored.

**Key Performance Indicators – Exceptions are highlighted in green.**

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

**Data** – February 2014

---

<table>
<thead>
<tr>
<th>NHS Constitution Standard</th>
<th>Key Performance Indicator</th>
<th>Monitor</th>
<th>Goal</th>
<th>Actual</th>
<th>YTD</th>
<th>NMT</th>
<th>Achieved?</th>
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<td><strong>Level 1: Performance Indicators</strong></td>
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<td><strong>Monitoring this month show all 5 indicators are green.</strong></td>
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<td><strong>CCG Everyone Counts, Data – February</strong></td>
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# Level 2a: Key Performance Indicators

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<th>Theme</th>
<th>Domain</th>
<th>KPI Measure</th>
<th>One-in-200</th>
<th>Baseline (Month</th>
<th>Actual (Month</th>
<th>YTD (Month</th>
<th>POET (Month</th>
<th>Previous months score and YTD (Month</th>
<th>Direction</th>
<th>Period</th>
<th>Director of Health</th>
<th>Data Source</th>
<th>Clinical Lead</th>
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<tbody>
<tr>
<td>1</td>
<td>Cancer Waiting - 31 Days</td>
<td>Max 31 day wait from diagnosis to first definitive treatment - of cancer.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>95%</td>
<td>95.5%</td>
<td>95.7%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>96.7%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>↓↓↓↓↓</td>
</tr>
<tr>
<td>2</td>
<td>Cancer Waiting - 31 Days</td>
<td>Max 31 day wait for subsequent treatment where treatment is surgery.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>95%</td>
<td>95.2%</td>
<td>95.2%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>96.7%</td>
<td>96.3%</td>
<td>96.7%</td>
<td>↓↓↓↓↓</td>
</tr>
<tr>
<td>3</td>
<td>Cancer Waiting - 31 Days</td>
<td>Max 31 day wait for subsequent treatment where treatment is an oral cancer drug regimen.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>95%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>98.3%</td>
<td>98.2%</td>
<td>98.3%</td>
<td>↓↓↓↓↓</td>
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<tr>
<td>4</td>
<td>Cancer Waiting - 62 Days</td>
<td>Max 62 day wait for first definitive treatment following a consultant decision to escalate priority of patient.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>95%</td>
<td>95.0%</td>
<td>95.2%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>98.3%</td>
<td>98.2%</td>
<td>98.3%</td>
<td>↓↓↓↓↓</td>
</tr>
<tr>
<td>5</td>
<td>Cancer Waiting - 62 Days</td>
<td>Max 62 day wait from urgent GP referral to first definitive treatment for cancer.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>95%</td>
<td>95.0%</td>
<td>95.2%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>98.3%</td>
<td>98.2%</td>
<td>98.3%</td>
<td>↓↓↓↓↓</td>
</tr>
<tr>
<td>6</td>
<td>Mixed use accommodation (freelance)</td>
<td>In-hospital inpatients.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>80%</td>
<td>79.6%</td>
<td>80.2%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>80.0%</td>
<td>80.2%</td>
<td>80.2%</td>
<td>↓↓↓↓↓</td>
</tr>
<tr>
<td>7</td>
<td>Healthcare Associated Infections</td>
<td>MRSA</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>↓↓↓↓↓</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔↓↓↓↓↓</td>
</tr>
<tr>
<td>8</td>
<td>Healthcare Associated Infections</td>
<td>Clostridium Difficile</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↑↓↑↑↑</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↑↓↑↑↑</td>
<td>Andrew Furber</td>
</tr>
<tr>
<td>9</td>
<td>4 Week RTT Waiting Time Standard</td>
<td>Admitted pathways</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>90%</td>
<td>90.0%</td>
<td>90.7%</td>
<td>↓</td>
<td>↑↓↓↓↓</td>
<td>92.4%</td>
<td>92.1%</td>
<td>92.1%</td>
<td>↑↓↓↓↓</td>
</tr>
<tr>
<td>10</td>
<td>4 Week RTT Waiting Time Standard</td>
<td>Incomplete pathways</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>90%</td>
<td>90.0%</td>
<td>91.4%</td>
<td>↓</td>
<td>↑↓↓↓↓</td>
<td>92.4%</td>
<td>92.1%</td>
<td>92.1%</td>
<td>↑↓↓↓↓</td>
</tr>
<tr>
<td>11</td>
<td>4 Week RTT Waiting Time Standard</td>
<td>New admitted pathways</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>90%</td>
<td>90.0%</td>
<td>91.4%</td>
<td>↓</td>
<td>↑↓↓↓↓</td>
<td>92.4%</td>
<td>92.1%</td>
<td>92.1%</td>
<td>↑↓↓↓↓</td>
</tr>
<tr>
<td>12</td>
<td>Number of 150 RSA referrals to laboratory pathways</td>
<td>Number of patients in incomplete pathways over 50 weeks</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
<td>↔↓↓↓↓</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔↓↓↓↓</td>
</tr>
<tr>
<td>13</td>
<td>Diagnostic test waiting times</td>
<td>Patients waiting for a diagnostic test who should be waiting for less than 6 weeks.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>↓↓↓↓↓</td>
</tr>
<tr>
<td>14</td>
<td>Improving Access to Psychological Therapies</td>
<td>Regular out-patient psychological therapies.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>↑</td>
<td>↑↓↓↓↓</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>↑↓↓↓↓</td>
</tr>
<tr>
<td>15</td>
<td>Care Programme Approach (CPA)</td>
<td>The proportion of people under adult mental health care pathways who were followed up within 6 months.</td>
<td>monthly</td>
<td>Feb 13/14</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>↓</td>
<td>↓↓↓↓↓</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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</tr>
</tbody>
</table>
Level 2a: Strategic Plan – Quality Premium Performance Scorecard

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

Quality Premium Scorecard - As of Data Available 09/12/2013

NHS Constitution

CCG Financial Status

18 waits RTT (Target: Admitted, non-admitted w/ & incorporated w/)
4 hour A&E (Target: All)
62 day Cancer wait for 1st definitive treatment (Target: All)
32 Red 8 mins (Target: All)

Admitted Patients
Non-admitted/Patients
Patients on incomplete pathways
Patients waiting 52 weeks or more

62 day Cancer wait for admitted
62 day Cancer wait for non-admitted
62 day Cancer wait for GP Referral

62 day Cancer diagnosis
62 day Cancer diagnosis + Screening

National Measures

DOMAIN 1: Preventing people from dying prematurely
DOMAIN 2: Enhancing the quality of life for people with long term conditions and helping people to recover from episodes of ill health or following injury
DOMAIN 3: Helping people to recover from episodes of ill health or following injury
DOMAIN 4: Ensuring that young people and young people and young people

Potential years of life lost from avoidable emergency admissions
Available Emergency Admissions
Read-out of friends and family test - inpatient response
Read-out of friends and family test - acute services
Number of MRSA reported infections (HPA reported)
Number of C-Diff bloodstream infections

Local Measures

Smoking in pregnancy
Taking Therapies
Stroke Improvement

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.
3. Quality Premium financial value calculations.
4. The current population baseline for Wakefield CCG is 306,679
5. The estimated current QP for Wakefield CCG is £3,795,685
6. 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).
7. It is estimated that the CCG will qualify for between £335k and £836k based upon current performance.
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>Indicator</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>Previous month score card</th>
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<tr>
<td><strong>Patient Safety</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>MRSA</td>
<td>February</td>
<td></td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>↓</td>
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<td>C. Difficile</td>
<td>February</td>
<td>≤99</td>
<td>3</td>
<td>41</td>
<td>41</td>
<td>↓</td>
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<td>VTE - Risk Assessment</td>
<td>February</td>
<td>95%</td>
<td>95.40%</td>
<td>95.20%</td>
<td>-</td>
<td>←</td>
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<td>Harm Free Ear (new VTE, falls, pressure ulcers and catheter &amp; urinary tract infections)</td>
<td>February</td>
<td>-</td>
<td>91.65%</td>
<td>-</td>
<td>-</td>
<td>←</td>
<td></td>
</tr>
<tr>
<td>Never Events</td>
<td>March</td>
<td>n/a</td>
<td>39</td>
<td>39</td>
<td>39</td>
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<tr>
<td>Mt. Number Open</td>
<td>March</td>
<td>n/a</td>
<td>39</td>
<td>39</td>
<td>39</td>
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<tr>
<td>Mt. New for month</td>
<td>March</td>
<td>n/a</td>
<td>39</td>
<td>39</td>
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<td>SHM - Latest Data</td>
<td>Apr 12 - Jun 13</td>
<td>&lt;100</td>
<td>-</td>
<td>29</td>
<td>-</td>
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<tr>
<td>HSMR 2012/13 rebased - latest data</td>
<td>April - Dec 2013</td>
<td>&lt;100</td>
<td>-</td>
<td>99</td>
<td>-</td>
<td>↑</td>
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<td>Amenable Mortality</td>
<td>Nov 2013</td>
<td>-</td>
<td>-</td>
<td>1.40%</td>
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<td><strong>Patient Experience</strong></td>
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<td>Single sex Accommodation Breaches</td>
<td>February</td>
<td>-</td>
<td>1.79</td>
<td>-</td>
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<tr>
<td>Complaints handled within timescales</td>
<td>January</td>
<td>99%</td>
<td>98.6%</td>
<td>71.21%</td>
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<td>Friends and Family Test response rate</td>
<td>February</td>
<td>51.51%</td>
<td>28.50%</td>
<td>24.20%</td>
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<tr>
<td>Friends and Family Test net promoter score</td>
<td>February</td>
<td>50-100</td>
<td>87</td>
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<td><strong>Operational Efficiency</strong></td>
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<td>Nurse to bed ratio</td>
<td>February</td>
<td>-</td>
<td>1.79</td>
<td>-</td>
<td>-</td>
<td>↓</td>
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<tr>
<td>Doctor to patient ratio</td>
<td>November</td>
<td>-</td>
<td>0.12</td>
<td>-</td>
<td>-</td>
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<td>Staff sickness rate (with Safety Workforce) Rolling 12 months</td>
<td>January</td>
<td>4.00%</td>
<td>3.95%</td>
<td>3.67%</td>
<td>-</td>
<td>↑</td>
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<td><strong>External Assurance</strong></td>
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<td>National Acute Quality Dashboard undesirable alerts</td>
<td>March</td>
<td>0</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>↓</td>
<td></td>
</tr>
<tr>
<td>CQC Conditions or Warning Notice</td>
<td>March</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>←</td>
<td></td>
</tr>
</tbody>
</table>
## Level 2b: Quality Dashboard – SWYPFT

### Patient Safety

<table>
<thead>
<tr>
<th>Condition</th>
<th>Reporting Period</th>
<th>SWYPFT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Feb 2013</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C. Difficile (Wakefield bdu)</td>
<td>Feb 2013</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Harm Free Care (new VTE, falls, pressure ulcers and catheters &amp; urinary tract infections)</td>
<td>Dec 2013</td>
<td>95.45%</td>
<td>n/a</td>
</tr>
<tr>
<td>Never Events</td>
<td>Mar 2013</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5% Number Open (Wakefield bdu)</td>
<td>Mar 2013</td>
<td>n/a</td>
<td>12</td>
</tr>
<tr>
<td>5% New for month (Wakefield bdu)</td>
<td>Mar 2013</td>
<td>n/a</td>
<td>2</td>
</tr>
</tbody>
</table>

### Clinical Effectiveness

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Period</th>
<th>SWYPFT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>% service users on CPA followed up within 7 days of discharge</td>
<td>Feb 2013</td>
<td>95%</td>
<td>97.6%</td>
</tr>
<tr>
<td>% service users on CPA having formal review within 12 months</td>
<td>Feb 2013</td>
<td>95%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Delayed transfers of care</td>
<td>Feb 2013</td>
<td>≤7.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>% of admissions who had access to crisis resolution team</td>
<td>Feb 2013</td>
<td>95%</td>
<td>92.2%</td>
</tr>
</tbody>
</table>

### Access (all data relates to Wakefield bdu not SWYPFT as a whole)

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Period</th>
<th>SWYPFT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis referrals (4 hours) receiving a face to face contact within 4 hours</td>
<td>Q3 2013</td>
<td>85% Q1, 90% Q2-4</td>
<td>90.7%</td>
</tr>
<tr>
<td>Crisis referrals (2 hours) receiving a face to face contact within 2 hours for CAMHs</td>
<td>Q3 2013</td>
<td>95% by Q4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Routine referrals (excl. Memory service) receiving a face to face contact within 14 days of referral</td>
<td>Q3 2013</td>
<td>80%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Routine referrals commencing treatment within 6 weeks of face to face contact</td>
<td>Q3 2013</td>
<td>90% Q1, 95% Q2-4</td>
<td>96.0%</td>
</tr>
<tr>
<td>Routine referrals receiving a face to face contact within 4 weeks (CAMHs)</td>
<td>Q3 2013</td>
<td>55% Q1, 75% Q2, 90% Q3</td>
<td>52.0%</td>
</tr>
<tr>
<td>Routine referrals receiving a partnership appointment within 4 weeks (CAMHs)</td>
<td>Q3 2013</td>
<td>55% Q1, 75% Q2, 90% Q3</td>
<td>24.0%</td>
</tr>
<tr>
<td>New referrals for psychological therapies assessed within 14 days</td>
<td>Q3 2013</td>
<td>93% Q1, 95% Q2-4</td>
<td>98.5%</td>
</tr>
<tr>
<td>New referrals for psychological therapies starting treatment within 16 weeks following assessment</td>
<td>Q3 2013</td>
<td>93% Q1, 95% Q2-4</td>
<td>96.0%</td>
</tr>
</tbody>
</table>

### Complaints

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Period</th>
<th>SWYPFT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user survey - inpatients (% rating care as excellent or good)</td>
<td>Q2 2013</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Service user survey - community (% rating care as excellent or good)</td>
<td>Q2 2013</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Complaints including staff attitude as an issue</td>
<td>Feb 2013</td>
<td>&lt;30%</td>
<td>4%</td>
</tr>
</tbody>
</table>

### Operational

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Period</th>
<th>SWYPFT</th>
<th>Trend Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff sickness rate (Wakefield bdu)</td>
<td>Jan 2013</td>
<td>4.00%</td>
<td>4.61%</td>
</tr>
<tr>
<td>External Governance Rating</td>
<td>Feb 2013</td>
<td>Green</td>
<td>n/a</td>
</tr>
<tr>
<td>CQC Conditions or Warning Notice</td>
<td>Feb 2013</td>
<td>0</td>
<td>compliance breach</td>
</tr>
</tbody>
</table>
## Level 2b: Quality Dashboard – YAS

### Patient Safety

<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>Rate of patient related incidents (ops and A&amp;E)</td>
<td>February</td>
<td>N/A</td>
<td>.03%</td>
<td>0.028%</td>
<td>↓</td>
<td>-</td>
</tr>
<tr>
<td>Staff related incidents (ops and A&amp;E staff)</td>
<td>February</td>
<td>N/A</td>
<td>3.46%</td>
<td>2.58%</td>
<td>↑</td>
<td>-</td>
</tr>
<tr>
<td>Medication related incidents</td>
<td>February</td>
<td>N/A</td>
<td>30</td>
<td>331</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>SI’s number open</td>
<td>January</td>
<td>N/A</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>SI’s new for the month</td>
<td>January</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Clinical Effectiveness – Ambulance Quality Indicators

<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>Stemi: Proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle</td>
<td>November</td>
<td></td>
<td>80.8%</td>
<td>80.2%</td>
<td>%</td>
<td>↓</td>
</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>November</td>
<td></td>
<td>9.5%</td>
<td>11.0%</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>November</td>
<td></td>
<td>66.9%</td>
<td>62.3%</td>
<td>61.6%</td>
<td>↔</td>
</tr>
</tbody>
</table>

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

<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>Family and Friends Test Score</td>
<td>January</td>
<td></td>
<td>75-100%</td>
<td>66.7%</td>
<td>77.68%</td>
<td>↓</td>
</tr>
<tr>
<td>Concerns, complaints, comments: Response within 24 working days</td>
<td>January</td>
<td></td>
<td>90%</td>
<td>29.4</td>
<td>47.55%</td>
<td>↓</td>
</tr>
</tbody>
</table>

### Operational

<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>Staff sickness rate (West Yorkshire A&amp;E)</td>
<td>February</td>
<td></td>
<td>5.4%</td>
<td>7.17%</td>
<td>6.0%</td>
<td>↓</td>
</tr>
<tr>
<td>PDRs for all of workforce within the last 12 months (all staff)</td>
<td>February</td>
<td></td>
<td>95%</td>
<td>74%</td>
<td>67.9%</td>
<td>↑</td>
</tr>
</tbody>
</table>

### External Assurance

<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>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>March</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>↔</td>
</tr>
</tbody>
</table>

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*Note: The table values and colors are placeholders and should be replaced with actual data.*
Level 2b: Mortality Wakefield CCG

Summary Hospital Mortality Index (SHMI) October 2012 – September 2013

The SHMI is an index which is adjusted for patient’s risk of death using primary diagnosis, co-morbidities, age, gender and admission method. In theory, variation in the SHMI across hospital providers as due to variations in the quality of healthcare alone, and is unaffected by disease prevalence or severity in the hospital’s catchment population. A SHMI ratio above 100 indicates there are more deaths than would be expected given the characteristics in the patient group.

Key messages
- Wakefield CCG has a SHMI of 90 (irrespective of hospital provider), which is significantly lower than the national average of 98.
- This is a further improvement from the previous reporting period (April 2012 – March 2013) in which the SHMI was 94.
- Wakefield CCG is ranked 178th highest out of 211 (1 - low performing; 211 – high performing) CCG’s nationally.
- **Wakefield CCG continues** to be in the best 20% of CCG’s nationally.
SHMI Monthly Trend

- This data pertains to all patients irrespective of the CCG they are registered with.
- At Pinderfields General Hospital the SHMI was 5% lower than the national average in the most recent 12 months.
- At Dewsbury District Hospital the SHMI has been roughly equal to the England value, although there has been an increase from July 2013 to September 2013.
- Public Health England (commissioned to produce Wakefield CCG’s mortality report) has not included Pontefract in their analysis due to the low number of deaths, which would have made the SHMI deaths unreliable.

SHMI Deaths Above Average - Pinderfields

- The SHMI for ‘Lung disease due to external agent’s was significantly higher than England at the 95% level during Oct 12-Sep 13 and Apr 12-Mar 13. There were 4 more deaths than average among patients with this diagnosis in October 12-Mar 13.
- The SHMI for ‘Aortic; peripheral; and visceral artery aneurysms’ was significantly higher than England at the 95% level during Oct 12-Sep 13, there were 8 more deaths per year than average among patients with this diagnosis.

Dewsbury

- The SHMI for ‘Residual codes; unclassified’ (CCS 259) was significantly high during Oct 12-Sep 13 at the 95% level. There were 13 more deaths than average among patients whose primary diagnosis could not be accurately determined at the point of admission. A more definitive diagnosis may have improved the survival chances of some of these patients. This may also be indicative of a high proportion of admissions being inadequately coded more generally.

Action

- The data should be treated as a ‘smoke alarm’ as a high SHMI does not necessarily indicate poor quality care.
- The future re-design of hospital services at MYHT will see non elective care transferred to Pinderfields, which will enhance access to senior clinicians.
- MYHT reviews every death and findings are discussed at the weekly Patient Safety Panel.
- Mortality is discussed regularly at MYHT Executive Quality Board.

Responsible Clinical Lead: Dr Patrick Wynn  Commissioning Lead: Jo Pollard  CCG Assurance: MYHT Executive Quality Board
Level 2b: Friends and Family Test: A&E and Inpatient – February 2014

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.

**Key Messages**
- Pontefract A&E had the 14th highest and Dewsbury A&E the 15th highest response rate of all 200 A&E sites in England during February 2014.
- A&E at Pinderfields has not achieved a response of greater than 20% since August 2013.
- 95.09% of patients in the February FFT would recommend MYHT. This figure has remained consistent since the introduction of FFT.
- Waiting for treatment, staffing levels and food have been identified as the top 3 themes for improvement based on patient feedback.
- 3 inpatient wards at MYHT all had response rates of below 20% and at least 10 eligible patients in February 2014, this is an increase from 3 in January 2014.

*PGH G31b – 5.63%  PGH G33a – 8.97%  PGH G43 – 14.44%*
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>Dec 13 11.30%</td>
<td>Jan 14 16.72%</td>
<td>Feb 14 17.16%</td>
<td>Dec 13 50</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>Dec 13 12.70%</td>
<td>Jan 14 17.20%</td>
<td>Feb 14 17.6%</td>
<td>Dec 13 93</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>Dec 13 21.70%</td>
<td>Jan 14 21.71%</td>
<td>Feb 14 18.76</td>
<td>Dec 13 62</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>Dec 13 3.6%</td>
<td>Jan 14 6.26%</td>
<td>Feb 14 3.88%</td>
<td>Dec 13 70</td>
</tr>
</tbody>
</table>

**Key messages**
- Trusts are expected to achieve an overall response rate of >15%. MYHT achieved a combined response rate of 14.37 %.
- One woman was unlikely to recommend MYHT maternity services:
  - They were extremely unlikely to recommend the postnatal ward at Pinderfields
- The antenatal FFT score of 53 is below the national average. No women were unlikely to recommend MYHT, but 6/81 women would neither recommend nor not recommend the service. 26/81 women were likely to recommend the service which suggests there is a significant amount of women who do not feel the service is good but not outstanding.
- Improving postnatal community response rates continues to be a challenge for MYHT
- The national FFT should be interpreted with caution. Some trusts use multiple methods to capture a response such as a postcard and SMS. In some cases this results in duplicate responses being included.

**Action:**
- MYHT has held discussions with York Teaching Hospital NHS Foundation Trust about how they have achieved a response rate of 25% for the postnatal community service question. Following the discussion MYHT are assessing the feasibility of adopting some of the methods used by York to improve response rates.
<table>
<thead>
<tr>
<th>Area</th>
<th>New Actions</th>
</tr>
</thead>
</table>
| Ambulance Turnaround Times and Ambulance Handover                     | • The Trust is working with YAS to improve the patient flow, including ordering a number of extra trolleys, providing an extra screen in resus, and an improved booking process is being worked through.  
• The commissioning lead has met specifically with YAS, nursing staff and lead consultant at MYHT to work through actions to improve local performance at PGH.  
• To improve performance relating to the timeliness of ambulance handovers, the Trust has representation on regional meetings that bring together stakeholder organisations.  
• YAS have written to individual crew members who have been identified as having low compliance on the notify screens. Addressing this on an individual basis has been shown to have demonstrative improvements in performance in other south Yorkshire areas. |
| A&E 4hour Waiting Time Standard                                       | • Daily operational call – active dialogue between the two CCG’s and the Trust, on going during the winter period and continuing during March.  
• Active monitoring of the 18 week RTT position and weekly updates from the Trust in relation to long term impact of A&E performance on treatment pathways.                                                                                                 |
| Ambulance Response Times – YAS Cat A (Red 1), (Red 2) and (Red 1&2)  | • Performance action plan is being reviewed and monitored by the CSU and through the Contract management board.  
• Service improvement plan continues to be monitored through the WYCBU.  
• Rota changes were put in place in early February which will take sometime to embed but are expected to improve performance by matching staffing rotas to busier weekend periods.  
• 14-15 CQUIN has been included in this years contract which will ensure delivery of 75% at CCG level (except in some of the worse performing CCG where an agreed trajectory is in place)  
• YAS continue with the roll out of a community defibs which will improve the speed of clinical input to patients.                                                                                                                                 |
| Cancer Waits – 62 Days Urgent GP Referral 31 Days Radiotherapy Treatment | • The Urology team have a medium to long term plan that includes recruitment of a locum consultant.  
• Short-term plans include increasing nurse-led clinic capacity for diagnosis and pathway management, and flexing urgent suspected cancer referrals capacity to match the demand according to the urology cancer site.  
• Working in partnership with Leeds Teaching Hospital to develop and agree a robust 38-day Inter Provider Transfer process.                                                                                                                                 |
| MRSA                                                                | • Aseptic non touch technique training (ANTT) and competence assessment data for staff assessed as competent by end of February 2014 remains at 84%.  
• Further analysis of the mapping processes for CDI and MRSA against GP post codes is being undertaken to identify the rate of these alert organisms against the practice population size. This will be provided in Q4 DIPC report to the Integrated Governance Committee.  
• A visit by the Head of Health Protection and Deputy to Barnsley Foundation Hospital Trust identified key learning as they have not reported any post 48 hour MRSA cases.  
• MYHT have now received the TDA report for their visit 23 January 2014 and are producing an action plan, which will be shared at the MYHT EQB in May 2014.                                                                                                                                 |
| Clostridium Difficile                                                | • Cases are reviewed at the weekly CDI group.  
• Prescribing of cephalosporins and quinolones is included as a prescribing indicator in the Improvement in Prescribing Plan (IMPP) and
| **18 week RTT waiting Time Standards** | • A new ‘Access Group’ has been established with MYHT to embrace a collaborate approach to patient pathways and operating standards.  
• MYHT are to provide a summary of 2013/14 performance achievements and barriers at the speciality level in association with Q1 trajectories. |
| **RTT - 52 Week Waits** | • A full root cause analysis (ENT) has been completed and concluded that the process for dealing with rejected referrals in the pre-operative service was not robust. As a result of this a new standard operating procedure is being implemented and full training being given to staff. |
| **Diagnostic Test Waiting Times** | • MRI – appointment letters have been recorded on the Datix system and is currently under investigation.  
• In Audiology - An action plan has been requested from the service to seek assurance that it will reduce waiting times to 2 weeks. In addition, the business delivery unit are undertaking a review of audiology services. |
| **MYHT Staff absence rates** | • The sickness rate for January is 4.93% compared to an updated December position of 5.13%.  
• The Occupational Health team identify any absences related to Mental Health or musculoskeletal issues in order to contact the individual and offer early intervention through the EASE service of Physiotherapy Medic.  
• Actions to improve the timeliness and quality of data (so information about the daily staffing position is more robust) include;1: Clinical divisions ensuring that e-rostering system is updated in a more timely fashion by ward clerks. 2: Developing twilight ward clerk provision to enable the data to be updated throughout the evening as sickness is reported. |
| **SWYPFT Staff Sickness** | • The sickness rate for Wakefield BDU in January was 4.61% compared to a December position of 4.51%.  
• Stress continues to be the main reason for absence across the Trust, accounting for approximately 1 in every 4 to 5 days lost.  
• Reducing absence related to stress and reducing long term absence are the main focus of BDU action plans and the Wellbeing agenda. |
| **YAS – Concerns, comments complaints (3c’) response within 24 working days** | • There has been no evident improvement in the percentage of concerns, comments and complaints responded to within 24 working days. 24 working days is a local target set by YAS.  
• The Trust has provided assurance that updates are provided to complainants via the Patient Relations team while their issue is being reviewed.  
• National guidelines now requests that the deadlines for response are agreed with the patient to reflect the fact that some complex cases might need a longer period to resolve. Implementing this guidance will enable response times to be set based on the complexity of the case. |
| **YAS – Staff sickness** | • It is anticipated that YAS will fail to meet its sickness absence target for 2013/14.  
• Sickness levels are lower compared to the same period last year.  
• The Trust is expecting that on-going negotiations regarding Unsocial Hours and sick pay will result in an agreement being reached in February 2014. YAS expects that the outcome of these negotiations will help to reduce absence rates if there are reductions in sick pay.  
• YAS intends to implement its new absence management policy in February 2014, which it hopes will help reduce absence rates. |
| **YAS - PDR** | • Performance on this measure has reduced this year, although performance improved significantly in November and December 2013.  
• When the CQC visited the Trust in July 2013 paramedics and managers told inspectors that they did not feel their PDR was worthwhile as they had little time to prepare and they did not see a copy of their previous appraisal to review progress.  
• YAS acknowledge that A&E and Patient Transport Service remain the most significant areas on non-compliance.  
• 20% of YAS staff have had a PDR, but not within the last 12 months.  
• YAS are working towards having met this target by March 2014. |
Quality Intelligence Group
The Group represents every team within the CCG, plus colleagues from Public Health, Healthwatch and the Commissioning Support Unit working in relevant functions, such as complaints, PALS, engagement and communications. At each meeting a template captures and triangulates ‘soft’ intelligence from sources such as Patient Opinion, feedback from member practices, PALS enquiries, media reports, staff observations (including patient safety walkabouts) and staff/family experiences. From this key themes are identified and any actions agreed dependent on the strength of evidence, link with ‘hard’ data sources, and judgement on the level of concern.

February 2014 – 63 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>
<tbody>
<tr>
<td><strong>Discharge</strong>&lt;br&gt;- mental health&lt;br&gt;- no involvement of carers/other professionals&lt;br&gt;- missing information, inappropriate</td>
<td>Engagement PSU / GP Staff feedback</td>
<td>🟢🟢🟢🟢🟢 🟢🟢</td>
<td>CQC reports</td>
<td>MYHT Care homes</td>
<td>High</td>
<td>1. Discharge CQUIN for MYHT.&lt;br&gt;2. Continuing Health Care team sending recommendations on improving care plans to various homes.&lt;br&gt;3. Continuing Health Care audit of checklists.</td>
</tr>
<tr>
<td><strong>Cancer</strong>&lt;br&gt;- late diagnosis&lt;br&gt;- test results (ok if on pathway, but if not time gets longer/more complex over reliance on tests)</td>
<td>Incidents Other</td>
<td>🟢🟢</td>
<td>Cancer waiting time data</td>
<td>GP MYHT</td>
<td>High</td>
<td>1. Individual incidents raised with MYHT – follow up on responses.&lt;br&gt;2. Use cancer locality group - learning</td>
</tr>
<tr>
<td><strong>Transport</strong>&lt;br&gt;- pulmonary rehab&lt;br&gt;- security O2 cylinder&lt;br&gt;- wheelchair harness</td>
<td>Staff feedback</td>
<td>🟢🟢🟢</td>
<td>YAS MYHT</td>
<td></td>
<td>Med</td>
<td>1. Raise with YAS PTS CQUINs/KPI’s</td>
</tr>
<tr>
<td><strong>Access</strong>&lt;br&gt;- GP&lt;br&gt;- Hospital&lt;br&gt;- Crisis</td>
<td>PALS / Complaints Engagement Staff feedback PSU / GP PSW</td>
<td>🟢🟢🟢🟢🟢 🟢🟢</td>
<td>Sentinel Stroke National Audit Programme 18 week wait referral to treatment data</td>
<td>GP MYHT SWYPFT</td>
<td>High</td>
<td>1. CQUIN for MYHT on outpatient’s appointments.&lt;br&gt;2. SWYPFT contractual requirement for 4 hour urgent access.&lt;br&gt;3. MYHT attending PRG Network in March.&lt;br&gt;4. Systm One pilot: GPs can now contact MYHT consultants using Systm One in some specialities to seek advice</td>
</tr>
<tr>
<td><strong>Maternity SIs</strong></td>
<td>Incidents PALS / Complaints</td>
<td>🟢🟢</td>
<td>SI reports</td>
<td>MYHT</td>
<td>High</td>
<td>1. MYHT commissioned external review of SIs in addition to internal review.</td>
</tr>
</tbody>
</table>
## March 2014 – 29 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>
<tbody>
<tr>
<td>Appointments</td>
<td>Engagement PALS / Complaints PSU / GP Feedback Other</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️</td>
<td>Referral to treatment performance</td>
<td>MYHT GP</td>
<td>High</td>
<td>1. 2014/15 CQUIN indicator to be split by speciality. 2. Outpatient improvement plan ongoing. 3. PPG Network – MYHT attended on 12 March.</td>
</tr>
<tr>
<td>GPs</td>
<td>- Health checks offered. - Reluctant to offer tests/screening. - Being ‘struck off’ if complain</td>
<td>PALS / Complaints</td>
<td>✔️ ✔️ ✔️</td>
<td>GP</td>
<td></td>
<td>1. Lead commissioner aware of issues re: Health checks and plans to increase uptake. 2. Report as incident if patient consents.</td>
</tr>
<tr>
<td>Reception staff</td>
<td>Staff feedback</td>
<td>✔️ ✔️</td>
<td></td>
<td>GP MYHT</td>
<td></td>
<td>1. Network 3 are training in customer care evaluation. 2. Customer care training – HQ team.</td>
</tr>
</tbody>
</table>
Deep Dive: MYHT Patient Safety Walkabout February 2014

This summarises the findings from Walkabouts that took place at Dewsbury District Hospital, Pinderfields General Hospital and Pontefract General Infirmary in February and March 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. Representatives from Healthwatch in Wakefield and North Kirklees now participate in the walkabouts.

Following the PSW took place on Ward 4 at Dewsbury District Hospital on 8 January 2014 which identified significant concerns about the standard of care provided, it was agreed that PSWs would take place on all medicine and elderly care wards in the Trust to determine if the problems identified on the visit are confined to Ward 4 or more widespread.

Pinderfields – 11 February

Gate 20 – Respiratory: The interaction between nursing staff and patients was exceptionally good and demonstrated a genuine caring attitude to work. There were 12 discharges from this ward on this day and it seemed to be a very smooth process. It was evident that there was good staff morale on the ward.

Gate A2 – Stroke: The PSW team were impressed with the design of the stroke pathway documentation. Documentation was completed to a high standard. Patients stated that they were well cared for. Staff were observed to interact with patients in an appropriate manner. One patient was wearing a restraint glove to prevent them removing a nasal gastric tube. Clear evidence of mental capacity assessment and best interest decision prior to application of the restraint glove was evident.

Pinderfields 4 March

A1 – Intermediate Care: Patients were clearly well cared for. One patient reported that they were given information about potential medication side-effects when discharged and knew who to contact if they were worried about their condition. Non-sharps items were found in a sharps bin.

G4 – Spinal Injuries: Patients felt staff were caring but there was not enough of them. The PSW observed that a call bell took longer than 5 minutes to respond to and saw gaps in the record keeping.

G20a – Acute respiratory: Patients praised the care received but the ward lacked a sense of identity. There was no signage to direct people to the ward or to differentiate it from G20.

Dewsbury 5 March

Ward 2 – Care of the Elderly: Staff were observed being polite, courteous and caring to all patients. One patient developed an infection after antibiotic treatment which started in the community was repeated in hospital.

Ward 8 – Respiratory: Most patients praised the attitude of staff. One patient expressed frustration about how a scan result was communicated. Staff had limited access to continuing professional development.

Ward 10 – Short stay: Patients felt well cared for. The door of a patient isolated in a side room for infection control reasons was found to be open on two occasions.

Ward 4 – Stroke and neuro rehab: A PSW did not take place on this ward but MYHT did invite the PSW team to visit the ward and talk to the new Ward Manager about the improvements being made following problems identified in January. The PSW team were impressed by the transparency shown by MYHT.

Pontefract 13 March

Medical Unit: Documentation was completed to a high standard, patients praised the staff. Staff expressed concern that they sometimes didn’t feel able to leave the ward to collect equipment such as a hoist due to the staffing levels.

Maternity: Staff described excellent partnership working with YAS. There were no women on the unit at the time of the visit.
Dewsbury 19 March
CCU: Patients felt involved in their care planning, were complimentary of the staff delivering care but 5 nurses had left the ward in recent weeks due to uncertainty caused by the future re-organisation of MYHT services.

Ward 12 - Elective Orthopaedic: Patients all said they had a good experience on the ward. One patient stated their experience was much better than an earlier part of their stay on Ward 14 where staff did not have time to attend to their needs and they felt bad about asking for help as staff were very busy.

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 Committee. The report will be shared at MYHT Executive Quality Board meeting on 20 March and 17 April 2014.
MYHT 18 Week Performance Update

- In January the Trust achieved all 3 Referral to Treatment 18 week standards.
- The Trust had already identified that three specialties were not going to achieve specialty level performance, these were respiratory, plastic surgery and general surgery. In addition to this there were a further nine specialty level failure across the three RTT pathways.
- Since these were confirmed a number of these specialties have been placed into special measures and full reviews, recovery plans and root cause analyses completed to appraise the Chief Executive of the reasons for the non-achievement and to seek assurance that performance would recover.
- The following assessment shows the anticipated specialty level performance in February and March, those in red are confirmed as fails, those in amber have been risk rated as potential to achieve but not confirmed, and those in green indicated a confirmed achievement. All of these assessments have been made based on current data and knowledge of position, and present the reporting period performance not the cumulative performance.

<table>
<thead>
<tr>
<th>Non Admitted</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-ADMITTED</td>
<td>Plan</td>
<td>Actual</td>
<td>Plan</td>
</tr>
<tr>
<td>TRUST</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Gastro</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Fail</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Neurology</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Urology</td>
<td>Fail</td>
<td>Fail</td>
<td>Fail</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
</tbody>
</table>

The additional non-admitted completed fails in January were in gastroenterology, ENT, Oral Maxillo Facial Surgery (OMFS), dermatology, neurology and rheumatology. For rheumatology, neurology and dermatology this was due to a very small amount of patients breaching 18 weeks. On investigation this was due to a reduced amount of management and administration time spent on tracking patients through their pathways. Whilst this is still a fail of the target, all three specialties have undertaken full reviews and confirmed that they have revised processes to have a more robust tracking system in place and confirmed that they do not have a fundamental capacity or waiting list issue.

For gastroenterology, ENT and OMFS have forecasted continued non-achievement of the completed non-admitted target in February and March.
Completed admitted performance was in line with plan and will continue to be so for February and March.

<table>
<thead>
<tr>
<th>Admitted</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMITTED</strong></td>
<td>Plan</td>
<td>Actual</td>
<td>7/3/14 position as discussed at control tower</td>
</tr>
<tr>
<td>TRUST</td>
<td>ACHIEVE</td>
<td>ACHIEVE</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>Gastro</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
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<tr>
<td>Neurology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>ENT</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>OMFS</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>Fail</td>
<td>Fail</td>
<td>Fail</td>
</tr>
<tr>
<td>Urology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
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<tr>
<td>Orthopaedics</td>
<td>Achieve</td>
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<td>Achieve</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
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<tr>
<td>Gynaecology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Other</td>
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<td>Achieve</td>
<td>Achieve</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Incomplete</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOMPLETE</strong></td>
<td>Plan</td>
<td>Actual</td>
<td>7/3/14 position as discussed at control tower</td>
</tr>
<tr>
<td>TRUST</td>
<td>ACHIEVE</td>
<td>ACHIEVE</td>
<td>ACHIEVE</td>
</tr>
<tr>
<td>Gastro</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Fail</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
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<tr>
<td>Neurology</td>
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<td>Achieve</td>
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<tr>
<td>Cardiology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Fail</td>
<td>Fail</td>
<td>Fail</td>
</tr>
<tr>
<td>ENT</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>OMFS</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>Fail</td>
<td>Fail</td>
<td>Fail</td>
</tr>
<tr>
<td>Urology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
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<tr>
<td>Orthopaedics</td>
<td>Achieve</td>
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<td>Achieve</td>
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<tr>
<td>Ophthalmology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
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<tr>
<td>Gynaecology</td>
<td>Achieve</td>
<td>Achieve</td>
<td>Achieve</td>
</tr>
<tr>
<td>Other</td>
<td>Achieve</td>
<td>Fail</td>
<td>Achieve</td>
</tr>
</tbody>
</table>

See below
Gastroenterology
The root cause of the non-delivery of RTT standards in this service is a result of ongoing capacity problems within the speciality that have existed for the last 3 years. This year these have been compounded by the increase in G.P. referrals of nearly 7%. Capacity issues include not being able to appoint to substantive consultant vacancies despite repeated attempts; unable to secure NHS locums; unable to secure agency locums to fully cover gaps; unable to appoint to Staff Grade vacancy; increased need to provide endoscopy capacity, these issues have been long-standing. In addition performance has also been impacted by ongoing validation issues with the waiting lists. A trajectory is in place for validation improvement.

The service believes that they will continue to underperform for the remainder of 2013/14, although key personnel are now refocused on 18 week delivery. The Trust, together is currently working on forecasting for 2014/15 Q1 performance.

ENT
The root cause of the non-delivery of RTT standards in this service are as a result of increased demand and specifically in January related to focus of the management team being turned to urgent care pressures. ENT has seen a 27.8% increase in G.P. referrals in the period April to December 2013 in comparison with the same period in 2012, this equates to 1486 patients of which 833 are WCGG patients. The increased demand has put significant pressure on the outpatient clinics and therefore impacted on 18 week waiting times. The service began the year with a polling range of 9 weeks and had plans in place to reduce to 6 weeks, due to the increased referrals all additional capacity that was set up to reduce the wait to first appointment was in fact used to maintain the current position, as the year has passed the impact of the increased referrals has led to a growth in the waiting list and compromised 18 week performance.

The service believes that they will continue to underperform for the remainder of 2013/14, although key personnel are now refocused on 18 week delivery. The Trust are currently working on forecasting for 2014/15 Q1 performance.

OMFS
The root causes of non-delivery in OMFS are similar to those described in ENT. The service has seen an increase of 20% in G.P. referrals April to December 2013, this corresponds to 782 patients of which 582 are form WCGG and therefore additional capacity secured to reducing overall waiting times was used to maintain position. The service is currently undergoing a process change in relation to triage of referrals as previously heavily dependent on one individual. This will lead to reduced pressure on individual consultants waiting lists. OMFS will be losing a consultant in April due to a resignation and conversations are ongoing with colleagues in Leeds and South Yorkshire to support this service going forward.

The service believes that they will continue to underperform for the remainder of 2013/14, although key personnel are now refocused on 18 week delivery. The Trust, are currently working on forecasting for 2014/15 Q1 performance.
**MYHT Control Arrangements**

All three of the above specialties are now being managed under special measures. This involves:

1. Progress reports on a Monday, Wednesday and Friday.
2. Progress reports with the Director of Performance, Commissioning and Informatics and the 18 Week Performance Manager on Tuesday and Thursday.
3. Weekly Control Tower to scrutinise all levels and aspects of elective care including efficiencies.
5. Weekly specialty control tower with clinical attendance.
6. Direct support and intervention from the 18 Week Performance Manager.

**CCG Control Arrangements**

- The CCG and MYHT have established a new ‘Access Group’ which promotes understanding and challenge of all access performance – RTT and Cancer Waits, reviewing the Trusts performance at specialty level against NHS Constitution requirements and collaborative solutions to improve performance.
- A weekly provision of waiting time performance against the Trusts new 10 week tracking intervention
- MYHT have created a new performance dashboard to be provided monthly.
- WCCG have established through the MYHT Contract Management Group that the contractual levers will be implemented for failure to meet the required operational standards at the specialty level.
In the Spotlight: CQC Reviews – Care Homes

Vicarage Court Care Home provides nursing and personal care for up to 86 older people, some with a diagnosis of dementia (or related condition).

<table>
<thead>
<tr>
<th>Provider</th>
<th>Vicarage Court, Featherstone</th>
<th>Outcomes</th>
<th>Action needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>18 November 2013</td>
<td>04 – Care and welfare of people who use services</td>
<td>Action needed, moderate impact</td>
</tr>
<tr>
<td>Review Type</td>
<td>Routine Inspection</td>
<td>06 – Cooperating with other providers</td>
<td>Compliant</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Vicarage Court</td>
<td>16 – Assessing and monitoring quality</td>
<td>Compliant</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 January 2013 –</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inspection to check</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>improvements made</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 May 2012 –</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inspection in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>response to concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 March 2012 –</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inspection in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>response to concerns</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Hemsworth Park provides residential care for older adults, and those with dementia. The home also consists of a residential unit for adults, and a unit for younger people with disabilities.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Hemsworth Park, Kinsley, Wakefield</th>
<th>Outcomes</th>
<th>Action needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>3 December 2013</td>
<td>04 – Care and welfare of people who use services</td>
<td>Action needed, minor impact</td>
</tr>
<tr>
<td>Review Type</td>
<td>Inspection to check improvements made</td>
<td>09 – Management of medicines</td>
<td>Compliant</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Hemsworth Park</td>
<td>21 – Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 and 6 September 2013 – inspection to check improvements made</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 April 2013 –</td>
<td>routine inspection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 October 2012 –</td>
<td>routine inspection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The warning notice has now been lifted following this inspection.

Langtree Park Nursing Home provides accommodation and nursing care for up to 60 older people.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Langtree Park, Castleford</th>
<th>Outcomes</th>
<th>Enforcement action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>16, 17 January 2014</td>
<td>04 – Care and welfare of people who use services</td>
<td>Enforcement action taken, moderate impact</td>
</tr>
<tr>
<td>Review Type</td>
<td>Inspection to check if improvements made</td>
<td>09 – Management of medicines</td>
<td>Compliant</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Langtree</td>
<td>13 – Supporting workers</td>
<td>Enforcement action taken, moderate impact</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 June 2013 –</td>
<td>inspection to check improvements made</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 October 2012 –</td>
<td>routine inspection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Action:** The CQC have served a warning notice to be met by 7 February 2014.
Attlee Court provides accommodation and nursing care for up to 66 people.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>19 and 25 February 2014</td>
</tr>
<tr>
<td>Review Type</td>
<td>Inspection to check improvements made</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Attlee Court</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14 October 2013 – inspection to check improvements made</td>
</tr>
<tr>
<td></td>
<td>11 July 2013 – inspection in response to concerns</td>
</tr>
<tr>
<td></td>
<td>25 April 2013 – routine inspection</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</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></td>
</tr>
<tr>
<td></td>
<td>02 October 2013 – routine inspection</td>
</tr>
<tr>
<td></td>
<td>14 August 2012 – routine inspection</td>
</tr>
</tbody>
</table>

Carr Gate Nursing Home provides nursing and personal care for up to 65 people, some of whom may have dementia.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>23 January 2014</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced routine inspection</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Carr Gate</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11, 16 September 2013 – routine inspection</td>
</tr>
<tr>
<td></td>
<td>25 March 2013 – inspection to check improvements made</td>
</tr>
</tbody>
</table>

Snapethorpe Hall provides personal care and nursing care for up to 62 older people, some of who may have dementia.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>13 February 2014</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced inspection</td>
</tr>
<tr>
<td>Link to Report</td>
<td>Snapethorpe</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 May 2013 – routine inspection</td>
</tr>
<tr>
<td></td>
<td>7 November 2012 – inspection in response to concerns</td>
</tr>
</tbody>
</table>

February’s IQP report included a summary of the CQC’s draft report for this home, which recommended that the provider needed to take action to improve standards. The CQC has since published their final report, which details that they have taken enforcement action. The CQC has served a warning notice which must be met by 6 December 2014.
## In the Spotlight: CQC Reviews – GP Practices

<table>
<thead>
<tr>
<th>Provider</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>St Thomas Road, Featherstone</strong></td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Date of Inspection</strong></td>
<td>24 February 2014</td>
</tr>
<tr>
<td><strong>Review Type</strong></td>
<td>Announced inspection – follow-up</td>
</tr>
<tr>
<td><strong>Link to Report</strong></td>
<td>St Thomas Rd</td>
</tr>
<tr>
<td><strong>CQC history:</strong></td>
<td>Announced inspection – 5 November 2013. Moderate concern identified against Outcome 12.</td>
</tr>
<tr>
<td><strong>Compliant</strong></td>
<td></td>
</tr>
</tbody>
</table>

| **Dr Newland and Partners, Knottingley** | Compliant                                                                 |
| **Date of Inspection**            | 31 October 2013                                                           |
| **Review Type**                   | Announced routine inspection                                              |
| **Link to Report**                | Newland                                                                   |
| **Outcomes**                      |                                                                           |
| **04 – Respecting and involving people who use services**                  | Compliant                                                                 |
| **05 – Care and welfare of people who use services**                        | Compliant                                                                 |
| **07 – Safeguarding people who use services from abuse**                   | Compliant                                                                 |
| **12 – Requirements relating to workers**                                  | Compliant                                                                 |
| **17 – Complaints**              |                                                                           |

| **Church Street Surgery, Ossett** | Action needed, minor impact                                             |
| **Date of Inspection**           | 7 November 2013                                                          |
| **Review Type**                  | Announced routine inspection.                                            |
| **Link to Report**               | Church Street                                                            |
| **Outcomes**                     |                                                                           |
| **04 – Respecting and involving people who use services**                  | Compliant                                                                 |
| **05 – Care and welfare of people who use services**                        | Compliant                                                                 |
| **07 – Safeguarding people who use services from abuse**                   | Compliant                                                                 |
| **12 – Requirements relating to workers**                                  | Action needed, minor impact                                             |
| **16 – Assessing and monitoring the quality of services**                  | Compliant                                                                 |

| **Warrengate, Wakefield**        | Action needed, minor impact                                             |
| **Date of Inspection**           | 13 November 2013                                                         |
| **Review Type**                  | Announced routine inspection.                                            |
| **Link to Report**               | Warrengate                                                               |
| **Outcomes**                     |                                                                           |
| **04 – Respecting and involving people who use services**                  | Compliant                                                                 |
| **05 – Care and welfare of people who use services**                        | Compliant                                                                 |
| **07 – Safeguarding people who use services from abuse**                   | Compliant                                                                 |
| **12 – Requirements relating to workers**                                  | Action needed, minor impact                                             |
| **17 – Complaints**              | Compliant                                                                 |
WRS PMS Plus Ltd is located within a GP practice in South Elmsall. The service provides consultations, investigations and treatments, including clinics for pain management and orthopaedic conditions. The clinic also performs some surgical procedures.

<table>
<thead>
<tr>
<th>Provider</th>
<th>WRS PMS Plus Ltd, South Elmsall</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection</td>
<td>11 February 2014</td>
<td>04 – Consent to care and treatment</td>
</tr>
<tr>
<td>Review Type</td>
<td>Unannounced routine inspection.</td>
<td>05 – Care and welfare of people who use services</td>
</tr>
<tr>
<td>Link to Report</td>
<td>WRS</td>
<td>08 – Cleanliness and infection control</td>
</tr>
<tr>
<td>CQC history:</td>
<td></td>
<td>12 – Requirements relating to workers</td>
</tr>
<tr>
<td></td>
<td>21 March 2013 – inspection to check improvements made</td>
<td>17 – Complaints</td>
</tr>
<tr>
<td></td>
<td>9 August 2012 – routine inspection</td>
<td></td>
</tr>
</tbody>
</table>

Compliant

In the Spotlight: CQC Reviews – White Rose Surgery PMS Plus Ltd
In the Spotlight: MYHT National Staff Survey

Background: The annual National Staff Survey was published recently. Surveys were distributed to staff in Autumn 2013.

Key messages
- Surveys were distributed to all 7217 staff with their salary slips. In previous staff surveys MYHT distributed them to a random sample of 850 staff.
- The survey highlights a number of staff concerns including:
  - Staff who would recommend MYHT as a place to work and receive treatment
  - Senior management communication with staff
  - Access to job relevant training
  - Staff reporting that they’ve experienced physical violence from patients or the public
  - Staff experiencing bullying, harassment or abuse from staff
  - Fairness of incident reporting procedures
  - Staff morale, job satisfaction and work related stress
- Performance has deteriorated in the 2013 survey

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Rate</td>
<td>53%</td>
<td>46%</td>
</tr>
<tr>
<td>Number of responses</td>
<td>430</td>
<td>3289</td>
</tr>
<tr>
<td>Green (highest 20%)</td>
<td>5 questions</td>
<td>0 questions</td>
</tr>
<tr>
<td>Green (better than average)</td>
<td>3 questions</td>
<td>1 questions</td>
</tr>
<tr>
<td>Amber (average)</td>
<td>6 questions</td>
<td>5 questions</td>
</tr>
<tr>
<td>Red (worse than average)</td>
<td>5 questions</td>
<td>6 questions</td>
</tr>
<tr>
<td>Red (bottom 20%)</td>
<td>9 questions</td>
<td>16 questions</td>
</tr>
</tbody>
</table>

Action
- The Trust has an action plan to address the concerns raised in the report, including:-
  - MYHT has commissioned a Listening Into Action Programme which is designed to improve staff engagement.
  - MYHT is introducing 1 nurse to 8 patients on wards during the day.
  - Establish values based reward and recognition arrangements including awards via staff communications.
  - Develop a simplified proforma and guidance for staff carrying out appraisals and ensure the number of appraisals each manager is expected to undertake is achievable.
  - Link appraisal and mandatory training compliance to Agenda for Change gateways.
  - Develop a partnership agreement between staff side and management
  - Develop a rolling programme of senior manager visits to operational areas.
  - Intensive support package developed for best performing teams. Team leaders to be prioritised for Great Line Management Passport and coaching / mentoring made available for team leaders.
- The action plan was discussed at MYHT Executive Quality Board on 20 March 2014, and a progress update will be given in August 2014.

Responsible Clinical Lead: Dr Patrick Wynn  Commissioning Lead: Jo Pollard  CCG Assurance: MYHT Executive Quality Board
The full YAS staff survey report is available [here](#). Participation on the 2013 staff survey has decreased by 10% from 2012.

### Areas of success:
- YAS performs well compared to other ambulance trusts.
- The percentage of staff who reported that they received job relevant training, learning or development in the last 12 months improved by 9%.
- 34% of staff witnessed potentially harmful errors, near misses or incidents in last month. 78% of these incidents were reported, which is in line with the national average.
- The percentage of staff recommending YAS as a place to work and receive care is in line with the national average.

### Areas for improvement
- 19% of staff reported that they had a well-structured appraisal in the last 12 months. The quality of appraisals for emergency staff was also identified as a cause for concern by the CQC.
- 40% of staff said that they received health and safety training in the last 12 months, compared to 52% nationally.
- 32% of staff experienced physical violence from patients, relatives or the public in last 12 months. This is consistent with the national average, but its unacceptable that nearly a third of staff have experienced physical violence.
- 47% of staff experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- 22% experienced harassment, bullying or abuse from fellow staff in last 12 months. This is the lowest figure of any ambulance trust in the country, but it is still concerning.
- 15% of staff reported good communication between senior management and staff. This is 2% higher than the national average, but well short of the best performing ambulance trust which achieved 32%.

### Action:
- The results of the survey will be discussed at the next YAS Quality Board.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Rate</td>
<td>53%</td>
<td>43%</td>
</tr>
<tr>
<td>Number of responses</td>
<td>430</td>
<td>364</td>
</tr>
<tr>
<td>Green (better than ave)</td>
<td>6 questions</td>
<td>9 questions</td>
</tr>
<tr>
<td>Amber (average)</td>
<td>7 questions</td>
<td>17 questions</td>
</tr>
<tr>
<td>Red (worse than ave)</td>
<td>15 questions</td>
<td>2 questions</td>
</tr>
</tbody>
</table>

Responsible Clinical Lead: Dr Adam Sheppard  
Commissioning Lead: Jenny Feeley  
CCG Assurance: YAS Quality Board
In the Spotlight: SWYPFT Staff Survey

The SWYPFT staff survey results are available [here](#).

### Areas of success
- SWYPFT is listed as one of the 20% best performing trusts for the following questions:
  - Feeling satisfied with the quality of work and patient care they are able to deliver
  - Work pressure felt by staff
  - Percentage of staff working extra hours
  - Percentage of staff appraised in last 12 months, although less than half of all staff felt their appraisal was well structured
  - Staff recommendation of the trust as a place to work or receive treatment
  - Experience discrimination at work in the last 12 months
- The percentage of staff reporting experience of harassment, bullying or abuse from fellow staff in last 12 months reduced to 18%, which is better than the national average.

### Areas for improvement
- SWYPFT is one of the worst performing 20% of trusts for the following questions:
  - Percentage of staff reporting errors, near misses or incidents witnessed in the last month. Performance dipped from 95% in 2012 to 87% in 2013. 28% of staff witnessed potentially harmful errors, near misses or incidents in last month which is worse than average.
  - Support from immediate managers
  - 57% of staff received health and safety training in last 12 months
  - 48% of staff received equality and diversity training in last 12 months
- There was a small reduction to 81% in the percentage of staff who received job-relevant training, learning or development in the last 12 months.
- 4% of staff said they had experienced physical violence from colleagues in the last 12 months.
- 30% experienced harassment, bullying or abuse from patients, relatives or the public in last 12 months, which is the same as the national average. There was no improvement from last year.

### Action
- The findings from the staff survey will be discussed at the SWYPFT Quality Board on 12 May 2014.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Rate</td>
<td>53%</td>
<td>50%</td>
</tr>
<tr>
<td>Number of responses</td>
<td>430</td>
<td>410</td>
</tr>
<tr>
<td>Green (highest 20%)</td>
<td>3 questions</td>
<td>6 questions</td>
</tr>
<tr>
<td>Green (better than ave)</td>
<td>9 questions</td>
<td>9 questions</td>
</tr>
<tr>
<td>Amber (average)</td>
<td>7 questions</td>
<td>3 questions</td>
</tr>
<tr>
<td>Red (worse than ave)</td>
<td>5 questions</td>
<td>6 questions</td>
</tr>
<tr>
<td>Red (bottom 20%)</td>
<td>4 questions</td>
<td>4 questions</td>
</tr>
</tbody>
</table>

Responsible Clinical Lead: Dr Clive Harries  Commissioning Lead: Phil Smedley  CCG Assurance: SWYPFT Quality Board
### Executive Summary:
The Month 12 Finance Report provides a year to date actual position as at 31st March 2014. Overall the CCG has an annual surplus of £5,580k against a year-end forecast of £5,502k. There are 9 key financial performance indicators for the year end:

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

The report highlights any significant adverse variances.

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

<table>
<thead>
<tr>
<th>Principle</th>
<th>Outcome of Equality Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health equality across our population</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Support for individual health and wellbeing</td>
<td></td>
</tr>
<tr>
<td>Care provided in the right setting and close to home</td>
<td></td>
</tr>
<tr>
<td>Appropriate access and choice for all</td>
<td></td>
</tr>
<tr>
<td>Understanding our population and putting patients at our centre</td>
<td></td>
</tr>
<tr>
<td>Safe and high quality experiences and clinical outcomes</td>
<td></td>
</tr>
<tr>
<td>Transparent clinically-led commissioning</td>
<td></td>
</tr>
<tr>
<td>Service transformation through redesign</td>
<td></td>
</tr>
<tr>
<td>Improvement through collaboration and integration</td>
<td></td>
</tr>
<tr>
<td>Financial efficiency, probity and balance</td>
<td>√</td>
</tr>
</tbody>
</table>

### Outcome of Equality Impact Assessment:

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcome of Equality Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline public engagement</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Assurance departments/organisations</td>
<td></td>
</tr>
<tr>
<td>who will be affected have been</td>
<td></td>
</tr>
<tr>
<td>consulted</td>
<td></td>
</tr>
</tbody>
</table>

### Previously presented at committee / governing body:

<table>
<thead>
<tr>
<th>Previous Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 10 Finance Report was presented</td>
</tr>
<tr>
<td>at Governing Body meeting on 11 March</td>
</tr>
<tr>
<td>2014. The Month 11 Finance Report was</td>
</tr>
<tr>
<td>presented at Integrated Governance</td>
</tr>
<tr>
<td>Committee on 20 March 2014.</td>
</tr>
<tr>
<td><strong>Reference document(s) / enclosures:</strong></td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>3 Appendices are included to provide further detail on specific issues:</td>
</tr>
<tr>
<td>• Appendix 1: Prescribing Information</td>
</tr>
<tr>
<td>• Appendix 2: QIPP – updated position statement on the 13/14 programme</td>
</tr>
<tr>
<td>• Appendix 3: Summary of 2% Non-recurrent sources and application of funds</td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
</tr>
</tbody>
</table>
## NHS WAKEFIELD CCG

### Finance Report – Month 12 2013/14

1. **Introduction**

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

2. **Key Financial Performance Indicators**

   NHS Wakefield CCG key financial performance indicators are detailed below:

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>No.</th>
<th>Indicator</th>
<th>RAG Measure</th>
<th>RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>Underlying recurrent surplus</td>
<td>Green: &gt;= 2%  Red: 0-0.99%  Red: &lt;0%</td>
<td>Green</td>
<td>£9.7m (2.2%) calculated after impact of non-recurrent and QIPP savings</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Surplus - year to date performance (variance to plan as % of allocation)</td>
<td>Green: &lt;= 0.1%  Red: &lt;0.5%  Red: &gt;=0.5%</td>
<td>Green</td>
<td>£78k full year actual to plan = 0%</td>
</tr>
<tr>
<td></td>
<td>3</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></td>
<td>4</td>
<td>QIPP - year to delivery</td>
<td>Green: &gt;= 95% of plan  Red: &gt;=50%</td>
<td>Amber/Green</td>
<td>£9.4m delivered against YTD plan of £10m = 94%.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Activity trends - year to date</td>
<td>Green: &lt;101% of plan  Red: &gt;103%</td>
<td>Red</td>
<td>YTD Month 10 activity received for MYHT with an overtrade of 4.7% against YTD month 10 plan.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Running costs</td>
<td>Green: &lt;= RCA  Red: &gt;RCA</td>
<td>Green</td>
<td>£18k underspend at M12</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Clear identification of risks against financial delivery and mitigations</td>
<td>Green: Indicator met in full  Red: Indicator not met</td>
<td>Green</td>
<td>All risks identified with value and mitigation (see section 6)</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Assessment of internal and external audit opinion and on timeliness and quality of returns</td>
<td>Based on assessment of returns</td>
<td>Green</td>
<td>No audits undertaken to date. Self assessed green based on timeliness and accuracy of returns to WYAT</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Balance sheet indicators including performance against planned cash limit and BPPC performance.</td>
<td>to be defined</td>
<td>TBC</td>
<td>Cash at bank: £126k held at 31st March. BPPC: 96% of invoices paid by number and 90% paid by value.</td>
</tr>
</tbody>
</table>
3. Overall Financial Performance

There were no allocation adjustments during March. Total Allocations for 13/14 are presented below (£000):

<table>
<thead>
<tr>
<th>Total Recurring</th>
<th>Non-recurring</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>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>Funding for Personal Health budget rollout</td>
<td>20</td>
</tr>
<tr>
<td>Support to planning funding</td>
<td>10</td>
</tr>
<tr>
<td>Total Allocation at 31st March 2014</td>
<td>466,515</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>39,734</td>
<td>39,734</td>
<td>39,630</td>
<td>-104</td>
<td>-104</td>
</tr>
<tr>
<td>Acute - Mid Yorkshire Hospitals Trust</td>
<td>204,049</td>
<td>204,049</td>
<td>210,186</td>
<td>6,137</td>
<td>6,137</td>
</tr>
<tr>
<td>Acute - Leeds</td>
<td>12,866</td>
<td>12,866</td>
<td>13,136</td>
<td>270</td>
<td>270</td>
</tr>
<tr>
<td>Acute - YAS</td>
<td>15,213</td>
<td>15,213</td>
<td>15,216</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other Acute - NHS</td>
<td>12,993</td>
<td>12,993</td>
<td>11,530</td>
<td>-1,463</td>
<td>-1,463</td>
</tr>
<tr>
<td>Other Acute</td>
<td>19,706</td>
<td>19,706</td>
<td>20,943</td>
<td>1,237</td>
<td>1,237</td>
</tr>
<tr>
<td>Prescribing</td>
<td>60,486</td>
<td>60,486</td>
<td>60,570</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>Primary Care and Out of Hours</td>
<td>6,404</td>
<td>6,404</td>
<td>6,189</td>
<td>-215</td>
<td>-215</td>
</tr>
<tr>
<td>Continuing Care &amp; Free Nursing Care</td>
<td>25,633</td>
<td>25,633</td>
<td>28,717</td>
<td>3,084</td>
<td>3,084</td>
</tr>
<tr>
<td>Community Services</td>
<td>29,639</td>
<td>29,639</td>
<td>29,556</td>
<td>-83</td>
<td>-83</td>
</tr>
<tr>
<td>Other Contracts</td>
<td>11,174</td>
<td>11,174</td>
<td>10,872</td>
<td>-302</td>
<td>-302</td>
</tr>
<tr>
<td>QIPP</td>
<td>-2,441</td>
<td>-2,441</td>
<td>0</td>
<td>2,441</td>
<td>2,441</td>
</tr>
<tr>
<td>Winter Pressures</td>
<td>2,866</td>
<td>2,866</td>
<td>2,867</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Reserve-Contingency</td>
<td>2,251</td>
<td>2,251</td>
<td>0</td>
<td>-2,251</td>
<td>-2,251</td>
</tr>
<tr>
<td>Reserve-Emerg. Readmissions</td>
<td>2,426</td>
<td>2,426</td>
<td>0</td>
<td>-2,426</td>
<td>-2,426</td>
</tr>
<tr>
<td>Reserve-Committed reserve</td>
<td>300</td>
<td>300</td>
<td>0</td>
<td>-300</td>
<td>-300</td>
</tr>
<tr>
<td>Reserve - Other</td>
<td>2,674</td>
<td>2,674</td>
<td>2,970</td>
<td>296</td>
<td>296</td>
</tr>
<tr>
<td>Non Recurrent Reserve</td>
<td>2,240</td>
<td>2,240</td>
<td>0</td>
<td>-2,240</td>
<td>-2,240</td>
</tr>
<tr>
<td>Bfwd Surplus</td>
<td>4,230</td>
<td>4,230</td>
<td>0</td>
<td>-4,230</td>
<td>-4,230</td>
</tr>
<tr>
<td>Programme Allocation (exc planned surplus)</td>
<td>452,433</td>
<td>452,433</td>
<td>452,372</td>
<td>-60</td>
<td>-60</td>
</tr>
<tr>
<td>Running Costs</td>
<td>8,580</td>
<td>8,580</td>
<td>8,562</td>
<td>-18</td>
<td>-18</td>
</tr>
<tr>
<td>Total</td>
<td>461,013</td>
<td>461,013</td>
<td>460,934</td>
<td>-78</td>
<td>-78</td>
</tr>
<tr>
<td>13 / 14 Surplus</td>
<td>5,502</td>
<td>5,502</td>
<td>0</td>
<td>-5,502</td>
<td>-5,502</td>
</tr>
<tr>
<td>Total Allocation</td>
<td>466,515</td>
<td>466,515</td>
<td>460,934</td>
<td>-5,580</td>
<td>-5,580</td>
</tr>
</tbody>
</table>
The variance on QIPP is offset by underspends on The Practice (Ophthalmology), Assura (Dermatology) and other reserves.

Year to Date expenditure on NHS contracts reflects activity information received for April to February for some acute providers

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

4. Programme Budgets

- The outturn position for MYHT was agreed during January as part of the year end reconciliation exercise.

- Leeds outturn position was an overtrade of £270k, which related to overtrades on inpatients and day cases, offset by an underspend on critical care.

- Other NHS Acute includes £1.6m undertrade on Barnsley and Doncaster relating to non-elective procedures, an overtrade of £0.6m on Sheffield relating to 2 Critical Care patients and small undertrades on other contracts such as Rotherham, York and Sheffield Teaching Hospitals cost per case.

- Other Acute is showing £1.2m overspend. This includes overspends on Audiology AQP (£479k) and an overspend on non NHS providers (£546k).

- The prescribing outturn reflects the month 11 forecast position as per the PPA. Appendix 1 includes a comparison of the forecast outturns month on month against PPA prescribing data to demonstrate how the position has fluctuated in year. The PPA forecasts do not include centrally funded costs and Oxygen.

- Continuing Care ended the year with a significant overspend due to various cost pressures outlined in previous months. These include:

  - Palliative care patients traditionally cared for in hospital are now fast tracked and cared for at home by the Palliative Care out of hour’s team. Due to the increased activity there are now capacity issues within the out of hours team, resulting in increased use of private providers

  - Increasing numbers of cases are being entered into the continuing care pathway, and subsequently found to be eligible for continuing healthcare

  - In order to avoid discharge delays, increasing numbers of patients are discharged and then funded care homes
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. The remaining balance is offset by the underspend on ophthalmology and dermatology lines within each of the contracted positions.

- An updated position on the QIPP programme is shown in appendix 2. The position has improved from last month due to increased savings on ophthalmology, dermatology and PCLIF.

- Non-Recurrent plans include 3 reserves: 2% non-recurrent, non-elective readmissions and winter plan funds. Appendix 3 shows the year end position on each of the 3 accounts. The overall total was a surplus of £2.2m.

6. **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 12 is shown below. The majority of the NHS bills not paid within target were low value, NCA invoices, not processed by the CSU. This had a significant impact on the percentage paid by number of invoices, but as they were such low values, the percentage paid by value target was still met.

<table>
<thead>
<tr>
<th>Month 12 2013/14 - 31st March 2014</th>
<th>Number</th>
<th>£000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non NHS Creditors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bills at the end of the month</td>
<td>1,014</td>
<td>9,078</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>970</td>
<td>8,990</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>96%</td>
<td>99%</td>
</tr>
<tr>
<td><strong>NHS Creditors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bills at the end of the month</td>
<td>418</td>
<td>27,356</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>322</td>
<td>25,995</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>77%</td>
<td>95%</td>
</tr>
</tbody>
</table>

6. **Cash**

Cash at bank held at 31st March was £126k, which is within the year-end target.

7. **Other Legacy Issues**

Any payments made by CCGs in the current financial year in relation to legacy balances were reimbursed by NHS England before the year end.

8. **Recommendations**

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

Karen Parkin,
Associate Director of Finance, Governance and Contracting
08/05/2014
Appendix 1: Prescribing Spend

Prescribing 2012/13 actual Vs 2013/14 actual expenditure

<table>
<thead>
<tr>
<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 2013/14</td>
<td>4,854,913</td>
<td>4,975,765</td>
<td>4,572,425</td>
<td>5,052,907</td>
<td>4,736,002</td>
<td>4,728,203</td>
<td>5,152,036</td>
<td>4,814,816</td>
<td>4,977,008</td>
<td>4,979,258</td>
<td>4,504,451</td>
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</table>
Prescribing Forecast Out-turn Analysis

Prescribing Forecast Outturn Analysis 13/14

<table>
<thead>
<tr>
<th></th>
<th>CCG FOT</th>
<th>NHSBSA FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Variance £000's</td>
<td>Variance £000's</td>
</tr>
<tr>
<td>Apr-13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>May-13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Jun-13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Jul-13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Aug-13</td>
<td>-</td>
<td>651</td>
</tr>
<tr>
<td>Sep-13</td>
<td>651</td>
<td>-</td>
</tr>
<tr>
<td>Oct-13</td>
<td>1,000</td>
<td>-</td>
</tr>
<tr>
<td>Nov-13</td>
<td>1,023</td>
<td>-</td>
</tr>
<tr>
<td>Dec-13</td>
<td>516</td>
<td>-</td>
</tr>
<tr>
<td>Jan-14</td>
<td>516</td>
<td>-</td>
</tr>
<tr>
<td>Feb-14</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Mar-14</td>
<td>42</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG FOT Variance £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/14 Prescribing (above)</td>
</tr>
<tr>
<td>13/14 Oxygen</td>
</tr>
<tr>
<td>13/14 Central Drugs</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Note:
The NHSBA variance is 2 months in arrears and excludes non GP prescribing
The CCG forecast is based on local intelligence
## Appendix 2: 13/14 QIPP Schemes – Update as at 31/03/14

<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>Plan Outturn</th>
<th>Actual Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC001</td>
<td>Other Services</td>
<td>Childrens Complex &amp; Continuing Care Packages</td>
<td>Ann Carroll</td>
<td>Ian Carr</td>
<td>Ian Carr</td>
<td>1st Apr 13</td>
<td>67</td>
<td>73</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>379</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>300</td>
<td>398</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>
</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>500</td>
<td>0</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>170</td>
<td>1,622</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>864</td>
<td>1,603</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>60</td>
<td>0</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>20</td>
<td>0</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>2,000</td>
<td>1,500</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>3,347</td>
<td>1,948</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>
</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>0</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>400</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>Surplus budget review</td>
<td>Andrew Pepper</td>
<td>Karen Parkin</td>
<td>1st Apr 13</td>
<td>200</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>Detailed Budget Review and transaction of CCG reserves</td>
<td>Andrew Pepper</td>
<td>Karen Parkin</td>
<td>1st April 13</td>
<td>1,384</td>
<td>1,384</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SubTotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10,000</td>
<td>9,435</td>
<td></td>
</tr>
</tbody>
</table>
### 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>13/14 Value (k£)</th>
<th>13/14 Winter Pressures</th>
<th>13/14 2% non-recurrent reserve</th>
<th>13/14 non-elective readmissions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td>2% non-recurrent reserve</td>
<td></td>
<td>9,004</td>
<td>9,004</td>
<td>9,004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td>non-elective readmissions</td>
<td></td>
<td></td>
<td></td>
<td>2,426</td>
<td>2,426</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub Total</td>
<td></td>
<td></td>
<td>9,004</td>
<td>2,426</td>
<td>11,430</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td>NHS England Winter Pressures funding</td>
<td></td>
<td>3,576</td>
<td>3,576</td>
<td>3,576</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td></td>
<td>Total resource available</td>
<td></td>
<td>3,576</td>
<td>9,004</td>
<td>2,426</td>
<td>15,006</td>
<td></td>
</tr>
</tbody>
</table>

#### Potential Applications

| Matt England | PCLIF | Primary Care Local Improvement Framework | 18/09/2013 | 2,700 | 2,700 | 0 | 2,700 |
|             | b    | Performance Management of PCLIF | | 80 | 80 | 0 | 80 |
|             | TOTAL | | | 0 | 2,780 | 0 | 2,780 |

| Helen Childs | Care Close to Home | Single Point of Access | 30/08/2013 | 174 | 0 | 0 | 174 |
|              | d | Existing Virtual Ward | | 0 | 816 | 816 | 0 |
|              | TOTAL | | | 0 | 174 | 816 | 990 |

| Helen Childs | CC2H Additional Resource | ESD (Early Supported Discharge) - Toronto Model/LACE Tool | | 0 | 0 | 0 | 0 |
|              | f | ESD - Pharmacists x2 | | 0 | 0 | 0 | 0 |
|              | g | ESD - Drug and Alcohol Workers x3 | | 0 | 0 | 0 | 0 |
|              | f | Integrated Care Team development (ICT) - Organisational Development | 05/11/2013 | 69 | 0 | 69 | 0 |
|              | g | Mobile Working - Assisted technologies/mobile working | | 0 | 0 | 0 | 0 |
|              | h | GP Network events | 30/08/2013 | 39 | 0 | 39 | 0 |
|              | CC2H Evaluation | 05/11/2013 | 13 | 0 | 13 | 0 |
|              | h | CC2H Evaluation - Patient Engagement | | 24 | 0 | 24 | 0 |
|              | TOTAL | | | 0 | 145 | 145 | 0 |

| Gaynor Connor | Urgent Care | 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 | 50 | 0 | 50 | 0 |
|               | l | Increased MY therapy services | 30/08/2013 | 63 | 0 | 63 | 0 |
|               | m | Spot purchasing / winter bed capacity | 30/08/2013 | 285 | 0 | 285 | 0 |
|               | n | Primary Care Foundation | 30/08/2013 | 0 | 0 | 0 | 0 |
|               | ab | Winter Plan | 05/11/2013 | 645 | 0 | 646 | 0 |
|               | v | Remaining Winter Pressures allocations | | 2,564 | 0 | 2,564 | 0 |
|               | TOTAL | | | 0 | 145 | 145 | 0 |

| Michele Ezro | Mental Health | Mental Health Transformation | 30/08/2013 | 350 | 0 | 350 | 0 |

| Andrew Pepper | Acute Trust | MYHT reserve for non-recurrent costs | 19/11/2013 | 2,568 | 2,568 | 0 | 2,568 |
|               | d | MYHT reserve for former SCG share of non-recurrent costs | 19/11/2013 | 200 | 0 | 200 | 0 |
|               | TOTAL | | | 0 | 2,568 | 0 | 2,568 |

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jo Harlon</td>
</tr>
<tr>
<td>Various</td>
</tr>
<tr>
<td>Andrew Pepper</td>
</tr>
<tr>
<td>A Middleware</td>
</tr>
<tr>
<td>Gill Day</td>
</tr>
<tr>
<td>Rosemary Davison</td>
</tr>
<tr>
<td>Lisa Chandler</td>
</tr>
<tr>
<td>Michelle Ashbridge</td>
</tr>
<tr>
<td>Mandy Sheffield</td>
</tr>
<tr>
<td>Jane Maskill</td>
</tr>
<tr>
<td>Michele Ezro</td>
</tr>
<tr>
<td>M Ashbridge</td>
</tr>
<tr>
<td>Becky Gunn</td>
</tr>
<tr>
<td>Andrew Pepper</td>
</tr>
<tr>
<td>Andrew Pepper</td>
</tr>
<tr>
<td>Jayne Beecham</td>
</tr>
<tr>
<td>Andrew Pepper</td>
</tr>
<tr>
<td>Jayne Beecham</td>
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<tr>
<td>Helen Childs</td>
</tr>
<tr>
<td>Michele Ezro</td>
</tr>
<tr>
<td>±256</td>
</tr>
<tr>
<td>Michele Ezro</td>
</tr>
<tr>
<td>Jenny Feeney</td>
</tr>
<tr>
<td>Linda Driver</td>
</tr>
<tr>
<td>Michele Ezro</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

| B | Sub Total | | | 3,608 | 8,342 | 816 | 12,766 |
| C | Difference | | | 32 | -662 | -1,610 | -2,240 |
| D | Proposed reconciliation | | | 0 | 0 | 0 | 0 |
| E | TOTAL | | | 3,608 | 8,342 | 816 | 12,766 |
| | DIFFERENCE | | | 32 | -662 | -1,610 | -2,240 |
Title of meeting: Governing Body
Date of Meeting: 13 May 2014
Paper Title: Business Case: Non-recurrent investment to pump prime the Integrated Care service in Wakefield District
Purpose (this paper is for): Decision ✓ Discussion Assurance Information
Report Author and Job Title: Helen Childs – Interim Director of Community Transformation
Responsible Clinical Lead: Dr Avijit Biswas, Clinical Lead
Responsible Governing Board Executive Lead: Jo Webster, Chief Officer

Recommendations:

i. it is recommended that the Governing Body approve the business case submitted to support district wide implementation of Integrated care Services; and
ii. note the latest position in relation to the Better Care Fund metrics.

Executive Summary:

This business case sets out proposals to implement the adult Integrated Care model within a 12 month period across Wakefield District. This will involve the integration of adult social care services, NHS community health services and community and voluntary sector provision across the district. It is proposed that this will be taken forward as part of a rapid but phased approach to inform learning and development across all other Practice Networks. Full implementation is planned to be achieved by October 2014. There is a requirement to significantly reduce emergency bed days by admissions avoidance and reduction in length of stay from 15/16. This business case supports this requirement enabling the reconfiguration of acute services in line with MYHT FBC timescales.

The non recurrent investment will be managed in the overall context of the Better Care Fund (BCF) resources and the emerging new governance arrangements to support this approach. This business case to utilise a significant part of the CCG’s non-recurrent funds have been recently presented and supported by Clinical Cabinet in April 2014. The BCF will see £3.8bn of existing national resources invested in a pooled budget between local health and social services from 2015/16. Wakefield district has committed to pool circa £42 million in a Section 75 from 15/16. The CCG has continued dialogue with NHS England regarding the appropriate metrics against which to measure success of the Better Care Fund. As part of the initial submission, The Health and Well Being Board and CCG Governing Body agreed a locally decided metric for the BCF which was “proportion of adults who get as much social care support as they want.” This was felt to be an appropriate choice due to it being focused on patient and service user experience. Subsequent engagement and feedback from NHS England suggests that as this measure can only be collected on an annual basis a more timely measure may be requested. There are a number of potential metrics which may be appropriate such as “satisfaction of domiciliary care users”, which will enable measurement of the impact on service users quality and experience of the health and social care system. Discussions are ongoing. As a principle, the selected metrics would need to adhere to the overall direction set by the Health and Well Being Board and CCG Governing Body of focusing on quality of life and also meet a number of NHSE requirements on data quality.
| 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: | As part of Care Closer to Home OBC chapter |

| Outline public engagement: | As described in Better Care Fund submission |

| Assurance departments/ organisations who will be affected have been consulted: | Not applicable |

| Previously presented at committee / governing body: | On the 24th April 2014 the Clinical cabinet received an earlier version of this business case which described the outcomes and objectives of the proposed transformational investment in Integrated Care Teams. It was noted that Network 2 had begun roll out of the ‘proof of concept’ on the 1st February 2014. As such, to remain within project timescales, Clinical Cabinet agreed to release non recurrent resources of £529K over two years for Network 6 and 1. This was in advance of the Governing Body consideration of the overall programme to ensure the project remained on track to secure and assess the ‘proof of concept’ benefits |

| Reference document(s) / enclosures: | Not applicable |

| Risk Assessment: | Risks are described in the business case |

| Finance/ resource implications: | Finance/resource implications are described in the business case |
Title: Business Case: Non recurrent investment to pump prime the Integrated Care service in Wakefield District

Date: 13 May 2014

Programme Manager: Helen Childs, Interim Director of Community Transformation

Clinical Commissioning Lead: Dr Avijit Biswas, GP

Senior Responsible Officer: Jo Webster, Chief Officer

1. Executive Summary

Health and social care commissioners in Wakefield District are committed to the integration of services to improve outcomes for residents. A “Wakefield Integration Shared Narrative,” has been produced to outline their integration strategy and provide a statement of intent for how they will achieve their vision for the district by 2018/19.

Wakefield District recognises that there is a persuasive case for change;

- **People need greater control over their lives**: Moving from a paternalistic attitude where we “do-to” people to finding shared solutions.
- **Current experience of patients, service users and carers**: This can be fragmented and is often designed around the needs of services rather than the patient/service user.
- **Sustainability of current services**: Demand is rising and resources are reducing.
- **Demographic change**: Ageing populations require differing levels of care.
- **Increasing deprivation**: Whilst life expectancy is increasing overall, for some communities this is happening more slowly. Some communities also experience a poorer quality of life than others. These communities are also not engaging with services.
- **Overuse of services in the acute setting**: Need to prevent problems at the earliest possible stage.

Our vision is therefore that:

“Communities in Wakefield District achieve the best possible outcomes for themselves and their families, facilitated by co-ordinated health and social care, provided as close to home as possible.”

The approaches that we will adopt, enshrined in our Health and Wellbeing Strategy are:

- Prevention
- Partnerships
- Personalisation
- Evidence and Innovation

Over the next five years we will concentrate on the following levers to bring about change:

- Attitudes and behaviours e.g. placing the person at the centre of all we do.
- Information sharing e.g. Commitment to shared assessment.
• Leadership and organisational development e.g. Commitment to support workforce to bring about transformational change.
• Market development e.g. Commitment to developing a joint commercial strategy.
• Finance and procurement e.g. Outcome driven payment and procurement models.

This business case outlines the plans to roll out the proof of concept Integrated Care Team (ICT) model across Wakefield District. Building on the earlier implementation of the ‘proof of concept’ in Network 2 this business case describes the ‘pump priming requirements to support implementation in the remaining 6 GP networks for a 24 month period. The roll out involves the integration of adult social care services, NHS community health services and community and voluntary sector provision across the district.

The plans will work towards delivering outcomes in the following areas:

• Care is co-ordinated and seamless
• Nobody is admitted to or kept in hospital or residential care unnecessarily
• People are supported and in control of their condition and care, enjoying independence for longer
• Care is cost-effective and within available budgets
• All staff understand the system and work in it effectively
• Unpaid carers are prepared and support to care for longer

It is expected that full implementation will have taken place by the autumn of 2014. the Integrated services will specifically focus on the delivery of:
2. Expected benefits and Outcomes

A robust assurance framework (Appendix 1) has been developed to ensure expected outcomes and benefits are realised through the transformation of services. These include:

Our overall aims for our integrated system for older people and vulnerable adults are that:

- Care is co-ordinated and seamless
- Nobody is admitted to or kept in hospital or residential care unnecessarily
- People are supported and in control of their condition and care, enjoying independence for longer
- Care is cost-effective and within available budgets
- All staff understand the system and work in it effectively
- Unpaid carers are prepared and support to care for longer

The objectives that will achieve our aims are:

- Admission avoidance to prevent emergency admissions for elderly and frail individuals by providing a comprehensive and rapid crisis assessment support service
- Early supported discharge to provide timely and safe supported discharge for elderly and frail individuals by in reaching into hospital to ‘pull’ patients home whilst producing a holistic care plan for implementation by the team in the community;
- Providing more choice for citizens by building community capacity, through increasing ‘good neighbourliness’ and creating age friendly communities that give greater access to sources of support within, and by, the community;
- Creating a holistic service, reducing the need for unnecessary hospital admissions and facilitating more timely and safe discharge, whilst reducing the risk of readmission;
- Reducing the need for complex and expensive care packages; through earlier intervention and preventative services and support;
- Empowering staff to develop their skills through collaboration, knowledge sharing and greater responsibility with effective and significant relationships with GPs and the community and voluntary sector.
- Ensuring parity of care between mental health and physical health. For example, the introduction of a psychiatric liaison service to address mental health crisis intervention for those patients presenting to the acute trust.
- Integrated clinical services supporting the acute services reconfiguration in Mid Yorkshire Hospitals Trust

In order to support the delivery of the acute services reconfiguration in Mid Yorkshire Hospital evidence based interventions have been modelled to support the reduction in emergency bed days.
<table>
<thead>
<tr>
<th>Health and social care services (pro-active care and crisis intervention) to prevent the need for individuals’ to require emergency care at Mid Yorkshire Hospitals NHS Trust</th>
<th>Impact on emergency admissions</th>
<th>Average length of stay</th>
<th>Impact on emergency bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>5160</td>
<td>2.05</td>
<td>10,578</td>
<td></td>
</tr>
</tbody>
</table>

### 3. Implementation Timescales

<table>
<thead>
<tr>
<th>High Level Key Milestones</th>
<th>Planned Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage Key stakeholders in individual networks to share new core service offer to develop Integrated Care.</td>
<td>May 2014</td>
</tr>
<tr>
<td>Secure non recurrent investment to support development and implementation of Integrated Care model</td>
<td>May 2014</td>
</tr>
<tr>
<td>Network staff engaged to inform and support service design and patient and service user pathways</td>
<td>May 2014</td>
</tr>
<tr>
<td>Recruitment processes initiated to secure additional resources across Health, Social Care and Community and Voluntary Sector</td>
<td>June 2014</td>
</tr>
<tr>
<td>Integrated Care operating model including high level design principles agreed</td>
<td>June 2014</td>
</tr>
<tr>
<td>Gateway to Care operational</td>
<td>June 2014</td>
</tr>
<tr>
<td>Agree governance, policies, processes and procedures for the new ways of working to support the operating model</td>
<td>May 2014</td>
</tr>
<tr>
<td>Recruitment and initial training completed for additional staffing resources across Health, Social Care and Community and Voluntary Sector</td>
<td>July 2014</td>
</tr>
<tr>
<td>Implementation of operating model for Integrated Care within Network 6 &amp; 1 commenced (teams in place, working in line with the agreed processes and procedures and in line with the agreed governance)</td>
<td>July 2014</td>
</tr>
<tr>
<td>Implementation of operating model for Integrated Care within Network 4 &amp; 3 commenced (teams in place, working in line with the agreed processes and procedures and in line with the agreed governance)</td>
<td>September 2014</td>
</tr>
<tr>
<td>Implementation of operating model for Integrated Care within Network 5 &amp; 7 commenced (teams in place, working in line with the agreed processes and procedures and in line with the agreed governance)</td>
<td>October 2014</td>
</tr>
<tr>
<td>Integrated performance monitoring of measures and outcomes in place</td>
<td>May 2014</td>
</tr>
<tr>
<td>Six Month Initial Evaluation</td>
<td>September 2014</td>
</tr>
<tr>
<td>12 Month Project Evaluation Report</td>
<td>March 2015</td>
</tr>
</tbody>
</table>

### 4. Governance

The Health and Wellbeing Board has taken the transformation and integration programme as its priority issue. It receives reports on progress at each meeting. Currently, the Joint Strategic Commissioning Board (JSCB), which is the engine room of the Health and Wellbeing Board, has been the place at which commissioners have received reports on progress and reported this up to the Health and Wellbeing Board for purposes of assurance or concern.
However, a new Integration Executive has been formed with an inaugural meeting on 7 April, 2014. This will be accountable to both the local authority and the CCG and is currently envisaged to oversee the pooled budget arrangements in place, specifically the Better Care Fund (BCF). Members will have appropriate delegated powers to make decisions about the management of the BCF. This Executive will also include both adults and children’s commissioning. All decisions made by this Executive will need to adhere to the Wakefield Integration Strategy.

The CCG will need to develop a robust governance framework with Local Authority partners to manage the BCF over the coming months. This will include the necessary oversight of investment committed by the health economy.

The Wakefield Integration Strategy underlines our partnership approach to governance with specific agreements on information sharing, procurement, finance, commercial strategy, market development and leadership. The strategy also makes a commitment to transparency.

The Assurance Framework will be presented to the Integration Board on a quarterly basis and six monthly reports from the independent evaluation will also be presented.

5. Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Pre mitigation Risk rating</th>
<th>Mitigating Actions</th>
<th>Post Mitigation Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity shift assumptions within the Care Closer to Home SOBC are too great, particularly relating to A&amp;E attendances and non-elective admissions. Evidence suggests that the new model may not support delivery of the required bed reductions in MYHT</td>
<td>25</td>
<td>1. Work on evidence base is being undertaken by Public Health consultant 2. Review outcome of evidence base work 3. Finance and Business Intelligence ‘deep dive’ testing will be aligned with the current assumptions</td>
<td>20</td>
</tr>
<tr>
<td>Required increase in workforce cannot be achieved due to lack of trained practitioners across the health and social care system</td>
<td>20</td>
<td>1. Detailed workforce review to be undertaken 2. Work being undertaken with training organisations to increase training opportunities</td>
<td>15</td>
</tr>
<tr>
<td>Inability to facilitate effective early supported discharge due to the lack of shared records and information across health and social care</td>
<td>15</td>
<td>1. Partnership agreement for information sharing in situ 2. Work with TPP to enable solutions</td>
<td>10</td>
</tr>
<tr>
<td>Slippage in implementation if partners have insufficient capacity to contribute to the programme.</td>
<td>20</td>
<td>1. Re-emphasise the importance of the programme 2. Identify alternatives or additional resources. 3. Minimise burden.</td>
<td>15</td>
</tr>
</tbody>
</table>
Potential changes within primary care contract and services may reduce motivation and capacity within primary care to develop services closer to home within the required timescales

| 15 | 1. Ensure effective communication of benefits.  
2. Tell the story and take people on the journey.  
3. Ensure stakeholder ownership of the programme. |

Delayed start to implementation due to the delayed release of non-recurrent monies required for initial investment

| 20 | 1. Identify and secure funding requirements.  
2. Provide indicative timescale for funding requirements.  
3. Ensure clear and timely lines of communication in relation to actual release requirements |

### 6. Finance

#### 6.1 Description of Financial Model

**Overall financial context**

The 2013 Spending Round indicated that NHS funding will grow in real terms and that an overall efficiency of 4% is expected to be required to maintain current services. In addition, the NHS and social care will pool resources into a Better Care Fund which will enable commissioning of optimised Health and Social Care services. This national approach is consistent with the objectives of the Mid Yorkshire Transformational Programme.

Over the coming years the economic outlook for the NHS is challenging. Effectively, this means that to maintain a financial balance we will need to provide more services to more people for less cost. To do this we’ll need to be more efficient and cost effective whilst at the same time reduce demand for NHS services.

Wakefield CCG’s financial strategy presents both risk and opportunity. There are risks around demand, inflation, QIPP efficiencies, funding formula, adjustments and tariff changes. However, transformation and partnership working provides the best opportunity to deliver the necessary efficiencies and respond to the long-term financial challenge.

To ensure that assumptions contained in a long-term financial strategy are recognised by the health economy as a whole, the CCG has constructed a high-level long-term financial plan which draws together assumptions to meet this challenge.

**Costing methodology for this business case**

The financial model within this business case starts with the existing community nursing baseline budget and sets this alongside the anticipated additional investment for the pilot project. No adjustment has been made for inflation so all figures used are at 2013/14 levels.
The model now developed, looks at the combined effect of the community commissioning budget and the transformation programme goals to address the common areas of both. This has led to the development of a range of financial models to evaluate options of GP list size, establishment needs and services.

The methodology for costing the options is based on anticipated numbers of workforce required and assumptions about the composition of each team.

A bottom-up estimated financial cost model has been developed to evaluate the baseline costs for a project programme and to estimate the establishment and support costs for the transformation programme, Care Closer to Home.

Securing best value

Based on the analysis to date it is apparent that beyond an approximate 22,000 population size per team the marginal cost of the programme increases as more teams are used.
Using this assumption, the following cost model was developed.

**Model population size – Wakefield** 355,464
**Optimum population per team** 22,225
**Model number of teams based on population per team** 16

**Suggested team composition**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 nursing teams, estimated cost</td>
<td>7.9</td>
</tr>
<tr>
<td>Anticipated support and ancillary costs</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Estimated recurrent total cost</strong></td>
<td><strong>12.8</strong></td>
</tr>
</tbody>
</table>

**Proposed funding requirements for staged investment**

However, in order to provide further scrutiny, the “proof of concept” project will consider two additional models to the one above:

- 30-40,000 population size
- 20-25,000 population size
- 10-15,000 (hybrid) population size

Thereby by assessing the initial financial model with team sizes greater and smaller that the initial concept this will provide some sensitivity analysis around the optimum team size which will allow opportunity to refine the estimates associated with the steady state model.

**Proposed Indicative Funding Estimates for 2014/15 and 2015/16**

<table>
<thead>
<tr>
<th>Description</th>
<th>2014/15 (£m)</th>
<th>2015/16 (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network support</td>
<td>0.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Anticipated support and ancillary costs</td>
<td>2.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Early Support Discharge</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Gateway to Care</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Optimisation of Systm-one</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Estimated Total Investment</strong></td>
<td><strong>3.8</strong></td>
<td><strong>5.3</strong></td>
</tr>
</tbody>
</table>

**Sources of Funding**

<table>
<thead>
<tr>
<th>Description</th>
<th>£’000s</th>
<th>£’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS non-recurrent investment</td>
<td>2.2</td>
<td>3.7</td>
</tr>
<tr>
<td>Funding from joint resources with local authority</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Sources of Funding</strong></td>
<td><strong>3.8</strong></td>
<td><strong>5.3</strong></td>
</tr>
</tbody>
</table>
## Appendix 1 - Assurance Framework - Adult Integration - Wakefield - April 2014

### Outcome 1: Care is co-ordinated and seamless

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
<th>Baseline</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
<th>Comparison to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>% of patients on (denominator) with shared care plan.</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2</td>
<td>% of patients discharged by 0pm</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>3</td>
<td>Midweek bed occupancy (Chart shows whether above or below target)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>When I use a new service, my care plan is known in advance and respected</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>5</td>
<td>The professionals involved with my care talk to each other as a team.</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Outcome 2: Nobody is admitted to or kept in hospital or residential care unnecessarily

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
<th>Baseline</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
<th>Comparison to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>No. of ABF attendances</td>
<td>Wakefield</td>
<td>11886</td>
<td>11900</td>
<td>11895</td>
<td>11910</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>7</td>
<td>No. of emergency admissions not including emergency GP admissions</td>
<td>Wakefield</td>
<td>53559</td>
<td>53600</td>
<td>53620</td>
<td>53650</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>8</td>
<td>LOS (length of stay) of admissions with a length of stay of 0-2 days in the adult (18+) population</td>
<td>Wakefield</td>
<td>21,751</td>
<td>21,726</td>
<td>21,701</td>
<td>21,676</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>9</td>
<td>LOS (length of stay) of admissions with a length of stay of 0-2 days in the elderly (&gt;65) population</td>
<td>Wakefield</td>
<td>7603</td>
<td>7590</td>
<td>7577</td>
<td>7564</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>10</td>
<td>LOS (length of stay) of admissions with a length of stay of 3-5 days in the adult (18+) population</td>
<td>Wakefield</td>
<td>6854</td>
<td>6840</td>
<td>6826</td>
<td>6812</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>11</td>
<td>LOS (length of stay) of admissions with a length of stay of 3-5 days in the elderly (&gt;65) population</td>
<td>Wakefield</td>
<td>3655</td>
<td>3640</td>
<td>3625</td>
<td>3610</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>12</td>
<td>LOS Average LOS in the adult (18+) population</td>
<td>Wakefield</td>
<td>5.6</td>
<td>5.6</td>
<td>5.6</td>
<td>5.6</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>13</td>
<td>LOS Average LOS in the elderly (&gt;65) population</td>
<td>Wakefield</td>
<td>8.5</td>
<td>8.5</td>
<td>8.5</td>
<td>8.5</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>14</td>
<td>Total no. of emergency bed days</td>
<td>Wakefield</td>
<td>158270</td>
<td>158270</td>
<td>158270</td>
<td>158270</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>15</td>
<td>Rate of emergency re-admissions within 30 days</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>16</td>
<td>Delayed transfers of care from hospital and those which are attributable to adult social care</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Outcome 3: People are empowered to perform their care and enjoy independence for longer

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
<th>Baseline</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>YTD</th>
<th>Comparison to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Percentage of people aged 65+ discharged from hospital, who were provided with re-admission services.</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>18</td>
<td>Percentage of people aged 65+ provided with re-admission services, who were still at home 91 days after discharge from hospital</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>19</td>
<td>Permanent admissions to residential and nursing care homes, aged 65+ per 100,000 population.</td>
<td>Wakefield</td>
<td>755</td>
<td>722</td>
<td>690</td>
<td>660</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>20</td>
<td>I am involved in discussions and decisions about my care, support and treatment as I want to be.</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>21</td>
<td>I feel in control of my condition.</td>
<td>Wakefield</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Outcome 4: Care is cost-effective and within available budgets

This outcome will be monitored annually

### Outcome 5: All staff understand the system and work in it effectively

This outcome will be monitored annually

### Outcome 6: Unpaid carers are prepared and supported to care for longer

This outcome will be monitored annually

---

**Notes and Data Sources:**

Unless otherwise stated, all figures are based on the registered population for the corresponding CCG.

1. To be decided.
2. The proportion of total discharges within the quarter who were discharged before 0pm. Mid Yorkshire Hospital Trust.
4-9. To be measured using participatory appraisal approach (PAA) based on % of cohort who answer “Agree” or “Strongly agree.”
6-7. Mid Yorkshire Hospital Trust activity on SUS.
9-11. Length of stay. Figures in brackets represent the proportion of all admissions that meet each criterion, computed at the Individual Trust level, and excludes discharges from other hospitals.
12-13. Average length of stay in hospital inpatient excluding maternity admissions, Mid Yorkshire Hospital Trust activity on SUS.
15. PBB guidance.
16. Mid Yorkshire Hospital Trust, published on Unify.
17-18. Indicator 28 from the Adult Social Care Outcomes Framework and shared with the NHS Outcomes Framework (Indicator 3.8). Figures are calculated at a Local Authority level. Data from the Adult Social Care Combined Activity Return (ASC-CAR) and Hospital Episodes Statistics (HES). Figures published annually on NHS Indicators portal.
19. Indicator 2A (Part 2) from the Adult Social Care Outcomes Framework. Figures are calculated at a local Authority level. Data from the Adult Social Care Combined Activity Return (ASC-CAR) and DMS mid-year population estimates. Figures published annually on NHS Indicators portal.
20-21. To be measured using participatory appraisal approach (PAA) based on % of cohort who answer “Agree” or “Strongly agree.”
**Title of meeting:** Governing Body  
**Date of Meeting:** 13 May 2014  
**Public/Private Section:** Public

**Paper Title:** NHS Wakefield CCG Constitution: Proposed amendments

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

**Report Author and Job Title:** Katherine Bryant, Governance & Board Secretary

**Responsible Clinical Lead:** Dr Philip Earnshaw, Chair

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

**Recommendation (s):**
It is recommended that the Governing Body agree to consult the CCG’s membership on the proposed amendments to the NHS Wakefield Clinical Commissioning Group Constitution.

**Executive Summary:**

**Background**
The CCG’s constitution and associated governance documents were developed from the Commissioning Board model documentation. Minor amendments were made to the constitution in August 2013; following approval from member practices, the Governing Body and NHS England.

**Proposed amendments**
Members of the Governing Body are invited to consider two proposed changes to the CCG’s constitution.

a) Removal as Appendix H to the constitution the Governing Body’s committee terms of reference. Interested members of the public will still be able to access copies of the committee terms of reference from the CCG’s website (web-links are included within the constitution, as required by NHS England).

It is good governance practice for the Governing Body to review committee terms of reference on an annual basis. By extracting the committee terms of reference from the constitution the Governing Body will have the freedom to amend the terms of reference without reference to NHS England. This will avoid the organisation going this resource intensive process every time they seek to revise and update the committee terms of reference.

b) Following the launch of the CCG’s website, web-links throughout the document have been updated to refer to the [www.wakefieldccg.nhs.uk](http://www.wakefieldccg.nhs.uk) (rather than the out-of-date Wakefield PCT site [www.NHSHWakefielddistrict.nhs.uk](http://www.NHSHWakefielddistrict.nhs.uk)).

**Next steps**
In order for amendments to be made to the constitution and/or its appendices; NHS England requires that all changes are presented to them for approval. This must follow approval from the CCG’s member practices for the amendments. There are only two opportunities each year for CCGs to apply to NHS England to make amendments to their constitution (in June and November).

Member practices will be consulted about the proposed amendments, and invited to signify their approval. Then if approval is received from the CCG’s members an application to NHS England will be made by 1st June 2014.

**Review of the constitution**
A wider review of the constitution is underway; this has been facilitated by support from a small working group made up of two members of the Governing Body (a Lay Member and the Practice Manager representative) and two GPs. Unfortunately it has not been possible to progress the review to a sufficient degree to propose broader amendments at this point.

The extended constitution review period will allow appropriate legal advice to be obtained and provide assurance to the Governing Body that the constitution reflects all regulatory requirements and reflects current best practice.

| 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: | Completed, no impact on protected groups identified. |

| Outline public engagement: | None. |

| Assurance departments/organisations who will be affected have been consulted: | Ongoing consultation with members via a working group and the Local Medical Committee. |

| Previously presented at committee / governing body: | None. |

| Reference document(s) / enclosures: | A tracked changes copy of the revised constitution is available upon request from Katherine Bryant (katherine.bryant@wakefieldccg.nhs.uk). |

| Risk Assessment: | None identified. |

| Finance/ resource implications: | None identified. |
**Title of meeting:** Governing Body  
**Agenda Item:** 12  
**Date of Meeting:** 13 May 2014  
**Paper Title:** Integrated Risk Management Framework

### Executive Summary:

The Governing Body is asked to approve the attached draft NHS Wakefield Clinical Commissioning Group (CCG) Integrated Risk Management Framework. This was recommended for approval by the Integrated Governance Committee at the meeting on 20 March 2014.

The Integrated Risk Management Framework outlines the way in which NHS Wakefield CCG has effective governance arrangements in place to manage clinical, financial and corporate risk.

This Integrated Risk Management Framework covers:

- risk management processes;
- risk management objectives for NHS Wakefield CCG;
- organisational accountability for risk management.

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

<table>
<thead>
<tr>
<th>Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health equality across our population</td>
</tr>
<tr>
<td>Support for individual health and wellbeing</td>
</tr>
<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 commission</td>
</tr>
<tr>
<td>Service transformation through redesign</td>
</tr>
<tr>
<td>Improvement through collaboration and integration</td>
</tr>
<tr>
<td>Financial efficiency, probity and balance</td>
</tr>
</tbody>
</table>

### Outcome of Equality Impact Assessment:

Not applicable.
<table>
<thead>
<tr>
<th><strong>Outline public engagement:</strong></th>
<th>Not applicable.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assurance departments/organisations who will be affected have been consulted:</strong></td>
<td>Consultation on this Framework has been undertaken with the Governance and Board Secretary and the Integrated Governance Committee on 20 March 2014.</td>
</tr>
<tr>
<td><strong>Previously presented at committee / governing body:</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Reference document(s) / enclosures:</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Risk Assessment:</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Finance/ resource implications:</strong></td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Version Number</td>
<td>Changes Applied</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------</td>
</tr>
<tr>
<td>1.1</td>
<td>Initial Draft</td>
</tr>
<tr>
<td>1.2</td>
<td>Adjusted following feedback</td>
</tr>
<tr>
<td>1.3</td>
<td>Draft for NHSWD</td>
</tr>
<tr>
<td>1.4</td>
<td>Draft for CCE</td>
</tr>
<tr>
<td>1.5</td>
<td>Draft for Integrated Governance Committee</td>
</tr>
<tr>
<td>1.6</td>
<td>Draft for Governing Body following recommendation for approval by the Integrated Governance Committee</td>
</tr>
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</table>
## Contents

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Risk Management Approach</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Risk Management arrangements and Key Objectives</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Objective 1 – identify, report and manage risk</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Objective 2 – capture and learn</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Objective 3 – accountability framework</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Objective 4 – comply with external assessments</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Objective 5 – key partnerships and major projects</td>
<td>12</td>
</tr>
</tbody>
</table>
Introduction

NHS Wakefield Clinical Commissioning Group (CCG), as a publicly accountable organisation, needs to take many informed, transparent and complex decisions and manage the risks associate with these decisions. NHS Wakefield CCG therefore needs to ensure that it has a sound system of internal control working within the organisation.

Effective strategic and operational risk management is fundamental to ensuring that an effective system of corporate governance is in place within NHS Wakefield CCG. This integrated risk management framework outlines the way in which NHS Wakefield CCG has effective governance arrangements in place to manage clinical, financial and corporate risk.

This Integrated Risk Management Framework covers:

- risk management processes
- risk management objectives for NHS Wakefield CCG
- organisational accountability for risk management.

1 Risk Management Approach

Risk is inherent in all the activities we undertake. The Risk Management process within NHS Wakefield CCG should ensure that the organisation:

- Minimises risk of physical or emotional harm to our patients and workforce;
- Maintains comprehensive and responsive arrangements to respond appropriately to emergency situations;
- Minimises the loss or wastage of resources through poor internal control procedures;
- Manages sensitively issues which have a reputational impact or public interest;
- Manages CCG resources effectively for the short and long term;
- Effectively escalates issues internally and with partner organisations so that action is taken at the appropriate level and the impact is monitored.

Effective risk management relies on the full engagement of people in all areas and accurate and timely receipt and analysis of information.

In order to engage people, receive and use information the risk management arrangements must be effective, light touch and meaningful so the process supports the way we work and is not interpreted as an additional management function.

The NHS Wakefield CCG approach to risk management is based on ensuring a robust risk management system is in place, understood and effective. Outlined below are five risk management objectives of NHS Wakefield CCG’s integrated risk management framework for managing clinical, financial and corporate risk.

2 Risk Management Key Objectives

The key objectives for Risk Management are listed below:
1. The organisation has appropriate and effective systems in place to identify, report and manage risk.
2. The organisation has effective processes to capture and learn from mistakes to reduce future risks.
3. An effective accountability framework for the management and reporting of risk is in place.
4. The organisational risk management framework provides sufficient evidence and assurance to comply with relevant external assessment and best practice.
5. The organisation will develop risk management arrangements for key partnerships and major projects.

The detail to support the delivery of the above risk management objectives is given in the following pages.

2.1 RISK MANAGEMENT KEY OBJECTIVE ONE

The organisation has appropriate and effective systems in place to identify, report and manage risk

The Risk Assessment and Management process is illustrated in the chart below. Responsibilities for risk management are also covered in this section.
2.1.1 Identification of Risk

Risk can be defined as deviation from ‘plan’; where ‘plan’ can be a performance target, an outcome, or compliance with a standard. Risk can only be managed if it is identified. Triangulation of soft and hard information from different sources gives assurance that all significant risks have been captured.

The key sources of information used to check completeness of risk capture are:

- Performance indicators reporting variance from plan within commissioning performance contracts and their reports;
- The results of planned reviews of compliance with statutory and regulatory requirements e.g. fire regulations, Care Quality Commission (CQC) standards and reviews, Ofsted reviews, Parliamentary Ombudsmen, professional standards, information governance systems including IG Toolkit etc;
- Routine review of serious incidents, incident reports and complaints to identify emerging risks such as themes or specific concerns which can be escalated to the appropriate risk registers;
- Utilisation of intelligence through partner networks and from stakeholders to encourage the sharing of information to identify potential risks;
- Ensuring contact with regional and national professional associations that provide early warning on serious or major adverse events;
- Risk review and discussion through operational groups and formal meetings, i.e. Governing Body, Audit Committee, Integrated Governance Committee, Clinical Cabinet and their subgroups which highlight problems and issues which should be reflected in the risk register.

Risk identification is also supported through many review processes using the live risk register:

- Team or contract review meetings;
- 24/7 access to the risk register by NHS Wakefield CCG members;
- Governance meetings specifically reviewing risk and/or risk areas;
- Joint service providers meeting where the system can be viewed or risk logs shared and discussed.

Once every risk cycle, a corporate “reality check” of the content of the risk registers including a moderation of the scores and actions taken is conducted through:

- Review of the risk register by the Senior Management Team (SMT), the Integrated Governance Committee and the Governing Body.

2.1.2 Risk Assessment

Risk Assessment is a structured process used to:

- Identify a risk;
- Understand its potential impact;
- Examine what control measures can be applied and their effectiveness;
- Decide if further actions are necessary other than control measures;
- Score Risks and categorise the potential of any outstanding risk after the above processes.
Statutory Health and Safety training is available to new staff and as a refresher for existing staff and includes risk assessment information. Individual training and support on risk assessments and the risk register is available to all staff from the West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU) Governance and Risk Team.

Risk scores are achieved by multiplying the potential consequence or severity by the potential likelihood or frequency level to provide a risk score utilising a 5 x 5 matrix scoring system which produces a range of scores from 1 to 25.

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

The online system has guidance regarding the risk scoring process and illustrations of this guidance can be seen in the appendix.

The online guidance is reviewed regularly and can be updated and changed as required.

2.1.3 Risk Prioritisation

The risk score determines the prioritisation and allocation of resource. Higher scores have a higher priority for action, as the impact of failing to reduce the risk is greater.

Risk scores are categorised into five sections. The table below shows the categories of risk scoring.
<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Priority No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Risk (20-25)</td>
<td>Black</td>
</tr>
<tr>
<td>Serious Risk (15-16)</td>
<td>Red</td>
</tr>
<tr>
<td>High Risk (8-12)</td>
<td>Yellow</td>
</tr>
<tr>
<td>Moderate Risk (4-6)</td>
<td>Green</td>
</tr>
<tr>
<td>Low Risk (1-3)</td>
<td>Clear</td>
</tr>
</tbody>
</table>

### 2.1.4 Risk Recording / Risk Register

NHS Wakefield CCG will use an electronic / on line risk register, provided by WSYBCSU, to identify and record all the organisational risks are identified and recorded. The data base is archived on an agreed cycle (currently four times a year) at which point any closed risks for the preceding period will be removed from the new live register but remain in the archived record allowing any retrospective review or report to be published. The five principles that support this approach form the basis of the risk management strategy and are described below.

The five principles underpinning the risk register are:

i. To use a bespoke, server based data base to hold the risk register that is maintained and supported within the NHS network.

ii. To use this risk register system to deliver “live” information on risks at all times.

iii. To use this risk register system to support “dynamic” meetings and reviews which will be paper light or paperless.

iv. Risk scoring using the industry standards - the system will be designed to deliver risk management records and risk scoring in line with national and internationally recognised risk standards.

v. Flexibility – the risk register system is flexible enough to develop and respond to a changing NHS environment.

The on line risk data base archives the risk register on a regular cycle (currently four times per year), with a capability to review retrospectively risks from previous periods. The system has analysis functions that are used for ensuring review deadlines are achieved and the system requires a 100% review signed off by owner and senior manager before the risk register can complete its archive. Statistical reports and viewing of the register is part of the regular risk management cycle and this is conducted by risk owners, senior managers and executive members of the Governing Body.

### Board Assurance Framework (BAF)

The BAF is a simple but comprehensive method for the effective and focused management of the principal risks to meeting the principles of NHS Wakefield CCG which are outlined within the Strategic Plan. It also provides a structure for the evidence to support the Annual Governance Statement.
The BAF is a high level view of risk and sits above the risk register system and deals with strategic and long term risks / threats where the risk register will identify and manage performance based risks that may rise and fall within relatively short term periods.

The BAF is supported by the risk register and may make reference to the risk register risks, within one of the BAF threats if they affect this area of the organisation.

The BAF is reviewed a minimum of twice yearly and agreed by the Governing Body as:

- a true and fair reflection of strategic risks/threats;
- evidence that satisfactory progress is being maintained to manage risk.

Responsibilities for Reporting and Management of risks

Chief Officer

Overall responsibility for the management of risk within the CCG lies with the Chief Officer who, on behalf of the Clinical Commissioning Group, is required to sign off the Annual Governance Statement.

Chief Financial Officer

The Chief Financial Officer is responsible for the oversight of risk management within NHS Wakefield CCG.

Chiefs, Associated Directors and Heads of Service

Chiefs, Associated Directors and Heads of Service are responsible for:

- Promoting a risk aware culture within the organisations;
- Ensuring sufficient resource and support is available for managing risks;
- Ensuring organisational Risk Management policies and procedures are implemented within their area of responsibility and adapted as necessary to reflect the local risk profiles;
- Identifying and rectifying poor performance on a timely basis;
- Promoting a “team spirit” so that individuals provide high quality care, protect their colleagues, and promote the reputation of the organisations;
- Promoting a supportive environment to facilitate the reporting of risks and incidents
- Keeping staff informed of the significant risks faced by the organisations and what is being done to reduce them;
- Ensuring staff complete mandated training and relevant developmental events.

Senior Managers

All risks identified must be assessed and recorded in the appropriate format on the system and reported to the immediate line manager. Line managers at all levels are responsible for ensuring identified risks are reviewed, prioritised and managed.

Risk owners and senior managers will be responsible for the management of identified risks and their control measures.
Owners identify and report risks onto the system and regularly review and update all their risks.

Senior managers are responsible for ensuring the review process is conducted in a timely and accurate manner and for ensuring the risk score and quality of information is fit for purpose.

Senior managers are responsible for informing the relevant Clinical Lead of new risks and significant changes.

**Clinical Leads**

Clinical leads are responsible for supporting and working with managers and risk owners to identify and manage risk within their own specialist areas.

The ultimate management of the risk register lies with the executive members of the Governing Body, who will review the risk register every risk cycle.

**Risk Owner:**

- Identifies, assesses and if appropriate records new risk on the system;
- Regularly reviews their risks in line with the review process and schedule which includes updating information, reviewing current risk score and if appropriate closing risks that have been managed back to acceptable risk levels;
- Works closely with clinical leads, performance managers and other service providers to monitor performance and activities to allow the early identification of risk;
- Keeps their line manager informed of any significant changes that may affect any risks they have recorded in the system.

**WSYBCSU Governance and Risk Team**

- Supports the maintenance of the Risk Management Strategy and Policy;
- Maintains up to date risk assessment and management systems for NHS Wakefield CCG;
- Facilitates the reports and updates from the Risk Register to committees, Directors and Managers as necessary;
- Develops and improves reporting and analysis of risks and incidents;
- Develops and maintains appropriate risk awareness and risk assessment within NHS Wakefield CCG;
- Acts as expert input into risk management processes; and
- Delivers required training to managers and the organisation.

### 2.2 RISK MANAGEMENT KEY OBJECTIVE TWO

**The organisation has an effective process to capture and learn from mistakes to reduce future risks**

An effective risk management process learns from experience so that risks do not reoccur. There are two main elements to this objective:

**Learning from experience in the organisations**

NHS Wakefield CCG is committed to the following principles:
An improvement philosophy – when things go wrong we want to learn from them;
- Honesty and openness;
- The involvement of stakeholders, partners, patients, families and staff in our learning processes;
- Appropriate response in our investigations when things go wrong.

Valuable learning information can be identified through a variety of systems and activities:

- Incident reporting;
- Development of individual skills and experience through effective appraisal and personal development reviews;
- Claims made against Trusts or other NHS service providers commissioners;
- Complaints received;
- Issues raised via Patient And Liaison Services (PALS);
- Feedback from Independent Contractors and their associated bodies.

Processes to capture this learning are:

- The review of the risk register for risks that are closed, to assess whether there are any issues which need to be incorporated in processes to minimise occurrence in future;
- The investigation of incidents, complaints and claims using root cause analysis techniques to identify underlying issues which require improvements or interventions to reduce the chance of re-occurrence;
- Feedback to the operational managers who are able to triangulate intelligence on complaints, incidents and claims with soft intelligence and feedback from stakeholders;
- Quarterly incident reporting to the Integrated Governance Committee;
- Monthly reporting to the Integrated Governance Committee through the Integrated Quality and Performance Report.

**Learning from others and using best practice**

The collation of information sources to identify and implement best practice where applicable. Examples of data sources are listed below:

- National Patient Safety Agency (NPSA) and NHS England guidance and learning from accidents will be implemented into organisational systems and procedures
- Feedback from external reviews of organisational systems e.g. internal audit, Audit Commission, Care Quality Commission reviews, Ofsted, Ombudsman etc.
- Using local or national professional networks to identify best practice and benefit from the experience of others
- Research and guidance published by professional bodies
- Recommendations from external investigations and formal enquiries.

2.3 **KEY OBJECTIVE THREE**

The organisation has effective accountability frameworks for the management and reporting of risk

The accountability arrangements can be split into two elements:
• Accountability to NHS Wakefield CCG for scrutiny of risk processes and management
• Accountability to NHS England for the operational management of risk.

**Scrutiny of Risk Processes and Management**

**Governing Body**

NHS Wakefield CCG is collectively responsible and accountable for ensuring an integrated risk management framework is in place including clinical, financial and corporate risks.

The BAF will be reviewed a minimum of twice yearly and agreed by the Governing Body as:

- a true and fair reflection of strategic risks;
- evidence that satisfactory progress is being maintained to manage risk.

All members of the Governing Body will have responsibility for relevant risks/threats on the BAF and will be responsible for reviewing these on a regular basis where applicable.

The Risk Register will also be reviewed by the Governing Body twice per year.

**Integrated Governance Committee**

The Integrated Governance Committee has an overall “scrutiny” role and will provide the Governing Body with assurance that the risk management systems and processes are working effectively. This will include regular review of the risk register to ensure that all clinical, financial and corporate risks are identified.

This Committee will also be responsible for agreeing and monitoring risk management policies.

The Integrated Governance Committee will receive the Risk Register regularly during the year and the BAF periodically during the year.

**Audit Committee**

The Audit Committee will have oversight of the BAF.

**Executive Team**

The Executive Team will regularly scrutinise the risk register.

The Integrated Governance Committee has the ultimate responsibility for risk management and for agreeing the Annual Governance Statement. NHS England requires evidence to provide assurance that appropriate policies and strategies are in place and that systems are functioning effectively.

Responsibilities of individuals for risk management are given at objective one.

**2.4 KEY OBJECTIVE FOUR**
The organisational Risk Management accountability and reporting framework provides sufficient evidence and assurance to comply with relevant external assessment and best practice.

The accountability and reporting processes to support Risk Management identified in this Risk Management Framework is designed to support the collection of evidence to comply with external assessments and best practice by:

- The maintenance of the organisational process to monitor changes to regulatory frameworks and ensuring this is reflected in objectives and performance targets.
- Scheduling programmes of work for baseline self-assessment for key areas of compliance e.g. Care Quality Commission standards.
- Implementing a programme to collect evidence to support compliance with regulations and best practice, using the Integrated Governance Committee work plans.
- Scrutiny of the effectiveness of the risk management arrangements by the Integrated Governance Committee.

2.5 KEY OBJECTIVE FIVE

The organisations will develop risk management arrangements for key partnerships and major projects.

The key partnerships for the organisational include a number of NHS providers, the local authority and independent contractors including social enterprise / community interest companies, the commissioning support service, voluntary sector and the public involvement representatives.

In addition to having robust internal scrutiny arrangements; the organisations are required to contribute to joint “risk registers” and frameworks with partner organisations. This recognises the need to manage risk across organisations and partnerships to deliver whole system change and improvement.

This will be achieved by the following:

- Transition Projects and other major projects/work streams are reflected on the Risk Register, with additional project management monitoring arrangements in place, such as the QIPP Tracker, to ensure close monitoring of identified or potential risks to projects.
- Maintaining a corporate record of the key partnerships for the organisations.
- Implementation and maintenance of a scoring system to identify partnerships with high risk scores.
- Prioritised implementation programme of partnership risk registers for those areas categorised as high risk. The Risk Registers are reviewed through appropriate internal and external governance frameworks.
<table>
<thead>
<tr>
<th>Level</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost Certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>Not expected to occur for years</td>
<td>Expected to occur at least annually</td>
<td>Expected to occur at least monthly</td>
<td>Expected to occur at least weekly</td>
<td>Expected to occur at least daily</td>
</tr>
<tr>
<td>Probability</td>
<td>&lt; 1%</td>
<td>1 – 5%</td>
<td>6 – 20%</td>
<td>21 – 50%</td>
<td>&gt; 50%</td>
</tr>
<tr>
<td>Likelihood</td>
<td>Will only occur in exceptional circumstances</td>
<td>Unlikely to occur</td>
<td>Reasonable chance of occurring</td>
<td>Likely to occur</td>
<td>More likely to occur than not</td>
</tr>
<tr>
<td>Chance</td>
<td>1 in 20,000 chances.</td>
<td>1 in 2,000 chances.</td>
<td>1 in 200 chances.</td>
<td>1 in 20 chances.</td>
<td>1 in 2 chances.</td>
</tr>
<tr>
<td>Table 3: Consequence/severity table</td>
<td></td>
<td></td>
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<tr>
<td><strong>Financial Loss or Impact</strong></td>
<td><strong>Patient &amp; Public Experience</strong></td>
<td><strong>Legal / Regulatory</strong></td>
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| **Insignificant (1)** | £1k to £5k | Unsatisfactory patient experience not directly related to patient care | Minor non-compliance with standards  
Minor recommendations e.g. clinical audit, internal audit, external audit etc |
| **Moderate (2)** | Up to £50k. | Unsatisfactory patient experience - readily resolvable  
Justified complaint peripheral to clinical care  
Adverse local media report – short term | Possible minor out of court settlement or civil small claims court.  
Isolated failure to meet local standards.  
Coroners Court Inquest |
| **Serious (3)** | Up to £250k. | Mismanagement of patient care  
Justified complaint involving lack of appropriate care  
Ongoing adverse local media reports | Defensible civil action.  
Improvement notice  
Persistent failure to meet local standards.  
Intermittent failure to meet national performance standards  
Coroners Court – narrative verdict |
| **Major (4)** | Up to £500k.  
Destabilises provider market | Serious mismanagement of patient care  
Several justified complaints (of a Ombudsman 2nd stage complaint)  
Adverse national press interest (<3 days) | Criminal prosecution.  
Persistent failure to meet national performance targets.  
Coroners Court – neglect verdict |
| **Catastrophic (5)** | Over £1m.  
Significantly destabilises provider market | Totally unsatisfactory patient experience  
Multiple justified complaints  
On-going adverse national press interest (>3 days), MP questions | Corporate Manslaughter or Corporate manslaughter prosecution  
Persistent failure to meet national, professional and statutory requirements. |
| **Health/ Clinical Outcome** | **Safety / Injury / Harm (patients or staff)** | **Impact on Services** |
| **Insignificant (1)** | Minor adverse clinical outcome, e.g. slight delay in referral or treatment with low impact | Short term verbal abuse. Less than 3 days absence.  
Patients required extra observation or minor treatment | Short term capacity issue (staff/facilities) reducing service quality (< 1 day) |
<table>
<thead>
<tr>
<th>Catastrophic (5)</th>
<th>One off failure to meet minimum clinical outcomes</th>
<th>Physical encounter (scratches / bruising). RIDDOR reportable injury with absence of 3 days to 1 week. Patients require minor increase in treatment, did not lead to permanent harm</th>
<th>Significant inconvenience or cost in maintaining activity</th>
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<tr>
<td>Moderate (2)</td>
<td>Minor increase in health inequalities (in only 1 area/group)</td>
<td>RIDDOR reportable injury with absence of 3 days to 1 week. Patients require minor increase in treatment, did not lead to permanent harm</td>
<td>Capacity issue (staff/facilities) reducing service quality (&lt;1 week)</td>
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<tr>
<td>Serious (3)</td>
<td>Intermittent failure to meet minimum clinical outcomes. Moderate increase in health inequalities (across 2 or more areas/groups)</td>
<td>RIDDOR reportable injury with absence of more than 1 week. Patients require moderate or major increase in treatment, did not lead to permanent harm</td>
<td>Ongoing unsafe staffing level Significant ongoing capacity issue (staff/facilities) preventing service delivery (&gt; 1 week)</td>
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<tr>
<td>Major (4)</td>
<td>Persistent failure to meet minimum clinical outcomes in one clinical area Significant increase in health inequalities (across 2 or more area/groups)</td>
<td>RIDDOR reportable major injury or dangerous occurrence Patient experienced permanent harm</td>
<td>Significant ongoing capacity issue (staff/facilities) preventing service delivery for (&gt; 1 month)</td>
</tr>
<tr>
<td>Catastrophic (5)</td>
<td>Persistent failure to meet minimum clinical outcomes in a range of services Extreme impact on health inequalities across Trust</td>
<td>RIDDOR reportable death. NRLS reportable death - Patient died as a direct result of incident</td>
<td>Interruption of all or significant range of Trust activities (&gt; 1 week)</td>
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To support this approach an on line data base has been designed and evolved to manage risk. The five principles that support this approach form the basis of the risk management strategy and are described below

The five is principles are:

i. To use a bespoke, server based data base to hold the risk register that is maintained and supported within the NHS network.

ii. To use this risk register system to deliver “live” information on risks at all times.

iii. To use this risk register system to support “dynamic” meetings and reviews which will be paper light or paperless.

iv. Risk scoring using the industry standards - the system will be designed to deliver risk management records and risk scoring in line with national and internationally recognised risk standards.

v. Flexibility – the risk register system is flexible enough to develop and respond to a changing NHS environment.

i. To use a bespoke, server based data base to hold the risk register that is maintained and support within the NHS network

The choice of a bespoke system allows instant user access and easy to populate and understand data entry. Based within the NHS network the system has security, the resilience of the network and its maintenance and will have compliance with information governance requirements such as the information Governance tool kit.
ii. To use this system to deliver “live” information on risks at all times
The data base holds single records of all risks and therefore changes as entries or alterations are made. This allows the use of this live data for producing reports or holding meetings has significant benefits over a manual system that relies on printed reports to be produced, edited and reviewed.

iii. To use this system to support “dynamic” meetings and reviews which will be paper light or paperless
Dynamic meetings can be defined as meeting where accurate, timely and clear information is received, reviewed and actions taken or planned. The system can where appropriate, be instantly updated at the meeting which reduces the need to create action notes and the use of future resource. As described in live information, all the latest changes are included in the meeting and the risk analysis operations of the system will demonstrate the review and governance arrangements and support discussion, questions and queries regarding the wider risk agenda and actions to control the risks.

iv - Risk scoring using the industry standards - the system will be designed to deliver risk management records and risk scoring in line with national and internationally recognised risk standards.
The system is based on the Australian and New Zealand standard on risk management AS/NZS 4360:2004 which has been adopted by the NHS. This standard uses a 5 x 5 risk scoring matrix and the on line risk system has guidance on risk scoring to support a consistent approach to risk scores.

v – Flexibility – the risk register system is flexible enough to develop and respond to the changing NHS environment.
The data is designed around standard server based software which has bespoke functionality written by software developers to provide easy access, instant reviews and reports on risk information. This approach allows changes to be made to ensure the system can be adapted to changes that occur within the NHS and also to refine and improve the governance of the system and the reporting and information service from the system.
PAPER 13

Building Health Partnerships

Presentation
**Recommendation:**

It is recommended that the Governing Body receive and note the minutes of the Integrated Governance Committee held on 20 February and 20 March 2014.

**Executive Summary:**

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

20 February 2014

- **Individual Funding Request Panel updated Terms of Reference** was approved subject to agreed amendments, noting that a Head of Service is now included as part of the IFR panel membership.

- **Quality & Performance Report - YAS Cat A Red 1 Red 2** have worsened in comparison to last month although year to date performance is above target. **Ambulance Turnaround Times at MYHT** continues to be below target and a recovery plan is in place. **Cancer waits 62 days referral to definitive treatment** continues to be below target, the matter is to be discussed at the next Cancer Network meeting. CCG performance has improved across admitted and incomplete pathways for **18 weeks Referral to Treatment**. A speciality level route cause analysis for the high risk specialities has been commissioned. **Patient Safety Walkabout** in Dewsbury identified significant concerns in a particular ward. A Quality Summit was held across elderly care and medical wards. The CCG were re-assured that the concerns raised were not widespread and there was assurance that the issues were improving.

- Due to potential conflicts of interest the **Improvement in Prescribing Plan (ImPP) 2014/15** plan will be considered by the Chief Officer in consultation with a Lay Member outside of the meeting.

- Jo Webster and Sandra Cheseldine to meet to discuss Sandra’s comments on the Board Assurance Framework prior to the document being presented to the Governing Body.

- Current **Risk Register** position noted by the Committee.

- **Incident Reporting Q1, Q2 and Q3** – report noted with agreement that future reporting will be on a quarterly basis. Clarification will be sought from NHS England as to how they intend to take forward the reporting of independent contractor incidents. In the interim independent contractors are able to report incidents using the CCG Datix incident reporting system.

- **Finance Report** – CCG has a year to date surplus of £4,586k in line with planned surplus and year end forecast of £5,502k which is equal to plan.

- Details in relation to costs and detailed service specification of the **WSYBCSU Service Level Agreement** – were discussed. Key performance indicators will be set as part of the service specifications, request made for contract to include a break clause at year one.

- **Draft Financial Planning Update** – provides details of the draft resource allocation and planned expenditure for 2014/15 and 2015/16 which will in due course form the basis of budget setting for next year.

• Details of services previously commissioned through a **Local Enhanced Service** were presented. CCG holds 13 LES agreements with GP practices and local optometrists including shared care pathways with MYHT.

20 March 2014

• Draft version of the five Strategic Plan will be submitted to NHS England by 4 April and final version submitted by 20 June 2014. The **Strategic Planning Templates** templates were shared for information.

• **Quality & Performance Report** – MYHT require improvement within the **18 week admitted pathway** to meet the operational standard for the year to date position. Improvement in **Ambulance Turnaround targets** in February. Six 52 week breaches reported by MYHT for the period. **62 Day Urgent GP Referral standard** not achieved for the period. MYHT on target for achieving the **C.Difficile standard** for the year, the CCG will breach the target for the year. Target will be higher next year. No **MRSA incidents** reported for MYHT or CCG for the period.

• A position statement on the implementation of actions of the **Winterbourne Review Action Plan** were presented. Further update in June 2014.

• **Integrated Risk Management Framework** – outline of governance arrangements in place to manage clinical, financial and corporate risk. Framework to be presented to Governing Body on 13 May 2014.

• **Finance Report** – year to date surplus of £5,043k in line with planned surplus and year end forecast of £5,502k which is equal to plan. Any payments made by CCGs in the current financial year in relation to legacy balances will be reimbursed by NHS England before the year end where appropriate.

• The final submission of the **Strategic financial plans** is to be made on 4 April 2014.

• Guidance was presented setting out the conditions under which **Risk Stratification Tools** should be procured by CCGs. WSYBCSU is developing a Risk Stratification assurance statement for NHS England, this will include a completed supplier statement signed by the Managing Director, SIRO and Caldicott Guardian.

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**Policies approved:**

<table>
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<th>20 February 2014</th>
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<tr>
<td>Primary Care Prescribing Rebate Schemes Policy</td>
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<td>Incident Reporting Policy</td>
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NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 20 February 2014

Present: Rhod Mitchell (Chair) Lay Member
Jo Webster Chief 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
Katherine Bryant Governance and Board Secretary
Karen Parkin Head of Finance and Governance
Matt England (items 7i, 12ii, 12iii) Head of Contracting and Commercial Strategy
Andrew Singleton (item 7i) Quality Co-ordinator
Lyndsey Clayton (items 7ii, 7iii) Chief Technician, Medicines Management Team
Adam Bassett (items 7iv, 7v, 7vi, 7vii, 7viii) Senior Associate Governance and Risk, WSYBCSU
Satbir Saggi (item 7ix) Senior Associate Research, WSYBCSU
Caroline Wray (item 9i) Senior Associate, Head of Information Governance, WSYBCSU
Stephen Rose (item 9i) Senior Information Governance Officer (The Health Informatics Service)
Mandy Sheffield (items 10i, 10ii, 10iii) Head of Safeguarding
Heather Prest (item 11i) Senior Associate Learning and Development, WSYBCSU
Hayley Hesketh (item 12i) IFR Business Manager, WSYBCSU
Linda Driver (item 12ii) Head of Service Development and Transformation
Angela Peatfield Minute taker

14/25 Apologies for Absence

Apologies for absence were received from Andrew Pepper, Dr Avijit Biswas

14/26 Declarations of Interest

Dr Phil Earnshaw and Dr David Brown declared an interest in respect of Paper 7iii – Improvement in Prescribing Plan

Sandra Cheseldine declared an interest in respect of Paper 12i – Individual Funding Requests (IFR) Update and Terms of Reference.
Dr Phil Earnshaw and Dr David Brown declared an interest in respect of Paper 12ii – Local Enhanced Services.

14/27 Minutes of the Meeting held on 16 January 2014

The minutes of the meeting held on the 16 January 2014 were agreed as an accurate record.

14/28 Action Sheet from the Meeting held on 16 January 2014

13/214 – Minutes of meetings

Details of who represents the CCG at meetings across the patch has been completed and further discussion will take place at an Executive Team meeting to ensure appropriate attendance at future meetings.

14/7 – Q3 Infection, Prevention and Control Report

Following the update provided on the action sheet noting that at present there is no electronic training available it was agreed that this action is completed and will be closed.

14/29 Constitution Review Verbal Update

Katherine Bryant gave a verbal update on the Constitution Review, advising that as part of the review involved seeking comments from the Practice Support Unit, a working group made up of Practice Managers and GPs had taken place this morning. Jo Webster commented that the Constitution would be discussed by the Executive Team and the agreed amendments would be presented to a future meeting of the Governing Body.

Jo Webster felt it was not necessary for the draft document to be presented to the Integrated Governance Committee.

It was RESOLVED that:

i) the Committee noted the verbal update and that the amended Constitution would be presented at a future Governing Body meeting

14/30 Integrated Governance Closure Report

Katherine Bryant presented this report advising that in March 2013 KPMG reviewed the CCG’s integrated governance reporting arrangements and made a number of recommendations. An update report was provided in July 2013 and this further report provides an update on the progress undertaken and confirms that all recommendations and associated actions are now complete.

It was RESOLVED that:

i) the Committee noted that all recommendations and associated actions are now complete
Individual Funding Requests Update Report and Terms of Reference

Hayley Hesketh attended the meeting to present the quarter three update relating to IFR activity. The new format of the report was acknowledged and it was agreed this would form the basis of future reporting.

Hayley also presented the revised Terms of Reference noting that a head of service is now included as part of the IFR panel membership. The document also noted that a timescale for approved funding had been added. Approved treatment should commence within one year of approval, otherwise a new funding request will be required. Hayley confirmed that the audit of the cases which have been outstanding for over 12 months will be completed by the end of the financial year.

A discussion followed and Sandra Cheseldine requested the wording in respect of how urgent matters are dealt with should be amended to reflect that the decision making will be through consultation between members of the Executive Team or Head of Service as it could prove difficult for the Chair of the IFR panel, as a Lay Member, to be available to make decisions at short notice.

Dr Phil Earnshaw commented that a report of any urgent decisions made between meetings should be reported to the next available meeting of the IFR panel.

Jo Webster requested that where appropriate a link should be included in the Terms of Reference in respect of the Commissioning Policy review.

Stephen Hardy commented that it would be useful to provide refresher training to those members who do not regularly sit on the IFR panels. Hayley confirmed that she would be happy to arrange refresher training.

The amendments to the Terms of Reference were approved and it was agreed that Hayley would make the amendments and forward the revised document to Sandra Cheseldine for approval and this would be noted at the next meeting of the Integrated Governance Committee.

It was RESOLVED that:

i) the Committee noted the quarter three update on IFRs 2013/14; and

ii) approved the revised Terms of Reference subject to the agreed amendments detailed below being made:
   • Urgent matters – amend wording to reflect decision making will be through consultation between members of the Executive Team or Head of Service
   • Urgent decisions should be reported to the next available meeting of the IFR panel
   • Add a link to the Commissioning Policy review
**14/32 Integrated Quality and Performance Report**

Matt England 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.

Matt and Andrew highlighted the following from the exception report:

- December 2013 performance is below target for CCG Ambulance targets CAT A Red 1 and Red 2 8 minutes response times, this has worsened in comparison to last month although year to date performance is above target
- Ambulance turnaround times at MYHT has continued to be below target, there is a recovery plan in place
- Cancer waits 62 days referral to definitive treatment continues to be below target and worsened in two consecutive months. The matter will be discussed at the next Cancer Network meeting to identify any wider inter-provider issues
- MYHT reported one post 48 hour MRSA bacteraemia case in the period December 2013
- CCG performance has improved across the admitted and incomplete pathways for 18 weeks Referral to Treatment, the non admitted pathway has dropped below the required operating standard. A speciality level Route Cause Analysis for the high risk specialities has been commissioned
- A Patient Safety Walkabout in Dewsbury identified significant concerns in a particular ward. This prompted a Quality Summit to be held across elderly care and medical wards. The CCG were re-assured that the concerns raised were not widespread. Staffing levels were to be increased and there was assurance that the issues were improving.

A discussion took place and it was suggested that following on from the quality review work already undertaken, a Board to Board meeting would be helpful to consider what good assurance looks like. It was agreed that Jo Webster, Dr Phil Earnshaw and Rhod Mitchell would consider the actions agreed following the Quality Summit and seek assurance that they were being completed.

Following an item on the news regarding mental health services for children. Dr David Brown asked for the following information to be confirmed:

1. How many children are there in hospital mental health adult wards?
2. How many children are in localities away from home and what is the distance from their home?

**It was RESOLVED that:**

i) the Committee noted the contents of the report

**14/33 Policy for Approving Primary Care Prescribing Rebate Schemes**

Lyndsey Clayton attended the meeting to present this policy supporting evaluation and approval of rebate schemes. A number of pharmaceutical manufacturers have established ‘rebate schemes’ for drugs used in primary
Improvement Board

Adam

i) It was RESOLVED that:

the Committee approved the Policy for Approving Primary Care Prescribing Rebate Schemes for implementation within Wakefield CCG

14/34 Improvement in Prescribing Plan (ImPP) 2014/15

Lyndsey Clayton presented this paper explaining that the plan for 2014/15 has been revised following feedback from member practices as part of the consultation process. It is proposed there will be ten indicators that will be the same for every practice. Eligibility criteria will still be in place and practices will need to achieve 4 out of the 10 indicators before they can receive any award.

A discussion followed and it was agreed there needs to be clarity on the payment structure and details of what is spent against what the savings are.

Due to the potential conflicts of interest presented by the ImPP, it was agreed that the paper would be considered by the Chief Officer and, if appropriate, approved following consultation with a Lay Member.

It was RESOLVED that:

i) the paper would be considered by the Chief Officer and, if appropriate, approved following consultation with a Lay Member

14/35 Board Assurance Framework

Adam Bassett attended the meeting to present the updated Board Assurance Framework (BAF) following a number of meetings and discussions with the lead for each threat on the BAF.

Adam advised that the BAF will be refreshed following the completion of the 2014/15 Strategic Plan.

Sandra Cheseldine advised that she had several comments on the document and following discussion it was agreed that Jo Webster and Sandra Cheseldine will discuss the comments outside of the meeting and arrange for the amendments to be completed prior to the BAF being presented at the Governing Body.
It was RESOLVED that:

i) the Committee noted the 2013/14 Board Assurance Framework; and
ii) agreed that Jo Webster and Sandra Cheseldine would meet outside of the meeting to discuss Sandra’s comments on the document.

14/36 Risk Register

Adam Bassett presented the Risk Register advising that version 2 of the Risk Register was introduced in January 2014. The historic data will continue to be held on the existing system.

It was noted that there are currently 57 risks on the register.

Adam advised that an updated report will be presented to the Governing Body on 11 March 2014.

It was RESOLVED that:

i) the Committee noted the current position on the risk register

14/37 Incident Reporting Policy

Adam Bassett presented the Incident Reporting Policy and Incident Management and Investigation Procedure.

Following discussion it was highlighted that an amendment was required on page four, section two, the last bullet point should read Chief Finance Officer. Also ensure consistency throughout documents when referring to the West and South Yorkshire and Bassetlaw Commissioning Support Unit.

It was RESOLVED that:

i) the Committee approved the policy and procedure subject to the agreed amendments:
   • Page Four, section two, last bullet point to read Chief Finance Officer
   • Consistency in the documents when referring to West and South Yorkshire and Bassetlaw Commissioning Support Unit

14/38 Incident Reporting Q1, Q2 and Q3 2013/14

Adam Bassett presented this report outlining the incidents reported during quarters one, two and three of 2013/14. The report provides an overview of the incidents reported, lessons learnt and actions which have been taken to address the issues raised. Adam proposed future reporting to be on a quarterly basis.

Adam explained that following the introduction of the NHS Reforms in 2013 NHS England became responsible for monitoring the contractual arrangements for Independent Contractors. However, as yet NHS England has not introduced systems and processes for independent contractors to report incidents to them.
In the interim independent contractors are currently able to report incidents to the CCG using the Datix incident reporting system and to date 52 incidents have been reported since 1 April 2013.

Following discussion it was agreed that Jo Webster, on behalf of the CCG, formally writes to NHS England to enquire how they intend to take forward the reporting of independent contractor incidents.

**It was RESOLVED that:**

i) the Committee noted the report;
ii) agreed to receive quarterly reports on Incident Reporting; and
iii) agreed to formally write to NHS England regarding future incident reporting from independent contractors.

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**14/39 Health and Safety Policy**

Adam Bassett presented this policy for approval. Jo Webster commented that there were some amendments required on this policy regarding NHS Property Services.

It was agreed that this policy would be revised and presented at a future meeting.

**It was RESOLVED that:**

i) the Committee agreed that the policy would be revised and presented at the next meeting

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**14/40 Update of Research Activity**

Saggu Satbir attended the meeting to present this update on research activity within the locality to increase awareness of the work being undertaken. It was noted that there is a forward plan of meetings available which details the subjects to be discussed.

A discussion followed and it was acknowledged that the CCG need to draw on the evidence and research available to assist in the commissioning process. Saggu requested that any suggestions for future topics of research should be forwarded to him.

Dr Phil Earnshaw advised that some of the GP information included in the update was incorrect and Saggu agreed to amend.

**It was RESOLVED that:**

i) the Committee noted the contents of the report

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**14/41 Finance Report Month 10**

Karen Parkin presented the Finance Report providing a year to date and year
end forecast position as at 31 January 2014. Overall the CCG has a year to date surplus of £4,586k in line with its planned surplus and year-end forecast of £5,502k which is equal to plan.

Karen highlighted the following:

- Year end reconciliation exercise has now been concluded with MYHT. A forecast year end position of £6.4m has been agreed and this is reflected on the month 10 position
- Continuing Health Care overspend position has increased to £2.3m
- The QIPP target for prescribing was £2m, although the year end position shows less than target. Work undertaken by the Medicines Management team shows that savings of £1.5m have been made to date

A discussion followed and Dr Phil Earnshaw raised a concern regarding the prescribing target. Karen explained that there had been fluctuations earlier in the year, however now that an internal forecast is being used instead of the forecasts provided by the Prescription Pricing Authority this provides an improved prescribing forecast.

**It was RESOLVED that:**

i) the Committee received and noted the contents of the report

**14/42 Update on WSYBCSU Service Level Agreement**

Karen Parkin presented this paper which outlines the current state of negotiations with the CSU for 2014/15 and 2015/16, sets out the strategic direction of CSUs and the progress the CCG has made in relation to costs and detailed service specification.

Karen confirmed that key performance indicators will be set as part of the service specifications. Rhod Mitchell commented that the KPIs need to be strong with penalties for financial redress if the CSU do not deliver.

As this is a two year contract, Jo Webster expressed a desire for the contract to include a break clause at year one.

**It was RESOLVED that:**

i) the Committee noted the progress made on the CSU SLA

**14/43 Draft Financial Planning Update**

Karen Parkin presented this paper providing an update on the progress made on the financial planning process and on setting CCG budgets for 2014/15.

Appendix 1 details the draft resource allocation and planned expenditure for 2014/15 and 2015/16. This will in due course form the basis of budget setting for next year.
It was RESOLVED that:

i) the Committee noted the current development of the detailed financial plan towards a budget for future years

**14/44 Information Governance Update**

Caroline Wray and Stephen Rose attended the meeting to present this paper providing an update on the Information Governance Toolkit Assessment and Improvement Plan. Details on the findings and recommendations following the completion of the Information Asset Risk Management work programme were also presented. Stephen Rose advised that the asset data flow is considerably less as a CCG compared to the previous PCT.

The Network Security Policy and Records Management Policy were also presented for approval.

It was RESOLVED that:

i) the Committee noted the updated report

ii) noted the Summary of Information Governance Toolkit Assessment and Improvement Plan

iii) the Network Security Policy and Records Management Policy were approved

iv) noted the invoice validating arrangements in place until November 2014

v) noted the Information Asset Risk Management report

**14/45 SIRO/Caldicott Guardian Update**

Katherine Bryant presented this update detailing the Caldicott Guardian/Senior Information Risk Owner requests received up to 12 February 2014.

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

It was RESOLVED that:

i) the Committee noted the SIRO/Caldicott Guardian update

**14/46 Local Safeguarding Adult’s Board Annual Report 2012/13**

Mandy Sheffield attended the meeting to present this report advising that the report will be presented at the Governing Body meeting being held on 11 March 2014.

It was RESOLVED that:

i) the Committee noted the Local Safeguarding Adult’s Board Annual Report 2012/13
Local Safeguarding Children’s Board Annual Report 2012/13

Mandy Sheffield attended the meeting to present this report advising that the report will be presented at the Governing Body meeting being held on 11 March 2014.

It was RESOLVED that

i) the Committee noted the Local Safeguarding Children’s Board Annual Report 2012/13

Ofsted Safeguarding and Looked after Children Inspection Briefing

Mandy Sheffield attended the meeting to present this report outlining the updated process OFSTED will utilise to inspect the performance of Local Councils in their safeguarding processes.

The CCG will not be directly involved in the OFSTED inspection of the Local Authority, although health services in the district are likely to be involved. The CCG as a partner in the Local Safeguarding Children’s Board (LSCB) will be directly involved in the inspection of the LSCB, as will the role it plays in the sub committee structure.

It was RESOLVED that

i) the Committee noted the content of the report

Workforce Services Update Report

Heather Prest attended the meeting to present this report providing workforce information and intelligence relating to the directly employed CCG workforce together with key workforce headlines. Heather advised that a Social Partnership Forum had held a meeting on 17 February and ten workforce policies were discussed. It has been agreed that a working group made up of members of the Integrated Governance Committee will meet to consider these policies and recommend their approval at a future Integrated Governance Committee meeting.

Heather tabled the updated mandatory training figures for both employed staff and members of the Governing Body for information.

It was RESOLVED that

i) the Committee noted the content of the report

Contract Governance and Assurance

Matt England and Linda Driver presented this paper providing an update on contracts awarded, varied and notices service.

Matt also outlined the approach to the contract review process proposing that
a desk top exercise is undertaken to further define the level of review, appendix 2 provides details of the timescales. It is proposed there will be two types of review:

- Rapid Review which will take a period of 12 weeks from its commencement to contract award
- Full Review which will take a period of 3 – 18 months from commencement to contract award dependent on the procurement decision timeline

A discussion followed and it was queried why in some cases a tender waiver was proposed rather than a longer term extension. Matt explained that in some instances the existing contracts do now allow for an extension.

Jo Webster requested a summary of the contract information where a tender waiver was proposed and Matt agreed to provide this outside of the meeting.

It was RESOLVED that

i) the Committee noted the update; and
ii) approve the proposed review process

14/51 Local Enhanced Service

Dr David Brown and Dr Phil Earnshaw declared an interest. Dr Earnshaw also advised that he is the West Yorkshire Lead for the review of the PMS contract in General Practice.

Matt England presented this paper outlining the position regarding services previously commissioned through the Local Enhanced Service (LES) contractual route. The CCG currently holds 13 LES agreements with GP practices and local optometrists for a range of services including shared care pathways with Mid Yorkshire Hospitals Trust. The services have been clinically reviewed and the outcome and recommendations were shared for information.

It was RESOLVED that

i) the Committee noted the outcomes of the LES service reviews
ii) noted the Local Area Team response to PMS practice position
iii) noted the actions to move the services to mobilisation
iv) approved the proposal to award contracts in line with the Operating Scheme of Delegation (Jo Webster to consider quotation waivers)

14/52 Minutes of meetings

The minutes of the following meetings were shared for information:

- **Mid Yorkshire Hospitals NHS Trust Executive Quality Board** meeting held on 23 January 2014
- **Mid Yorkshire Hospitals NHS Trust Executive Contract Board** meeting held on 19 December 2013
- **Quality Intelligence Group** meeting held on 9 January 2014
YAS 999 Clinical Quality Group meeting held on 7 January 2014
Urgent Care Strategic Group meetings held on 24 October, 26 November and 17 December 2013

For Information

14/53 Information Governance Bulletin – tenth edition
The tenth Information Governance bulletin was shared for information.

14/54 Any other business
None

14/55 Date and time of next meeting
Thursday, 20 March 2014, 2.30 to 5.00 pm, Seminar Room, White Rose House
NHS Wakefield Clinical Commissioning Group

INTEGRATED GOVERNANCE COMMITTEE

Minutes of the Meeting held on 20 March 2014

Present:  Rhod Mitchell (Chair)  Lay Member
          Jo Webster  Chief Officer
          Jo Pollard  Chief of Service Delivery and Quality
          Andrew Pepper  Chief Finance Officer
          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
                Michele Ezro (item 5, 6ii)  Transformation Programme Lead Mental Health & Learning Disabilities
                Matt England (items 6i, 10i)  Head of Contracting and Commercial Strategy
                Laura Elliott (items 6i)  Head of Quality & Engagement
                Adam Bassett (item 6iii)  Senior Associate Governance and Risk, WSYBCSU
                Elizabeth Goodson (items 7i, 7ii)  Commissioning Accountant
                Caroline Wray (item 8i)  Senior Associate, Head of Information Governance, WSYBCSU
                Katherine Duke (item 9i)  Associate Learning and Development, WSYBCSU
                Jo Hanlon (item 8iii)  Head of Public Health
                Nadeem Murtuja (item 11i)  Senior Associate Equality & Inclusion, WSYBCSU
                Angela Peatfield  Minute taker

14/60  Apologies for Absence

Apologies for absence were received from Karen Parkin.

14/61  Declarations of Interest

Rhod Mitchell reminded members of the Committee that any conflicts of interest should be declared. There were no declarations of interest.

14/62  Minutes of the Meeting held on 20 February 2014

The minutes of the meeting held on the 20 February 2014 were agreed as an accurate record subject to the inclusion of the following paragraph in item
Following an item on the news regarding mental health services for children. Dr David Brown asked for the following information to be confirmed:

1. How many children are there in hospital mental health adult wards?
2. How many children are in localities away from home and what is the distance from their home?

Action Sheet from the Meeting held on 20 February 2014

14/32 – Integrated Quality and Performance Report

It was noted that a date for the Board to Board meeting has not yet been agreed. It is expected that this meeting will take place in May 2014.

Strategic Planning Templates

Michele Ezro attended the meeting to present the Strategic Planning Templates. Michele explained that the draft version of the five year Strategic Plan will be submitted to NHS England by 4 April and the final version will be submitted by 20 June 2014. It was noted that a Governing Body Development Session has taken place to discuss the content in detail.

A discussion followed and comments were made regarding format. This will be considered when the paper is presented at the Governing Body Public meeting on Thursday, 27 March 2014.

It was RESOLVED that:

i) the Committee noted the five year Strategic Planning template containing the information required by NHS England to be submitted in draft form by 4 April 2014

Integrated Quality and Performance Report

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

Matt and Laura highlighted the following from the report:

- MYHT still require performance improvement within the 18 Week Admitted pathway to meet the operational standard for the Year to Date position, an Access Summit meeting is taking place next week to discuss performance
- YAS have shown improvement in February with regard to Ambulance Turnaround targets
- MYHT have reported six 52 week breaches for the period
- The CCG and MYHT have not achieved the 62 Day Urgent GP Referral standard for the period
- The CCG has not achieved the 31 Day wait for Radiotherapy Treatment for the period, this is due to performance at Leeds Teaching Hospitals Trust
• MYHT are on target for achieving the C.Difficile standard for the year, the CG will breach the target for the year. The target for next year will be higher
• There were no reported incidents of MRSA for either MYHT or the CG during the period

A discussion followed:

**Cancer Waiting Times** – concerns were raised regarding the breaches and Dr Phil Earnshaw commented that the PCTs in Yorkshire provided additional monies for machinery and it is hard to understand why there is no machine capacity. It appears that this is a long standing issue and currently deteriorating. It was agreed that the MYHT Cancer Lead should be invited to attend the next meeting of the Committee to discuss the reasons for the breaches. The matter is to be raised as a significant concern and Matt England will draft a letter to MYHT inviting the Cancer Lead to the next Integrated Governance Committee meeting.

**Referral to Treatment 52 week breaches** – Matt advised that the CCG have reported no 52 week breaches during the period. MYHT reported six all of which are North Kirklees patients. Of the six cases identified, one patient was identified and treated within the month the breach occurred. In the remaining five cases these patients were identified in January 2014 as waiting in excess of 52 weeks for review by an Orthopaedic Consultant, a further update on these patients will be reported in the next report. A Breach Notification has been issued to the Trust and a full route cause analysis undertaken. Jo Webster commented that she would be raising this as a concern with Stephen Eames, Chief Executive at MYHT.

Sharon Fox queried why the CQUIN quality indicators have gone down from Q2 to Q3. Laura explained that this was due to the process for data collection and confirmed that in Q4 the indicator will be achieved.

Dr Phil Earnshaw asked whether future reports could include a section on primary care issues.

A request was made for a deep dive on gastroenterology for the next meeting. Jo Pollard advised that a review of this service is being undertaken and there will be an update next month.

**It was RESOLVED that:**

i) the Committee noted the Integrated Quality and Performance report

**14/66 Winterbourne Review Action Plan**

Michele Ezro attended the meeting to present this paper on behalf of Phil Smedley, Head of Partnership Commissioning. The paper presents a position statement on the implementation of actions across both health and social care relating to Winterbourne View, all actions have now been rag rated. Work has already commenced in identifying people placed out of district who wish to
return and some people have returned into recently commissioned supported tenancies. Work is also underway with local support and accommodation providers to commission further services and ensure appropriate expertise within the workforce.

A discussion followed regarding the pooled budget arrangements between the Local Authority and the CCG. Jo Webster felt that the contractual arrangements have not significantly progressed and further assurance is required to ensure robust monitoring arrangements are in place and actions are being completed. It was agreed that a further update would be brought back to the Committee in June.

It was RESOLVED that:

i) the Committee noted the report

14/67 Integrated Risk Management Framework

Adam Bassett attended the meeting to present this draft framework which outlines the way in which the CCG has effective governance arrangements in place to manage clinical, financial and corporate risk.

The Committee were asked to support the recommendation that this framework if presented to the Governing Body for approval at the meeting on 13 May 2014.

It was RESOLVED that:

i) the Committee noted the draft Integrated Risk Management Framework; and

ii) agreed that the draft framework be recommended for approval by the Governing Body on 13 May 2014.

14/68 Finance Report Month 11

Andrew Pepper presented the Finance Report for month 11. Overall the CCG has a year to date surplus of £5,043k in line with its planned surplus and year-end forecast of £5,502k which is equal to plan. There have been no significant movements since month 10, noting that all the risks and opportunities detailed in section 6 of the report are now incorporated into the financial position.

On page 2 of the report the forecast year end variance for Prescribing is £58k overspend, this is slightly under break even against budget.

Andrew advised that any payments made by CCGs in the current financial year in relation to legacy balances will be reimbursed by NHS England before the year end where appropriate.

With regard to QIPP, Dr David Brown commented that Dermatology activity had increased at MYHT, Andrew Pepper advised that a paper was going to the Clinical Cabinet with regard to the QIPP schemes and agreed to check the
forecast savings on Dermatology.

The NHS target is 95% of invoices to be paid within 30 days both in terms of value and on number of invoices. Section 251 data validation issues relating to patient confidentiality are still resulting in some invoices not being paid within the 30 days. However, the issue is improving and the overall target is now being exceeded on invoice values paid. Rhod Mitchell expressed his thanks to the team for this improvement.

It was RESOLVED that:

i) that the Committee noted the contents of the report

14/69

2014/15 Budget

Andrew Pepper advised that strategic financial plans were submitted to NHS England on 7 March 2014. A final submission is to be made on 4 April. Draft budgets have been calculated in line with submission and contract negotiations. Budgets are structured as per the strategic plan submission and show a balanced budget. Details also include QIPP and use of non-recurrent resources.

Programme allocations and running costs allocations were detailed in the paper noting these have been confirmed by NHS England and were included in the financial planning return submission on 7 March 2014. Andrew explained that three anticipated allocation adjustments known for 2014/15, not included in the plan, are:

- offender health expected increase to the CCG allocation of £544k;
- Angel Lodge (mental health) expected increase to CCG allocation of £295k; and
- Cervical screening expected decrease to CCG allocation (corresponding decrease to MYHT overall contract), amount to be confirmed.

In 2015/16 the CCG also receives £7,557k additional resource for contribution toward the better care fund. This has been included in the plans as recurrent investment so that there is an expenditure line to exactly match the allocation.

A full discussion took place and Jo Webster advised that the Clinical Cabinet would be holding informal sessions to identify further QIPP savings generating productivity and quality.

It was RESOLVED that:

i) the Committee noted the approach to setting the draft budgets for the CCG which inform the overall CCG strategic plan submission

14/70

Information Governance Update

Caroline Wray attended the meeting to present this update detailing activities undertaken since the last report in February. It was noted that a number of policies transferred from the PCT are now surplus to requirements as the
function is provided by another organisation or the subject matter is covered as part of another policy. Details of the policies that have been identified to be decommissioned were included in the paper.

Caroline advised that a records management strategy and action plan has been developed and will form part of the information governance work programme for 2014/15.

Caroline also informed the Committee that requirement 11-235 on the Information Governance Toolkit update shown as amber is now complete and is green. Caroline confirmed that the CCG will achieve a level two on the Information Governance Toolkit which will be submitted by 31 March 2014.

**It was RESOLVED that:**

i) the Committee noted the update;
ii) noted the Information Governance Toolkit Assessment and Improvement Plan;
iii) approved the Records Management Strategy and Action Plan 2014/15; and
iv) noted the decommissioned policies, Data Quality, Information Risk Management and Registration Authority.

**14/71 SIRO/Caldicott Guardian Update**

Katherine Bryant presented the SIRO/Caldicott Guardian update which provides details of the requests received to 13 February 2014 providing assurance that appropriate systems and processes are in place. Katherine advised that reference number 103 where information had been recorded onto the incorrect child’s record was because there were two children with identical name and date of birth. Katherine confirmed that following assessment it has been agreed that this is not a serious incident.

**It was RESOLVED that:**

i) the Committee note the SIRO/Caldicott Guardian Update

**14/72 Information Governance and Risk Stratification – advice and options for CCGs and GPs**

Jo Hanlon attended the meeting advising that following discussions at the Integrated Governance Committee in August further guidance has now been received from NHS England. This guidance sets out the conditions under which Risk Stratification Tools should be procured by CCGs. The risk assurance statement must be signed and returned to NHS England.

Jo explained that the governance leads at West and South Yorkshire and Bassetlaw Commissioning Support Service (WSYBCSU) have produced a document which sets out the impact of this on all organisations involved in the process, together with steps which now need to be taken to ensure that the data processing complies with the Confidentiality Advisory Group approval conditions. WSYBCSU is developing their Risk Stratification assurance
statement to NHS England. This will include a completed supplier statement, signed by the Managing Director, SIRO and Caldicott Guardian. It is expected that this will be sent out within the course of the next two weeks.

A discussion followed and a query was raised regarding what the process would be if a patient wished to opt out, clarification will be sought from the WSYBCSU to provide assurance to the CCG of the process.

*Dr David Brown requested clarification on point 5, page 11 where it states that GP system providers EMIS Web and TPP System One are providing options to risk stratify directly using GP data as part of their clinical systems.*

*It was RESOLVED that:*

i) the Committee noted the information provided by WSYBCSU in order for the CCG to respond to the requirements

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### Workforce Update

Katherine Duke attended the meeting to present this report providing workforce information and intelligence relating to the directly employed CCG workforce together with key workforce headlines.

Katherine highlighted the following from the report:

- Sickness rate for January 2014 is 2.2% which is within the 2.5% target set by the CCG and above average in comparison with other CCGs in the West and South Yorkshire area.
- It is anticipated that the CCG will achieve 100% compliance in all subject areas of mandatory training and this will be reported to the Integrated Governance Committee in April 2014
- The CCG is reporting the highest levels of appraisal completion compared to other CCGs in West and South Yorkshire.
- At the recent Staff Briefing on 13 March staff present voted in favour of introducing a Staff Forum, plans will be put in place for the selection of staff representatives.

A discussion followed and Jo Webster asked to be informed of the staff who have not yet undertaken their mandatory training.

It was also felt that the figure shown for completed appraisals on the updated dashboard was incorrect. Katherine advised that this would be checked and it may be that the completed forms had not yet been received or recorded on the workforce system.

It was noted that the Staff Partnership Forum had met to discuss the recently reviewed Workforce Policies and a Policy Working Group meeting will be held to consider the policies prior to recommending approval by the Integrated Governance Committee.
It was RESOLVED that:

i) the Committee noted the report

14/74

**Contract Governance and Assurance**

Matt England presented this report providing an update on contracts awarded, varied and notices served.

Matt advised there is still one outstanding healthcare contract for 2013/14 for Independent Vascular Services. The provider has not signed the contract and no activity has commenced. The provider has written a letter of complaint to Monitor with regard to the PBR tariff rules. Monitor has contacted the CCG with a series of questions and these will be responded to this week. A further update will be provided at the next meeting when it is expected the matter will be resolved.

Discussions are ongoing between the CCG, NHS England and Local Care Direct in respect King Street and the walk-in service. A provisional agreement has been reached with NHS England whereby the walk-in service would be extended until the end of the 2015/16 financial year. As part of this agreement the budget for the walk-in service would transfer from NHS England to the CCG. The Provider (Local Care Direct) has advised of increased unit prices required to maintain an effective service. This is currently being negotiated with the provider as part of wider negotiations regarding the extension of the service beyond 31 May 2014. A further meeting is to be arranged and it was acknowledged that any decisions made need to be linked to future urgent care transformation plans.

Notice has been served on White Rose Surgery PMS+ Ltd cataract service and the contract will not be renewed after 31 March 2014. The provider has communicated that they will appeal against this decision.

A commissioning procurement decision regarding the Musculoskeletal Service is required in April and it was agreed that discussion regarding this would be held outside of the meeting and a further update would be brought back to the next meeting.

Monitor has recently published a briefing document outlining the development areas and direction of travel for the National Payment System in 2015/16 and the key elements were included in the paper. The Finance and Contracting teams will be monitoring developments and contributing to consultations over the coming months. Jo Webster advised that she had written to Stephen Eames regarding the effect of the proposed changes on Community Services.

It was RESOLVED that:

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

ii) agreed further discussions regarding the MSK contract would take place outside the meeting and a further update would be presented at the next meeting
Nadeem Murtuja attended the meeting to present this paper providing an update on equality and diversity, including equality objectives and the Equality Delivery System.

Nadeem advised that following discussions at the December meeting a smaller working group convened on 11 February to review information from the Public Section Equality Duty (PSED) and Equality Delivery System (EDS) reports. Four specific equality objectives aligned to strategic objectives were agreed for recommendation to the Committee.

Objective 1 - Increasing screening rates where there are inequality
Objective 2 - Ensure access to local health provision from new EU Communities and improve the experience and confidence of the transgender community
Objective 3 - Enhancing member practice engagement
Objective 4 - Improving data quality and intelligence gathering and equality analysis, that informs evidence based commissioning and service improvement. Year one focus – mental health

Dr Phil Earnshaw commented that the CCG does not have direct responsibility in respect of Objective 1, it is Public Health England. This was acknowledged but it was felt that the CCG had indirect responsibility as part of addressing local health inequalities.

It was noted that the draft Equality Objectives will be presented to the Governing Body for approval and work will commence to develop an outline implementation plan. The working group will present a quarterly performance report to the Integrated Governance Committee.

Jo Webster requested that the paper presented to the Governing Body should include how the objectives will be achieved.

It was RESOLVED that:

i) the Committee noted the content of the update; and
ii) agreed the draft Equality Objectives be presented for final approval by the Governing Body following the addition of details on how the objectives will be achieved.

The minutes of the following meetings were shared for information:

Mid Yorkshire Hospitals NHS Trust Executive Contract Board – 23 January 2014
South West Yorkshire Partnership Foundation Trust Quality Board – 20 February 2014
Quality Intelligence Group – 6 February 2014
Urgent Care Strategic Group – 23 January 2014
PIPEC – 5 December 2014

It was RESOLVED that:

i) the Committee noted the minutes for information

14/77 YAS 999 Commissioning News

The February issue of the YAS 999 Commissioning News publication was shared for information. Previously, Sandra Cheseldine attended meetings approximately every six months. Following discussion it was agreed that Katherine Bryant would inform YAS 999 group that Sandra Cheseldine is the CCG link and will advise them of Sandra’s contact details.

14/78 Any other business

Andrew Pepper raised the issue of the GP IT budget allocation by NHS England noting that there is no consistency across the patch. The issue has been discussed at the Clinical Cabinet and with Dr Clive Harries and it has been agreed the present arrangements will be honoured until the end of the year.

A discussion followed and it was suggested that for 2014/15 a process of considering case by case may be the preferred option. Andrew Pepper agreed to draft a letter to all practices, noting any new process would be phased in over the next three to six months.

14/79 Date and time of next meeting:

Thursday, 17 April 2014, 1.30 to 4.30 pm in the Seminar Room, White Rose House.
**Title of meeting:** Governing Body  
**Date of Meeting:** 13 May 2014  
**Paper Title:** Clinical Cabinet: presentation of minutes and items for approval by Governing Body  
**Purpose (this paper is for):** Decision  

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<th>Agenda Item:</th>
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**Committee chair:** Dr Adam Sheppard – Assistant Clinical Leader  
**Meeting minutes enclosed:** 27 February and 27 March 2014  
**Recommendation:**  
It is recommended that the Governing Body receive and note the minutes of Clinical Cabinet held on 27 February and 27 March 2014.

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

**27 February 2014**  
- The local authority and the CCG jointly run the Integrated Community Equipment and Wheelchair Service, the service has experienced a 50% increase in equipment usage and the level of activity is no longer able to be supported with the current staffing levels. A joint review of the service and how the systems sit with Care Closer to Home will be discussed at JSCB.  
- Review of section 256 and 75 agreements between the CCG and the local authority were discussed and the need to ensure real commissioning transparency to take forward via the Better Care Fund and Care closer to Home.  
- Looked After Children report presented raising issues in respect of complex needs children, a paper will be prepared and presented to the JSCB  
- Outline framework of Network Development Scheme was presented for discussion  
- MSK Business Case – option 3 agreed, 2 year project board agreed. Pain Clinic Business Case to be presented at April meeting to discuss options  
- DVT Business Case option 3 approved subject to work between CCG/CSU colleagues on governance arrangements and further discussion re financial implications  
- Approved Pathology project subject to appropriate clinical engagement and consideration of a separate work stream  
- Approved Option 2 - 1 year 24/7 for Wakefield and Pontefract Rapid Intervention Service  
- Five weeks remaining of the Primary Care Local Improvement (PCLIF) Scheme, overall reduction in A&E and Emergency admissions  
- Outline Business Case currently being revised, these will be taken back to the Programme Executive meeting on 7 March 2014

**27 March 2014**  
- Revised Commissioning Policy presented with the removal of the criteria policy for wisdom teeth extraction in line with dental commissioning transferring to NHS England. The policy was approved.  
- Clinical Cabinet members noted the contents of the Commissioning Policy for Paediatric Insulin Pumps and agreed to approve this policy in order to provide an insulin pump service that is equitable for the paediatric population  
- The approach to the Mental Health Strategy and Transformation Programme was discussed and it was
agreed that this would be discussed further at the next Informal Clinical Cabinet

- Funding for Special School Nursing changed last year resulting in no funding available to cover children with multi problems, following discussion it was felt this was a joint responsibility between the CCG and the Local Authority.
- Lycra Garments Commissioning policy to be included in the CCG General Commissioning policy
- Request to approve the Ophthalmology single point of access regarding The Practice, members agreed it was right to continue to support The Practice subject to feedback from MYHT in respect of quality improvement.
- Update on Strategic Work Programme presented with agreement that the Care Closer to Home Business Case should be presented at the April meeting.
- Primary Care Local Improvement Framework scheme will finish at the end of March 2014.
- Presentation on E-Consultation was given explaining that this was advice and guidance through a shared electronic base The content of the presentation will be shared with the Networks.
- Update on Children and Young Peoples’ Strategies and Programmes of Work highlighting Wakefield’s local position reflecting high admissions re alcohol, drugs, injury and self harm. To be discussed further at the next Informal Clinical Cabinet meeting.
- What Matters Most? Outcome of Commissioning Priorities Engagement presentation given highlighting the importance of the work done. Further discussion will take place at the April Informal Clinical Cabinet.

Policies approved:

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<td>27 March 2014</td>
<td>Commissioning Policy - removal of the criteria policy for wisdom teeth extraction</td>
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<td>Commissioning Policy - Paediatric Insulin Pumps</td>
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<td>Commissioning Policy - Lycra Garments</td>
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NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday 27 February 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
Dr Phil Earnshaw (PE) Clinical Chair, NHS WCCG
Andrew Pepper (AP) Chief Financial Officer, 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
Dr Patrick Wynn (PW) GP, NHS WCCG
Dr Som DaSilva (SDS) GP, NHS WCCG
Dr Alex Thalhanily (AT) GP, NHS WCCG
Sandra Greenwood (SG) Nurse, NHS WCCG
Stephen Hardy (SH) Lay Member

In Attendance:
Andrew Furber (AF) Director of Public Health
Helen Childs (HC) Interim Programme Manager, PMO (Item 6a and 6b)
Linda Driver (LD) Head of Service Development & Transformation, WCCG
Joanne Fitzpatrick (JF) Head of Medicine Management, WCCG
Alix Jeavons (AJ) Project Manager for Mental Health, Learning Disabilities and EOL Care Programmes, PMO, WCCG (Item 8a and 8b)
Heiko Krauch (HK) Senior Project Manager – Transformation, WSYBCSU (Item 10)
Maciek Gwozdiewicz (MG) Senior Project Manager – Transformation, WSYBCSU (Item 11 & 12)
Dr Shakeel Sarwar (SS) GP, NHSCCG Chair of Network 3 (Item 11)
Petra Strong (PS) Associate – Transformation, Projects and Programmes, WSYBCSU (Item 12)
Esther Ashman (EA) Head of Strategy & System Development, NHS WCCG
Kate Trevelyan (KT) Senior Management Support, NHS WCCG

1 APOLOGIES FOR ABSENCE

Apologies were received from Jo Webster

2 DECLARATIONS OF INTEREST

Item 7 – Network Development Scheme – All GP members declared an interest
Item 10 – MKS – Dr Sheppard declared an interest re Novus at Lupset Surgery
Item 11 – DVT – All GP members declared an interest re Primary Care to deliver the DVT service
3 A MINUTES OF THE MEETING HELD ON 30 JANUARY 2014

The minutes were agreed as a true record.

4 ACTION LOG

The Action Log was reviewed and updated accordingly.

5a INTEGRATED COMMUNITY EQUIPMENT AND WHEELCHAIR SERVICE

IC updated members on the key issues informing members that the local authority and the CCG ran a joint community equipment service (ICES). Over the past six years the service has experienced a 50% increase in equipment usage due to the strategies in place to reduce the length of stay. The level of activity is no longer able to be supported with the current staffing levels. In addition the rental bill for pressure care had increased by 174% over the past four years. IC highlighted that:

- ICES had not got resource to maintain the equipment;
- 90% of the equipment was recycled
- Additional staff required to support the service
- The pressure care system 50% of the equipment rented and 50% was purchased
- The request is to purchase systems which will save money on rentals

Members note that the service was a good use of resource in line with CCG strategy, but at the same time concerns were expressed that

- there was not a strategy in place to support within Care Closer to Home
- issues in respect of a budget which had not changed
- non recurrent funds being used which needed to be reviewed.

IC stated that they could not profile the effect on the budget to reduce rental costs and in 12 months’ time, the Non recurrent money for staff would be reviewed. JoP thought that a joint review of the systems needed to be commissioned in respect of how it sits with Care Closer to Home and it was noted that this was being discussed at JSCB.

Members approved the additional expenditure as outlined in the report.

5b REVIEW OF AGREEMENTS WITH LOCAL AUTHORITY

AP updated members that the paper provided an update of the current and proposed section 256 and 75 agreements between Wakefield CCG and Wakefield Metropolitan District Council (LA). These agreements are arrangements under the NHS Act 2006 whereby the CCG can transfer funds to the LA and there is deemed to be a wider health benefit to the Wakefield health economy re carers and contracts. There were still areas for further investment and AP highlighted Section 6 New proposals.

PE was concerned around the issue of mobile working and assisted technologies and that any further investment should also come with assurances around the investment. JoP
queried whether there was real commissioning transparency to take forward via the Better Care Fund and Care closer to Home. Members agreed JoP would discuss the issue of commissioning transparency with Helen Childs and Linda Driver.

**Action:** JoP to discuss issue of transparency with Helen Childs and Linda Driver

Members noted the update and progress made

6 **LAC HEALTHCARE SUPPORT**

Members reviewed the report and AC stated that the content did raise issues around the Complex Care budget and highlighted a need to identify better services to support children with severe complex needs. Members discussed LAC issues in respect of complex needs children and agreed that a paper was required. After debate it was agreed that the paper should go to JSCB.

Members noted the proposed outlined in the report and agreed subject to:

- No change in arrangements;
- The issue of cross charging needs to become a core commissioning duty;
- Issues of resource need to be taken out of Clinical Cabinet with more investigation done around this;
- Paper re complex needs children should be taken to JSCB

7 **NETWORK DEVELOPMENT SCHEME**

Dr Greg Connor, Kerry Munday and Liz Blythe attended the meeting. GC highlighted that the paper was for consultation, outlining the Development Framework has been developed to pull together

- Primary Care resilience
- Care Closer to Home agenda re integrated care team working
- PCLIF scheme evaluation (very positive position re care planning with viable performance)
- Everyone counter strategic Planning Guidance (£5 per patient to spend on initiatives in primary care) in Primary Care

The Outline Framework proposal funded by non recurrent resource was to provide £5 per patient re initiatives within Primary Care and Integrated Care backed by expanded team in the Primary Support Unit (PSU). It was noted that the paper would also be presented at Executive Team, LMC and then the NHS Executive Approvals Group with a commencement date of 1 April 2014.

Members debated the issue of the new scheme versus PCLIF and comments included:

- PCLIF had helped create capacity in primary care, e.g. same day appointments which needed to be taken into consideration in the new scheme.
- It was noted that it was important that the framework takes into account Everyone Counts covering LTC, over 75s, emergency admissions and mental health needs, Integrated Care, Better Care fund objectives and pathology.
- it would be sensible to go to the Improvement Academy for external support re good practice.
- There was a need to triangulate the impact
- Query re QIPP around how to triangulate inclusion of the specialty areas such A&E and outpatients and also was concern about engagement with membership by possibly sharing the draft framework.

Members agreed that it was an excellent proposal and noted GC’s request to further consider and feedback any comments by email through to GC, KM or LB within the next week.

8a  INVESTMENT FOR LIAISON PSYCHIATRY CASE

Alix Jeavons (AJ) presented an updated paper which outlined the current position stating that the Liaison Service at Pinderfields had seen more that 250 patients since 9 December with an average of 60% reduction in admissions.

It was noted that the paper was for a decision re implementation of a full psychiatry team at Wakefield, Dewsbury and Pontefract with the necessary increases in staff to support to extend opening hours. Work has been ongoing to record, achievement of benefits of for a 2 year pilot with £336K for Wakefield CCG split between the two CCGs coming out of non recurrent funds.

JoP commented that there was a need to understand how it is improving the patient experience and quality of the pathway with critical data (patient stories) to be captured as part of the pilot whilst at the same time getting a view from the Acute Clinician pre and post service. It was noted that one of the advantages of the investment was that the Crisis Team would undertake intensive ‘home’ based treatment to patient and support GPs re follow up issues.

PE expressed concern about engagement of GPs and overall involvement and it was noted that this would be covered under the wider Business Case. Concern was expressed around inappropriate referrals to A&E and the need for a governance challenge.

Members approved the investment required for the Psychiatric Liaison Service Subject to engagement of GPS and governance challenge being followed through

8b  MENTAL HEALTH NON RECURRENT FUNDING

The Business Case was for non recurrent funding for 2013/14 for a series of schemes which will support and ‘pump prime’ the Mental Health & Learning Disability Services Transformation Programme and the delivery of Mental Health QIPP working in collaboration with SWYPFT and the voluntary community services would be supported. AP confirmed that monies were within the mental health financial position. AC commented that there was a need for IAPT to be taken into account. Members also noted the benefit of the Recovery College which supported recovery through learning.
Members approved the bids for the non recurrent funding subject to the recognition of the community IAPT service within the existing budget.

9a CLASS UPDATE – RE ALIGNMENT OF SERVICES

HC presented the paper which related to Care Closer to Home model and residential care support re emergency bed days. The paper outlines outcomes and intervention to confirm the direction of travel.

Members noted and approved the proposals in the report.

9b BETTER CARE FUND UPDATE

HC provided a verbal update indicating that the Better Care Fund template had been submitted on the 14 February. The Local Area Team were asking CCGs to peer review each others submission and it was noted that Wakefield CCG’s submission was in line with other submissions with no areas of significant concern.

The Health and Well Being Board would not review the final draft unless there are any significant changes and the final draft would be submitted on the 4 April. Members agreed that an update should be brought to the Clinical Cabinet.

10 MSK BUSINESS CASE /OPTIONS PAPER

HK introduced the implementation options as noted in the paper and LD stated that Dr Patrick Wynn supported Option 3 (Prime Contractor Procurement). LD further updated members from a contractual viewpoint that:

- working closely re transformation work with a possible 2 year procurement plan;
- looking at all the providers and possible difficulties;
- decisions needed to be made within the procurement timetable of April re a component model.

Members noted a need for assurance around the contractual issues in the procurement and AS stated that it was a 2 year proposed project management group with appropriate governance which would lead a component charge to deliver a service. PE was concerned in respect of an integration service and it remaining an integral part of Primary Care. Other comments included

Members were concerned that the paper felt very technical, however it was noted that GPs had been involved in the events and the Options Paper had been based around discussions with GPs. Members considered that a pain clinic in primary care needed to be on the top of the agenda if going down the component route. It was noted that the model would need to be tested and members agreed that a Business Case should be brought back to the April meeting.

Action: Pain Clinic Business Case paper to be brought back to the April meeting
Members approved Option 3 and with the component approach, supporting a 2 years implementation and support the project plan over the timeline.

Due to clinical commitments, PW attended the meeting and AS summarised the agreements as being

- Option 3 agreed
- 2 year project board agreed
- Project stage plans through project change
- Pain clinic option to be considered and brought back to the next Clinical Cabinet around values

PW commented that the

- Pain clinic had a lot of risks involved re lack of value, costs and preliminary information on scope done but a lot of good reasons to do something
- Primary care section need to be correct on criteria based commissioning
- Do not want to lose the primary care input re inhouse physiotherapy

11 DVT BUSINESS CASE

Dr Shakeel Sarwar and Maciek Gwozdziewicz attended the meeting to present the first Business Case from membership and network.

MG introduced the presentation which followed a patient’s journey on the DVT pathway. SS updated members on the work done re DVT and D Dimer as a community solution, looking at alternative DVT solutions involving the following options:

1. DDimer and Rivaroxaban 7days & Warfarin;
2. DVT with D Dimer in community;
3. DVT with D Dimer in Community and Rivaroxaban full treatment;

Members noted that there were governance issues and a need of independent contracting involvement re actual commissioning of the service (CSU on behalf of the CCG), the financial implications of increased prescribing of Rivaroxaban and possible transport issues which would need to be discussed outside of the meeting.

Members approved Option 3 subject to the work between CCG/CSU colleagues re governance arrangements and further discussion re financial implications.

12 PATHOLOGY

Maciek Gwozdziewicz and Petra Strong attended the meeting. MG introduced the paper and it was noted that this was a QIPP project to enable the reduction of unnecessary laboratory pathology requests by primary care clinicians, to improve the quality of tests ordered and to ensure that tests ordered are necessary to achieve the best health and well being outcomes for patients.
Members comments included:

- Sensitive communication required back into primary care;
- helpful towards informed discussions to see some graphs;
- lot more could be done towards educating GPs around best practice in collaboration with Pathology Services.

PE commented that there should not be the only QIPP in Pathology, it was also about the possibility of contracting one service for the whole of West Yorkshire including 7 day working and general modernisation of the service as a separate work stream.

Members approved the project subject to appropriate clinical engagement and consideration of a separate work stream.

13 WAKEFIELD & PONTEFRACT RAPID INTERVENTION SERVICE

LD introduced the paper which recommends that Wakefield CCG approves £444,272 of non recurrent monies (for 2014/15) to support the provision of Wakefield Hospice and The Prince of Wales Hospice providing 24/7 hospice admission.

It was noted that value for money prospective had not been achieved but it provided excellent benefits from a patient’s perspective and the changes to the single point of contact had received excellent feedback from patients. The proposal was to continue with the hospice beds from non recurrent funds. Dr Linda Wright and Helen Childs supported the proposal from a Care closer to Homer perspective and benefits included:

- Community beds availability
- Supports Early Discharge
- Prevents hospital admission
- The service was in line with other areas.

It was noted that there was money allocated to support the project in 14/15 until the integration commences. Members acknowledged that from a sustainability prospective, the report needs to go to QIPP and Care closer to Home Commissioning Board.

AP commented that he would discuss possible financial implications and risks with HC around Care closer to Home and Better Care Fund. LD commented that there was money left over from the Marie Curie Pilot which could be utilised and agreed as part of the contract negotiations.

Members approved support Option 2 for 1 year 24/7 subject to AP investigating the financial issues.

14 STRATEGIC WORK PROGRAMME FOLLOW UP

Esther Ashman attended the meeting to give a verbal update. The first draft was finalised on the 14 February with initial feedback received. A draft copy of the Strategic plan will be
ready next Friday and EA commented that they were working in close communication with other CCGs. Key dates to note:

- Going to Health and Well Being Board on 13 March to sign off
- Workshops next week with various leads
- To NHS England meeting on 7 March to feedback on initial template
- Feedback on the operation plans next Tuesday

Members thanked EA for the update.

15 QIPP

The QIPP position remained as discussed at the meeting on the 13 February. Members agreed that assurance on risks was required and that MG should provide an update containing more transparency on QIPP around the high risks which will need escalation to Board.

AS commented that there was a need to engage with membership and this would need to be brought to the informal cabinet for further discussion around communication with membership, PSU staffing etc.

Action: MG to provide assurance around transparency on QIPP around high risks

16 NETWORKS UPDATE

IH introduced Dr Alec Thalhanilary and provided an update on comments from the network which included:

- Feedback required on Care Closer to Home;
- No contact to date from Social Workers with Practices;
- Lack of District Nurse resource;
- Lack of clarity re Care closer to Home;
- Lack of clarity around referrals
- Lack of clarity need around assessment follow ups
- Date and information re support
- Funding between Community Care to primary care
- Workforce availability

LD/IH working on feedback from the Locality with HC and it was noted that HC will be attending the next Locality Meeting together with representation from Health and Social Care to enable issues to be dealt with promptly.

PE updated members re meeting with Robert Flack (Locala) re community services and it was noted that JoP had a meeting scheduled with Liz Howarth next week in respect of the resource to manage communications.
AS updated members that there were 5 weeks for the PCLIF left to run with an overall reduction in A&E and Emergency admissions. At the end of December Care planning showed that 7 out of 10 had been achieved and action plans were in place to deliver by the end of March. Work was not ongoing to review governance issues.

Members noted this as being very good news and an immense achievement.

18 TRANSFORMATION PROGRAMME OUTLINED BUSINESS CASE (OBC) UPDATE

Liz Howarth had provided a written update:

The current position is that the draft OBC was signed off by the Programme Executive in December but since that date there have been a number of changes and so the OBC is currently being revised to reflect:

- the financial allocations for CCGs
- the impact of the Better Care Fund
- the move from 6 networks to 7
- the feedback from the Clinical Senate

The revisions will be taken back to the Programme Executive meeting on the 7 March 2014.

19 WHAT MATTERS MOST? OUTCOME OF COMMISSIONING PRIORITIES ENGAGEMENT

Members noted the paper contents and that Laura Elliott would be attending the next Clinical Cabinet to provide a presentation next month.

20 ANY OTHER BUSINESS

20.1 Informal Clinical Cabinet meetings

Due to the length of the agenda, time was not available to allow for items to be debated in detail. AS proposed that there should be an informal bi monthly meeting (in between the formal Clinical Cabinet meeting) to review business cases. It was suggested that the informal meeting be scheduled over lunch to target key people and members to cover 1 or 2 topics and to get other colleagues more involved. Clinical Cabinet needs to provide mandate for initiatives so that they can progress in a similar way to formal and informal Board.

It was agreed that AS and JoP would further discuss the proposal outside of the meeting.

Action: AS and Jo P to discuss the proposal of an informal Clinical Cabinet outside of the meeting

20.2 Decisions outside of the meeting
JoP asks for it to be formerly noted that due to the extensive agenda, the following decisions had been taken outside of the meeting in line with guidance:

- Agreement on the investment of E Consultation and the use of non-recurrent money;
- Public Health;
- Patient Evaluation of Care Closer to Home

21 DATE AND TIME OF THE NEXT MEETING

Thursday, 27 March 2014
09.00 – 12.30
Seminar Room, White Rose House
NHS Wakefield Clinical Commissioning Group

CLINICAL CABINET

Minutes of the Meeting held on
Thursday 27 March 2014
09.00 – 12.30
Boardroom, White Rose House

Present:
Adam Sheppard (Chair) (AS) Asst. Clinical Chair, NHS WCCG
Jo Pollard (JP) Chief of Service Delivery and Quality, NHS WCCG
Dr Phil Earnshaw (PE) Clinical Chair, NHS WCCG
Andrew Pepper (AP) Chief Financial Officer, NHS WCCG
Dr Clive Harries (CH) 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
Dr Som DaSilva (SDS) GP, NHS WCCG
Stephen Hardy (SH) Lay Member

In Attendance:
Andrew Furber (AF) Director of Public Health
Linda Driver (LD) Head of Service Development & Transformation
Jenny Feeley (JF) Senior Transformation Manager (Item 5)
Sarah Shepherd (SS) Transformation Manager (Item 5, 16)
Janet Wilson (JW) Diabetes Network Manager, PH (Item 6)
Michele Ezro (ME) Programme Lead for Mental Health and Learning Disabilities (Item 7, 11)
Alix Jeavons (AJ) Project Manager for Mental Health, Learning Disabilities and EOL Care Programmes, PMO, WCCG (Item 7)
Morna Cook (MC) Senior Commissioning Manager, Maternity and Children, WCCG (Item 8, 9)
Debra Taylor-Tate (DTT) Senior Commissioning Manager, WCCG, (Item 10)
Sharon Wallis (SW) Senior Commissioning Manager, WCCG, (item 17)
Tracey Sparkes (TS) Programme Lead – Maternity, Children and Young Peoples’ Transformation, WCCG (Item 17)
Laura Elliott (LE) Head of Quality and Engagement, WCCG (Item 19)
Gisela Clark (GC) Engagement & Patient Experience, WSYBCSU (Item 19)
Kate Trevelyan (KT) Senior Management Support, NHS WCCG

1  APOLOGIES FOR ABSENCE

Apologies were received from Dr I Hanney, Jo Webster, Dr G Connor, Karen Parkin

2  DECLARATIONS OF INTEREST

Item 10 – Ophthalmology, Single Point of Access: AS re The Practice Service at Lupset Surgery
3 A MINUTES OF THE MEETING HELD ON 27 FEBRUARY 2014

The minutes were agreed as a true record.

4 ACTION LOG

The Action Log was reviewed and updated accordingly.

5 COMMISSIONING POLICY REVISION AND BACK PAIN SUB POLICY

JF and SS attending the meeting to present and it was noted that the paper was in two parts with the commissioning policy available on the CCG web site:

- Approval of the removal of the criteria policy for wisdom teeth extraction from the NHS Wakefield CCG commissioning policy in line with dental commissioning transferring to NHS England.

- Approve the immediate introduction of the criteria for facet joint and epidural injections for the treatment of lower back pain for newly referred patients.

JF updated members around the proposed introduction of a new criteria policy re injections and it was noted that Public Health would be undertaking an evidence based review which fits in with current NICE guidelines (although it was acknowledged that this would be monitored as the guidelines were changing).

SH emphasised that as it was criteria based commissioning, it was of great importance to engage with patients and the public. JF stated that, due to the speed of implementation, this had not been undertaken to date, but that they were already trying to set up meetings with patient representative groups re engagement.

Members noted that this policy would only apply to new patients as opposed to those already in the system. LD commented that it all links together with the MSK, component parts and the Pain Management Clinic pathway.

AS summarised that there was a need for a debate at Informal Cabinet on April 10, involving all parties which JF should organise for a broader clinical debate. It was noted that LD would check with Heiko Kaush about his ongoing work.

It was resolved

i) approval of the policy re extraction of wisdom teeth;

ii) the proposed lower back pain policy should be discussed at the Informal Clinical Cabinet meeting on the 10 April 2014.
PAEDIATRIC INSULIN PUMPS

JW attending and advised members that the paper had been prepared following a discussion at QIPP and IFR where it had been requested that a process be written for an alternative to Children’s Insulin Pumps.

Members noted that the pumps preferred by MYHT were not always suitable for children and the use of a patch pump was a better alternative. JW explained the benefits of the patch pump versus the pump of choice by MYHT and members noted the new policy had financial implications. Discussions would be starting with MYHT in May and support was required from Clinical Cabinet. It was recommended that Clinical Cabinet note the contents of the Commissioning Policy for Paediatric Insulin Pumps and agree to approve this policy in order to provide an insulin pump service that is equitable for the paediatric population within MYHT.

It was RESOLVED that

i) The contents of the paper were noted;
ii) The policy was approved.

APPROACH TO THE MENTAL HEALTH STRATEGY AND TRANSFORMATION PROGRAMME

CH introduced ME and AJ explaining the background to the Liaison Psychiatry Business Case which sets out the approach for the next five years.

AJ explained that the detail behind the Joint Mental Health Strategy involving both Local Authority and Public Health to deliver on the Transformation Programme scope. The agenda focused on scenarios for the future and after public engagement main issues identified included:

- Public awareness needs to improve;
- Austerity/deprivation;
- Improvement in Waiting times;
- A need for Clinicians who understand mental health conditions;
- Reduction of Stigma issues;
- Generally falling through the gaps;
- Level of Care;
- GP involvement (although this was deemed as already good)

The strategic ambitions included delivery and harnessing with would require engagement/communications to reduce stigma and improve culture. AJ indicated that they were engaging with Network colleagues over the 5 year plan to:

- Review of core services;
- Promotion of self management;
- Service users, carers and public to decide on services;
- Holistic review no borders re age;
- Need to involve other providers re delivery;
- Needs to be evidence based;
- Joined up and integrated engagement;
- October timescale;
- SPOC in crisis;
- No cut off between Children and Adults;
- Need to review over the 5 years
- Cross analysis of pathways

Members were asked

- to note the contents of the presentation;
- confirm support of the approach being taken;
- agreed to looking at services for all ages;
- give advice re engagement with GP colleagues;

Members agreed that this was a massive opportunity for clinical redesign and noted that it links into the Mental Health and Well Being strategy and the Urgent care agenda. AC commented that it needs local authority engagement around being IAPT driven.

AP commented that the procurement would need to focus and tie into the existing programme implementation to eliminate duplication but at the same time austerity technology.

Members recognised that it was a great piece of work by CH, PS, ME and AJ which had evolved over the 12 months.

It was agreed that membership should be involved around

- key priorities and wider consultation;
- Need to know what pressures exist re IAPT modelling

It was agreed that the issue should be brought to the next Informal Clinical Cabinet for wider discussion in detail.

**Action:** Transforming Mental Health Services on the Agenda for Informal Clinical Cabinet 10 April meeting

### 8 FUNDING FOR SPECIAL SCHOOL NURSING

MC presented the paper advising that this was part of the joint commissioning team work and that the School funding changed last year with the outcome that there was no funding available to cover children with multi problems which had previously been covered by three Band 5 nurses who had been funded as part of the block contract.

There was a query around whether this item should be discussed with CCG or with LA. JP stated that it was a £17.5K cost pressure and it felt right to include on the Clinical Cabinet agenda. AF agreed that it needed to be resolved and commented that it was not discussed at JSCB as it was not felt to be a strategic issue. AF commented that the issue had arisen due to a change in the way that schools were funded. PE responded that there was a need for a commitment to ensure it happens and where the responsibility sat. It was felt to be joint responsibility and members agreed that it should be resolved before the next Clinical Cabinet.
It was agreed that the Funding for Special School Nursing should be discussed outside of the meeting and brought back to the April Clinical Cabinet for sign off.

**Action:** Special School Nursing to be brought back to the April Clinical Cabinet for sign off

### 9 LYCRA GARMENTS COMMISSIONING POLICY

It was noted that Lycra splinting is primarily used to support children with movement disorders relating to cerebral palsy and similar conditions.

The recommendation was that Lycra garments are approved for adults who have successfully used them as a child because there was no evidence base for their use in adults.

It was RESOLVED with agreement that this policy was included in the CCG General Commissioning Policy.

### 10 OPHTHALMOLOGY SINGLE POINT OF ACCESS

DTT attended to present the paper and AS took the opportunity to thank DTT for her hard work as she was leaving the CCG tomorrow (moving to Urgent Care at Leeds CCG).

It was noted that the previously agreed three month pilot was due to end and there was a need to make a decision as to whether to continue. The implementation date had been 16 December and since that time there had been a marked increase in referrals to The Practice (80%). Activity levels were now in line and delivering QIPP re Care Closer to Home.

DTT commented that the Clinical Cabinet were being asked to approve the single point of access re The Practice. It was noted that patients were being given choice and there was good feedback re the service.

Members expressed concern about the evidence in respect of referrals and the slight problems in the past with The Practice service. AP commented on the assurances around The Practice position as there had also been integrity issues. It was noted that a process to review all Ophthalmology services would be undertaken at the end of the year and PD asked to be involved in the review.

There was a discussion about the drugs being prescribed by The Practice and it was agreed that Simon Rowe (SR) would check with JF on this point.

**Action:** SR to check with JF on the list of drugs being prescribed by The Practice. PD to be involved in the end of year review (SR to follow through)

Members agreed that it was the right to continue to support The Practice subject to feedback from MYHT in respect of quality re Formal expectations and improvement in quality. JP indicated that she would speak to PW to formalise a letter to Richard Jenkins for assurance around this point.

**Action:** JP to speak to PW to formalise a letter to Richard Jenkins
It was RESOLVED to support the recommendation to continue the utilisation of the Single point of Access for all ophthalmology services up to the end of the year subject to assurance re quality.

11 STRATEGIC WORK PROGRAMME FOLLOW UP

ME gave an update which included

- Draft of Operational and Strategic Plan to NHS England on 4 April 2014;
- Strategic Plan had been combined into one template;
- The final draft will be completed by 20 June with a review to provide a succinct document all subject to the normal decision process;
- The Strategic and Operational Plan turned into the CCG Business Plan and there was a need re transparency on issues.
- Workplan would be used to ensure appropriate streamlining of Plans on a Page as presented at the Governing Body.

AF asked if discussions were ongoing with the LA and other CCGs particularly Kirklees, which ME confirmed, elaborating that it was good to have a simple plan for Wakefield and other plans would then sit underneath (ie. Closer to Home). It was agreed that the Care Closer to Home Business Case should be escalated to the April Clinical Cabinet.

**Action:** Care Closer to Home Business Case to be on the April Clinical Cabinet agenda.

12 QIPP

AP commented that the position remained as previously reported and QIPP schemes were still being identified for next year.

JP indicated that there was a meeting on Monday to look at ideas and that discussions would be held outside of this meeting between AP/IP, noting that the CSU would be presenting on this at the 10CC meeting. Information would be shared with Networks around the intelligence to deliver re secondary care budgets. CH commented that GPs needed a simple breakdown around budgets and activity.

13 NETWORKS UPDATE

It was noted that Network 6 had concerns re admissions, not being involved in Care Closer to Home and impact on other pilots.

LD responded that they (LD, JM and HC) would attend the Network Meetings to ensure engagement.

**Action:** LD, JM and HC to attend Network Meeting to ensure appropriate communications and engagement
14 PCLIF UPDATE

It was noted that the scheme would finish at the end of March with Justine Joy leading. A&E attendances had reduced with targets met and there was a need to send a message out to Practices in respect of the achievements.

Action: AS to send message out to the practices in respect of achievements

15 BETTER CARE FUND UPDATE

AP commented that he was fully sighted on activity and there was no issues to discuss.

16 E-CONSULTATION (TECHNOLOGY ENABLERS)

CH introduced SS and the important work which had been done for clinicians to now comment on. E Consultation was advice and guidance through shared electronic base in a simple efficient manner.

SS presentation included

- Steering Group set up which included MYHT, Locala, LA, CSU and PH;
- CH working on the IT Strategy which includes E Consultation;
- The clinical aspects were highlighted by CH as being a speedier response to clinical questions, consultations using shared records for completeness (similar to the diabetes model);
- E Consultation would be rolled out over the next few months in Radiology, Cardiology, Neurology, Endocrinology and Urology;
- Bradford implementation had 11 specialities which had shown a significant decrease in referrals;
- Pilot would be for 6 months using non recurrent funds negotiated with MYHT and referral data would be monitored;
- Future funding would come from the reduction in Outpatients;
- Risks at the moment around the 5 working day target and processes to solve being considered;
- GPs would be part of the Project Teams and will take into account issues with the Diabetes Model.

CH stated that the next steps would be incorporating into SystmOne and that the process taken would need to be open and transparent.

Members noted the contents of the presentation and that it would be shared with Networks.

17 UPDATE ON CHILDREN AND YOUNG PEOPLES’ STRATEGIES AND PROGRAMMES OF WORK

AC introduced this presentation and it was noted that national strategies had been taken into account with savings of 3% against plan acknowledging the effect of same day PCLIF had made a lot of difference. The presentation highlighted Wakefield’s local position reflecting high admissions re alcohol, drugs, injury and self harm. PD commented that the position should be reviewed against to areas more akin to Wakefield such as Rotherham, Barnsley and Doncaster.
Action: TS to review Wakefield’s local position against Rotherham, Barnsley and Sheffield

SW presented that Behaviour Pathway (AHSD) Transformation Programme which was commenced in September 2013. The design group was multi agency and the analysis identified areas to be reviewed.

It had been decided to have one dedicated specialist multi agency service with SPOA but it was unclear where this would feed back through as the reporting structure included JSCB. The Planning phase document had been presented to JSCB with a commencement date of April. The Business Case would be Mid August and implementation in October with an evaluation after that.

SW updated members around communications and workshop and it was noted that there was no programme management support and discussions were being held with Liz Howarth on this point.

Members noted the presentation and acknowledged the work.

TS presented the Safeguarding composite report which was to provide assurance covering

- Methodology with recommendations
- Notable improvements;
- Identifying gaps – domestic violence, multi agency agreements

It was noted that important evidence had not been provide in CAFCAS and IC indicated that this was still being chased for sign off and members acknowledged the importance of this.

Members noted the presentation and AP indicated that the report containing 15 recommendations, would be taken to IG and the next ET meeting around CH record keeping.

It was agreed that this would be put on this issue would be added to the agenda of the next Informal Clinical Cabinet meeting.

Action: Safeguarding Composite report re Childrens’ services to be added to the April Informal Clinical Cabinet

18 FUTURE SHAPE OF CHILDREN’S SERVICES 2014

AF updated members commenting that the draft described the strategic intentions and themes around development of children’s services which had been discussed with Carly Speechley.

PE expressed concern that there was not enough emphasis around health issues.

Members noted the draft and look forward to receiving the final document.
19 WHAT MATTERS MOST? OUTCOME OF COMMISSIONING PRIORITIES ENGAGEMENT

SH introduced the presentation, highlighting the importance of the work done. LE stated that the survey had been conducted through October and December with a three fold approach of engagement work in Castleford, Pontefract and South Elmsall market with trans genders community, older people’s group and at Wakefield College.

Members noted that the issues which the community have are

- Access to Services
- GP access
- Frontline staffing
- Reduce bureaucracy
- Governance issues
- Leisure facilities and access
- Prevention
- Older People services

It was agreed that the work should be taken to the Informal Clinical Cabinet in April and in the meantime LE/GC should provide members with questions to think about beforehand.

Members noted that Wakefield CCG are award winning organisation being identified in the top four for the NHS England for Excellence in Participation Awards.

20 CLINICAL CABINET ANNUAL REPORT

AS stated that it had been proposed that a report should be produced to show the added value of Clinical Commissioning through the year of the Clinical Cabinet. It would demonstrate outcomes with a summary showing clinical work services.

Members supported the proposal, commenting that it should be succinct and focus on clinical decisions. It was also noted that when finalised it should be user friendly and posted to the web site. It was anticipated that the report would be produced within the first quarter.

21 ANY OTHER BUSINESS

No Items were discussed

22 DATE AND TIME OF THE NEXT MEETING

Informal Clinical Cabinet:
Thursday, 10 April 2014
10.30 – 12.00
Boardroom, White Rose House

Clinical Cabinet:
Thursday, 24 April 2014
09.00 – 12.30
Seminar Room, White Rose House
NHS Wakefield Clinical Commissioning Group
EXECUTIVE APPROVALS GROUP MEETING

Minutes of the Meeting held on Tuesday 18 March 2014
9 am-11 am
Seminar Room, White Rose House

Present:
Sandra Cheseldine (SC) Lay Member
Sharon Fox (SF) Nurse Member
Stephen Hardy (SH) Lay Member
Rhod Mitchell (RM) (Chair) Lay Member
Andrew Pepper (AP) Chief Financial Officer
Jo Webster (JW) Chief Officer

In Attendance:
Greg Connor (GC) Executive Clinical Advisor
Pam Howson (PH) Admin Support (Minutes)
Jo Pollard (JP) Chief of Service Delivery & Quality

1 APOLOGIES

Apologies for absence were received from Mr Hany Lotfallah.

2 PCLIF EVALUATION AND PROGRESS – VERBAL UPDATE

The Primary Care Local Improvement Framework (PCLIF) Evaluation and Progress report will soon be completed. The final report will be sent to the Executive Approvals Group for the consideration of members. The report will include lessons learnt from PCLIF last year and the proposal will be investment in primary care.

3 PROPOSED NETWORK OUTCOMES FRAMEWORK 2014/16

GC outlined the proposed Network Outcomes Framework; an engagement and development framework which will help build capacity. He confirmed that the scheme builds on lessons learnt from the PCLIF scheme. GC confirmed that there has been a favourable response from the Local Authority.

It was noted that the Framework is resource constrained. It is to be tightly performance managed and offers value for money for the CCG. The first year is developmental and will build a platform for the second year. GC asked members to consider whether the Framework is good value for public money and in patients’ best interest.

The scheme looks at overall health needs. Practices will be asked to look at all over 75s with 2 or more conditions and also patients on the mental health register. For the baseline assessment, utilisation is set at 90% or more before practices can claim claw backs.

Members discussed the responsibility of working on the project, and the best way to measure the start and finish points of the scheme. SC noted the lack of hard outcomes and concern around the
£5 per patient being split at £4 and £1, and what actions are to be taken that are measurable. JW noted that the majority of the money is to be spent on extra staff and resources and AP noted that this is not a bad investment – value and cost are 2 separate issues.

JP informed the Group that the scheme is critical due to strategic leverage, and it was necessary to explain to patients:
- how access to primary care is to be increased
- patients to be empowered to increase self care
- enabling patients to have a say in local health care

SH asked for clarification on the type of access in terms of quality eg out of hours. The issue of hours is governed by the core contract. The scheme will lead to a reduction in routine waiting times, appointment times which are more convenient, plus care home reviews.

Concerns were expressed that it would 12 months before patients would be engaged in discussions. It was suggested that this deadline should be brought forward.

It was agreed that the deadline for some key areas, including the Action Plan, should be brought forward to enable more activity.

SC noted there was very little mention of QIPP and felt there should be more focus on it. JP informed the Group that practices are to participate in external peer reviews. The path lab is a priority as £1m could potentially be clawed back. As practices are not engaged in doing their own QIPP, they need to have indicative budgets and understand activity data. This method has been successful in prescribing and is a tried and tested method of engaging practices. A shift of resources is required from secondary care to primary care in order to fund Year 3 onwards. Once practices understand the scheme and the benefits to patients, they will make clinical changes to make this happen.

The group discussed the sign-off procedure for practices and it was agreed that a Lay Member should carry out the final sign-off. JW suggested splitting the Action Plans and Network Plans into three sections; one for each Lay Member, to work with the teams as described in the Framework.

It was **RESOLVED** that:

1. The Executive Approval Group approved the Network Outcomes Framework subject to the following amendments and caveats:
   a) A split of £3 and £2 was agreed
   b) To tie domains into the strategic plan
   c) To include clear benchmarks and starting points for each practice
   d) To include pay rate ranges
   e) To bring forward the deadline on some initiatives
   f) Ensure IMPP is funded from additional prescribing budgets
   g) Expand QIPP in the proposal and measure performance against Year 2 targets
2. GC to amend the Framework as agreed and circulate to the Group
3. To agree the final ‘sign off’ / approval process at the next meeting on 27 March 2014.
4. The PCLIF Evaluation Report will be discussed at a future meeting of the Executive Approvals Group to be arranged at the beginning of April.
4 ANY OTHER BUSINESS

No other business was raised.

5 FUTURE MEETINGS

The next meeting will be held on 27th March 2014 at 4.00 in the Board Room at White Rose House. The meeting consolidate actions at today’s meetings and ensure The Network Outcomes Framework is signed off.
HEALTH AND WELLBEING BOARD

Thursday, 13 February 2014

Present: The Chair (Councillor Mrs P Garbutt)
Councillor Mrs Cummings
Councillor Mrs Rowley
Mr A Balchin Corporate Director, WMDC
Ms K Curry Service Director, WMDC
Dr A Furber Director of Public Health
Dr L Kamal CCG Representative
Dr A Sheppard CCG Representative
Mr S Hardy Non-Executive Member of CCG
Ms A Knowles Commissioning Director, NHS England
Mr P Loosemore Healthwatch
Ms P Bee Voluntary Sector Representative

Also in Attendance:
Ms C Griffiths Mid Yorkshire NHS Trust
Ms A Farrell SWYFT
Ms A Middlemiss Wakefield MDC, Public Health
Ms H Childs CCG
Ms H Laird Wakefield MDC, Public Health

67. ACCEPTANCE OF APOLOGIES FOR ABSENCE
Apologies for absence submitted prior to the meeting were accepted on behalf of Dr P Earnshaw, Ms J Roney OBE, Mr J Wilson, Ms J Webster, Mr S Eames, Ms T Holder, Mr K Dodd and Mr S Michael.

68. MINUTES - 16 JANUARY 2014
Resolved – That the minutes of the meeting of the Health and Wellbeing Board held on 16 January 2014 be approved as a correct record.

69. CHAIR’S ANNOUNCEMENTS
It was acknowledged that there had been a delay in circulating some of the reports for consideration at the meeting. Officers were thanked for their hard work in getting the required documentation ready for submission within such a tight timeframe.

70. MEMBERS DECLARATIONS OF INTEREST
No declarations of interest were made.

71. BETTER CARE FUND
Consideration was given to a report and presentation on the Better Care Fund Plan. The Better Care Fund was a single pooled budget to support health and social care services to work more closely together in local areas. Its aim was to transform local services to deliver better integration of health and social care, giving people more choice and control over their own care and support. The Plan placed great emphasis on care closer to home – it was felt that many people could be treated effectively in their own home with the support of appropriate wraparound services without having to be admitted to hospital. It was acknowledged that this would be a significant challenge given the shift in attitude and culture that would need to take place, however it was felt that Wakefield was in a good position to make changes due to the amount of work already undertaken.

Members were provided with an overview of the national conditions with which Wakefield would have to comply, together with the national metrics on which
Wakefield’s performance would be judged. This included admissions to residential and care homes, avoidable emergency admissions and patient/service user experience. Wakefield had also been able to choose its own local metric and had chosen ‘satisfaction with level of social contact’. 25% of the Fund was performance related and if 70% of the targets were not reached Wakefield would be visited and asked to draw up action plans to address the shortfall.

The presentation also provided Members with details of how the BCF could be distributed. The current estimated total of 42.1million would be given further consideration before the Plan was resubmitted to NHS England in April 2014.

It was acknowledged that pooling such a significant amount of resources would inevitably create risks. The most important risks had been identified and were included as part of the BCF Plan, together with proposed mitigating actions.

The importance of engaging with the public and communicating the changes that were being made was highlighted. The ‘This is our Street’ tool would create a collection of real life stories that could illustrate at an early stage whether the changes that were taking place were making a real difference.

A query was raised regarding the early intervention and prevention work that was being undertaken in relation to the Better Care Fund, Proof of Concept and Care Closer to Home programme. It was suggested that it would be beneficial for the Board to have more information relating to the Care Closer to Home project, with particular regard to the proof of concept work (pilot of integrated teams in certain parts of the District). It was agreed that this information would be presented at the next Board meeting.

The Health and Wellbeing Board was requested to sign off the Better Care Fund Plan in order that it be submitted to NHS England by the required deadline of 14 February 2014. The Board requested that it be made aware of any substantial changes made to the Plan before it was resubmitted in April 2014.

Resolved – (1) That the report be noted.

(2) That the Health and Wellbeing Board sign off the Better Care Fund Plan on behalf of the CCG and the Council in order that the Plan be submitted to NHS England.

(3) That further information on early intervention and prevention work in relation to the Care Closer to Home project, with particular regard to the proof of concept work, be presented at the next Board meeting.

(4) That the Board be made aware of any substantial changes made to the Better Care Fund Plan before it was resubmitted to NHS England before 4 April 2014.

72. CCG STRATEGIC PLAN
Consideration was given to a report outlining the CCG’s strategic planning process. NHS England had asked all CCGs to produce a detailed two-year operational plan, to be submitted to NHS England by 4 April 2014, and a five-year strategic plan, to be submitted by 20 June 2014. The plans were in the process of being developed within the context of the NHS mandate, taking into consideration identified local needs and priorities and engagement with stakeholders. The importance of aligning the plans with existing health strategies, plans and priorities across the District to ensure a joined-up approach was also emphasised.
The CCG would agree local and national measures which would act as Quality Premiums. These would be paid to the CCG in 2015/16 on the basis of performance throughout 2014/15. It had been proposed, and agreed at Clinical Cabinet, that ‘maternal smoking at time of delivery’ be used as the local Quality Premium measure for Wakefield for 2014/15.

The national Quality Premium measure was set as a specified increase in reporting of medication errors from specified local providers. However, the Strategic Planning Team was currently taking advice from the NHS Local Area Team as to whether, within the Wakefield District, this could be applied to GPs rather than the Mid Yorkshire Hospital Trust. This matter would be submitted for consideration at a future Board meeting once guidance was received.

The CCG would continue to bring updates to the Health and Wellbeing Board as the operational and strategic plans were developed.

It was felt that the Board was being presented with a large amount of information relating to various different strategies and plans and the changes that were taking place throughout the District. It was requested that a presentation be provided at the Board’s next meeting that would provide a clear picture of the changes that were taking place and how all the relevant plans and strategies linked together. It was also suggested that it would be beneficial for the Board to view the This is Our Street animation.

Resolved – (1) That the report be noted.

(2) That the draft operational plan be submitted to NHS England on 14 February 2014.

(3) That the CCG’s direction of travel be supported.

(4) That the local Quality Premium of reducing maternal smoking at time of delivery be approved.

(5) That the Quality Premium of reducing medical errors be considered at a future Board meeting when further guidance was available.

(6) That the identified priorities and proposed Quality Premium measures be noted when carrying out future strategy and plan development work.

(7) That a presentation summarising the changes that were taking place throughout the District and how all the relevant plans and strategies linked together be provided at the next Board meeting.

S256 AGREEMENT RE SOCIAL CARE FUNDING BY NHS ENGLAND
Consideration was given to a report on the Section 256 Agreement and related spending plan prior to it being forwarded to NHS England. For the 2013/14 Financial Year, Wakefield had been allocated £5,901,600, which had to be used to support adult social care services. The spending plan outlined the NHS England Categories, the Wakefield Council Service Areas that had been earmarked for funding and the proposed amount, together with details of the particular schemes that would benefit and the expected outcomes of those schemes.

The Board was asked to approve the S256 Agreement in order that it be submitted to
NHS England and that the transfer of monies be achieved before 31 March 2014.

Resolved – That the Section 256 Agreement and spending plan be approved and progressed to NHS England.

74. DATE AND TIME OF NEXT MEETING
Resolved – That the next meeting of the Health and Wellbeing Board be held on Thursday 13 March 2014, at 12.30pm, in the Pontefract Suite, Wakefield One.