<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Attachment</th>
<th>Presented By</th>
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</thead>
<tbody>
<tr>
<td><strong>1.00pm 1. Apologies</strong></td>
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<tr>
<td><strong>1.00pm 2. Declarations of Interest</strong></td>
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<tr>
<td>2.1 To request members to disclose any interest they have, direct or indirect, in any items to be considered during the course of the meeting and to note that those members declaring an interest would not be allowed to take part in the consideration for discussion or vote on any questions relating to that item. (Enclosed)</td>
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<tr>
<td>2.2 This meeting will be held in public and will be recorded purely as an aide memoir for the minute taker to ensure an accurate transcript of the meeting, decisions and actions. Once the minutes have been approved the recording will be destroyed. All care is taken to maintain your privacy; however, as a visitor in the public gallery, your presence may be recorded. Should you contribute to the meeting during questions from the public, you agree to being recorded.</td>
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<tr>
<td><strong>1.05pm 3. Minutes</strong></td>
<td>Enclosed Enclosed</td>
<td>Dr D Hegarty Dr D Hegarty</td>
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<tr>
<td>3.1 Minutes from Board held on 13 September 2018</td>
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<tr>
<td>3.2 Matters Arising</td>
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<tr>
<td><strong>1.10pm 4. Public Voice</strong></td>
<td>Presentation Verbal</td>
<td>Mr M Samuels Mrs J Jasper</td>
</tr>
<tr>
<td>4.1 Forging a Future for all in the Dudley Borough</td>
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<tr>
<td>4.2 Questions from the Public</td>
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<tr>
<td>To respond to questions from members of the public received prior to the Board, in writing, on the provision of health care to the population served by the CCG.</td>
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<tr>
<td><strong>1.30pm 4.3 Public Update</strong></td>
<td>Presentation Enclosed</td>
<td>Mrs L Broster Mrs L Broster</td>
</tr>
<tr>
<td>4.3 Feet on the Street: Use of Digital Technology in the NHS</td>
<td></td>
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<tr>
<td><strong>1.50pm 5. Chairman &amp; Chief Executive Officer Report</strong></td>
<td>Verbal</td>
<td>Mr P Maubach</td>
</tr>
<tr>
<td>5.1 Report from Partnership Board</td>
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<tr>
<td><strong>2.00pm 6. Strategy</strong></td>
<td>Enclosed Enclosed</td>
<td>Dr C Handy Mr P Maubach</td>
</tr>
<tr>
<td>6.1 Report from Partnership Board</td>
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<tr>
<td>6.2 Black Country Joint Commissioning Committee Assurance Reports and Minutes</td>
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<tr>
<td>Time</td>
<td>Agenda Item</td>
<td>Attachment</td>
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<tr>
<td>2.20pm</td>
<td>7. <strong>Quality &amp; Safety</strong>&lt;br&gt;7.1 Quality and Safety Committee Report</td>
<td>Enclosed</td>
</tr>
<tr>
<td>2.30pm</td>
<td>8. <strong>Governance</strong>&lt;br&gt;8.1 Report from Audit &amp; Governance Committee</td>
<td>Enclosed</td>
</tr>
<tr>
<td>2.40pm</td>
<td>8.2 Board Assurance Framework and Risk Register</td>
<td>Enclosed</td>
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<tr>
<td>2.50pm</td>
<td>8.3 Report from Remuneration &amp; HR Committee</td>
<td>Enclosed</td>
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<tr>
<td>3.00pm</td>
<td>8.4 Decisions made under Emergency Powers</td>
<td>Enclosed</td>
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<tr>
<td>3.10pm</td>
<td>9. <strong>Finance, Performance and Business Intelligence</strong>&lt;br&gt;9.1 Report from Finance, Performance &amp; Business Intelligence Committee</td>
<td>Enclosed</td>
</tr>
<tr>
<td>3.20pm</td>
<td>10. <strong>Acute &amp; Community Commissioning</strong>&lt;br&gt;10.1 Commissioning Development Committee Report</td>
<td>Enclosed</td>
</tr>
<tr>
<td>3.30pm</td>
<td>10.2 MCP Procurement Project Board Report</td>
<td>Enclosed</td>
</tr>
<tr>
<td>3.40pm</td>
<td>10.3 Integrated Commissioning Executive Report</td>
<td>Enclosed</td>
</tr>
<tr>
<td>3.50pm</td>
<td>11. <strong>Primary Care Commissioning</strong>&lt;br&gt;11.1 Report from Primary Care Commissioning Committee</td>
<td>Enclosed</td>
</tr>
<tr>
<td>4.00pm</td>
<td>11.2 Locality Feedback Report – September/October 2018</td>
<td>Enclosed</td>
</tr>
<tr>
<td>4.10pm</td>
<td>12. <strong>Reflection Time</strong></td>
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<tr>
<td>4.15pm</td>
<td>13. <strong>Exclusion of the Press and Public</strong>&lt;br&gt;That under the Public Bodies (Admission to Meetings) Act 1960, the public and representatives of the press and broadcast media be excluded from the meeting during the consideration of the following items of business as publicity would be prejudicial to the public interest because of the confidential nature of the business to be transacted.</td>
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<tr>
<td></td>
<td>14. <strong>Date and Time of Next Meeting</strong>&lt;br&gt;Thursday 10 January 2019&lt;br&gt;1pm – 4pm&lt;br&gt;3rd Floor Boardroom, Brierley Hill Health and Social Care Centre</td>
<td></td>
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</tbody>
</table>

A Glossary of terms is included at the end of the papers.
<table>
<thead>
<tr>
<th>Title</th>
<th>First Name</th>
<th>Surname</th>
<th>Job Title</th>
<th>Declarations of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs</td>
<td>Laura</td>
<td>Broster</td>
<td>Director of Communications &amp; Public Insight</td>
<td>Director of Shrops Hire Solutions Ltd</td>
</tr>
<tr>
<td>Mrs</td>
<td>Caroline</td>
<td>Brunt</td>
<td>Chief Nurse</td>
<td>None</td>
</tr>
<tr>
<td>Mr</td>
<td>Neill</td>
<td>Bucktin</td>
<td>Director of Commissioning</td>
<td>Chairman of the Corporation, Heart of Worcestershire College (A general further education college which provides services for young people with special educational needs and disabilities of the sort commissioned from time to time by the CCG.) Member of Managers in Partnership Director - North East Worcestershire Enterprises Ltd.</td>
</tr>
<tr>
<td>Mrs</td>
<td>Stephanie</td>
<td>Cartwright</td>
<td>Director of Organisational Development &amp; Human Resources</td>
<td>In a personal relationship with Chief Executive Officer Dudley CCG</td>
</tr>
<tr>
<td>Mrs</td>
<td>Andrea</td>
<td>Crew</td>
<td>Chief Officer – Healthwatch Dudley</td>
<td>None</td>
</tr>
<tr>
<td>Dr</td>
<td>Jonathan</td>
<td>Darby</td>
<td>Clinical Executive for Acute &amp; Community Commissioning</td>
<td>Salaried GP at St Margaret’s Well Surgery Medical Advisor for BBC Drama, Birmingham Director Manor Abbey Investments Non-Executive Director for the Royal Wolverhampton Hospitals NHS Trust</td>
</tr>
<tr>
<td>Dr</td>
<td>Ruth</td>
<td>Edwards</td>
<td>Board Member Kingswinford, Amblecote &amp; Brierley Hill Locality / Clinical Executive for Quality &amp; Safety</td>
<td>GP Partner - AW Surgeries Shareholder, Future Proof Health Limited (via practice shareholding)</td>
</tr>
<tr>
<td>Dr</td>
<td>Richard</td>
<td>Gee</td>
<td>GP Engagement Lead</td>
<td>Appointed member of Dudley Group Foundation Trust Council of Governors</td>
</tr>
<tr>
<td>Dr</td>
<td>Purshotam</td>
<td>Gupta</td>
<td>Board Member Dudley &amp; Netherton Locality</td>
<td>GP Partner at Links Medical Practice Member of Labour Party Shareholder, Future Proof Health Limited (via practice shareholding)</td>
</tr>
<tr>
<td>Dr</td>
<td>Christopher</td>
<td>Handy</td>
<td>Lay Member for Quality &amp; Safety</td>
<td>Chief Executive, Accord Group Visiting Professor at Birmingham City University Board Member of: - Black Country LEP Board - Matrix - Redditch Co-operative Homes - Black Country Consortium - Walsall Housing Regeneration Agency - Direct Health - Eurohnet</td>
</tr>
<tr>
<td>Mrs</td>
<td>Deborah</td>
<td>Harkins</td>
<td>Chief Officer for Health &amp; Wellbeing (Director of Public Health)</td>
<td>None</td>
</tr>
<tr>
<td>Mr</td>
<td>Matthew</td>
<td>Hartland</td>
<td>Chief Operating &amp; Finance Officer</td>
<td>Director of Dudley Infracare Lift LTD Director of Whitbrook Management Company Member of Chartered Institute of Public Finance and Accountancy Strategic Chief Finance Officer, Walsall CCG Strategic Chief Finance Officer, Wolverhampton CCG</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Position</th>
<th>Extra Information</th>
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</thead>
<tbody>
<tr>
<td>Dr David Hegarty</td>
<td>CCG Chair / Board Member Stourbridge, Wollescote &amp; Lye Locality</td>
<td>Chairman of Black Country STP Clinical Leadership Group Partner is Director of Strategy at Worcestershire CCG Shareholder, Future Proof Health Limited (via practice shareholding) Shareholder with D C Corporation Ltd Council member- West Midlands Clinical Senate Member of LMC Member of BMA</td>
<td></td>
</tr>
<tr>
<td>Dr Tim Horsburgh</td>
<td>Clinical Executive for Primary Care &amp; LMC Representative</td>
<td>Sessional GP - Netherton Health Centre. Member of the Local Medical Committee Clinical Lead for Partners in Paediatrics</td>
<td></td>
</tr>
<tr>
<td>Mrs Julie Jasper</td>
<td>Lay Member – Patient &amp; Public Involvement</td>
<td>Lay Member - Sandwell and West Birmingham CCG Managing Director of Westland’s Associates Ltd</td>
<td></td>
</tr>
<tr>
<td>Mr Alan Johnson</td>
<td>Secondary Care Clinician</td>
<td>None</td>
<td></td>
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<tr>
<td>Ms Sue Johnson</td>
<td>Deputy Chief Finance Officer</td>
<td>None</td>
<td></td>
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<tr>
<td>Mr Daniel King</td>
<td>Director of Membership Development &amp; Primary Care</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Dr Rebecca Lewis</td>
<td>Board Member Halesowen &amp; Quarry Bank Locality</td>
<td>GP Partner – Feldon Practice Surgery Shareholder, Future Proof Health Limited (via practice shareholding)</td>
<td></td>
</tr>
<tr>
<td>Dr Mohit Mandiratta</td>
<td>Board Member Halesowen &amp; Quarry Bank Locality</td>
<td>Partner at Feldon Road Practice Shareholder, Future Proof Health Limited (via practice shareholding)</td>
<td></td>
</tr>
<tr>
<td>Dr Steve Mann</td>
<td>Board Member Stourbridge, Wollescote &amp; Lye Locality / Clinical Executive for MCP</td>
<td>GP Partner - Lion Health. Sister provides the Paediatric Triage Service Shareholder, Future Proof Health Limited (via practice shareholding)</td>
<td></td>
</tr>
<tr>
<td>Mr Paul Maubach</td>
<td>Chief Executive Officer</td>
<td>Member of Dudley Health &amp; Wellbeing Board Member of CIPFA Member of Managers in Partnership In a personal relationship with Director of OD &amp; HR at Dudley CCG Chief Executive Officer, Walsall CCG</td>
<td></td>
</tr>
<tr>
<td>Dr Kiranmaya Penumaka</td>
<td>GP Board Member, Dudley &amp; Netherton Locality</td>
<td>GP Partner – Quarry Bank Medical Practice</td>
<td></td>
</tr>
<tr>
<td>Dr Matthew Read</td>
<td>Board Member Sedgley, Coseley &amp; Gornal</td>
<td>GP Woodsetton Medical Practice Shareholder, Future Proof Health Limited (via practice shareholding)</td>
<td></td>
</tr>
<tr>
<td>Dr Fiona Rose</td>
<td>Board Member Sedgley, Coseley &amp; Gornal</td>
<td>GP Castle Meadows Surgery Providing Educational Support to Effective Consulting Ltd on a consultancy basis Husband works for Birmingham City Council via Service Birmingham IT Director of Rose Medical Consultancy - providing locum GP Support to Future Proof Health Limited.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Relationships</td>
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</tr>
<tr>
<td>Mr. Martin Samuels</td>
<td>Strategic Director – People, Dudley MBC</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Dr. Ruth Tapparo</td>
<td>GP Board Member and Clinical Executive Finance, Performance &amp; Business Intelligence</td>
<td>GP Partner - Three Villages Medical Practice Shareholder, Future Proof Health Limited (via practice shareholding)</td>
<td></td>
</tr>
<tr>
<td>Mr. Steve Wellings</td>
<td>Lay Member - Governance</td>
<td>Wife employed by Dudley MBC Housing Department One Niece employed by DGFT as a nurse Member of CIPFA</td>
<td></td>
</tr>
</tbody>
</table>

Updated 17/10/2018
MINUTES OF THE MEETING HELD IN PUBLIC ON THURSDAY 13 SEPTEMBER 2018
AT BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE

Members:

Dr D Hegarty  Chair and GP Board Member – Dudley CCG
Mrs C Brunt  Chief Nurse – Dudley CCG
Dr R Edwards  Clinical Executive – Dudley CCG
Dr P D Gupta  GP Board Member – Dudley CCG
Mr M Hartland  Chief Operating and Finance Officer – Dudley CCG
Dr T Horsburgh  Clinical Executive – Dudley CCG (LMC Representative) *
Dr R Lewis  GP Board Member – Dudley CCG
Dr M Mandiratta  GP Board Member – Dudley CCG
Dr S Mann  Clinical Executive – Dudley CCG
Mr P Maubach  Chief Executive Officer – Dudley CCG
Dr K Penumaka  GP Board Member – Dudley CCG
Dr M Read  GP Board Member – Dudley CCG
Dr R Tapparo  Clinical Executive – Dudley CCG
Mr S Wellings  Lay Member for Governance/Vice Chair – Dudley CCG (Vice Chair)

Non-Voting Members:

Mrs L Broster  Director of Communications and Public Insight – Dudley CCG
Mr N Bucktin  Director of Commissioning – Dudley CCG
Mrs S Cartwright  Director of Organisational Development and Human Resources – Dudley CCG
Ms K Jackson  Head of Service, Health Communities and Place (Deputy Director of Public Health) (representing Ms D Harkins)

* Dr Horsburgh is also the LMC representative on the Board which is a non-voting role.

In Attendance:

Mrs E Smith  Governance Support Manager – Dudley CCG (representing Ms S Johnson)

Minute Taker:

Mrs T Green  Business Support Manager – Dudley CCG

CCG102/2018 APOLOGIES

Apologies were received from:

Mrs A Crew  Chief Officer – Healthwatch Dudley
Dr J Darby  Clinical Executive – Dudley CCG
Dr R Gee  GP Engagement Lead – Dudley CCG
Ms D Harkins  Chief Officer, Health and Wellbeing (Director of Public Health) – Dudley MBC
Prof C Handy  Lay Member for Quality and Safety – Dudley CCG
Mrs J Jasper  Lay Member for Patient and Public Engagement – Dudley CCG
Mr A Johnson  Secondary Care Clinician – Dudley CCG
Ms S Johnson  Deputy Chief Finance Officer – Dudley CCG
Dr F Rose  GP Board Member – Dudley CCG
Mr M Samuels  Strategic Director People – Dudley MBC
Members were asked to disclose any interest they may have, direct or indirect, in any of the items to be considered during the course of the meeting and to note that those Members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.

Dr Tapparo declared an interest with regards to the Three Villages Medical Practice branch closure proposal.

The minutes of the Board meeting held on 12 July 2018 were accepted as a true and accurate record, with the following exception:

Page 9 – first paragraph. Amend word from ‘risks’ to ‘incidents’ to read ‘It was recognised that the CCG take longer to close incidents but the correct thing to do is extract the learning….’

Page 17 – 8th paragraph. Include word ‘independent’ to read ‘Mr Wellings stressed the importance of the early appointment of an ‘independent’ Chair for the MCP as part of the conditions….’

Resolved:
1) The Board accepted the minutes from the Board held on 12 July 2018 as a true and accurate record, noting the above exceptions

It was noted that there were a small number of patients not identified by the national targets due to not being referred initially by a 2ww pathway. Where issues were identified through the patient safety inbox, the Quality and Safety Team sent to DGFT Governance Team for further investigation. Ongoing work was also being done on the reporting schedules for cancer performance. It was agreed to close the action.

End of Life Strategy to be discussed at the September Partnership Board, and WMAS to be invited for the specific item. Action to be closed.

GDPR amber ratings to be discussed at Information Governance Steering Group and presented to Audit and Governance Committee in October. Action ongoing to be updated at November Board.

A future Board to receive financial position across the Integrated Care System as a whole to understand any surplus or deficit positions which could impact on Dudley.

The update received was that it had been discussed at a recent JCC and a financial map produced for Dudley CCG and for Walsall CCG with the aim to do the same for Wolverhampton and Sandwell and West Birmingham CCGs, which should be available for the November Board. Action ongoing and further update to be received in November.

Partnership Board to produce a report in terms of investment made in Children and Young People and how the CCG engage with that cohort of the Dudley population.

Action to be transferred to Mr Bucktin and Mrs Broster to be discussed at the Children’s Alliance which is the more appropriate forum for it to be discussed.

Discussion to be held at Partnership Board on the Dudley Borough ‘Vision’. This was being discussed at the September Partnership Board.

Resolved:
1) The Board noted the updates from matters arising
Mrs Broster spoke to this item and advised that four questions had been received, which were tabled.

**Question asked:**
1) *Does Dudley operate a NHS mediation service in Dudley?*

2) *Could you confirm the location of a MP MRI scanner within the Dudley Group of Hospitals? I was told I had a MP MRI scan even though the trust has no such scanner till November 2018.*

3) *Is it possible for me to meet the commissioner?*

**Response provided by Mark Curran, Commissioning Manager for Planned Care and Dr Jonathan Darby, Clinical Executive for Acute & Commissioning Services**

1) Dudley Clinical Commissioning Group has a policy and process for the management of complaints. This includes an element of mediation.

2) MP MRI scanner, this is not a particular type of scanner, but something that an MRI scanner can be set up to do. MP stands for multi parametric and this is a scanning modality that is often used to supplement standard T1 and T2 imaging allowing better images and better predictive for cancer, especially prostate cancer.

   Dudley Group NHS Foundation Trust has 3 MRI scanners, which have MP scanning available to it.

3) Yes, Mark Curran – Commissioning Manager for Planned Care can be contacted via email – markcurran@nhs.net or telephone 01384 321748

**Question asked:**

*Why does health watch Dudley not have the patient’s advocacy service as most other trust health watches do?*

**Response provided by Andrea Crew, Chief Officer – Dudley Healthwatch**

People accessing NHS services in Dudley borough who wish to make a complaint about NHS treatment do have access to independent complaints advocacy.

The service is commissioned separately by Dudley Council and the contract is currently held by an organisation called POhWER.

More information about the service can be found by visiting [https://www.pohwer.net/dudley](https://www.pohwer.net/dudley) or by contacted POhWER on 0300 456 2370 or pohwer@pohwer.net

**Resolved:**

1) The Board received questions from the public

**CCG107/2018 FEET ON THE STREET: PROCEDURES OF LIMITED CLINICAL VALUE (PLCV)**

Mrs Broster invited Dr Lewis to speak to this item as she had been out with Feet on the Street for the Board’s presentation.

Procedures of Limited Clinical Value (PLCV) was discussed at a recent Clinical Forum and Dr Lewis felt strongly that the expectation starts with the patient and therefore she went with Feet on the Street to explore patient views and to find out if they were aware of the CCG policy, which the majority were not.

Dr Lewis had been working with Mrs Broster and her team on how more communications can be circulated to members of the public and how to empower GPs to have the conversation with patients. As a result, flyers had been produced to promote general awareness with patients in GP surgeries. Dr Lewis invited feedback from the Board and reported that she was extremely grateful to the members of the public and how well they engaged.

The Board felt that a different emphasis should be put on the literature that explains the reasons why we have the policy rather than the challenging times the NHS in Dudley is facing. Emphasis to be on the clinical reasons first followed by the financial aspects.
As a lengthy discussion had been held at Clinical Forum, it was agreed that a further discussion should be had at the next meeting to obtain views.

The Board complimented Dr Lewis on going out to speak to members of the public.

Dr Hegarty summarised the comments that had been heard from Board members. There was an element of the language being used and understanding how it aligns with the prescribing policy that had been rolled out approximately 12 months ago. Healthwatch Dudley should also be involved in the language being used for members of the public to understand, rather than using medical terminology, particularly with regards to the list of procedures. In addition, there was an element of trying to align the policy with neighbouring CCGs as there are other parts of the Black Country that have a similar policy. The final point made was that the policy was not about the money, but the need to have honest conversations and about procedures being carried out based on clinical guidelines.

Resolved:
1) The Board received the Feet on the Street presentation

Mrs Broster spoke to this item to update Board Members with Communications and Engagement issues.

Dying Matters
The Communications and Engagement Team are now part of a ‘Dying Matters’ group which works with partners including Mary Stevens Hospice, Public Health and clinical staff to plan and promote ‘Dying Matters’ for next year. Three more workshops would be organised starting in November with colleges to develop a communications and engagement strategy.

Consultation – Three Villages Medical Practice
A consultation began on 16 July 2018 on a proposal to close the Wollaston branch surgery of Three Villages Medical Practice and house all services under one roof at Stourbridge Health and Social Care Centre. The consultation ended on 19 September 2018 and a decision on the proposal was to be made at the Primary Care Commissioning Committee which was due to be held on 19 October 2018.

Crestfield Surgery
Dr Mittal was due to retire from general practice at the end of September 2018 and as a single handed practice, there was no one willing to take on the contract. As a consequence, the practice was due to close on 28 September 2018. Patients were contacted by letter with information of other local practices and NHS Choices website for them to decide where else they can register.

GP Patient Survey
The results had been released which showed an average response rate for Dudley GP practices of 35% compared to 39% in 2017. The survey would be discussed further at the Primary Care Commissioning Committee, together with an action plan where some of the outliers could be targeted and where improvements could be made.

Media Coverage
The coverage was produced at the end of August where the negative coverage focused on the Wheelchair Service and Crestfield Surgery. At the time of Board the negative coverage focussed on ED at DGFT and the CQC. With regards to positive coverage, this was in respect to the Minor Ailments Scheme.

With regards to ‘Dying Matters’ it was noted that a wider conversation of dying in Dudley needed to take place, regardless of age group, which should include clinicians and patients towards end of life. Mrs Broster advised that she was supporting Dr Lucy Martin with the development and implementation of a strategy and would include an additional stream on public engagement and education. The strategy was due to be presented at the End of Life Strategy Group in October.

Resolved:
1) The Board received the report for assurance

Dr Hegarty and Mr Maubach spoke to the report, which was tabled.

Notices and Acknowledgements
A formal recruitment process had begun to recruit two Non-Executive Directors for Governance and Patient & Public
Involvement. This would be to replace Mrs Jasper and Mr Wellings who would be leaving the CCG at the end of this year/early next year.

Mrs Cartwright had taken a secondment to be the Interim Managing Director for the MCP Transition Team.

A letter had been received from Jeremy Hunt, thanking the CCG for all the work and innovation that was being done.

**Dudley Emergency Department**
Concerns continued with regards to DGFT Emergency Department, which had been highlighted by the CQC report. Dudley CCG were contributing to a dedicated oversight group chaired by NHS Improvement which was overseeing and coordinating work and actions with the Trust. It was noted that there was a great deal of oversight and support being put into the Trust to try and resolve the situation and as reassurance to the public, daily scrutiny of the ED was also being carried out.

**Preferred Bidder**
At the last meeting, the Board approved the preferred bidder for the MCP but as a co-commissioner with the Local Authority, it was reported that Dudley MBC had also approved the preferred bidder and the CCG were working with them to establish the transition arrangements involving all partners across the health and care system, together with the bidding team.

**Sustainability and Transformation Partnership**
NHSE and NHSI were increasingly utilising the STP as the route through which they conduct much of their business with the system. The CCG needed to ensure the right relationship is in place with partners within the system in order to respond effectively.

**National Working Groups**
The expectation was for the 10 year plan to be published in December. NHSE had established a number of national working groups which focus on three themes that Dudley CCG were making an input to. The themes are life course programmes, clinical priorities and enablers.

**NHS EXPO – Digital Working**
Matt Hancock MP, The new Secretary of State, gave a speech at the NHS Expo where he spoke about his plans for the development of digital technology in the NHS, setting out six points of action. Dudley CCG were ensuring that digital technology was included in the current work and future plans where appropriate.

**Contingency Planning for a Hard Brexit**
Dudley CCG had received guidance from NHSE on plans to be put in place as a contingency for a hard Brexit.

Mr Wellings advised that he would be leaving his post at the end of March.

With regards to the appointment of Mrs Cartwright, the Remuneration and HR Committee were concerned with how DGFT had handled the recruitment of the appointment and subsequently the Committee instructed HR at DGFT that it was not repeated. Therefore the details of the secondment would be discussed at the Committee in order to protect Mrs Cartwright and the CCG.

The Board were informed that the Non-Executive Director vacancies would be circulated to all members and also to members of staff. Both were live on NHS Jobs.

Mrs Cartwright advised that the secondment she was doing was interim into the MCP leadership team to oversee the transition process to creating the MCP. Although she was unable to comment on the recruitment of the post, she assured the Board that this should improve. It was noted that some posts would need to be advertised although not all as they are part of people’s current roles.

Mr Steve Stanier, HR and OD Lead, would be taking on the main elements of HR and Business Support. Mr Stanier would report to Mr Maubach on the wider organisational HR aspects and to Mr Hartland on a day to day basis. The OD agenda would be led by Mr Maubach with external support from the Strategy Unit.

Resolved:
1) The Board noted the report for assurance
Local Digital Roadmap (LDR)
LDR was discussed at the July meeting where concern was raised about the lack of progress made with DWMH and BCPFT due to the lack of contact details for their IT Leads. However, it was reported at Board that this was being rectified and information was starting to be obtained.

Single Point of Access (SPA)
The SPA Working Group had been established and there was more system support for SPA which is the communications hub with regards to the MCP. The Ambulance Service were starting to use the SPA which was encouraging. DGFT who run the SPA were interested in getting more support from GPs on what the model should look like.

Public Health
A discussion was had regarding Public Health funding cuts to Health Checks. Further discussions would be had at September’s Partnership Board.

Future of the Partnership Board
At the August meeting, the future of the Partnership Board was discussed, taking account of the newly established MCP Transition Board. The discussion took place without DGFT representation therefore no conclusion was made. It was further discussed at the Transition Board that took place on 12 September 2018 where the decision was made to continue with both Boards. The Partnership Board would continue with the wider system and the Transition Board would focus on the development of the MCP care model.

Renegotiation of the contract with West Midlands Ambulance Service (WMAS)
Unfortunately, WMAS were unable to send a representative to attend the Partnership Board where this issue was discussed. There were a number of concerns raised regarding the number of conveyances and the issue with patients being taken to hospital who should stay at home. Dialogue with Sandwell and West Birmingham CCG, who commission the service, would continue and a joint meeting with them and Dudley and Walsall Mental Health was being held to discuss further.

Impact of Housing and Health
Local Authority colleagues who were involved in housing developments attended the meeting. They gave a commitment take forward how housing developments and health developments needed to be more connected and the impact it can have on people in poor housing. A working group would be established to take this piece of work forward, which would be led by Deborah Harkins.

It was felt important to get the message to council colleagues regarding the positive message with regards to housing and health which Mrs Cartwright had highlighted. Mrs Broster agreed to speak to Deborah Harkins to connect the council agenda with the CCG’s. It was also agreed that primary care representation was required in the working group which was supported at the Partnership Board.

The Board were informed that the local authority would attend the next local health estates forum with a map of proposed housing developments over the next 20 years as these would impact on GP Practice workload. As part of that work consideration would be given to changing policy so that cash from developers when they are building houses (Section 106 contributions) might contribute to health. It was reassuring that the Local Authority were involved in these discussions and it was felt beneficial to have a housing summit for Dudley to consider all housing issues.

As a point of clarification, the Board were advised that the Terms of Reference for both the Partnership Board and Transition Board would be amended and sent to all partners for sign off.

Resolved:
1) The Board noted the report for assurance

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<th>BLACK COUNTRY JOINT COMMISSIONING COMMITTEE (JCC) ASSURANCE REPORTS AND MINUTES</th>
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Mr Maubach spoke to this item to provide a summary of business considered at the Black Country JCC meetings held on 12 July 2018 and 9 August 2018 and the minutes from the 12 July 2018 meeting.

In addition to the paper, it was reported that the scope of delegation was limited although it was a useful forum. A debate was had at the JCC on what the long term purpose of the JCC was and how it related to the STP agenda. As a result, the JCC Terms of Reference would be reviewed to scope what had been collectively discussed and recommendations would be presented to the relevant governing bodies.
With regards to Sandwell and West Birmingham CCG, it was noted that West Birmingham was not part of the Black Country and because they had a different agenda, there was a need for this issue to be addressed in order for the STP to work across Birmingham. It was recorded that a paper was due to be presented at the next JCC that would consider the geographical issues and what options there were.

Resolved:
1) The Board noted the report for assurance

QUALITY AND SAFETY

Dr Edwards spoke to this item summarising the key issues discussed at the Quality and Safety Committee on 31 July 2018 and asked that the Board receive the report for assurance.

Dudley Group NHS Foundation Trust (DGFT)
At the July Committee, a presentation was given regarding concerns associated with the quality and safety of care at DGFT. The Committee opened the attendance and a specific invitation was extended to the CCG Governing Body. Information was presented in relation to ED activity, performance and quality and safety concerns; hospital mortality data; Cancer wait information; Serious Incident (SI) investigations and quality of Root Cause Analysis and staffing and leadership.

Emergency Department
Five unannounced visits from the CQC had taken place between December 2017 and July 2018 and three of the five reports had been produced at the time of Board, with a fourth being anticipated. The latest Section 31 notice had been given on 17 August which was being discussed further in the private section of the Board.

As a consequence of the visits the recurring themes were sepsis management in ED; triage and assessment process; safeguarding in relation to children and young people; leadership and culture.

Oversight and Assurance
Since the visits a system wide oversight and assurance meeting had been put in place with partners from DGFT, NHSI, NHSE, CCG and CQC.

Assurance Data
It was noted that there had been some improvements from the assurance data provided from DGFT to the CQC however, further assurance was required.

Assurance Calls
Daily (and up to 3 times a day) assurance calls had also been put in place from 26 July 2018 until 27 August 2018. These had been reduced to twice a week plus weekends which focused on key quality metrics.

External Support to DGFT
Support from Royal Wolverhampton NHS Trust had been put in place to provide peer to peer provider support which included leadership support and development for band 5, 6 and 7 nurses, sharing of best practice and educational and training opportunities, so staff could observe ED practices across both Trusts. DGFT were also receiving ongoing support from the Emergency Care Intensive Support Team who were deploying a range of service improvement techniques to support triage and flow within the ED.

Mortality Data
An independent review of mortality was due to commence and be completed by the end of September 2018. DGFT had strengthened their own processes in regards to mortality.

Cancer Waits
Issues had been highlighted regard 2 week wait compliance at DGFT which appeared to have been resolved however RCAs and SI management remained a challenge and were not meeting KPIs.

Peer Review
An external peer review had been undertaken to support the management and oversight of SIs by the CCG, and a number of recommendations were proposed and adoption was supported by the CCG Chief Nurse.

Maternity Performance and Assurance Group (MPAG)
A new Clinical Director for Obstetrics and Gynaecology was due in post on 24 September 2018. They would meet with Dudley CCG’s external obstetric adviser to discuss the themes and ongoing concerns identified by the Maternity Quality Improvement Board in 2016.
Safeguarding Children and Young People
An unannounced visit by the CCG Safeguarding Team took place at the DGFT Paediatric ED in July 2018. There was an overall improvement seen however there were several improvements required.

Malling Health – Urgent Treatment Centre
The CCG was aware of challenges within their organisation in terms of workforce capacity and senior clinical oversight. A meeting was being held with IMH to address the issues.

Primary Care
Lion Health had been rated ‘outstanding’ following their recent CQC inspection.

Risk Register
Two risks had been added to the register relating to DGFT Emergency Department and the capacity issues within the Quality and Safety Team.

There was a lack of assurance from Board members with regards to DGFT as it was being reported that improvements were being made within the Trust, however there was no evidence to support it and the question was raised as to how transparent the Trust were being and whether the CCG were receiving the correct data and being made aware of any trends.

It was advised that the Board report reflected on the system wide review of the position which did show an improvement in the quality of data being submitted to the CQC. However what was not improving was a sustained position with regards to compliance.

With regards to transparency, it was felt that there was in relation to serious incidents. Agreement had been made with the Trust to carry out an assurance visit in relation to other incidents in order to ensure they were being reported appropriately within the Trust as Serious Incidents.

In relation to governance, this was an issue for the CCG as it can only go on data received and what was being received highlighted that there was significant improvement with regards to performance and compliance which CQC were leading and the CCG were supporting. Mrs Brunt was assured that the CCG were doing all they could but it was DGFT who had to work on their own compliance.

In order for the Board to gain assurance on the governance agenda, the Board suggested it would be useful to set out all the factors that were effective in terms of the relationship with the Trust, with regards to the challenges and questions raised through the Clinical Quality Review (CQR) meetings. A Board to Board was in the process of being organised where it could be discussed in more detail.

With respect to maternity, a collective case review was undertaken which was partly due to the delay in releasing case notes. The next stage was to make sure the Trust did not lose the organisational memory of the issues around the original QIB to enable them to move forward. However they have to be mindful that the CQC carried out a visit which included maternity and it was rated good. Assurance had been given to the Quality and Safety Team by an external expert that the Trust’s MDT processes, the quality of their RCAs and their ability to learn lessons had improved significantly but there was still work to be done.

Referring back to process and assurance, the report did not provide assurance to the Board, therefore as a governing body, the assurance needed to be split. To be assured that the services were in a good state and improving and also that the oversight and governance worked. This was to ensure the Board had the ongoing assurance it required. To gain this it was felt necessary, as a governing body, to have a complete oversight of how all the contracts work, how the CCG engages with the Trust and what issues there were and to what extent.

In addition, and focusing on ED, there was a question as to whether the services being delivered were improving to the required standard. This element should be considered by the oversight group reported back to all parties.

Dr Horsburgh advised the Board that he and Dr Gillian Love would be spending time in secondary care concentrating on the flow in ED which would provide more insight to enable the CCG to contribute to a much better solution to the long term issues.

The Board thanked those people who were working within the CCG on the issues within DGFT and appreciated the effort being put in to try and resolve them.

As a result of the discussion, the Board were not in a position to have full assurance from the Trust, noting there was a requirement for a Board to Board, which NHSE had requested to be present at, with the main agenda item being the quality agenda of the ED. Dr Hegarty advised that he had met with Mike Bewick, former Medical Director. He had been tasked on leading a mortality review at the Trust and Mrs Brunt and her team were involved in this.

Resolved:
1) The Board received the report, noting that full assurance was not given
Mrs Brunt spoke to this item to present the Board with findings from the EPRR Core Standards Self-Assessment where Dudley CCG had self-assessed itself as 'Substantially Complaint' against the 2018 EPRR Core Standards.

The Board were asked to note the next steps within the report to achieving full compliance by 31 March 2019, which were being overseen by the Audit and Governance Committee. The Board agreed to all the recommendations being made in order to achieve full compliance.

Resolved:
1) The Board noted Dudley CCGs self-assessment finding the organisation ‘Substantially Compliant’ against the 2018 EPRR Core Standards
2) The Board noted the next steps to achieve full compliance by 31 March 2019 which would be overseen by the CCG Audit and Governance Committee
3) The Board noted the requirement of the CCG to lead on the local review of its commissioned providers EPRR self-assessments and provide an evaluation of these to the Local Health Resilience Partnership by 30 September 2018
4) The Board ratified the revised EPRR policy

GOVERNANCE

Mr Hartland spoke to this item in Mrs Jasper’s absence, highlighting the key areas that were considered at the Audit and Governance Committee on 19 July 2018 and the decisions made under delegated authority.

Information Governance
Data Protection Impact Assessments were a requirement of GDPR and it was reported there had been five undertaken during the first quarter which had been incorporated into the Business Case process.

At the last Board meeting it had been noted that the CCG was not fully compliant. However, it was confirmed that some of the amber ratings had changed to green and would continue to improve. The Information Commissioner’s Officer had not expected organisations to be fully compliant on 25 May 2018, but required them to demonstrate they had a plan in place to achieve this, which Dudley CCG had.

Constitutional Change
Two submissions had been made to NHSE for Constitutional changes; one in March which was approved and a further submission in June to change the CCG boundary in respect of Kinver. The application was not accepted as it was not a joint application with South East Staffs and Seisdon Peninsula CCG.

Conversations were still taking place with the practice, South East Staffs CCG and NHSE to try and conclude this matter and there was a meeting due to take place which had unfortunately been cancelled. Dudley had reinforced its offer to the CCG from a financial perspective and it was felt that the CCG had done all that it could to facilitate the transfer.

CCG Financial Control, Planning and Governance Self-Assessment 2018/19
The requirements of the national assessment process had been submitted and approved however, it was noted that there were some red ratings which were in relation to not having a fully established finance department. The Board were advised that this was due to vacancies which were being covered by temporary support but that Dudley did still meet the minimum standard.

National Audit Officer (NAO) Cyber Security Review Report
Dudley CCG were required to self-assess against the NAO Cyber Security guidelines. The Committee referred this to the IT Strategy Group, where it had been discussed in detail. The Audit and Governance Committee had assured the report and as a result a work and action plan had been produced which would be overseen through the Information Governance Steering Group. It was noted that the CCG was confident that it was operating securely.

Resolved:
1) The Board received the report for assurance
Mr Hartland spoke to this item in Mrs Jasper’s absence, to update the Board on the combined Board Assurance Framework (BAF) and Risk Register as at 4 September 2018.

The Board was asked to note that the Audit and Governance Committee had agreed that the Board should always receive an update on the most recent version of the BAF and Risk Register to ensure it was considering and being assured about the latest position of risks. Although the latest BAF and Risk Register being presented might not have been reviewed by the Audit and Governance Committee due to timing, it meant that Board members had the opportunity to question and challenge any changes recommended by the individual Committees.

There had been two changes to the residual risk scores which related to risk 129 ‘Lack of effective management of waiting list within the ophthalmology department which results in poor patient outcome. Lack of follow up appointment due to process failure’. The Quality and Safety Committee agreed to decrease the residual risk score from 12 to 8 due to evidence received of learning following SI’s being shared across the ophthalmology directorate.

The second change to residual risk scores related to risk 136 ‘There is a risk that the provision of Primary Care Medical Services are adversely affected partially or fully due to insufficient workforce’. The Primary Care Commissioning Committee agreed to increase the residual risk score from 6 to 9 due to the delay in mobilisation of the MCP.

Two new risks had been added (risks 152 and 153). Risk 152 was accountable to the Governing Body which would be considered by Board members later within the item. Risk 153 was accountable to the Quality and Safety Committee ‘There is a risk that there are failures of clinical care in the DGFT emergency department (ED) and this will impact on the quality and safety of patient care’. Specific issues highlighted by the CQC from December 2017 include: failure to manage the deteriorating patient and sepsis pathways; paediatric care including safeguarding appropriately; timely and appropriate triage and assessment’. The Board were informed that both the initial risk and residual risk had a maximum score of 25.

The Board needed to consider the risks that were accountable to them, one of which Mr Hartland recommended increasing the score which related to risk 151 ‘There is a risk that the CCG fails to meet its statutory duties in respect of the delivery of high quality care to the population of Dudley’.

With regards to the ophthalmology risk (129), it had become evident that there were other services where there are issues in relation to follow ups, paediatrics and dermatology being two of those services, therefore it had been recommended to have a generic risk rather than specific services.

In relation to risk 152 ‘There is a risk that the pace of change in the transformation of the system will not be aligned to the views of the public. This may result in the CCG moving too quickly to allow time for adequate involvement or not moving quickly enough to meet public expectations’, Mrs Broster requested the Board to consider the gap in assurance as it stated that the Board could not be fully assured that adequate patient and public involvement had taken place regarding making a decision. It was felt that significant assurance had been received on systems and processes on decisions that had taken place however the gap in assurance related to the pace of change for transformation being at the correct pace for the public. Mrs Broster agreed to liaise with Mrs Smith to amend the gap in assurance.

The risks accountable to the governing body were considered and agreed as:

**Risk 13** – ‘Failure of the governing body to demonstrate appropriate leadership/clinical leadership may result in poor strategy and implementation, and thereby fail to meet statutory and regulatory responsibilities’. Members agreed this risk would remain unchanged.

**Risk 112** – ‘There is a risk that Governance arrangements between organisations (that are part to the STP) are either insufficient or inconsistent. This may lead to inadequate governance and insufficient transparency which could create unintended financial risk, inconsistent decision making or misalignment of strategic direction and implementation’. Members agreed this risk would remain unchanged.

**Risk 150** – ‘There is a risk that change of leadership in local system organisations will impact on system delivery, particularly in relation to loss of local knowledge’. Members agreed this risk would remain unchanged.

**Risk 151** – ‘There is a risk that the CCG fails to meet its statutory duties in respect of the delivery of high quality care to the population of Dudley’. Members agreed this risk would remain unchanged but there was some discussion on being more specific on what statutory duties were being referred to.

**Risk 152** – ‘There is a risk that the pace of change in the transformation of the system will not be aligned to the views of the public. This may result in the CCG moving too quickly to allow time for adequate involvement or not
moving quickly enough to meet public expectations’. This was discussed earlier and agreed that Mrs Broster would liaise with Mrs Smith to amend the gap in assurance, however the risk score should remain unchanged.

Resolved:
1) The Board received the report for assurance
2) The Board ratified the Audit and Governance Committee Chair’s action in respect to risk 153
3) The Board considered the risks accountable to them which remain unchanged with the exception of risk 152 where Mrs Broster would liaise with Mrs Smith in relation to the gap in assurance
4) The Board accepted risk 152 as its responsibility

CCG116/2018 REPORT FROM REMUNERATION AND HR COMMITTEE

Mr Wellings spoke to this item to provide assurance to the Board regarding key issues discussed by the Remuneration and HR Committee held on 1 August 2018.

Sickness Absence
It was noted that the sickness absence rate had improved and decreased to 0.64% which continued to remain below the CCG target of 3%.

Mandatory Training
Mandatory training was reported at 81% and the Committee had asked for details of those staff members who were frequently non-compliant.

PDR Compliance
PDR compliance was reported as 82.41% however it was noted that there were some concerns with regards to the ESR system not recording information correctly which would be addressed at a meeting with the ESR Central Team.

STP and Black Country and West Birmingham Joint Commissioning Committee
Jonathan Fellows had been appointed as Chair of the STP. He would commence his new role on 1 September 2018 and would step down as a lay member at DGFT. The STP was also in the process of recruiting a Clinical Leadership Chair and STP Portfolio Director.

GP Contracts Update
New contracts were being issued to GPs employed by the CCG detailing contractual arrangements.

Interim MCP Leadership Team Appointment Process
It had been noted earlier in the meeting on the poor recruitment process of the Interim Managing Director for the MCP and the Committee had agreed a set of key principles for future recruitment which it was hoped would be adhered to.

VSM Cost of Living Increase
The Committee had discussed the cost of living increase for the three Very Senior Manager positions, and agreed to a cash value cost of living increase of £2,075 per annum per Very Senior Manager position (this equates to the equivalent amount for someone at the top of a band 8c).

National Pay Awards
The Committee considered at length, the national three year pay award for all staff on Agenda for Change terms and conditions. The Committee were informed that some staff would not be receiving the pay award they had been expecting given the complexities of the pay award and how it had been communicated. It was therefore decided by the Committee to write individually to all CCG staff detailing the pay changes to them. In addition, it was also agreed by the Committee that the organisation would maintain the retrospective non-consolidated local pay award which is reviewed by the CCG on an annual basis.

Mrs Cartwright added that since the report had been written the STP Portfolio Director had been appointed to; this was Alistair McIntyre, who was in the role until the end of December.

With regards to the letters which were being sent to staff in relation to their pay award, Mrs Cartwright advised that confirmation was awaited from payroll that the figures were correct, prior to sending the letters out. A statement would also be in the letter advising that the local pay award is not permanent and should they leave or TUPE, the local pay award would not transfer with them.

It was noted that with regards to 2.5 there was an error in the last list of bullet points which should read ‘for new positions, contacts (not contracts) from each of the partner organisations (including primary care) should be provided for an informal discussion.’
Dr Tapparo spoke to this item summarising the key issues discussed by the Finance, Performance and Business Intelligence Committees on 28 June 2018 and 26 July 2018.

Statutory Financial Duties
It was noted that the CCG was expected to meet all its financial duties in 2018/19. The CCG has an annual budget as at July 2018 of £492.1m. The year to date underspend was £4.2m and the CCG was forecast to achieve the end of year control total of £12.7m. The QIPP programme had a total of £16.9m and was forecast to over achieve by approximately £20,000 but all programmes are monitored and RAG rated. At the September Board it was requested to have oversight of the financial position across the system as a whole which would be available at the November Board.

Performance Exception Reporting
It was reported that the main area of concern related to A&E and day cases at DGFT in July 2018, particularly in relation to ambulance handovers and A&E 4 hour waits. The latest figure reported with regards to A&E 4 hour waits was 85.2% in comparison to June figures which was 86.52% so there was a reduction.

Cancer waits had reduced in July 2018 to 79.9% which was predominantly related to urology and colorectal surgery but this should improve by the next Board meeting.

With regards to IAPT access, this continued to underperform and although a joint action plan was in place there was yet to be any improvement.

There had a slow increase in relation to delayed transfers of care so this was being monitored.

Dementia rates were reported at 62.5% with a target of 66.7% so they were below target.

Reports from Groups accountable to the Committee
The Committee reviewed the Estates Strategy to ensure premises were maintained to standard. The Business Case for the new development in Kingswinford and Lye was discussed by the Committee and there was a reported delay. This was to ensure the requirements fit in with the MCP requirements, therefore the business case would be expected to complete in February 2019.

Draft Finance, Performance and Business Intelligence Annual Report
It was reported that attendance of voting members of the Committee was aligned to Board attendance and was recommended to be included in the Terms of Reference. A recommendation was being taken to the Audit and Governance Committee that all Committees mirror the Board attendance of 75% for voting members to ensure Committees are always quorate.

With regards to quality premium figures, it was agreed to present a full report at the November Board meeting which Mr Hartland would action.

In addition, it was also requested to have an update on the current capital investment opportunities and for the Board to be sighted on those. Mr Hartland to action through the Finance and Performance Committee on the position and bring an update to the Board in November.

Resolved:
1) The Board received the report for assurance
2) Mr Hartland to bring a full report in relation to the Quality Premium figures to the November Board
3) Mr Hartland to bring a report on the current capital investment opportunities to the November Board
Musculoskeletal (MSK) services is a significant item in the QIPP programme and a business case had been approved regarding the management of joint injections.

The Prescription Ordering Direct (POD) is also a significant item. There had been a delay with the expansion of the service due to telephony issues, however this had been resolved.

NHS Continuing Healthcare
There continued to be increased financial pressure relating to meeting the cost of care for eligible patients. Nevertheless, the team had met all the national performance targets for 2017/18.

Improving Access to Psychological Therapies (IAPT) – Proposed Pathway Change
A working group had been established to consider the IAPT pathway and following an audit carried out by DWMHT, it was concluded that all primary care mental health referrals should be made to IAPT in the first instance which should streamline the service.

Patient Choice
The Committee approved two policies relating to patient choice; the first being developed by the A&E Delivery Board relating to choice issues for patients due to be discharged from secondary care; and a specific CCG policy relating to the promotion of choice for planned care services designed to support the CCGs statutory duty to promote choice.

Wheelchair Service – Eligibility Criteria
A review of the eligibility criteria was proposed and a report on the outcome of the engagement would be considered in due course.

Memory and Dementia Assessment Service
The Committee considered a business case on the implications of a lack of integration between the dementia nursing assessment and diagnostic service provided by Midland Partnership NHS Foundation Trust. Three options had been proposed which were set out in the report. The preferred option that was being recommended to the Board was the provision of a mid-grade full-time psychiatrist, with one day of a consultant psychiatrist and a clinical psychologist, together with additional neuro-imaging at a cost of £232,706 plus the inclusion of two Admiral nurses at an additional cost of £305,564.

Dr Lewis and Dr Mandiratta declared that they were not involved in the decision making of the MSK business case relating to joint injections and the report was written by their partner at Feldon Lane Surgery. This was duly noted.

With regards to IAPT access, a meeting had taken place between Dr Lewis, Mrs Cartwright and the Mental Health Commissioning Manager at the CCG. It was evident from that meeting that targets were not being achieved because the people who are visible in primary care are the mental health nurses and not the IAPT workers, therefore GPs are sending referrals to the mental health nurses because IAPT workers are not in house. There was also an issue regarding self-referrals and no contact being made once the referral had been placed. It was agreed that a paper be produced for the November Board which Mr Bucktin would action.

In relation to the wheelchair service, it was noted that when patients do not want to use wheelchairs in their own homes, the referrals were being rejected. It was agreed that Mr Bucktin would review the service specification to clarify the situation.

As the Commissioning Development Committee was not quorate at its August meeting, the Board were being asked to approve the changes to the Memory and Dementia Assessment Service at a potential recurrent cost of £402,196. It was noted that a Business Case had been produced and the suggestion at the Committee was to add it to next year’s QIPP programme, or in order to meet the mental health investment standard next year, to change the allocation to reflect this.

There was a lengthy discussion with regards to the quoracy of the Commissioning Development Committee and the funding of the memory and dementia assessment service. It had been presented to the Committee twice and it was noted that should the Committee been quorate the report would have been presented to the Board for assurance. However due to the ongoing non-quoracy of the Committee, the Board were being asked for approval, which was not supported.

In order to resolve the issue, it was agreed that further debate was required at the next Clinical Executive Team with regards to the quoracy of the Commissioning Development Committee and how it could be addressed. It was also agreed that the full business case be considered by the Clinical Executive Team and that delegated authority be given to Dr Hegarty, Mr Maubach and Mr Hartland to report back to the November Board.
Resolved:
1) The Board received the report for assurance
2) The Board approved the proposed change to the IAPT pathway but requested Mr Bucktin to produce a paper on IAPT referrals to be considered at the November Board
3) Mr Bucktin agreed to review the eligibility criteria for the wheelchair service for patients using wheelchairs within their own homes
4) The Board did not approve the proposed changes to the Memory and Dementia Assessment Service, however the following actions were agreed:
   a) Further debate to be had at the next Clinical Executive Team with regards to quoracy of the Commissioning Development Committee and how it could be addressed
   b) A full Business Case to be considered by the Clinical Executive Team
   c) Delegated authority to be given to Dr Hegarty, Mr Maubach and Mr Hartland to report back to the November Board

CCG119/2018  MCP PROCUREMENT PROJECT BOARD

Mr Bucktin spoke to this item to provide the Board with an update on the procurement process for the MCP and for Board members to consider entry into Checkpoint 2 of the Integrated Support and Assurance Process (ISAP).

It was reported that a meeting was due to be held on 28 September 2018 with NHSE and NHSI to review the ISAP timetable. In terms of the assurance model, the Project Board had reclassified the ratings in the Repeatable Assurance Model (RAM) and had introduced a blue category where work was fully completed. At the time of Board, the RAM had 24 blue ratings, 2 green, 24 amber and 7 red. All of the outstanding areas were outlined within the report which included financial modelling; populating the MCP contract; along with various other areas.

Additional documentation had been circulated with the report which included Appendix 3 – a summary of legal advice received; Appendix 4 – future contract management arrangements; Appendix 5 – a review carried out by Good Governance Institute to provide assurance, noting a separate report was also being completed by internal audit; and a report on how statutory duties continued to be discharged both as a CCG and as a MCP once the contract is in place; Appendix 6 – commissioner requested service, which is what the MCP would be expected to make arrangements for to continue to deliver services if they were to get into financial difficulty.

Board members were being asked to approve the final documentation that formed the final submission of the ISAP; to note outstanding items; and consider moving to Checkpoint 2 of the ISAP. It was reported that the ISAP process cannot be entered into until the Integrated Care Provider (ICP) contract was available and the consultation period on the contract would end on 26 October 2018.

The point was made that one of the key issues in the process was one of the major partners involved in the MCP was facing serious challenges and asked if they were assured that the Trust would get through that. With this in mind, the Board needed to be sighted on what the timetable is and to what extend it was reliant on the Trust and how much commitment the Trust would need to give as its priority was to resolve the issues within the ED.

It was reported that all partners were involved in the appointments process and was not reliant on one organisation. In terms of the timetable, further work was required with all partners to complete the ISAP submission in November, and the work the Trust needed to be involved in was the preparation of the detailed financial case of the separation and creation of two Foundation Trusts. It was suggested a clear timetable was produced on how the process would progress to discuss with the regulators at the meeting on 28 September to provide clarity and assurance to the Board. This would enable DGFT to focus their attention on the issues within ED in the short term as this was a major priority before significant steps could be made to move to the mobilisation process of the MCP.

It was noted that assurance would be required that there was enough resource in the system in order to take the process forward effectively as staff who deliver the services would become more unsettled and no definitive answers were being given so it was felt important to keep staff engaged.

The latest position on the mobilisation process was requested and how the resource would be allocated to ensure it happened. It was reported that a case was being prepared to submit to the regulators on the resources required to mobilise the MCP, which was in the region of £4m for this year and next year that would include external scrutiny that NHSI would commission in terms of consultancy support required for the development of the two Foundation Trusts. Dialogue with the regulators would be had to debate whether a technical adjustment to the financial position would allow the resource to be spent, and if that was not an option, a bid for funding support would need to be made to NHSE.

Clarity was sought in relation to 1.10 and 1.11 within Appendix 7 which stated ‘whilst the CCG retains its statutory duty to “arrange” this activity is not exclusive to the CCG.’ It was clarified that in the second judicial review the argument raised that in effect the CCG was delegating its duty to arrange to another body. What the statement
says is that whilst the CCG retains and continues its duty throughout the contract, there would be certain activities that the MCP would have to do that were not dissimilar to the duty to arrange, particularly how they sub-contract services.

This raised a further question that if general practices choose not be included in the MCP, would that mean the CCG would need to commission services for that patient population alongside services commissioned and provided by the MCP. The response was that the scope of services the MCP would be responsible for, the CCG would commission those from the MCP which would cover the totality of the population regardless of where practices sat in relation to the MCP. The difference being that some practices would have integration agreements with the MCP and some may not. In addition, the difference between practices who were part of the MCP and those who were not would become apparent within the practices themselves and the standards they would work to. Those within the MCP would have an integration agreement and would work to outcome standards in the MCP. Those practices who continued to be outside of the MCP would remain on a GMS Contract and retain the national QOF however, this would be inconsistent with the MCP and not fully aligned. As a separate point, it was asked that there be a clear mechanism for testing clinical governance and the translation of putting theory into practise.

Resolved:
1) The Board noted the progress in relation to the procurement of the MCP
2) The Board were assured in relation to the Key Lines of Enquiry and supporting evidence, to make an initial submission for Checkpoint 2 of the ISAP
3) The Board noted that a further report be made to the Board in November 2018

Mrs Brunt spoke to this item summarising the key issues discussed at the meetings of the PCCC held on 20 July 2018 and 17 August 2018 and the work in which the Primary Care Team were involved in.

It was noted that there were 55 projects locally which were underway, 7 of which were STP related. It was highlighted to the Board the intensity of the work required which related to the STP and the reporting associated with the work streams. Proportionally, the work of the STP was identified as being as much as it was for the core work of the other projects within the team. In terms of capacity, the challenges of the team were recognised between the local and STP projects. As an example, the PMS scheme was a model used locally and the difference it had made locally meant it had been shared across the STP. This creates a centralised function and loses some of the local connections and context which Board members were asked to note.

Members were also asked to note the assurance processes that were required in relation to template completion which was taking a day a week for the team in terms of feedback to NHSE which sometimes were for relatively small projects. It was recognised that a large amount of effort was being put into resource to deliver projects but a significant change was not being made.

It was suggested to understand what the resilience was within primary care and whether the initiatives being developed were having a positive or negative impact. The Board were advised that a discussion would be taking place at the next GP Members meeting to take other workforce solutions as options for practices to engage with and to take to their locality meetings for discussion. In addition to this, it was also felt that the CCG needed to articulate the degree of resilience within primary care and the issues, therefore it was incumbent on the CCG to explain it more clearly.

The Board noted that the Committee congratulated Lion Health on their ‘outstanding’ CQC rating.

With regards to the PCAT Tool, it was noted that the individual developmental needs of practices were being identified through the use of the tool and was enabling practices to improve if necessary. The tool is currently reported within the private section of the Committee whilst work continues, but it will be reported in public at the point when it is deemed appropriate to.

In conclusion, it was requested that a report is presented to the Board on resilience within primary care, noting the conflicts as GP Board members, but it was recognised that there were significant issues within primary care on resilience. In addition, it was also requested a review took place on age profile demographics.

It was recognised that there were previous issues around how some of partners behave within the NHS, Propco was mentioned as an example, with increased rents and service charges for primary care estate.

There were a number of pieces of work being carried out relating to resilience and it was felt that some of that work needed to be captured and evaluated and presented to the Board at a later date.
Resolved:
1) The Board received the report for assurance and noted the decisions taken by the Primary Care Commissioning Committee
2) It was agreed to receive a report at a future Board on resilience issues within primary care, including a review of age profile demographics

<table>
<thead>
<tr>
<th>CCG121/2018</th>
<th>LOCALITY FEEDBACK REPORT – JULY/AUGUST 2018</th>
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</table>

Mrs Brunt spoke to this item to advise the Board of themes emerging from discussions held at Locality meetings in July 2018.

It was noted that Dr Gee and Mr King had concluded 40 practice visits out of 43. The remaining three practices were planned but it was highlighted that there had been issues with accessing those three practices due to them cancelling on several occasions.

Resolved:
1) The Board received the report for assurance

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<thead>
<tr>
<th>CCG122/2018</th>
<th>REFLECTION TIME</th>
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There were no issues raised from Board members in terms of reflection time.

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<tr>
<th>EXCLUSION OF THE PRESS AND PUBLIC</th>
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That under the Public Bodies (Admission to Meetings) Act 1960, the public and representatives of the press and broadcast media be excluded from the meeting during the consideration of the following items of business as publicity would be prejudicial to the public interest because of the confidential nature of the business to be transacted.

<table>
<thead>
<tr>
<th>DATE AND TIME OF NEXT MEETING</th>
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Thursday 10 January 2019
1pm – 5pm
Boardroom, Brierley Hill Health and Social Care Centre

<table>
<thead>
<tr>
<th>MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD</th>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Signed</td>
<td>Date</td>
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</table>
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

## MATTERS OUTSTANDING

### PUBLIC BOARD MEETING – NOVEMBER 2018

<table>
<thead>
<tr>
<th>ITEM NO</th>
<th>AGENDA ITEM</th>
<th>ACTION TO BE TAKEN</th>
<th>ACTION FOR</th>
<th>UPDATE</th>
<th>COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG083/2018 (July 2018)</td>
<td>Feet on the Street: End of Life Care</td>
<td>Mrs Cartwright to discuss the End of Life Strategy at Partnership Board and invite West Midlands Ambulance Service to attend for this specific item</td>
<td>Mrs Cartwright</td>
<td>To be discussed at Partnership Board in September</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG092/2018 (July 2018)</td>
<td>GDPR Board Assurance Update</td>
<td>An update report on the GDPR amber ratings to be presented to a future Audit &amp; Governance Committee and reported back to Board</td>
<td>Mr Hartland</td>
<td>Discussed at Information Governance Steering Group. To be presented to Audit &amp; Governance Committee. Further update to be provided at November Board</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG094/2018 (July 2018)</td>
<td>Report from Finance, Performance and Business Intelligence Committee</td>
<td>1) A future Board to receive the financial position across the Integrated Care System as a whole to understand any surplus or deficit positions which could impact on Dudley</td>
<td>Mr Hartland</td>
<td>In progress via JCC Further update to be provided at November Board</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG095/2018 (September 2018)</td>
<td>Report from Commissioning Development Committee</td>
<td>Partnership Board to produce a report in terms of investment made in Children &amp; Young People and how the CCG engage with that cohort of the Dudley population and bring to a future Board for discussion</td>
<td>Mrs Cartwright</td>
<td>To be discussed at Children's Alliance. Action transferred to Mr Bucktin and Mrs Broster to arrange</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG096/2018 (September 2018)</td>
<td>Report from Health and Wellbeing Board (HWBB)</td>
<td>Discussion to be held at Partnership Board on the Dudley Borough “Vision” that was being launched in September and how the health system can support its achievement</td>
<td>Mrs Cartwright</td>
<td>To be discussed at Partnership Board in September</td>
<td>ONGOING</td>
</tr>
<tr>
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<tr>
<td>CCG115/2018 (September 2018)</td>
<td>Board Assurance Framework and Risk Register</td>
<td>Mrs Broster to liaise with Mrs Smith with regards to the gap in assurance wording which related to Risk 152: ‘There is a risk that the pace of change in the transformation of the system will not be aligned to the views of the public. This may result in the CCG moving too quickly to allow time for adequate involvement or not moving quickly enough to meet public expectations’</td>
<td>Mrs Broster</td>
<td>Discussed at Audit and Governance Committee and is included in the Board Assurance Framework report</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>CCG117/2018 (September 2018)</td>
<td>Report from Finance, Performance &amp; Business Intelligence Committee</td>
<td>Mr Hartland to present a report in relation to the Quality Premium figures at November Board</td>
<td>Mr Hartland</td>
<td>Included within the Finance, Performance &amp; Business Intelligence Committee report</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>CCG117/2018 (September 2018)</td>
<td>Report from Finance, Performance &amp; Business Intelligence Committee</td>
<td>Mr Hartland to present a report in relation to the current capital investment opportunities at November Board</td>
<td>Mr Hartland</td>
<td>Included within the Finance, Performance &amp; Business Intelligence Committee report</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>CCG118/2018 (September 2018)</td>
<td>Report from Commissioning Development Committee</td>
<td>Mr Bucktin to produce a paper on IAPT referrals to be considered at November Board</td>
<td>Mr Bucktin</td>
<td>Awaiting implementation plan to be produced by DWMHPT</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG118/2018 (September 2018)</td>
<td>Report from Commissioning Development Committee</td>
<td>Mr Bucktin to review the eligibility criteria for the wheelchair service for patients using wheelchairs within their own homes</td>
<td>Mr Bucktin</td>
<td>Subject to engagement process</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG118/2018 (September 2018)</td>
<td>Report from Commissioning Development Committee</td>
<td>A full Business Case to be considered by the Clinical Executive Team for the Memory and Dementia Assessment Service and delegated authority be given to Dr Hegarty, Mr Maubach and Mr Hartland to report back at November Board</td>
<td>Dr Hegarty, Mr Maubach &amp; Mr Hartland</td>
<td>Update to be provided at November Board</td>
<td>ONGOING</td>
</tr>
<tr>
<td>CCG120/2018 (September 2018)</td>
<td>Report from Primary Care Commissioning Committee</td>
<td>Report to be received on resilience issues within primary care, including a review of age profile demographics, to be reported at a future Board</td>
<td>Mrs Brunt</td>
<td>To be reported back at January Board</td>
<td>ONGOING</td>
</tr>
</tbody>
</table>
Forging a Future for all in Dudley borough

An exciting new vision for Dudley borough has been unveiled by community leaders across the area.

Under the heading ‘Forging a Future for all’, the Dudley borough vision sets out aspirations for the kind of place Dudley borough wants to be in 2030. The vision, which has been developed by organisations across the borough following extensive engagement with the whole community, including borough residents, businesses, Dudley Council, the police and fire service, NHS organisations, faith groups and voluntary sector organisations, sets out seven key aspirations.

The aspirations include ensuring Dudley borough is an attractive and affordable place to live and visit, with vibrant and diverse towns being home to healthy and safe communities. It also emphasises the importance of high quality schools and colleges to provide the skilled workforce to help innovative businesses prosper in a better connected borough both in terms of transport links and through digital technology.

Councillor Patrick Harley, leader of Dudley Council, said:
“From the outset of engaging with people across the borough, as a council we have made it clear this cannot be a council vision, it needs to be a true borough vision. We are proud to have supported the development of the Forging a Future for all vision with its seven aspirations with all of our partners and we now look forward to working together across the borough to make the aspirations a reality. A group is now being formed, made up of representatives from across organisations in the borough and the community to help drive the project forward and help forge a future for all.”

Newsquest has teamed up with Dudley Council and partners to help launch the vision, through the ‘Forging a Future for all’ Awards. Through a number of awards, each representing the different aspirations of the vision, we want to celebrate people and organisations who are already working to make the vision a reality.

This is a unique way to bring the vision to life and to ensure that borough residents and organisations can get involved and play a part in making the vision a reality. If you know someone or an organisation doing great things for our borough, get involved and nominate them now for a Forging a Future for all award.

Information about the vision and details of the awards can be found at www.dudleyboroughvision2030.org.uk
Borough vision – Forging a future for all
Dudley borough…

forging a future for all

• An **affordable and attractive place** to live with a green network of high quality parks, waterways and nature reserves that are valued by local people and visitors

• A place where everybody has the **education and skills they need**, and where outstanding local schools, colleges and universities secure excellent results for their learners

• A place of **healthy, resilient, safe communities** with high aspirations and the ability to shape their own future

• Better connected with **high quality and affordable transport**, combining road, tram, rail, and new cycling and walking infrastructure

• Renowned as home to a host of **innovative and prosperous businesses**, operating in high quality locations with space to grow, sustainable energy supplies and investing in their workforce

• A place to **visit and enjoy** that drives opportunity, contributing to its ambitious future while celebrating its pioneering past

• Full of **vibrant towns and neighbourhoods** offering a new mix of leisure, faith cultural, residential and shopping uses
Borough vision campaign

• Seven themes identified and agreed – How do we bring this to life and make it real to the general public?

• From the outset of engagement process the warmth of the people and homeliness of the place has shone through

• One of the challenges has been to ensure the People element comes through with the easier Place narrative (eg DY5, Metro etc)
Borough vision - HOME campaign

• People + Place (house) = HOME

• Dudley has been HOME to people for 1,000 years (medieval castle and Domesday book reference 1086)

• Dudley Council priorities are to build 1,000 new HOMEs each year and to make the borough HOME to more businesses (DY5, Metro, Regeneration projects)
Bringing the vision to life

Full Forging Our Future Video

Short extract (1 of 7): Tourism Video
**Introduction**

This report is presented with the aim of keeping Board Members up to date with important communications and engagement issues and ‘hot topics’.

It is also produced with the specific aim of further strengthening the patient voice at the meetings of our Governing Body, by including sections dedicated to feedback from our Patient Participation Groups, Patient Opportunity Panel (POPs) and Healthwatch.

Specific feedback from public involvement activities is used to inform committee decisions and full details of all our involvement can be found in the ‘your voice’ section of our website www.dudleyccg.nhs.uk.

This month Feet on the Street ventured out to find out views on the use of technology in a digital NHS. We wanted to explore whether people understood the terminology of digital health, what role they thought technology could play in helping people to manage their health and what they might want to see in the future.

This feet on the street, represents the start of our conversations on this topic. We hope to host more focussed conversations with the public and clinical colleagues to inform any future digital strategy.

**Patient Opportunity Panel (POP) Meeting** - The group met in October and found out more about the roll out of online consultations, safeguarding and pharmacy first.

**Dudley Borough Healthcare Forum (HCF)** – The HCF gave an opportunity for members of the public to hear from Geraint Griffiths-Dale, Deputy Director of Commissioning as he explained and invited feedback on the CCG Commissioning Intentions. This feedback will be used by CCG commissioners to inform any developments throughout the year.

**Self-care workshop** - Following on from the planning session held in September, a resource pack has now been developed and is available for groups to use so they can start conversations on what self-care means to them covering a range of topics. All groups participating are being asked to feedback their conversations to Healthwatch by the end of November so that a report can be written.
This will help inform the strategy for self-care across Dudley which the CCG are working on with partners.

**Personalised Care Programme** – the programme continues at pace across the STP footprint to further develop personalised care.

- 3 Villages have trained a member of staff in health coaching and they are being supported by our Peer Health Coach to start using Patient Activation Measures (PAM).
- We are in conversations with a number of staff teams and organisations about the potential of using a PAM and health coach approach including Community Dietetics.
- 20 participants from a range of backgrounds including staff and patients and carers attended the design session for personalised care. Feedback has helped shape a further session aimed at staff to support personalised care conversations. This training will happen in December and will help improve the experiences of staff and patients during the long term conditions reviews.
- We have a number of health coach training sessions across the STP which have been well received. Sessions will take place throughout November and December and a package is being developed to support staff and practices in taking the training and PAM forward within their own practices.
- A mapping exercise of peer support groups has taken place across the STP.
- A team member will be attending facilitative co-production leadership training in Nottingham over the next 6 months to help support an organisational approach to co-production. We anticipate further training and mentorship for patients to be available soon with the Peer Leadership Academy and The People Hub.

**Transforming Care Partnership (TCP) – Learning Disabilities & Autism** - Involvement to date with service users has been valuable and has informed the development of the new clinical model. We will now be embarking on a formal involvement period to give patients, carers and the general public an opportunity to express their views on how the new model is working for them, to ask any questions on the proposed reduction in Assessment and Treatment Beds and to understand and express views on the providers preferences for the future location of the Assessment and Treatment Beds.

We are now working with the TCP Programme Lead and the provider to develop materials with a view to starting the involvement in November.

In Dudley we will be working with Dudley Voices to ensure we have events and materials which are accessible and maximise the opportunity for people to get involved.

**Public Panel for Lay Person on the Board for Championing Patient & Public Involvement** – as part of the recruitment process for the post, a public panel was formed to provide feedback on the appointable candidates. The public panel helped to set a presentation question and then had the opportunity to ask questions of the candidates prior to any decision being made by the formal interview panel.

**Winter Information Event** – The team attended an event at DY1 in Dudley to promote Winter Staywell messages. Approximately 150 people took the opportunity to attend, ask questions and take away information.

**Death Cafes** – the team ran 3 death cafes with the help of Dr Lucy Martin with Health and Social Care students at Dudley College. It was clear that the topic was perceived as uncomfortable but by using a range of materials we had some positive conversations which will help shape the way we talk about death and dying. A plan for Communications and Engagement has been developed and approved at the End of Life Strategy Group with a view to promoting positive conversations around dying in Dudley. We hope to see this activity culminate in a series of focussed events for Dying Matters Week in May 2019.
MEFESTIVAL 2018 - 22nd November 2018 will see the 4th #MEFESTIVAL taking place which will focus around the 5 ways to wellbeing. This year the team have organised a fly in/landing with the Midlands Air Ambulance (pending operational needs), Beautifully Human and Dr Tim Horsburgh will be dusting off his outfit again for another performance of ‘What’s Up Doc’.

Consultation 3 Villages - the 3 Villages consultation on their proposal to close the branch surgery in Wollaston came to an end on 19th September. A signed petition was received by the CCG and the practice prepared a full report including feedback themes.

The Primary Care Commissioning Committee (PCCC) was held on 19th October 2018 at Amblecote Christian Centre as we wanted to ensure the meeting was held in a suitable and local venue. Approximately 45 people attended the meeting. The PCCC made the decision to support the proposal of the branch surgery closing.

NHS Continuing Healthcare (CHC) Policy - a draft policy has been developed which sets out the commissioning principles that the CCG will work to when commissioning individual packages of continuing healthcare for patients eligible for NHS Continuing Healthcare funding by the NHS.

We will be seeking views on the draft policy through a period of engagement which runs from Monday 5th November through to Monday 3rd December. Information will be shared with patients who may be impacted by the draft policy and wider stakeholders. All feedback will be taken on board and considered at Commissioning Development Committee in December for a final decision and policy.

Maternity Voices - The ‘You Said, We Did’ event was held on 26th September to follow on from the previous ‘Whose Shoes’ events which have happened over the last year. These events are focussed on talking to women, their families and professionals about their experiences and thoughts on maternity services.

The four Trusts within the Black Country Local Maternity System have reviewed the feedback from these events and identified a number of themes to focus on. Matrons from each of the Trusts presented one each of the themes at the ‘You Said, We Did’ event;

- Continuity of Care
- Privacy and Dignity
- Communications Governance
- Culture Change Compassion and support

They also shared any recent actions which have been taken to address any issues within these themes, as well as ways to develop and move maternity services in the Black Country forward.

The event was well attended by over 60 people and it expressed to those women and families who had attended previous events, that their views and experiences had been listened to.

Reduced Foetal Movement Survey and Continuity of Carer – we are seeking views of maternity service users within the Black Country in terms of reduced foetal movement and continuity of carer. The surveys have been shared on the CCG website and via social media.

Friends of Ridgeway PPG Event – The team dropped in to an event that had been organised by Ridgeway Surgery PPG. The event was aimed at local people and was an opportunity to find out more about local initiatives and support including Healthwatch, local library services and the Living Well, Feeling Safe team. A great example of our practices connecting with communities through their PPGs.

Fibromyalgia Activate at Feldon Lane – the team worked with Dudley Council for Voluntary Services and Feldon Lane Surgery to organise a session for patients living with fibromyalgia. We used the Activate pack (developed as part of the Listening Exercise for the MCP) to work through ideas with participants using an asset based approach. 10 patients attended and were positive about
meeting again to discuss next steps and what they might like to do as a group. We will be organising a meeting in the near future.

**Young Health Champions** – we are exploring options with public health for extending the Young Health Champions project. The project has been up and running for nearly 2 years and a steering group has been formed to look at how we want this service to be focussed moving forwards.

**Wheelchair Services** – a time limited task and finish group session has been organised for mid-November to listen to views on the current wheelchair service and any ideas for improving delivery. This will be used to review our wheelchair policy. The group will focus on real experiences and views of current wheelchair users and their carers. We hope that the group can discuss options for the policy around wheelchair provision to inform any future involvement exercise.

**Health and Wellbeing Board Conference** – the team attended and presented the CCG story around community resilience to a range of stakeholders. This involved the development of the Multi-Speciality Community Provider and a recap of some the engagement work that has been underpinning a community resilience approach.

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**Choose Wisely** - Following extensive engagement with members of the public, primary care and CCG leadership teams, we have now developed and sought approval on print materials for Procedures of Limited Clinical Priority (PLCP). These include a leaflet for GPs to hand to patients to support constructive conversations around PLCP and a list of all the procedures for each consulting room.

We are now in the process of sharing these with lead consultants at our local providers before going live in practices.

**Patient Online** - Last year the GP Patient Survey showed that nationally there had been an increase in awareness amongst patients of online services offered by GP practices over the last year; however, there had only been a modest increase in patients using them.

To improve this in Dudley we have developed the Patient Online Delivery Package provided by NHS England to help promote the service in practices, this included the following;

- Quick Start Guide to promoting Patient Online
- What are the benefits
- What all practices could be doing
- Focus for practices under 14% target
- Focus for practices from 14-20%
- Focus for practices over 20%
- Resources available

Since the end of April 2018 we have been working with the Primary Care Team to do an audit of Patient Online promotion across all Dudley practices with the help of PPG members. This was conducted in a ‘mystery shopper’ way with patients checking against the ‘What all practices could be doing’ list for each practice to ensure all patients across the borough are receiving the awareness and opportunity to sign up.

We have recently worked more closely with a number of practices whose online services uptake is still particularly low and have provided additional support to them to help them improve this. We will
continue to review this and provide support to help them demonstrate the actions required to reach the national target.

**Winter Information Event** – The team attended an event at DY1 in Dudley to promote Winter Staywell messages. Approximately 150 people took the opportunity to attend, ask questions and take away information.

**Winter** - This year Dudley CCG will implement a locally led campaign with elements of the Black Country social marketing campaign developed by Arden & Gem CSU where collaboration is advantageous.

The Help Us Help You Stay Well This Winter campaign aims to ease seasonal pressure on NHS services. It is designed to reduce the number of people, who become so ill that they require admission to hospital. In Dudley we will use the three pillars of communication:

- **Prevention** – change public behaviour
- **Prepare** – build awareness of winter pressures and the impact on the NHS
- **Performance** – ensure the health and care system respond to all reputational issues associated with performance

With a focus on:

- **GP Extended Access**
- **Flu**
- **LTC’s**
- **Pharmacy & Self Care**

In the event of adverse weather, this will also include advice for preparedness, adverse weather warnings and actions for different levels of escalation from the Met Office and implementation of the Cold Weather Plan available to view [here](#).

To ensure that this campaign is as effective as possible, Dudley CCG will work with partners to align all local activity using the national timeline to ensure consistent messaging to deliver tailored messages to our target audiences.

We will where possible include links to local services as a call to action in addition to the national messages.

Artwork, toolkits and brand guidelines are now available on the Public Health England Campaign Resource Centre website and are being used to plan our local weekly activity.

Our winter communications plan is now complete and has been submitted to the A&E Delivery Board for approval.
Infants and young children - their healthcare journeys

**Background**

Healthwatch Dudley was asked by Dudley Clinical Commissioning Group to listen to the views of parents and carers of babies and infants accessing health care services.

In July we spent a week at Russells Hall Hospital finding out about the help and advice families accessed before and during their hospital visits.

We covered a 24-hour timeframe during seven days of activity in Urgent Care, Children’s Emergency Department and the Paediatric Assessment Unit.

A report detailing project activity and recommendations has been produced and sent to the Dudley CCG Chief Nurse for consideration and discussion.

**Who we listened to:**

We captured 43 stories listening to the experiences of 41 mothers and 18 fathers, with on occasion other family members who were also included in conversations.

**Impact of lifestyle:**

Context is important and as such, our final report details the personal circumstances of new families and how this impacts on the decisions they make about accessing healthcare, for example their working arrangements or care of other children.

**Communication:**

Our report also explores the consistency and clarity of information new families receive about care of their children or how to access healthcare services.

**Empowerment:**

There are issues to do with the types of conversations that some parents and carers have with healthcare staff, where they do not work well there is a risk that parents and carers end up in inappropriate parts of the healthcare system. Our report details the impact of this.

**Building a better pathway:**

The report discusses how more must be done to develop a more effective healthcare pathway for infants and young children who are unwell, which is clear for parents and carers.

**Recommendations:**

The final section of our report includes recommendations for action, derived from analysis of conversations and emerging themes. Areas covered include; improved communications, better understanding of family circumstances, improved access to general practice, listening to and involving parents and carers, reducing confusion surrounding services and their purpose, encouraging greater collaboration and improved pathways.

**Feedback on recommendations**

The report also includes arag rateable template to enable progress on recommendations to be recorded and fed back to Healthwatch Dudley.
Proactive and Reactive Media Activity - The table in appendix 1 gives a breakdown of recent media activity for the CCG.

The Advertising total has been calculated as £89,464.70 with the main coverage relating to:

- Lion Health rated as outstanding
- Opposition to the Three Villages merger/closure

Appendix 1 Media Update
Communications and Engagement – Media Monitoring – Sept - Oct 2018

### Media Summary September 2018

<table>
<thead>
<tr>
<th>Title/weblink</th>
<th>Summary</th>
<th>Release Date</th>
<th>Coverage (with links where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley CCG Invites Public to attend Board Meeting</td>
<td>Press Release</td>
<td>05.09.2018</td>
<td>Release</td>
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<tr>
<td>Campaigners rally support to save village GP surgery</td>
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<td>06.09.2018</td>
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<td>MECS introduced in Dudley</td>
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<td>We can all help make life better</td>
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<td>Forging a Future for All awards latest</td>
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<td>Halesowen, Dudley News (Web)</td>
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**Media Summary October 2018**

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<td>What are Accountable Care Organisations?</td>
<td>Coverage of Media Enquiry (Interview with Paul Maubach)</td>
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<td>New Statesman</td>
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### DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Board:** 8 November 2018  
**Report:** Partnership Board  
**Agenda item No:** 6.1

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<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Update from Partnership Board</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the Board on the developments of the Partnership Board</td>
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<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs Stephanie Cartwright, Director of Organisational Development, Transformation and Human Resources</td>
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<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs Stephanie Cartwright, Director of Organisational Development, Transformation and Human Resources</td>
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<tr>
<td>CLINICAL LEAD:</td>
<td>Dr David Hegarty, Chair</td>
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#### KEY POINTS:
- Since the last report the Partnership Board has met twice (26 September and 31 October 2018)
- The Partnership Board includes invitees from all organisations involved in the health and social care system in Dudley
- The development of the MCP in Dudley continues to receive very positive national support
- Governance arrangements continue to reflect the separation of procurement of the MCP from development of the MCP

#### RECOMMENDATION:
That the CCG Board notes the progress of the Partnership Board to date

#### FINANCIAL IMPLICATIONS:
None

#### WHAT ENGAGEMENT HAS TAKEN PLACE:
There is a specific workstream dedicated solely to communications and engagement on the new models of care that includes representation from all organisations involved

#### ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:

#### ACTION REQUIRED:
- **Decision**
- **Approval**
- ✔ **Assurance**
1. INTRODUCTION

The Dudley New Model of Care Partnership Board includes invitees from all organisations included in
developing the Dudley Multi-speciality Community Provider. These organisations are as follows:

- Dudley Clinical Commissioning Group (lead organisation)
- Dudley Metropolitan Borough Council
- Dudley Group NHS Foundation NHS Trust
- Dudley and Walsall Mental Health Partnership NHS Trust
- Dudley Council for the Voluntary Sector
- Black Country Partnership NHS Foundation Trust
- Dudley Primary Care Providers
- West Midlands Ambulance Service NHS Foundation Trust

2. REPORT

The Partnership Board meets on a monthly basis to oversee the implementation of the core components
of the MCP, the wider development of the health and social care system and to provide the opportunity to
raise robust challenge and to air issues that require partnership debate and discussion. The Partnership
Board has met twice since the last report to the Board meeting, on 26 September and 31 October 2018.

The Partnership Board in September received a presentation on the End of Life Strategy from Dr Lucy
Martin. Dr Martin explained that there has been a large consultation exercise on the Dudley End of Life
Strategy with the involvement of all partners. Dr Martin informed the Partnership Board about the quality
improvement event at the end of October 2018. Dr Martin explained the improvements that are also being
made in primary care and Dr Martin will be attending all of the GP locality meetings in November to promote
the strategy and improve awareness of the end of life and palliative care registers. A detailed discussion
took place on the input of the Ambulance Service and it was agreed that an end of life system summit will
be suggested to the Medical Director of West Midlands Ambulance Service by Dr David Hegarty.

The Partnership Board also discussed the funding for public health checks and Deborah Harkin’s, Chief
Officer Health & Wellbeing, explained how the public health grant ring-fenced funding will be changing in
the future. It was explained that the suggested changes to the funding for the checks is for consultation
with colleagues and it was agreed that a short term task and finish group would be established to review
the proposed changes.

The Partnership Board reflected on the Dudley vision that has been developed by partners across Dudley.
Seven aspirations have been developed and a lead identified for each aspiration. It was agreed that a
workshop would be arranged with Partnership Board members to look at how the health economy can
contribute to the vision.

The Partnership Board received an update from the Transition Board noting the progress being made
against the appointment of the Transition Team and were informed of a bid for external funding to support
the further development and the transaction process.

At the October meeting of the Partnership Board it reviewed its Terms of Reference. The Partnership
Board discussed and agreed the difference between the MCP Transition Board and the Partnership Board
as follows:

- The Transition Board is a short term Board to oversee the transactional and transformation elements
  of developing the MCP and will end once the Shadow Board of the MCP is in place.
- The purpose of the Partnership Board is the sustainability of the system. It was suggested and agreed
  that the Partnership Board should report to the Health and Wellbeing Board, and that it should focus
  on two or three key priorities. It was suggested that these priorities were linked to the Health and
Wellbeing Board priorities. The Partnership Board agreed to meet for a short workshop at the beginning of the November Partnership Board meeting to agree the priorities.

The Partnership Board received an update on the transformational elements of the MCP development including the Integrated Community Teams; the SPA (Single Point of Access); the Care Home teams; mental health; population health and Dudley Rehabilitation services. The Partnership Board also received an update on the appointment to the wider MCP transition team.

3. **RECOMMENDATION**

The CCG Board is asked to note the contents of this report for assurance.

Stephanie Cartwright  
Director of Organisational Development, Transformation and Human Resources  
October 2018
### Black Country Joint Commissioning Committee (BCJCC) Assurance Report

**Date of Board:** 8 November 2018  
**Report:** Black Country Joint Commissioning Committee (BCJCC) Assurance Report  
**Agenda item No:** 6.2

<table>
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<th><strong>TITLE OF REPORT:</strong></th>
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<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>This report provides a summary of business considered at the BCJCC meetings held on 13 September 2018</td>
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<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Alastair McIntyre, Interim STP Portfolio Director</td>
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<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mr Paul Maubach, Chief Executive Officer</td>
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<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr Anand Rischie, Chair – Walsall CCG/Chair Black Country JCC</td>
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**KEY POINTS:**
- Assurance reports for the BCJCC meetings held on the 13 September 2018 and 11 October 2018 for assurance
- Minutes from the BCJCC meetings held on the 9 August and the 13 September 2018 for information (Appendix 1)

**RECOMMENDATION:**
1. To note the contents of the reports for update on activity and assurance from the meetings held 13 September 2018 and 11 October 2018
2. To note the ratified minutes from the meetings held on the 9 August 2018 and the 13 September 2018

**FINANCIAL IMPLICATIONS:**
None

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
None

**ANY CONFLICTS OF INTEREST DECLARED:**
None

**ACTION REQUIRED:**
- Decision Approval
- Assurance

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**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**
REPORT FROM THE 13 SEPTEMBER 2018 MEETING

1. Terms of Reference

1.1. The meeting attendance was not quorate. It was therefore agreed to hold the meeting as a ‘general update’ discussion on the matters on the agenda.

2. Action Log and Matters Arising

2.1. There had been satisfactory progress on most items.

2.2. The JCC Risk Register template was again deferred to the next meeting as officers had not been able to meet due to annual leave.

2.3. Clinical Leadership Group - process of appointing the Chair – the committee noted that dates for interviews of the candidates for this important role were yet to be confirmed.

3. Place-Based Commissioning Update – Wolverhampton

3.1. Dr Helen Hibbs updated the committee on progress in Wolverhampton with the development of their alliance model.

3.2. The clinical priorities being addressed first are End of Life Care, Frailty, Paediatrics, Mental Health and Urgent and Emergency Care. The alliance is also working on developing a data sharing agreement to benefit population health management and bring patient benefit for support at the clinical pathways level.

3.3. The system is reviewing the benefits of the Canterbury, New Zealand outcomes framework.

4. Programme Performance

4.1. Alastair McIntyre tabled the monthly performance report. A&E, Cancer and Mental Health Transformation require improvement.

4.2. The committee heard briefly that work with the CSU on developing a performance reporting and dashboard tool was progressing well and a demonstration would be given to the Health Partnership Board on Monday 17 September. Reports, with narrative commentary were planned to come to JCC and STP boards from October.

5. Walsall and Dudley Integrated Care Systems

5.1. Matthew Hartland presented for discussion a draft model reviewing the potential financial flows supporting the development of integrated care. There was discussion about the differences of the models at the place level. It was agreed to develop, using the same framework, models for the Wolverhampton and Sandwell and West Birmingham systems and that these should be brought back to the next meeting for a further discussion.

6. Transforming Care

6.1. Dr Helen Hibbs informed the group that the recent Deep Dive discussion on the programme performance with NHS England had gone well. However, the recent progress with 4 discharges had been offset by 3 admissions. The programme is required to meet with the National Programme Director, Ray James.

6.2. A paper on the financial model to enable the supported discharge of patients is nearing completion and will be taken to CCG Governing bodies for agreement before it is then discussed with Local Authority partners.
7. **JCC Executive Development Session**

7.1. The committee discussed the agenda for the JCC executive Development session planned for the 20th September and noted that this would cover CCG commissioning intentions and have a facilitated session on developing strategic commissioning of the key priorities in the ICS development roadmap.

8. **Consent Agenda Reports**

8.1. No consent reports were presented at the meeting.

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**REPORT FROM THE 11 OCTOBER 2018 MEETING**

1. **Terms of Reference**

1.1. The meeting attendance was quorate.

2. **Action Log and Matters Arising**

2.1. There had been satisfactory progress on most items.

2.2. The draft JCC Risk Register was confirmed on the agenda for discussion.

2.3. Clinical Leadership Group – confirmation of dates for interviews remained unconfirmed and Officers were asked to confirm dates and convene interviews ASAP.

3. **Place-Based Commissioning Update – Dudley**

3.1. Paul Maubach updated the committee on progress in Dudley with the development of the Multi-specialty Community Provider (MCP) model.

3.2. There was a conference call with NHS England and NHS Improvement to review progress on the development of the MCP and state of readiness for the formal ISAP checkpoint 2 assurance review.

3.3. The national consultation on the contract by NHS England and the leave of appeal granted in one national Judicial Review had added a delay into the process. The technicalities of ‘splitting’ and FT are being worked through (this has not been done before and therefore is new ground for the regulators). The timeframe for establishing the MCP is now aiming for a January 2020 start with mobilisation expected from April 2020.

3.4. A transition board for the MCP has been established bringing the partners together and a lead director for that board has been identified.

3.5. An extended discussion on the detail of the MCP, Primary Care Workforce has been agreed for the next meeting.

4. **Programme Performance**

4.1. Alastair McIntyre tabled the monthly summary performance report. A&E, Cancer and Mental Health Transformation remain areas requiring improvement. It was noted that Sandwell and West Birmingham have an escalation meeting with NHS England on Dementia performance and improvement.

5. **Risk Register**

5.1. A draft risk register was presented for discussion.

5.2. The risks presented were acknowledged and work on identifying mitigations for those risks was requested for next time.
6. Integrated Care Systems

6.1. Matthew Hartland and James Green presented for discussion a draft model reviewing the potential financial flows supporting the development of integrated care in the four places in the Black Country.

6.2. This built on the discussion at the previous meeting.

7. JCC executive Development Session

7.1. It was noted that there had been good attendance at the session which covered two themes.

7.2. First the CCGs had shared their joint commissioning intentions and agreed to develop a single set of joint commissioning intentions for the Black Country. This has been done between meetings and the joint commissioning intentions are now going to each CCG GB for sign off.

7.3. Second was a facilitated session working on the road map developed for the STP. In taking forward the priorities identified through the ICS development programme over the spring and summer.

8. Service Change List

8.1. The meeting received the list of schemes being considered by commissioners where a service change assurance process may be required. This is to allow early dialogue with systems on realistic timelines for service change programmes, to ensure that there is public engagement consultation as required and that regulatory assurance process can be forward planned to support commissioner ambitions.

9. Transforming Care

9.1. Dr Helen Hibbs informed the group that the number of required discharges was being achieved but the increase in admissions had negated the impact. The recent Meeting with the national lead had indicated ‘green shoots’ for improvement in the programme performance.

9.2. A public engagement exercise is to be commenced in November to seek views on the development of the community model and influence any future location of assessment and treatment beds within the black country.

10. Consent Agenda Reports

10.1. JCC Delegation
It is recognised that there are an increasing number of areas where CCGs are rightly collaborating across the STP footprint and that each of these areas should be presented to a future JCC meeting with a proposal to delegate powers to the JCC. This was agreed. A forward plan will be drawn up to manage agendas.

11. AOB

The fourth wave of this programme would see the programme move to STP based contracts. For Black Country this means the Dudley; Walsall and Wolverhampton; Birmingham, Solihull Sandwell and West Birmingham contracts will end at the end of July 2019 and there will be a single contract for the Black Country STP. There is a short turnaround of a week to populate and submit a draft prospectus (template supplied) and nomination/appointment of a lead was required. The JCC suggested a decision should be made by the STP board.

Stroke review
Nick Harding requested that the West Midlands Stroke Programme modelling work be presented by the Commissioning Support Unit at the next JCC meeting. This was agreed.
1. **INTRODUCTION**

1.1 Welcome and introductions as above. Jonathan Fellows was introduced as the newly appointed Independent Chair for the Black Country STP.

1.2 Apologies noted as above.

1.3 Dr Anand Rischie asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. None were given.

1.4 The minutes of the meeting held on the 12th July were agreed as an accurate record of the meeting.

1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.

1.6 In regards to 075, Matthew Hartland requested this be brought back to the September meeting as an agenda item where there will be a formal report.
1.7 In regards to 092, Matthew Hartland informed this referred to the long term sustainability of Dudley. This will flow into the risk analysis work that is being carried out at the moment. They would be able to present the impact on Dudley now, but not the long term consequences as this level of detail is currently being worked through. Laura Broster noted that the proposal would mean that Dudley Group FT would be split into two FTs. There are still conversations to be had from NHS Improvement regarding the impact on providers and the proposal has not yet completed the ISAP assurance process. Dr Anand Rischie suggested it is good for system partners to see high level findings of the potential impacts of the proposals. There were reflections on the suggested work that did not commence last year around the financial sustainability of each trust due to the providers not being involved. It was agreed there would be a presentation regarding high level indicators for Walsall and Dudley at the next meeting. This could include a diagram or flow chart which highlights any potential income loss, gateways of approval and secondary plans if these are rejected. This will be reviewed to see whether the other areas will present at future meetings.

**Action:** Matthew Hartland to present the high level indicators for Walsall and Dudley regarding potential financial impacts at the September JCC meeting.

2. **MATTERS OF COMMON INTEREST**

2.1 **JCC Terms of Reference**

2.1.1 Prof Nick Harding had suggested at the last meeting that the Terms of Reference be amended so that the Chair has a yearly rotation to enable continuation of work. This would mean that Dr Anand Rischie would remain Chair for another six months, and then Dr Salma Reehana would take over for a year. Alastair McIntyre informed there had been additional changes to 2.6 and 3.2 in regards to changing the title to Portfolio Director. It was suggested to remove the sentence “Each of the four CCGs will nominate one lay member from their Governing Body as their fourth member” in 2.2 as this is covered in the previous statement. It was also noted in 8.1 the word should be respective, and not “retrospective”.

2.1.2 The Terms of Reference were agreed and signed off with the confirmed changes mentioned above. The Terms of Reference will need to be sent to each governing body with the monthly report.

2.2 **Place Based Commissioning Update – Sandwell and West Birmingham**

2.2.1 Andy Williams shared that in essence, they are trying to create a bilateral relationship between a strategic commissioning capability and a strategic provision capability. They are working on two sub-places, Western Birmingham and Sandwell, due to the accountability to Health and Well Being boards. Western Birmingham is working in partnership with Birmingham and Solihull CCG and Birmingham City Council. This is a geographical area bigger than the CCG. They are trying to establish a single place based fund and to define place based outcomes regarding transformation in health for population. The commissioners will be acting collectively, and the providers will be acting collectively. There is an emerging provider alliance for Western Birmingham that will work with the commissioner partners. This will be Primary Care, Secondary Care and the Voluntary sector. The accountability will be to the Birmingham Health and Well Being board. The trajectories are to be in a shadow form for the next financial year and formalise the year after. It was noted this is not procurement but a partnership. They will need to cement the provider alliance. There are existing Section 25 agreements that can be built on. This could be done by identifying a system integrator for coordination. There will be a long term agreement with a 5-10 year process. There will be a balance score card regarding outcomes which they will be held account for. This will include constitutional standards, legal requirements, a clear financial framework and experience. They will need to deliver against the entire score card to be successful.
2.2.2 There is the same pattern for Sandwell. However, this only includes one CCG. This will be a bilateral relationship for commissioning with the council. There will be a provider alliance and similar funding. There will be a single partnership for place with accountability for transforming healthcare for that place.

2.2.3 The progress includes a prototype for the balanced score card. This is due to be shared with partners over the next month. This proposed structure will be reflected in the commissioning intentions. The provider alliances in both Sandwell and Western Birmingham are beginning to mobilise. There will be reports to the Health and Well Being boards in September.

2.2.4 Andy Williams reflected on the last 5-10 years and the unintended flow from Sandwell and West Birmingham into Dudley and other parts of Birmingham. This needs to be properly quantified but could be as much as £10 million into Dudley, Sandwell and Western Birmingham. There will need to be initial relationships required to make that happen between Primary and Secondary Care. The impact on Walsall will be largely unchanged in regards to a flow into Walsall from unscheduled care and is reflected in the business case for A&E redevelopment. This still remains the intention. This structure includes the development of the Midland Metropolitan Hospital. The repatriation of activity from Dudley is predominantly elective. As this work develops, further details will be shared.

2.2.5 In regards to the Midland Metropolitan Hospital, the plan is still to mobilise the existing site/build. There has been resolution through the Trust board to pursue public funding as the preferred option due to the overall value of the public funding available and the lack of appetite in the market for PFI. There is movement for an enabling work contract which should result in work recommencing in the autumn. The new target date for completion is 2022. Public funding reduces the uncertainty on the date for completion.

2.2.6 There are tensions in the system regarding the exact nature of the relationship between commissioners of that system and the commissioners in the JCC. There is also uncertainty regarding the relationship between the two STPs. Andy Williams informed he has always been an active member of the Birmingham and Solihull STP. He is part of their Chief Executive Group and has been consulting on their strategic plan. This is important due to the relationship between the councils and the Health and Well Being boards as they are based on a locality basis and boundaries. The next milestones include adding this information into the commissioning intentions. The details have been shared with Walsall CCG as they are doing similar work so intelligence can be shared.

2.2.7 Andy Williams confirmed the outcomes framework will be the same for each area but the details of trajectory will be different. The first step will be to publish the framework and then to set place based trajectories for different measures. There will be work to sensitise these so they are suitable asks. The first public engagement event is due to take place tomorrow which will involve a joint stakeholder conference. The framework is likely to have resonance with local government.

2.2.8 Birmingham and Solihull CCG use traditional pathways such as thinking about a great start to life. However, it is important to enable a flexible provision response which means there will need to be movement between pathways. This is a big shift in regards to how commissioning is conducted. They are going to need to learn how to work in partnership over a number of years. There should be collaboration together with a purpose. There have been discussions on the integration of child and adult services. Andy Williams informed the plan is start broad and stay there but there may be some separate parts due to working with a procurement timeframe. The Clinical Leadership process is they are using existing processes but are creating within the partnership a clinical resource. The Medical Directors and Clinical Leads have been invited to create a clinical forum that will support this.
2.2.9 There were questions raised over the potential tension between the JCC and commissioners of this structure. Andy Williams suggested this is around the mechanism for commissioning at scale if a partnership has been made with the councils. The question was regarding how to scale this back up without causing tensions on the relationships already built and there being confusion on processes. This will have a place based focus but not at the expense of the whole system. This is possible but would need to be thought through.

2.2.10 Laura Broster questioned the commissioning intentions for the JCC and how these will be communicated to the providers. Mike Hastings informed the commissioning intentions of all four areas will be shared amongst others. There has been work with Paul Tulley and there is a template that will be sent. This will enable a clear view to be seen and a standardised narrative. There can be collective conversations with the public. Alastair McIntyre referred to the ICS roadmap work regarding population basis which are TCP, Mental Health, Maternity, Cancer, and Care Homes. This will involve engagement with Local Authorities.

2.3 Clinical Leadership Group Update

2.3.1 Alastair McIntyre informed there had been a meeting last week where the group looked at identifying the work that would be prioritised. Tim Cooper from the Quality Review Service has been supporting and is rewriting the strategy to reflect the feedback and highlight the areas of priority. There was an agreement on the appointment process for the Chair, whereby there would be expressions of interest and interviews with a panel including the Independent Chair, the STP SRO, the STP Lead Nurse, and another member of the CLG. There have been three individuals who have expressed interests. There is likely to be an appointment process carried out in September.

2.4 Programme Performance

2.4.1 Alastair McIntyre presented the monthly performance report from NHS England regarding the STPs. This includes the constitutional standards and comparison with other STPs. The assurance statements could be included when possible if the timeframes line up. Alastair McIntyre has met with Martin Stevens and Mike Hastings. There will be meeting with Chris Wood from NHS England regarding taking on own reporting and owning it.

2.4.2 There were questions raised regarding the usefulness of the reports. James Green suggested that the reports are visually helpful, with the donut charts highlighting how far off green they are. A suggestion was to have a narrative from each area. Mike Hastings suggested this can be done in two ways; by exception with focus on major issues or a rolling focus on each area. It was agreed there would be an analysis of exceptions and trends. These could then be presented to Boards with suggestions. There could be a deeper dive into areas with a focus on the issues discussed at the NHS England Risk and Review meetings. Mike Hastings noted that the STP Performance Group could identify the areas that would need to come to the JCC for review.

Action: Agreement to be made on the items of priority for discussion in regards to programme performance.

2.5 STP Performance Leadership/Programmes of Work

2.5.1 Alastair McIntyre informed this is a working progress. This is in regards to lining up the programmes of work that are business as usual to the high level ICS programmes. This will be populated with SROs and Leads for that work. There will be a full paper presented at the next JCC meeting.
2.6 Specialised Services

2.6.1 Simon Collings gave apologies for not attending previously as the JCC clashes with their Regional Board meeting. He reflected at the last meeting, he shared a spreadsheet regarding specialised commissioning at footprint levels and their spending. The Black Country spends £370 million per year; £150 million in Sandwell and West Birmingham and around £70 million in each of the other CCGs. The main providers are University Hospital Birmingham (UHB), Wolverhampton, Birmingham Women’s and Children’s Hospital (BWCH), and Dudley. Moving forward, the intention is to focus more of the work on the tier 1 and tier 2 providers. Tier 1 providers include UHB, BWCH and Birmingham and Solihull Mental Health Trust. Tier 2 includes Wolverhampton, Stoke and Coventry.

2.6.2 It was noted that throughout the region, there have been emerging provider alliances. The Specialised Commissioning budgets will be focused on the specialised lead provider within that alliance. There have been new care models for Mental Health. Key learning from the new care model for the West Midlands includes there has been a reduction in out of area placements, there has been a reduction in delayed discharges and better pace at dealing with quality issues. The clinicians have real time access to the data. The independent sector played a key role. They are starting to replicate the work for CAMHS although this is more complex as the Local Authority is more heavily involved. For the Black Country, Mark Axcell is leading. Steven Marshall will be attending on behalf of the STP.

2.6.3 Dr Helen Hibbs has met with Katherine O’Connell. It was noted there are specific areas in the Black Country for devolution. These include renal around dialysis, chemotherapy, cardiology, CAMHS, Children’s Mental Health and vascular. They are going to draft some outline proposals on what that would mean and how to approach it. The quickest vehicle would be to go through the provider but there are options around Communities Act. There is major work being carried out in Sandwell in regards to acute oncology. It was noted that the Sandwell oncology moved to UHB in October 2017. There has been public engagement and a request for the service to return to Sandwell and City Hospital. They are working through the proposition. There will be report back from mid-September. The aim for the repatriation is April 2019.

2.6.4 The specialised gynaecology surgery has a number of centres. These are in Stoke, Wolverhampton, Coventry and Sandwell. Last year, Sandwell informed they no longer wanted to provide this service. They sort expressions of interest to take on the service. There is complexity around transferring the service regarding continuation of care for patients. It was agreed Sandwell would remain a provider for two more years with Wolverhampton supporting. There are new algorithms for cancer and chemotherapy. They are working the network through the West Midlands for Hepatobiliary Cancer but this should not affect the Black Country.

2.6.5 There were questions raised regarding the spinal deformity work timeframe. Simon Collings informed they are reviewing the 52 week wait list. This has been reduced down to 42 patients from 152. They are ahead of trajectory for reduction. They will then review transfer. This has switched over to providers to deliver. This is on target. In the meantime, paediatrics have become unstable, therefore HEFT are providing 24 hour cover.

2.7 Risk Register

2.7.1 This was deferred until the September JCC.

3. FORMAL DELEGATION

3.1 Risk Register
3.1.1 This was deferred until the September JCC.

3.2 Transforming Care Partnership (TCP)

3.2.1 Mike Hastings discussed the TCP report provided as Dr Helen Hibbs was meeting the four Directors of Adult Social Care regarding TCP. Dr Helen Hibbs has attended a Regional development event with Ray James. The Black Country and Birmingham and Solihull STPs are rated red, and are part of the only three in the country. There have been patient discharges but there are still admissions occurring. There is a new Programme Director who has been appointed until April 2019. There is a big push to work more closely with communities. The support market needs to be stimulated and better developed. They are working closely with Specialised Commissioning and are initially looking at Walsall.

3.2.2 James Green presented on a paper provided; Black Country Transforming Care Programme, Report to the Joint Commissioning Committee (JCC) upon the Allocation of Resources Transferred from NHSE. In March 2016, there were 62 patients which is the cohort the Black Country is responsible for. For each patient that is transferred from Specialised Commissioning, the Black Country receives £180,000. The funding is on a net discharge basis. If one patient is readmitted, the proportion is reallocated. They raised the need for clarification of the 62 and it was confirmed it should be 63. However, at the moment this will not be adjusted. There is no national agreement on Children’s. The FTA process is for Adults only. They think CAMHS has been captured in the transfer which could be netting down resources. CAMHS are usually short term admissions. Simon Collings noted CAMHS is mainly around autism at the moment. This can give volatile admission profiles. The net impact can skew the data. There are more admissions as there is more awareness around autism now.

3.2.3 James Green informed Table 2 on page 3 referred to the distribution of money. They are proposing the funding be on gross discharge basis due to the volatile admissions skewing the data. Table 3 highlights the Local Authority and CCG estimates. Page 4 gives options for splitting the resource. The preferred option is 5 where in 2018/19 for discharges to a community setting between 1st April 2016 and 31st March 2019, the resource follows the patient to Local Authorities and the CCGs operate a risk pool for the remaining financial balance based on gross discharges. As a back-up, the next option is 6 where the risk share is between the Black Country Local Authorities and CCGs. The CCGs would take 100% risk of readmission. Simon Collings noted that with the discharge profile from quarter 3 to 4, if there is a spike in admissions, option 5 could put pressure on the CCGs. However with the £3.6 million funding, this risk can be reduced. With option 6, this requires more maintenance with regular reviews. This could be difficult to get the Local Authorities to agree to.

3.2.4 Julie Jasper noted credit should be given to the team that provided all the options available. It was confirmed all councils need to agree the same option for this to move forward. There have been general discussions on resources with the Local Authority finance representatives. These options have not been discussed at the Finance and Activity group. Matthew Hartland informed he had attended the Dudley OSCs meeting and there had been no discussion on finances and was more around the closure of beds. Laura Broster noted there need to be a willingness from officers to adopt. It was confirmed the risk sharing had not been done in the Black Country before. James Green confirmed there are other joint funding packages. The clinical dialogue will drive this.

3.2.5 It was confirmed the recommendation will be option 5 with option 6 as a back-up. It was confirmed Dr Helen Hibbs has seen the proposal. There will need to be a formal link with CCGs.
Actions:
The Chief Finance Officers to send the report regarding the allocation of resources transferred from NHS England for the Transforming Care Partnership to all private governing bodies for review and then to the TCP board.
A review of the delegation details of the Transforming Care Partnership to the JCC to be completed.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 There were no comments or issues raised.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 Joint Executive Development Session – September 2018

5.1.1 Andy Williams suggested there needed to be a discussion on strategic commissioning. He suggested there are two views; differentiate on a service by service area that would be commissioned at scale or through functions such as risk, allocating resource and accountability. Simon Collings noted with Specialised Services, they manage risk on a West Midlands footprint. If there was a strategic commissioner that held the budgets into the CCG budgets that pushed them down into place base, this would allow risk to be managed. This could not work at a local level and will need to be taken into account. Simon Collings also questioned whether there is a single provider for Specialised Commissioning as it is easier to devolve a budget into a provider. It was agreed Strategic Commissioning would be the topic for discussion for the September JCC Joint Executive Development Session on 20th September 2018.

Action: Alastair McIntyre to meet with the Accountable Officers to discuss the agenda for the Joint Executive Development Session in September which will include commissioning intentions and strategic commissioning.

5.2 Personalised Care

5.2.1 Laura Broster informed there was concern regarding reaching the Personal Health Budget (PHB) target of 900. In quarter 1, only 176 were made. The CHC assessors are the leads. There is concern that during the winter pressures, their focus will be split. There is an opportunity of gaining 600 through wheelchair patients. Laura Broster proposed an agency member from Sandwell and West Birmingham CCG to shift focus to PHBs. There is a risk around the programme regarding the assurance to NHS England.

5.2.2 There is a West Midlands Chief Finance Officers workshop regarding PHBs. There is also a Regional and Strategy event. There needs to be the right people attending. There will be a request submitted regarding attendance. Julie Jasper informed with Sandwell and West Birmingham they had a monthly PHB board. It was confirmed from the 1st April 2019, the first offer to a patient will be a PHB rather than a wheelchair. Therefore there will be change in the process. Alastair McIntyre suggested PHBs could be another STP level commissioning intention.

Action: Laura Broster to send individual Personal Health Budget targets for each locality to each organisation.

6. DATE OF NEXT MEETING

Thursday 13th September, 10:00-12:00, Meeting Room 1, Ground Floor, Kingston House, 438-450 High Street, West Bromwich, B70 9LD
<table>
<thead>
<tr>
<th>No.</th>
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<tbody>
<tr>
<td>075</td>
<td>10th Jan 2018</td>
<td>James Green and Matthew Hartland to develop a plan on how to undertake the necessary diligence to support the Black Country STP becoming an ICS in the future, for report back at the July JCC meeting.</td>
<td>James Green and Matthew Hartland</td>
<td>06/09/18 – This is being undertaken by Matthew Hartland.</td>
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<td>091</td>
<td>22nd Mar 2018</td>
<td>Clinical chairs to discuss CLG links into workstreams and the PMO to ensure there is no duplication of work.</td>
<td>Dr Anand Rischie</td>
<td>21/06/18 This will follow up with the refreshed clinical strategy and regular updates</td>
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<td>092</td>
<td>22nd Mar 2018</td>
<td>Paul Maubach to share details of the new Dudley MCP Foundation Trust once the case is finalised circa July.</td>
<td>Paul Maubach</td>
<td>21/06/18 This will be available in August.</td>
</tr>
<tr>
<td>095</td>
<td>22nd Mar 2018</td>
<td>Angela Poulton to support Prof Nick Harding to produce a refreshed clinical strategy to identify priority areas and how to progress delivery, for presentation at a future meeting.</td>
<td>Angela Poulton and Nick Harding</td>
<td>21/06/18 1st draft being discussed at CLG meeting 29/06/18. Report to July JCC.</td>
</tr>
<tr>
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<td>10th Apr 2018</td>
<td>Local Authority representatives to be invited to the Clinical Leadership Group meetings.</td>
<td>Charlotte Harris</td>
<td>21/06/18 This is on hold until the Clinical Strategy is finalised.</td>
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<td>098</td>
<td>10th Apr 2018</td>
<td>Prof Nick Harding to ensure the acute sustainability findings informs the work of the Clinical Strategy.</td>
<td>Nick Harding</td>
<td></td>
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<td>099</td>
<td>10th Apr 2018</td>
<td>Prof Nick Harding as Chair of the Clinical Leadership Group to write to all Trusts requesting representation at meetings.</td>
<td>Nick Harding</td>
<td>21/06/18 This is on hold until the Clinical Strategy is finalised.</td>
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<tr>
<td>100</td>
<td>10th Apr 2018</td>
<td>Dr Anand Rischie to discuss with Prof Nick Harding how to engage Local Authority colleagues in the work of the Clinical Leadership Group, including the working groups, before the next JCC meeting</td>
<td>Anand Rischie</td>
<td>21/06/18 This is on hold until the Clinical Strategy is finalised.</td>
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<tr>
<td>102</td>
<td>10th Apr 2018</td>
<td>Prof Nick Harding to include clinically based commissioning for outcomes as an agenda item for the Clinical Leadership Group.</td>
<td>Nick Harding</td>
<td></td>
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<tr>
<td>109</td>
<td>21st June 2018</td>
<td>Dr Rischie to schedule a meeting between the clinical Chairs to review the draft Clinical Strategy</td>
<td>Anand Rischie</td>
<td></td>
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<tr>
<td>111</td>
<td>21st June 2018</td>
<td>Alastair McIntyre, Paul Maubach and Jim Oatridge to populate the Risk Register</td>
<td>Alastair McIntyre, Paul Maubach and Jim Oatridge</td>
<td>23/07/18 – Meeting to be arranged in September.</td>
</tr>
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<td>114</td>
<td>12th July 2018</td>
<td>Prof Nick Harding to share the second iteration of the clinical sustainability review requested by Kiran Patel for the October JCC meeting.</td>
<td>Nick Harding</td>
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<td>116</td>
<td>12th July 2018</td>
<td>Alastair McIntyre to provide the service change programme for the Black Country from NHS England perspective.</td>
<td>Alastair McIntyre</td>
<td>20/07/18 – being reviewed on 25/07/2018.</td>
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<tr>
<td>118</td>
<td>9th August</td>
<td>Matthew Hartland to present the high level indicators for Walsall and Dudley regarding potential financial impacts at the September JCC meeting.</td>
<td>Matthew Hartland</td>
<td></td>
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<tr>
<td>119</td>
<td>9th August</td>
<td>Alastair McIntyre to meet with the Accountable Officers to discuss the agenda for the Joint Executive Development Session in September which will include commissioning intentions and strategic commissioning.</td>
<td>Alastair McIntyre</td>
<td>30/08/18 – Draft agenda to be brought to the JCC on 13/09/18</td>
</tr>
<tr>
<td>120</td>
<td>9th August</td>
<td>Agreement to be made on the items of priority for discussion in regards to programme performance.</td>
<td>Anand Rischie and Alastair McIntyre</td>
<td>30/08/18 – Paper to be tabled at JCC on 13/09/18</td>
</tr>
<tr>
<td>121</td>
<td>9th August</td>
<td>The Chief Finance Officers to send the report regarding the allocation of resources transferred from NHS England for the Transforming Care Partnership to all private governing bodies for review and then to the TCP board.</td>
<td>James Green and Matthew Hartland</td>
<td>06/09/18 – The report has gone to SWB CCG Governing Body and it has been approved. The report will be taken to Wolverhampton (11th) and Walsall (18th).</td>
</tr>
<tr>
<td>122</td>
<td>9th August</td>
<td>A review of the delegation details of the Transforming Care Partnership to the JCC to be completed.</td>
<td>Anand Rischie and Alastair McIntyre</td>
<td>30/08/18 – Verbal update at next meeting</td>
</tr>
<tr>
<td>123</td>
<td>9th August</td>
<td>Laura Broster to send individual Personal Health Budget targets for each locality to each organisation.</td>
<td>Laura Broster</td>
<td>29/08/18 – Completed</td>
</tr>
</tbody>
</table>
Black Country and West Birmingham Joint Commissioning Committee (JCC)

Minutes of Meeting dated 13th September 2018

Members:
Dr Anand Rischie – Chairman, Walsall CCG
Andy Williams – Accountable Officer, Dudley CCG & Walsall CCG
Paul Maubach – Accountable Officer, Dudley CCG & Walsall CCG
Dr Helen Hibbs – Accountable Officer, Wolverhampton CCG
Dr David Hegarty – Chair, Dudley CCG
Prof Nick Harding – Chair, Sandwell & West Birmingham CCG
Dr Salma Reehana – Chair, Wolverhampton CCG
Matthew Hartland – Chief Finance and Operating Officer, Dudley CCG; Strategic Chief Finance Officer Walsall and Wolverhampton CCG’s
James Green – Chief Finance Officer, Sandwell & West Birmingham CCG
Alastair McIntyre – Portfolio Director Designate, Black Country and West Birmingham STP

In Attendance:
Charlotte Harris – Note Taker, NHS England
Helen Cook – Communications and Engagement, Wolverhampton CCG

Apologies:
Julie Jasper – Lay Member, Dudley CCG and Sandwell and West Birmingham CCG
Jim Oatridge – Lay Member, Wolverhampton CCG
Peter Price – Lay Member, Wolverhampton CCG
Mike Abel – Lay Member, Walsall CCG
Paula Furnival – Director of Adult Social Care, Walsall MBC
Simon Collings – Assistant Director of Specialised Commissioning, NHS England

1. INTRODUCTION

1.1 Welcome and introductions as above.

1.2 Apologies noted as above. It was noted that the meeting membership was not quorate. Therefore, this meeting would only consist of updates on items on the agenda and no decisions would be made.

1.3 Dr Anand Rischie asked the committee if anyone had any declarations of interest they wished to declare in relation to the agenda of the meeting. Prof Nick Harding informed he had declared an interest in the Clinical Leadership Group Chair position.

1.4 The minutes of the meeting held on the 9th August were agreed as an accurate record of the meeting, with the following amendments; in section 2.2.6 it should read, “Andy Williams informed he has always been an active member of the Birmingham and Solihull STP.” Dr David Hegarty requested in regards to item 2.3.1; that he be on the panel for the interviews for the Clinical Leadership Group Chair. It was also noted that in the August JCC, it was agreed that the Chair for the JCC tenure will be 12 months. Therefore, from February, Dr Salma Reehana will take over.

Action: Charlotte Harris to confirm when the interviews for the Clinical Leadership Group Chair are and inform Sally Roberts that Dr David Hegarty requests to be on the panel for the interviews.
1.5 The action register was reviewed (see table at the end of the notes). Actions delivered were confirmed and others taken within the agenda.

1.6 In regards to 102, Prof Nick Harding suggested that chronology is important. The Clinical Strategy will need to be finalised, then the Clinical Leadership Group Terms of Reference and membership agreed. This action will continue to be pending depending on Clinical Leadership Group approval and the appointment of the Chair.

1.7 In regards to 114, work is currently being done. Prof Nick Harding informed NHS Improvement had requested a sustainability review of the trusts. This has been completed but has not yet been shared with I commissioners. It will be shared in due course via the STP/ICS.

1.8 In regards to 120, there will be the same report presented to the JCC and the STP.

**Action:** Sustainability and Vulnerable Services reviews to be added as an agenda item for the Health Partnership Meeting being held on 17th September 2018.

2. **MATTERS OF COMMON INTEREST**

2.1 **Place Based Commissioning Update – Wolverhampton**

2.1.1 Dr Helen Hibbs referred to the update Steven Marshall gave at the last JCC Development Session. It was noted a paper that went to governing body on 10th July 2018 can be found on their website. The Wolverhampton Alliance is being built from the bottom up and is being clinically led and managerial supported. There are monthly meetings where half of it has clinical items, such as discussions on pathways, and the other half has governance items, including terms of reference and transparency of resource allocation. The purpose of the alliance is to. Work in an integrated way and underpinning this will be the ability to move resource from the acute setting, into the community and Primary Care. Around the table there is Mental Health provider, acute and community provider, the local authority and the GP groupings. Salma Reehana and Jonathan Odum are the co-chairs, ensuring that this is clinically focused. The work with the CCG feeds into this.

2.1.2 They are currently at the point of nearly signing the risk share agreement with Royal Wolverhampton Trust (RWT). This puts the financial flows into blocks. There will be a fixed costs block which will predominantly be non-electives. There will be other blocks for a risk and gain share around the elective activity, cost and volume which includes A&E, and cost reduction which is predominantly medicines. Once this is signed and agreed, it will allow money to be moved from one to another. A key principle for the alliance working is having financial transparency. This change in relationship will take time. All partners are brought into working in this new way.

2.1.3 The clinical pathways that are being focused on in the first instance are End of Life Care, Frailty, Paediatrics, Mental Health and Urgent and Emergency Care. End of Life Care have a clear working group and there is a lot of work being done on it. They have Compton, Local Authority colleagues and the GP groupings all brought into this. The trust are about to open a new Ambulatory Frailty Front Door Unit. In addition to that they are looking at the whole Frailty Pathway. They are reviewing how their GPs manage Frailty, with one of their practices doing a lot of work on this and with Frailty Clinics in Primary Care. There are questions around whether this would be rolled out across the rest of the GP groupings. Urgent and Emergency Care is a bit more complex and a bigger system thing. A lot of this work is done through the A&E Delivery Board which already functions well. Once the pathways are set up and money can start moving then this will provide confidence to the
other GP groupings and more pathways can be developed. The model should work because RWT is getting more tertiary referrals. Therefore this is not about closing beds in the trust. They are continually attracting more work and therefore need more capacity. This works for Primary Care too as now their Networks are formed, they are looking to do more work together.

2.1.4 Dr Salma Reehana informed the meeting that the alliance is working on data sharing for the benefit of population management, as well as the clinical pathways that will work for a patient at that level. This is sharing data between the trust, Primary Care, Local Authority, and Health and Social Care. They are using Graphnet. They are experiencing some difficulties with ‘Information Governance’ agreements. The plan is to ask their Information Governance support to help write the agreements.

2.1.5 There is a well advanced Better Care Fund (BCF) workstream. This is wrapping community services around the practices and practice groupings, and working in a MDT way. It was noted that the council are predominantly involved with the BCF but this will become more part of the place based arrangements. They are reviewing an outcomes framework based on the Canterbury, New Zealand one. The Chief Nurse in RWT has worked in that system. There are aiming to start the patient engagement work in November. There is a more robust PMO arrangement around delivery of the alliance. A member of staff from the trust is working with the CCG PMO. The GPs are well engaged. They are making good progress.

2.1.6 It was suggested that it would be beneficial to understand the contractual arrangements. It was agreed that once this was signed off it could be shared with the committee. It was noted that the Risk Share agreement needs to benefit each party and should not destabilise either party. This year it should be in shadow form, with it going live in 2019/20.

2.2 Performance

2.2.1 Alastair McIntyre presented the monthly performance report from NHS England regarding the STPs. This includes the constitutional standards and comparison with other STPs. It was noted there is an issue with some of the data not being in the public domain and this is therefore not for dissemination.

2.2.2 Martin Stevens will be presenting the CSU Performance Tool to the Health Partnership on Monday 17th September 2018. This will allow a single report (with narrative) to come the both the JCC and the STP.

2.3 Risk Register

2.3.1 This was deferred until the October JCC.

2.4 Walsall and Dudley Integrated Care Systems and Financial Risks Discussion

2.4.1 Matthew Hartland informed the committee this work was in response to action 092. The Dudley MCP is going through the ISAP Assurance process at the moment. Matthew presented a diagram showing the financial flows for the Dudley system. The diagram highlighted each key participant and the financial flows into the proposed Dudley MCP. It was noted that there would be no material impact on NHS Dudley Group FT. It was noted that for Dudley Metropolitan Borough Council, that the diagram should state Public Health and not ‘continuing care’. The diagram also showed the allocation of resource.

2.4.2. Matthew Hartland presented a diagram regarding the financial flows for the Walsall integrated care system. It was noted that the numbers shown were draft and that this was a work in progress. In the proposed model providers will have two contracts until the alliance
has formed. It is expected that this will be in shadow form from April 2019 until April 2020. There is a challenge to the programme board as this may not be enough time for the Business Case being developed in November. The risk and gain share between partners is being worked through as a separate programme.

2.4.3 It was suggested that there is a need to highlight the substantive differences between the two systems and their consequences. Sandwell and West Birmingham and Wolverhampton systems will be presented at the October JCC meeting. Paul Maubach suggested once this has been mapped, it can then review assumptions for the next five years. The meeting considered whether other sources of income to the trusts could be shown.

2.4.4 Matthew Hartland presented a draft of the Black Country Risk Analysis. It was agreed that this will be brought back to the next JCC meeting for agreement. The next steps are to view other areas, change over time, and view by provider. This will be presented on separate diagrams.

3. FORMAL DELEGATION

3.1 Risk Register

3.1.1 This was deferred until the October JCC.

3.2 Transforming Care Partnership (TCP)

3.2.1 Dr Helen Hibbs informed that the NHS England deep dive had gone well. However, they are still required to go to the deep dive with the National Director, Ray James. There is a target of having nine discharges per quarter. In Q2, they had ten. They currently have plans for nine discharges in Q3 and eight in Q4. They have two patients on the cohort with no predicted discharge dates. There are 13 patients that have been identified as being discharged post programme. Two have been highlighted as green; and potentially the discharges may be able to be brought forward into the programme. Nine have been highlighted as amber; they might be able to be discharged by the end of the programme. Unfortunately, in the last two days there have been three admissions; one in Sandwell and West Birmingham, Wolverhampton and Walsall. Root cause analysis are being done to look at potential lessons that can be learned.

3.2.2 Daisy Bank has now been closed and the last patients moved. The trust has their community model up and running. The community model should be increasingly mobilising to prevent admissions. There has been lots of work with the care and support market. Wolverhampton Local Authority has led a procurement exercise and there have been five forensic providers appointed to a framework which can be used across the Black Country. The relationship with Specialised Commissioning has improved. There has been some increased case management around the responsibility of NHS Specialised Commissioning patients. There is a plan to discharge all the children that are mainly in Walsall CCG within the programme, except one that will become an adult within the year. The programme has worked well but the numbers are not reducing enough for the NHS England target due to the continued admissions.

3.2.3 Matthew Hartland suggested reviewing admissions and whether if the community model was in place, would this have prevented them. It was confirmed that there is a root cause analysis being carried out on all new admissions.

3.2.4 Prof Nick Harding suggested whether there were any other meetings that the programme needed to be discussed at. Dr Helen Hibbs noted that they have been articulating to NHS
England and Katherine Hudson, the programme manager, how seriously we are all taking the programme.

3.2.5 The paper on the financial aspects of the discharge programme is being sent to boards. Matthew Hartland informed the FTA process was previously agreed at the JCC and is being sent to governing bodies. They have had a conversation with councils, but the final offer will not be made until all governing bodies have signed off on the process. It was noted there have been no recent delays for patient transfers due purely to finances. The councils are all represented on the TCP board. The paper has been to Sandwell and West Birmingham, Wolverhampton and Dudley. It is due for discussion at Walsall next week. After this, it will go back to the TCP board and there will be discussions with the local councils.

4. SUBGROUPS UPDATE (CONSENT AGENDA)

4.1 There were no comments or issues raised.

5. SUMMARY OF ACTIONS AND ANY OTHER BUSINESS

5.1 Joint Executive Development Session – September 2018

5.1.1 There was a discussion on the agenda for the JCC Development Session next week. It was suggested there be an hour on Commissioning Intentions as the recent STP Stocktake with NHS England highlighted this as an item for concentration and there has been some discussions on joint work. There will also be Strategic Commissioning on the agenda. It was suggested that Mike Wallace from PWC could facilitate this part. The senior commissioners for each CCG could facilitate Commissioning Intentions with a focus on what approach each CCG is using. It was suggested there be a discussion on the ICS route map. There was a suggestion to link to the 10 year plan agenda and to cross reference with Mental Health, Learning Disabilities, Primary Care, Long Term Conditions and Cancer themes. It was noted that Personalised Care will link into Long Term Conditions. Dr David Hegarty will chair the session.

5.2 Black Country Service Change Programme

5.2.1 Alastair McIntyre presented the current Black Country Service Change Programme. He suggested that the Active Black Country Schemes Summary was the most important information. It was noted that Walsall Together and West Park needed to be included. The Sandwell and West Birmingham Vanguard will be removed. The table will be recirculated to members add any other programmes that had been missed.

6. DATE OF NEXT MEETING

Thursday 11th October, 10:00-12:00, T051, Third Floor, BHHSCC, Venture Way, Brierley Hill, DY5 1RU
<table>
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<td>12th July 2018</td>
<td>Prof Nick Harding to share the second iteration of the clinical sustainability review requested by Kiran Patel for the October JCC meeting.</td>
<td>Nick Harding</td>
<td></td>
</tr>
<tr>
<td>122</td>
<td>9th August 2018</td>
<td>A review of the delegation details of the Transforming Care Partnership to the JCC to be completed.</td>
<td>Anand Rischie and Alastair McIntyre</td>
<td>30/08/18 – Verbal update at next meeting</td>
</tr>
<tr>
<td>124</td>
<td>13th Sept 2018</td>
<td>Charlotte Harris to confirm when the interviews for the Clinical Leadership Group Chair are and inform Sally Roberts that Dr David Hegarty requests to be on the panel for the interviews.</td>
<td>Charlotte Harris</td>
<td>Completed 14/09/18</td>
</tr>
<tr>
<td>125</td>
<td>13th Sept 2018</td>
<td>Sustainability and Vulnerable Services reviews to be added as an agenda item for the Health Partnership Meeting being held on 17th September 2018.</td>
<td>Alastair McIntyre</td>
<td>Completed 17/09/18</td>
</tr>
</tbody>
</table>
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Board:** 8 November 2018  
**Report:** Quality & Safety Committee Report  
**Agenda item No:** 7.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Quality &amp; Safety Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board of key Quality and Safety issues discussed at the Quality &amp; Safety Committees on 18 September and 16 October 2018 and in other associated meetings</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs Caroline Brunt, Chief Nurse</td>
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<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs Caroline Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr Ruth Edwards, Clinical Executive Lead for Quality</td>
</tr>
</tbody>
</table>
| KEY POINTS: | Dudley Group NHS Foundation Trust (DGFT)  
- Emergency Department  
- System Oversight and Assurance Group  
- Mortality  
- Cancer waits  
- Serious Incidents (SIs) management and Root Cause Analyses (RCAs)  
- Staffing and Leadership  
- Maternity Performance and Assurance Group  
  
Dudley Walsall Mental HealthTrust (D&WMHT)  
- CQC inspection  
  
Black Country Partnership Foundation Trust (BCPFT)  
- Transforming Care Programme (TCP) and update on Dudley position  
  
Malling Health – Urgent Treatment Centre  
- Assurance and operational reviews  
  
Updates on:  
- Ramsay West Midlands Hospital  
- Primary Care  
- Infection Prevention & Control (IPC)  
- Wheelchair Services  
- Risk Register |
| RECOMMENDATION: | To accept this report, recognising the limited assurance that is currently available regarding DGFT and that the CCG Quality & Safety Committee and associated work-streams continue to maintain rigorous oversight of all clinical quality standards in line with the CCG’s statutory duties |
| FINANCIAL IMPLICATIONS: | None to report |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | User experience is an essential component of quality assurance and surveillance and as such public views and feedback form part of the triangulation of hard and soft intelligence |
| ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: | None to report |
| ACTION REQUIRED: | ✓ Assurance |
1.0 INTRODUCTION

The report summarises the key issues discussed by the Quality & Safety Committee at its meetings on 18 September and 16 October 2018 and contains details of activity being carried out by the Quality and Safety team alongside relevant information acquired since the last committee meeting.

2.0 DUDLEY GROUP NHS FOUNDATION TRUST (DGFT)

Discussions took place at the Quality and Safety Committees highlighting the CCG is not currently assured by the information that is being submitted by DGFT to the CQRM; the Trust have provided a number of Quality and Safety papers which inconsistently report activity, alongside failing to identify and report themes and trends regarding quality and safety issues. The DGFT Medical Director has agreed to a joint review of assurance documentation and quality reports which offers an increased quality of information and assurance.

The Quality & Safety Committee reviewed the CCGs newly developed quality dashboard for DGFT and the following areas were discussed;

- Emergency Department activity, performance and quality and safety concerns
- Hospital mortality data
- Cancer wait information
- Serious Incident (SI) investigations and quality of Root Cause Analysis
- Staffing & leadership

2.1 Emergency Department

**Background:**

There have been five Care Quality Commission (CQC) visits to the Emergency Department (ED) in recent months, as reported in detail in the previous (August 2018) Board paper; the ED continues to be rated as inadequate.

The issues include:

- Sepsis management;
- Lack of recognition of deteriorating patients;
- Safeguarding of children and young people;
- Clinical staff members lacked understanding of National Early Warning Score (NEWS);
- Appropriate and timely triage;
- Staffing levels and competencies;
- Specific concerns regarding the clinical oversight of patients in the waiting room area.

On 8 and 9 August 2018 the CQC returned to the Emergency Department to undertake the fifth unannounced focused inspection of all areas of the department and undertook a retrospective review of records of patients who had received treatment in the department since 1 July 2018. During the inspections the previous concerns remained evident.

The report from the August 2018 inspection, was published on 17 October. The most recent report published is available at https://www.cqc.org.uk/location/RNA01

2.2 System Oversight and Assurance Group

Since 27 February 2018 an Oversight and Assurance Group has met with all relevant stakeholders represented. The meetings are now bi-weekly with partners from DGFT; NHSI; NHSE; CQC and the CCG.

DGFT is required to evidence improvements regarding the safety of patients attending the Emergency Department. Whilst there is an acknowledgement of improved data quality received from the Trust, the
NHSI, NHSE, CQC and CCG recognise that there is a lack of pace regarding the required improvement and a number of targets are not being achieved.

While there had been concerns regarding false positive assurance, an external independent review by the Emergency Care Intensive Support Team (ECIST) has been undertaken to validate DGFT audits and self-reporting processes; these have been confirmed as appropriate.

The Trust is continually working through improvement cycles and implementing monitoring mechanisms; for example electronic sepsis observations have now been introduced. This system enables effective tracking of all patients and offers an audit trail for monitoring once fully embedded across the organisation.

**External Support to DGFT:**
NHSI and STP support continues including specific peer to peer provider support from the Royal Wolverhampton NHS Trust. This includes leadership support and development of senior nurses; sharing of best practice; and educational and training opportunities so that staff can observe ED practices across both Trusts.

DGFT is also receiving ongoing support from ECIST by deploying a range of service improvement techniques to support triage and flow within the ED. A further system-wide workshop has been undertaken with CCG input, in addition to a workstream called ‘the perfect week’ in October, which is aiming to identify the required improvements through ways of working differently.

**CCG actions and assurance:**
The CCG business intelligence team analyse DGFT data weekly to assess the level of assurance against the CQC Section 31 requirements. Whilst there has been significant effort noted from DGFT, the overall level of assurance is limited.

The CCG undertook a governance assurance visit on 28th September 2018; the report will be with the Trust for accuracy checking until 31st October 2018.

Members of the quality and safety undertook a walk-through of the Sepsis pathway within the ED department accompanied by the Medical Director and representatives from the DGFT sepsis team. The visit aimed to establish the current position in terms of sepsis documentation and use of the e-sepsis system.

A follow up unannounced visit by the CCG designated nurses for safeguarding to ED is planned.

### 2.3 DGFT Mortality data

There were concerns noted regarding the Summary Hospital level Mortality Index (SHMI) which has reported an increase. It was noted that there has been a change in the manner in which the information is reported nationally which might partly be responsible for the rise. Further information will be sought from the Trust for assurance purposes and an independent review of mortality is still awaited.

**CCG actions and assurance:**
- The CCG continues to review the Learning from Deaths reports provided by DGFT at CQRMs and challenge where there is a lack of evidence of learning
- Intrauterine deaths, stillbirths and neonatal deaths are monitored through the Maternity Performance and Assurance Group alongside the CCG being represented at the Child Death Overview Panel
- CCG designated nurses lead investigations into domestic homicide, deaths of patients with learning disabilities and child deaths
- Serious Incident (SI) investigation and root cause analysis findings associated with deaths are reviewed to ensure appropriate learning
- The CCG Clinical Lead for Quality and Safety attends the joint mortality review group
- The CCG will be seeking assurance that any issues identified within the independent review of mortality will be addressed.
2.4 Cancer waits

There are currently 21 patients on a 62 day pathway waiting 104 or more days. While the Trust currently undertake a weekly assessment of all 104 day waits, a full investigation has been requested for all patients who have waited in excess of 104 days to confirm that patients came to no harm; this information forms an integral part of the Remedial Action Plan (RAP) to address under performance. Work also continues with the cancer alliance regarding urology pathways which contributes significantly to the longest waits.

CCG actions and assurance:
- The CCG is agreeing a new dataset for information to be reported by DGFT to the CCG to meet the requirements of the quarterly reporting to the Quality Surveillance Group.
- The review of RCAs related to cancer breaches is now directed through the cancer Local Implementation Team (LIT) meeting Chaired by the CCG lead for End of Life Care and Cancer, to increase the assurance associated with these processes.

2.5 Serious Incident (SI) management and Root Cause Analyses (RCAs):

As of 23rd October, DGFT had a total number of 94 SIs.
- 41 are currently overdue including 37 pressure ulcer incidents which are due for closure in the next 2 weeks once a ‘dip test’ of RCA quality has been completed by the Q&S team.
- 53 are not yet due and are currently being managed within the timeframe

There have been ongoing concerns regarding the effectiveness of the serious incident investigations being undertaken by DGFT and their failure to meet the agreed KPIs. In recent weeks jointly agreed changes have been introduced following a peer review to support the required improvements, these include:

- CCG support for submission of a cohort report addressing the root cause analysis associated with 37 long standing pressure ulcers incidents and agreement of an effective action plan to address the emerging themes which will be monitored via CQRM.
- Joint reviews of ten longstanding complex SIs, with GP input from the CCG and Deputy Medical Director input from DGFT with themes such as sub-optimal care of the deteriorating patient and delayed diagnosis. Some of the RCA’s require further investigation, due to ineffective RCA processes and methodology, whilst others require clarification, prior to closure. However clear agreements have been reached regarding the additional information that is required and the timelines for reports to be submitted.

It is expected that these joint actions will result in a significant reduction in the number of open SIs by the end of November 2018.

An additional assurance review related to SI management was undertaken by NHSE on 21st August 2018. The report and the action plan agreed with NHSE was discussed and finalised at Quality & Safety Committee.

CCG actions and assurance:
Future KPIs will be included in the contracting round to create contractual implications if historical failure to achieve significant and sustained improvement is ongoing.

The CCG is undertaking a review of its internal processes for the oversight of SI’s in order to streamline and minimise the amount of administrative focus, with the short term appointment of a specialist in this area to work with the Quality and Safety team from November 2018 to January 2019.

The CCG has undertaken an assurance visit to DGFT, to review governance processes, including the Trust processes for managing all incidents including serious incidents. The report has been shared with the Trust for factual accuracy and a response is expected by 2nd November 2018.

A joint workshop is planned for 30th November 2018 to identify more effective ways of working toward timely management and closure of SIs. The key aims of these activities are:

- To gain assurance on internal incident management systems
• To gain assurance on how governance processes demonstrate continuity from ‘ward to board’
• Evidence of learning being shared and implemented
• To gain assurance on recent changes in ED regarding governance and incident identification
• To include a review of clinical governance processes and executive oversight, ED and a number of speciality areas, yet to be confirmed

2.6 Staffing & Leadership:

The workforce is being closely monitored. A review using a number of different data sources triangulated concerns regarding staffing, both in terms of safe staffing levels and management.

The Trust is currently recruiting additional ED consultant posts and a number of newly qualified nursing staff have been appointed and will benefit from a joint induction process with RWHT.

Information sources being used include:
• Staff & patient Friends & Family Tests (FFT) results
• Staff resignations
• Public staff concerns (including publication in the media)
• CQC ED assurance data

CCG actions and assurance:
Ongoing triangulation of data sources to gain further assurance by comparing different information sources including incidents, patient experience, PALs activity, complaints.

2.7 Maternity Performance and Assurance Group (MPAG):

Following release of all relevant clinical records, the DCCG external obstetric advisor has been able to complete his review. He met with DGFT’s new Clinical Director for Obstetrics & Gynaecology on the 24th September 2018 to discuss the main themes and ongoing concerns which were identified in the 2016 Maternity Quality Improvement Board (QIB).

All outstanding 2016/2017 Maternity SIs have been closed and ongoing assurance will be managed through MPAG with feedback and escalation via the DGFT CQRM.

Significant concerns have been raised via DGFT CQRM regarding the absence of a comprehensive audit programme within the maternity and neonatal services to ensure robust service level quality assurance. Assurance relating to a clinical audit programme has been requested repeatedly by the CCG over the last nine months.

CCG actions and assurance:
• Ongoing external scrutiny of maternity SIs, utilising appropriate clinical expertise
• Escalation regarding the lack of assurance associated with a comprehensive clinical audit programme
• Ongoing monitoring of maternity and neonatal service level performance through MPAG to CQRM.

3.0 DUDLEY & WALSALL MENTAL HEALTH TRUST (D&WMHT)

The CQC completed an inspection of inpatient wards; the Children and Adolescent Mental Health Service; home treatment; crisis and early intervention services. The initial feedback reported by D&WMHT suggests the inspection was positive. A well led review is planned for November 2018.

CCG actions and assurance:
Through the CQRM the Quality and Safety team are focusing on a specific inpatient ward training compliance levels. The CCG has requested Director level assurance to ensure that training is prioritised and appropriate levels of compliance achieved.
4.0 BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST (BCPFT) & TRANSFORMING CARE PROGRAMME (TCP) UPDATE

An event was hosted by the Black Country Partnership to share the vision of the new model of community care to deliver the Transforming Care programme. The event was attended by a range of partners who participated in workshops to discuss and shape plans for the clinical model and service design.

The trajectory for the Black Country TCP continues to prove challenging, however, Dudley CCG is in line with the planned trajectory for discharging patients into community settings.

CCG actions and assurance:
Ongoing weekly monitoring of TCP patient level data and participation in the TCP programme.

5.0 MALLING HEATH – URGENT TREATMENT CENTRE

The CCG has been aware of challenges to the organisation, both in terms of workforce capacity and senior clinical oversight.

CCG actions and assurance:
The CCG Chief Nurse met with the new Chief Executive and regional manager to gain assurance that recruitment had taken place to ensure resilience within the Urgent Treatment Centre (UTC) given the critical links to DGFT ED.

An information request was also submitted to Malling Health to seek assurance that there is appropriate management of the workplace rota to ensure that each shift/session is adequately covered. There has been recruitment to the vacancies for clinical lead and the Operations Manager post to strengthen the local management team and there are no gaps in the clinical rota.

The pathways between ED and the Urgent Treatment Centre were reviewed to ensure that the UTC was being utilised appropriately. The streaming protocol between the Urgent Treatment Centre and the Emergency department was also reviewed resulting in a higher proportion of site attendances being treated within the UTC during October.

<table>
<thead>
<tr>
<th>Month</th>
<th>UTC Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>41.18%</td>
</tr>
<tr>
<td>May</td>
<td>38.70%</td>
</tr>
<tr>
<td>June</td>
<td>39.04%</td>
</tr>
<tr>
<td>July</td>
<td>37.73%</td>
</tr>
<tr>
<td>August</td>
<td>37.29%</td>
</tr>
<tr>
<td>September</td>
<td>35.08%</td>
</tr>
<tr>
<td>October</td>
<td>38.20%</td>
</tr>
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</table>

The CCG Deputy Director of Commissioning has facilitated closer joint working between the UTC and ED and this has increased the number of patients being treated in the most appropriate setting and with the shortest wait. During October there has been a UTC Streamer in the ambulance triage area resulting in a number of ambulance arrivals being appropriately treated in the UTC. This has reduced the turnaround time for ambulances and increased flow through the ED.

6.0 RAMSAY WEST MIDLANDS HOSPITAL (WMH)

Two SIs remain open following post-surgery complications; closure of the reviews and monitoring of associated action plans are anticipated in the next four weeks.

7.0 PRIMARY CARE

An update of CQC Primary Care inspections is provided in Appendix 1.

There are two Primary Care SIs in progress; one, a cold chain incident being managed by NHSE and one managed by the Quality & Safety Team. This relates to a confidential information breach.
Datix training was provided by the CCG to the majority of practices on the 17th October 2018 to enable them to start utilising the system for their internal incident reporting and management alongside communicating with the CCG any patient safety concerns.

**CCG actions and assurance:**  
The Quality and Safety team work closely with primary care and public health colleagues in relation to patient safety issues.

### 8.0 INFECTION PREVENTION & CONTROL

For 2018/19 the linear trajectory for *C.Diff* suggests that Dudley CCG will end with **87** *C.Diff* cases, breaching the target of **75**.

**E.Coli** - A linear trajectory suggests that Dudley CCG will end the year with **217** breaching the target of **205**.

**CCG actions and assurance:**  
Bi-monthly HCAI partnership meetings take place with all main providers. The group is working through actions from the recent Gram Negative Blood Stream Infections (GNBSI) audit re E Coli and every effort is being made to ensure achievement of performance targets.

### 9.0 WHEELCHAIR SERVICES

Following an announced CCG visit to Ross Care premises in Birmingham on 6th August 2018, the organisation has responded to the report findings with an agreed action plan.

**CCG actions and assurance:**  
The action plan will be monitored via the Contract Review Monitoring meeting.

### 10.0 RISK REGISTER

The risk register has been updated and includes risks associated with DGFT Emergency Department and the capacity issues within the Quality and Safety team.

### 11.0 RECOMMENDATIONS

The Board is asked to accept this report, and the associated actions and assurance as a summary of the Quality and Safety Committee discussions regarding oversight of clinical quality standards in line with the CCG’s statutory duties.

Caroline Brunt  
Chief Nurse  
November 2018

**Attachment:** Appendix 1
### Care Quality Commission (CQC) Ratings

This section shows the results for the latest CQC inspections, the scores are calculated as follows: 1. Inadequate, 2. Requires Improvement, 3. Good, 4. Outstanding.

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Visit Date</th>
<th>Sum of CQC</th>
<th>Overall Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well Led</th>
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<tr>
<td>STOURSIDE MEDICAL PRACTICE</td>
<td>Oct 2018</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>COSELEY MEDICAL CENTRE</td>
<td>Aug 2018</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>LION HEALTH</td>
<td>Jul 2018</td>
<td>17</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
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<td>THORNES ROAD</td>
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<td>15</td>
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<td>AW SURGERIES</td>
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<td>14</td>
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<td>3</td>
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<td>CASTLE MEADOWS SURGERY</td>
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<tr>
<td>PEMMORE MEDICAL PRACTICE</td>
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<td>BATH STREET MEDICAL CENTRE</td>
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<tr>
<td>THE WATERFRONT SURGERY</td>
<td>Nov 2017</td>
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<td>2</td>
<td>3</td>
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<td>2</td>
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<td>KEELING HOUSE</td>
<td>Nov 2017</td>
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<td>3</td>
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<td>BEAN MEDICAL PRACTICE</td>
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<tr>
<td>COSELEY MEDICAL CENTRE</td>
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<td>3</td>
<td>2</td>
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**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 8 November 2018  
**Report:** Audit & Governance Committee Report  
**Agenda item No:** 8.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Audit &amp; Governance Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board of the key issues discussed and agreed at the Audit &amp; Governance Committee meeting on 18 October 2018</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
</tbody>
</table>
| MANAGEMENT LEAD: | Mr M Hartland, Chief Operating and Finance Officer  
Mrs J Jasper, Chair – Audit & Governance Committee. |
| CLINICAL LEAD: | Dr R Tapparo, Clinical Executive Finance, Performance & Business Intelligence |

**KEY POINTS:**

- Items received for assurance or approved under delegated authority at meeting held on 18 October 2018:
  - IG – Q2 Report & IG Steering Group reports received for assurance; revised FPN and IG Steering Group Terms of Reference approved.
  - BAF & RR – Update presented under separate agenda item; new risks 153 and 154 approved.
  - Committee’s Terms of Reference – Revised and recommended to Board for approval.
  - Polices – 7 revised policies approved.
  - Revised Operational Scheme of Delegation - approved.
  - Internal Audit – Progress Report; Recommendation Tracking Report; Key Development Briefings and Annual Customer Satisfaction Survey received for assurance.  

A number of other updates were received for information and assurance and these are detailed in the report.

<table>
<thead>
<tr>
<th>RECOMMENDATION:</th>
<th>The Board is asked to:</th>
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<tbody>
<tr>
<td></td>
<td>1) Receive this report for assurance</td>
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<tr>
<td></td>
<td>2) Note the decisions taken under delegated authority</td>
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<tr>
<td></td>
<td>3) Approve the revised Terms of Reference for the Committee</td>
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</tbody>
</table>

<table>
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<tr>
<th>FINANCIAL IMPLICATIONS:</th>
<th>None</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WHAT ENGAGEMENT HAS TAKEN PLACE:</th>
<th>Not applicable</th>
</tr>
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<table>
<thead>
<tr>
<th>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:</th>
<th>None</th>
</tr>
</thead>
</table>

| ACTION REQUIRED: | Decision  
✓ Approval  
✓ Assurance |
# 1.0 INTRODUCTION

The report summarises the key issues discussed at the Audit & Governance Committee meeting on 18 October 2018.

# 2.0 KEY INDICATOR SUMMARY

The following items are indicators of the current position in relation to the main responsibilities and obligations of the Committee as defined in the CCG’s Constitution and the Committee’s Terms of Reference.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Position</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>1. Regulation and Control</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>CCG Governance Arrangements – Constitution</td>
<td>Updated Constitution approved by NHSE 22 June 2018. Boundary changes not agreed by NHSE.</td>
<td></td>
</tr>
<tr>
<td>Compliance with Prime Financial Policies</td>
<td>No issues</td>
<td></td>
</tr>
<tr>
<td>Board &amp; Committee Effectiveness</td>
<td>Continued progress against Governance Improvement Plan.</td>
<td></td>
</tr>
<tr>
<td>2. Annual Report and Accounts (ARA) 2017/18 &amp; 2018/19</td>
<td>17/18 ARA Complete and AGM held. Senior Finance staff booked to attend national training events.</td>
<td></td>
</tr>
<tr>
<td>3. Operational &amp; Risk Management</td>
<td>Good Progress</td>
<td></td>
</tr>
<tr>
<td>Anti-Fraud and Security</td>
<td>Anti-Fraud and Local Security Management Specialist Work-plans 2018/19 approved. Progress reports being received.</td>
<td></td>
</tr>
<tr>
<td>Risk Management Arrangements – Combined BAF &amp; Risk Register in place; Chairs/Management Leads of committees attending &amp; updating Audit &amp; Governance Committee;</td>
<td>BAF &amp; Risk Register updated monthly and actively managed. BAF &amp; Risk Register critically reviewed and updated at Committee level.</td>
<td></td>
</tr>
<tr>
<td>Report newly commissioned services</td>
<td>Procurement Strategy &amp; reporting updated to reflect new managing conflicts of interest guidance.</td>
<td></td>
</tr>
<tr>
<td>External Audit</td>
<td>Audit findings report and External Audit Opinion issued for year ended 31 March 2018. Regular updates received.</td>
<td></td>
</tr>
<tr>
<td>Other Policies</td>
<td>Policies reviewed and updated routinely.</td>
<td></td>
</tr>
<tr>
<td>4. Information Governance</td>
<td>CSU IG staff on-site regularly progressing IG Work-plan and supporting CCG officers. Toolkit rated Green by Internal Audit.</td>
<td></td>
</tr>
<tr>
<td>Information Governance Group established</td>
<td>IG Steering Group meetings scheduled throughout 2018/19</td>
<td></td>
</tr>
<tr>
<td>Compliance with Information Governance toolkit</td>
<td>Toolkit 2017/18 IG Toolkit submitted with 92%</td>
<td></td>
</tr>
<tr>
<td>Information Asset Management structure to be established with IAOs and IAAs identified from CCG staff</td>
<td>IG working with IAOs &amp; IAAs to take forward information asset register update.</td>
<td></td>
</tr>
<tr>
<td>Freedom of Information requests (FOIs)</td>
<td>All responded to within required timescale</td>
<td></td>
</tr>
</tbody>
</table>
3.0 ITEMS DISCUSSED

3.1 Information Governance
The Committee received the Information Governance (IG) Quarter 2 Report for assurance.

This included a summary of Quarter 2 activity, highlighting that Data Protection Impact Assessment (DPIA) face to face training had been delivered to the Commissioning team in September; Data Security Awareness Level 1 training stood at 94% on 28 September; and that there had been 2 ‘near miss’ IG incidents reported during the quarter.

The report also included the Caldicott Guardian Log and the Information Governance Work/Improvement Plan for 2018/19.

The Committee received a report from the IG Steering Group for assurance. The included an attendance schedule and recommended the approval of revised Terms of Reference for the IG Steering Group; a revised Fair Processing Notice (FPN) and revised IG policies (covered under 3.4).

The Committee received and approved the revised Fair Processing Notice (FPN) and revised IG Steering Group Terms of Reference.

3.2 Board Assurance Framework & Risk Register
The Committee received the Board Assurance Framework & Risk Register as at 5 October for assurance. It noted the change to the risk descriptions and residual scores of a number of risks and approved proposed new risks 153 and 154 under its delegated powers (presented as a separate paper).

3.3 Committee Terms of Reference
The Committee agreed that its Terms of Reference should include the 75% attendance requirement for all members. The Board is asked to approve the revised Terms of Reference for the Committee.

3.4 Policy Update
The Committee received an update on policy development progress and the latest Policy Control document for assurance.

The Committee received and approved seven revised policies under its delegated authority. Five of these were previously included in the IG Handbook but it had been agreed that these should be held and maintained separately. The policies are listed under Section 4 – Decisions taken under Delegated Powers.

3.5 Revised Operational Scheme of Delegation
The Committee received and approved a revised Operational Scheme of Delegation under its delegated authority. This added the Heads of Financial Management Corporate and Commissioning to provide resilience in the absence of the Deputy Chief Finance Officer.

3.6 External Audit
The Committee received a Sector Update Report for information and assurance.

3.7 Internal Audit
The Committee received the Progress Report & Recommendation Tracking Report as at October 2018 for assurance.

It also received the Commissioning Arrangements (including decommissioning/disinvestment) internal audit report for assurance noting that it gave significant assurance.

The Key Development Briefings for August & September 2018 were received for information. The Annual Customer Satisfaction Survey Results were received for information and assurance.
3.8 Other Issues

The Audit & Governance Committee considered and received updates and assurance in respect of:

- FOI report for the period 1 July to 30 September 2018, noting that 1 request breached the 20 day response deadline due to delays in getting a response from a third party service provider.
- New Model Constitution
- Lay member appointments
- Governance Improvement Plan
- Conflicts of Interest Training
- Anti-Fraud Progress report
- Business Continuity and EPRR
- National Audit Office IT Security Update
- Monitoring Compliance with Prime Financial Policies

4.0 DECISIONS TAKEN UNDER DELEGATED POWERS

- Approved the CCG’s revised Fair Processing Notice (FPN)
- Approved the revised IG Steering Group Terms of Reference
- Approved new risks 153 and 154
- Approved revised policies:
  1. Risk Management Framework
  2. Information Governance Policy
  3. Subject Access Request – Standard Operating Procedure*
  4. Information Risk Management Policy*
  5. Information Security Policy*
  6. Data protection and Confidentiality Policy*
  7. Records Management Policy *

* previously incorporated in IG Handbook

- Approved the revised Operational Scheme of Delegation

5.0 DECISIONS REFERRED TO THE BOARD

- To Approve the Revised Terms of Reference for the Audit & Governance Committee (Appendix 1)

6.0 RECOMMENDATIONS

The Board is asked to:

1) Receive this report for assurance
2) Note the decisions taken under delegated authority
3) Approve the revised Terms of Reference for the Audit & Governance Committee

Mr M Hartland
Chief Operating and Finance Officer
October 2018
**TITLE OF REPORT:** Combined Board Assurance Framework and Risk Register

**PURPOSE OF REPORT:** To update the Board on the combined Board Assurance Framework (BAF) and Risk Register and present it as at 5 October 2018

**AUTHOR OF REPORT:** Mr M Hartland, Chief Operating and Finance Officer

**MANAGEMENT LEAD:** Mrs J Jasper, Lay Member for Patient and Public Involvement

**CLINICAL LEAD:** Dr D Hegarty, Chair

**KEY POINTS:**
- Update on the combined BAF & Risk Register as at the 5 October 2018.
  - To accept new **Risk 156 in relation to GDPR**
  - To consider **Risks 13, 112, 150, 151 and 152** as a standing item
  - To note that the residual risk score of **Risk 84** has decreased
  - To note that **no risks are proposed for closure**
  - These changes are outlined in the paper and will be reflected in the next iteration of the BAF & Risk Register.

**RECOMMENDATION:**
1) The Board is asked to receive the report for assurance and approve any recommendations made by the Audit & Governance Committee
2) The Board is asked to consider whether any updates to risks **13, 112, 150, 151 and 152** are required
3) The Board is asked to accept new risk **156** as its responsibility

**FINANCIAL IMPLICATIONS:** None direct. Potential consequence if risks materialise

**WHAT ENGAGEMENT HAS TAKEN PLACE:** None

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** None

**ACTION REQUIRED:**
- Decision
- Approval
- Assurance
1.0 INTRODUCTION
In accordance with the CCG’s Risk Management Strategy, an extract of the combined BAF and Risk Register for those risks scored 16 and over (which comprise the Board Assurance Framework) plus any risks less than 16 assigned to the Board is presented to the CCG Board. This is based on the position as at 5 October 2018.

2.0 COMBINED BOARD ASSURANCE FRAMEWORK (BAF) & RISK REGISTER
Those risks with an initial or residual score (after actions having been taken and controls implemented) of 16 or higher and any others assigned directly to the Board are presented in detail at Appendix 1. These risks are also summarised in the table below:

<table>
<thead>
<tr>
<th>Risks 16 or higher (plus risks assigned to Governing Body) as at the 5 October 2018</th>
<th>Initial Risk</th>
<th>Residual Risk</th>
<th>Accountable Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. There is a risk that the health and social care economy will fail to engage and work together to implement required service changes</td>
<td>16</td>
<td>12</td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>13. Failure of the governing body to demonstrate appropriate leadership/clinical leadership may result in poor strategy and implementation, and thereby fail to meet statutory and regulatory responsibilities.</td>
<td>12</td>
<td>8</td>
<td>Governing Body</td>
</tr>
<tr>
<td>36. There is a risk that key performance indicator will not be met resulting in the loss of the Quality Premium.</td>
<td>16</td>
<td>12</td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>77. There is a risk of failure to realise financial savings outlined in the value proposition because the MCP care model is not implemented.</td>
<td>16</td>
<td>9</td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>84. There is a risk that failure to control costs and deliver significant QIPP savings will put the future sustainability of the CCG at risk.</td>
<td>16</td>
<td>12</td>
<td>Finance, Performance &amp; Business Intelligence</td>
</tr>
<tr>
<td>98. Future shape of the CCG and consequential impact on staff and delivery.</td>
<td>16</td>
<td>12</td>
<td>Remuneration &amp; HR</td>
</tr>
<tr>
<td>104. There is a risk that there will be a lack of suitable bidders to enter into a contract for the MCP</td>
<td>16</td>
<td>4</td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>112. There is a risk that Governance arrangements between organisations (that are party to the STP) are either insufficient or inconsistent. This may lead to inadequate governance and insufficient transparency which could create unintended financial risk, inconsistent decision making or misalignment of strategic direction and implementation.</td>
<td>16</td>
<td>16</td>
<td>Governing Body</td>
</tr>
<tr>
<td>116. There is potential to destabilise the health system both clinically and financially as a result of MCP implementation</td>
<td>16</td>
<td>12</td>
<td>Commissioning Development</td>
</tr>
<tr>
<td>129. Lack of effective management of waiting list within the ophthalmology department which results in poor patient outcome. Lack of follow up appointment due to process failure.</td>
<td>16</td>
<td>8</td>
<td>Quality &amp; Safety</td>
</tr>
</tbody>
</table>
### 3.0 RECENT AMENDMENTS TO THE BAF AND RISK REGISTER

The following amendments to risks 16 and over have been made since the Board received the BAF and Risk Register as at 4 September 2018 at its meeting on 13 September 2018.

**Review & Updates** – Updates were received from the leads for the Primary Care Commissioning Committee; Quality & Safety Committee; Commissioning Development Committee; Finance, Performance & Business Intelligence Committee and Remuneration & HR Committee.

The Board is requested to review Risks 13, 112, 150, 151 and 152 for which it is directly responsible and update as appropriate.

#### 3.1 Risk Description, related controls, assurances, actions and comments

Exceptionally changes are made to the initial risk scores and description, particularly when an identified risk is new and additional information leads to a reassessment of the overall risk.

None
3.2 Changes to the Residual Risk Scores

**Risk 84** – “There is a risk that failure to control costs and deliver significant QIPP savings will put the future sustainability of the CCG at risk” The Finance, Performance and Business Intelligence Committee at its meeting in September agreed to decrease the residual risk score from \((4 \times 4) = 16\) to \((3 \times 4) = 12\) due to the year to date overachievement of the 2018/19 QIPP target with an increased confidence of achieving the full year QIPP target.

3.3 New Risks

The Audit & Governance Committee, as the committee with delegated responsibility for Information Governance, has received a proposed new risk, Risk 156, to reflect the potential risks in relation to the change in legislation to the General Data Protection Regulations (GDPR):

**Risk 156** - “There is a risk that Dudley CCG could be exposed to financial and reputational risk if it fails to comply with the requirements of the General Data Protection Regulation. The CCG could receive potential fines of up to €17m or 4% of annual turnover for failure to comply, or face other enforcement action from the ICO including warnings, enforcement notices, undertakings or audits.”

However, as the Committee also provides input to and oversight of the risk management process and the Board Assurance Framework (BAF), it would be a conflict for it to have responsibility for individual risks. **Therefore this new risk is recommended for ownership by the Board by the Audit & Governance Committee.**

3.4 Risks Proposed for Closure (Requiring Board approval)

No risks are proposed for closure.

4.0 RECOMMENDATIONS

1) The Board is asked to receive the report for assurance and approve any recommendations made by the Audit & Governance Committee

2) The Board is asked to consider whether any updates to risks 13, 112, 150, 151 and 152 are required

3) The Board is asked to accept new risk 156 as its responsibility

5.0 APPENDICES

Appendix 1 – Combined BAF & Risk Register as at 5 October 2018 (risks 16 and over & Risks 13, 112, 150, 151 & 152)

M Hartland
Chief Operating and Finance Officer
October 2018
## Dudley CCG Combined Board Assurance Framework and Corporate Risk Register 2018/19

### 01-Oct-18

**MASTER Document capturing changes to risks, agreed by Committee, for the month of September 2018**

<table>
<thead>
<tr>
<th>ID</th>
<th>Original Date</th>
<th>Last Update</th>
<th>Generation</th>
<th>Risk Description</th>
<th>Accountability Committee</th>
<th>Accountability Group or Office</th>
<th>Management Level</th>
<th>Local Risk (PxI)</th>
<th>Corporate Risk (PxI)</th>
<th>Key Controls</th>
<th>Internal Assessments and Tools</th>
<th>Performance Data</th>
<th>External Assurance</th>
<th>External Assurance Reports, OSC Reports</th>
<th>Internal Assurances</th>
<th>Score</th>
<th>Total Assurances</th>
<th>Residual Risk (PxI)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>01/08/2018</td>
<td>03/09/2018</td>
<td>3</td>
<td>There is a risk that the health and social care system will not be able to deliver safe, high-quality care to patients and public across Dudley CCG and the Local Health Economy</td>
<td>CCG</td>
<td>Neill Bucktin</td>
<td>Neill Bucktin</td>
<td>2</td>
<td>0</td>
<td>None</td>
<td>ISAP Checkpoint 2</td>
<td>DP reports to Board</td>
<td>Internal Audit</td>
<td>None</td>
<td>ISAP</td>
<td>1</td>
<td>0</td>
<td>To be reviewed monthly</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>01/08/2018</td>
<td>03/08/2018</td>
<td>3</td>
<td>The risk that Governance arrangements will be inadequate to ensure the Company’s performance is effectively managed and that the organisation is run in an orderly and transparent manner</td>
<td>GBSC</td>
<td>Paul Maubach</td>
<td>Paul Maubach</td>
<td>3</td>
<td>4</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>4</td>
<td>2</td>
<td>Oct-18</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>01/08/2018</td>
<td>03/07/2018</td>
<td>3</td>
<td>There is a risk that the CCG will not deliver on the outcomes of the Quality Premium</td>
<td>CCG</td>
<td>Neill Bucktin</td>
<td>Neill Bucktin</td>
<td>4</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Oct-18</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>20/07/2018</td>
<td>03/07/2018</td>
<td>3</td>
<td>There is a risk that failure in either financial or staff engagement and performance could result in the CCG failing to deliver on the Quality Premium</td>
<td>CCG</td>
<td>B T Teppan</td>
<td>B T Teppan</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Sep-18</td>
<td></td>
</tr>
<tr>
<td>84</td>
<td>07/10/2018</td>
<td>07/08/2018</td>
<td>3</td>
<td>There is a risk that failure in either financial or staff engagement and performance could result in the CCG failing to deliver on the Quality Premium</td>
<td>CCG</td>
<td>B T Teppan</td>
<td>B T Teppan</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Sep-18</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>01/08/2018</td>
<td>02/08/2018</td>
<td>3</td>
<td>There is a risk that failure in either financial or staff engagement and performance could result in the CCG failing to deliver on the Quality Premium</td>
<td>CCG</td>
<td>B T Teppan</td>
<td>B T Teppan</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Sep-18</td>
<td></td>
</tr>
<tr>
<td>104</td>
<td>08/08/2018</td>
<td>09/07/2018</td>
<td>4</td>
<td>There is a risk that failure in either financial or staff engagement and performance could result in the CCG failing to deliver on the Quality Premium</td>
<td>CCG</td>
<td>B T Teppan</td>
<td>B T Teppan</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Sep-18</td>
<td></td>
</tr>
<tr>
<td>112</td>
<td>08/08/2018</td>
<td>09/08/2018</td>
<td>4</td>
<td>There is a risk that failure in either financial or staff engagement and performance could result in the CCG failing to deliver on the Quality Premium</td>
<td>CCG</td>
<td>B T Teppan</td>
<td>B T Teppan</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Sep-18</td>
<td></td>
</tr>
<tr>
<td>116</td>
<td>08/08/2018</td>
<td>09/08/2018</td>
<td>4</td>
<td>There is a risk that failure in either financial or staff engagement and performance could result in the CCG failing to deliver on the Quality Premium</td>
<td>CCG</td>
<td>B T Teppan</td>
<td>B T Teppan</td>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>3</td>
<td>0</td>
<td>Sep-18</td>
<td></td>
</tr>
</tbody>
</table>
There is a risk that there are failures to manage the deteriorating patient care. This may result in the quality and safety of care on that day; triangulation report submitted to oversight board, monthly finance meetings with NHS England. This may result in the quality and safety of care on that day.

Lack of transparency and accountability to gain performance trajectory. Follow-up clinics, developed a process to follow up clinics, DGFT have since put in place extra parallel waiting list to support timely management. DGFT are aware of the root cause of the delay, DGFT have since put in place extra parallel waiting list to support timely management.

CCG will lead on developing new business case for the new model, developing and creating a business case for the transformation of the new model, developing and creating a business case for the transformation of the new model, and development of local knowledge.

The process of mobilisation of MCP RCFT have since put in place extra parallel waiting list to support timely management. DGFT have since put in place extra parallel waiting list to support timely management.

Evidence of learning following serious incidents being shared across the leadership organisations. Develop a joint action plan with local providers to improve transparency and accountability. Evidence of learning following serious incidents being shared across the leadership organisations. Develop a joint action plan with local providers to improve transparency and accountability.

Revised ITF & CFT Business Case and report on current state of the leadership organisations. Reporting of serious incidents to the Leadership organisations. Evidence of learning following serious incidents being shared across the leadership organisations. Develop a joint action plan with local providers to improve transparency and accountability. Evidence of learning following serious incidents being shared across the leadership organisations. Develop a joint action plan with local providers to improve transparency and accountability.

To determine how transparency and accountability will facilitate the risk management can be improved. Joint CFT quarterly meetings with senior leadership groups to facilitate transparency and accountability.


The risk of mobilisation of MCP RCFT have since put in place extra parallel waiting list to support timely management. DGFT have since put in place extra parallel waiting list to support timely management.

The risk of mobilisation of MCP RCFT have since put in place extra parallel waiting list to support timely management. DGFT have since put in place extra parallel waiting list to support timely management.

Red Amber Green flag system in place. Reporting of serious incidents to the Leadership organisations. Evidence of learning following serious incidents being shared across the leadership organisations. Develop a joint action plan with local providers to improve transparency and accountability. Evidence of learning following serious incidents being shared across the leadership organisations. Develop a joint action plan with local providers to improve transparency and accountability.
<table>
<thead>
<tr>
<th>ID</th>
<th>New/Review</th>
<th>External Support</th>
<th>Internal Assurances</th>
<th>External Assurances</th>
<th>Gaps in Assurance</th>
<th>Residual Risk Score</th>
<th>Risk Trend</th>
<th>Actions</th>
<th>Timescales</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>156 NEW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is a risk that Dudley CCG could be exposed to financial and reputational risk if it fails to comply with the requirements of the General Data Protection Regulation (GDPR). Failure to comply could result in fines of up to €17m or 4% of annual turnover, or face other enforcement action from the ICO including warnings, enforcement notices, undertakings or audits.

- External support is commissioned from Arden & GEM CSU to support the CCG in fulfilling the requirements of GDPR, ensuring actions are documented and completed.
- There is a GDPR work plan in place, managed through the IG Steering Group and Audit & Governance Committee.
- GDPR Awareness communications have been circulated to staff on a weekly basis via all staff email.
- Information Governance Policies and Procedures have been reviewed in line with changes to UK Data Protection laws.
- A Data Protection Officer has been appointed.
- All staff are required to complete Data Security Awareness Level 1 training on an annual basis. Face to face training is also delivered when a need is identified.

Full security review required to address any gaps in local security, data and IG compliance.

ICO Guidance: None

- Security Review taking place
- Completion of the GDPR Work plan and assurance provided to IGSG and A+G

Dec-18
### Title of Report:
Remuneration and HR Committee Report

### Purpose of Report:
To provide assurance to the Board regarding key issue discussed and approved by the Remuneration and HR Committee held on 27 September 2018

### Author of Report:
Mrs S Cartwright, Director of Organisational Development, Transformation and Human Resources

### Management Lead:
Mrs S Cartwright, Director of Organisational Development, Transformation and Human Resources

### Clinical Lead:
Dr D Hegarty, Chairman

### Key Points:
- Workforce Dashboard reviewed noting slightly increased sickness rate of 0.45%, mandatory training compliance of 86%, PDR compliance of 88% and a headcount of 115
- The Committee approved the revised Sickness Policy
- Committee received an update and agreed the appointment process for the MCP Transformation Team
- The Committee received information on the suggested plan to create an MCP directorate within the CCG
- The Committee discussed and agreed a way forward on agreeing remuneration for support provided during the sickness absence of the Chairman
- The Committee discussed concerns regarding staff working extra hours on a regular basis and agreed a staff survey pulse check
- The Committee discussed the proposed secondment of a CCG member of staff to the MCP Transition Team

### Recommendation:
The Board to receive the report for assurance and note the decisions taken under delegated powers

### Financial Implications:
Within financial plan

### What Engagement Has Taken Place:
n/a

### Any Conflicts of Interest Identified in Advance:
- Mrs Cartwright declared a conflict of interest in the MCP Alignment and MCP Secondment papers
- Dr Hegarty declared an interest in the Chairman role paper
- Dr Ruth Tapparo declared an interest in an outstanding action

### Action Required:
- Decision
- Approval
- Assurance
INTRODUCTION

1.1 This report provides assurance to the Board with regard to key issues discussed and approved by the Remuneration and HR Committee on the 27th September 2018. The following items are a description of current position in relation to the main responsibilities and obligations of the Committee as defined by the CCG Constitution and Terms of reference.

1.2 Due to the nature of the Committee, there are no set key indicators to report to the Board.

REPORT

2.1 STP and Black Country and West Birmingham Joint Commissioning Committee
The Committee received a verbal report which included that Alistair McIntyre had been appointed as the Programme Director for the STP, supporting Dr Helen Hibbs as the Senior Responsible Officer; the HR teams for CCGs are working together and looking at shared working in relation to payroll and other potential shared working opportunities; and an away day is planned for the Accountable Officers and Chairs of all CCGs to discuss and agree joint working in the future.

2.2 Remuneration and HR Committee Annual Report
The Committee received a paper detailing the work that had been undertaken by the Remuneration and HR Committee over the last twelve months which summarised the Committee’s work during the year and confirmed that the Committee had discharged all its responsibilities for overseeing all aspects of the CCGs arrangements for Remuneration and HR. A copy of this report is attached for information.

2.3 Workforce Dashboard
The Committee receives regular updates on HR and workforce metrics applicable to the CCG. This includes analysis of vacancies, banding/skill-mix ratios, sickness, Personal Development Review completion and mandatory training compliance.

In September, the Committee noted that the sickness absence rate had increased by 0.31% to 0.45% and noted that sickness continues to remain below the CCG target of 3%. The Committee was assured that there were no long term absences and were assured that short term absence was being managed appropriately in line with CCG policy.

The Committee reviewed mandatory training and PDR compliance. Mandatory training was reported at 86%. The Committee have requested that GP Board Members mandatory training is also monitored and recorded in future reports. PDR compliance was reported as 88% and it was agreed that PDR monitoring and recording will now move in house and be monitored by the Business Support Manager. The Committee were informed that the headcount was 115 and there were currently 2 staff on maternity leave.

2.4 Risk Register
The Committee reviewed the risk register, noted current risks and agreed to add an additional risk pertaining to the impact of the current position of DGFT on the progress of the MCP.

2.5 Sickness Policy
The Committee reviewed and approved the revised Sickness Policy. The policy now included more information in relation to staff side and human resources support in the sickness process, the authority to act during a Stage 3 process, de-escalation process and revised manager’s handbook. All managers with line management responsibility will receive training on the new policy and will be supplied with Manager’s Guidance.
2.6 Appointment of Staff for MCP Transformation Team
The Committee reviewed a paper which detailed two categories in which staff would be assigned to work as part of the interim MCP Transition Team. These are: posts that can be assigned from roles within an existing organisation that is part of the Transition Board because the work already forms part of (or all) of the work that the role under takes; or a new role that could be undertaken by any relevantly experienced individual from any of the Transition Board partner organisations and primary care. The Committee agreed with the proposed roles from the CCG that could be assigned to individuals as they are already undertaking work as part of the role pertaining to development of the MCP.

2.7 MCP Alignment
The Committee received a paper detailing the proposed alignment of staff to either CCG or MCP work areas. Members of the MCP Transition Board, of which the CCG is a member, have been asked to support a principle by which all participating organisations establish separate ‘divisions’ within their existing organisations for functions/posts that will be ‘in-scope’ of the MCP when formed. This would relate to both functions that would wholly transfer into the MCP, in addition to functions that support such services.

Functions and staff within the new ‘division’ would have dual accountability – to the CCG and to the MCP Transition Board. This allowed the CCG to continue to deliver on its duties and responsibilities, and continue to have professional accountability, whilst enabling the Transition Board to have visibility of the services for which it will be responsible and prepare for full operational management when the MCP is formed.

The Committee agreed with this proposal and the Board is asked to note the principle of establishing a ‘division’ within the CCG for staff aligned to the MCP via the concurrent CCG activities process.

2.8 MCP Secondment
The Committee received a paper detailing the appointment of the Interim MCP Managing Director post as a secondment from the CCG (Mrs Stephanie Cartwright). The paper detailed the proposed contractual mechanism for Mrs Cartwright and associated timeframes. The Committee agreed with the proposal and requested that the CCG should implement a Secondment Agreement Policy to facilitate and document any future secondment arrangements.

2.9 Cover for Chairman Absence
The Committee received an update on the agreed process for determining the level of cover to be remunerated during the sickness absence of the Chairman earlier in the year. The Committee agreed the process to determine the level of cover and asked for a report to be taken to the next Committee to approve the level of cover to be remunerated, and to detail key learning points.

2.10 Staff Working Extra Hours
The Committee received feedback from the CCG staff side representative regarding concerns about extra hours that are being worked by a significant number of CCG staff. The Committee were assured that a pulse check staff survey would be undertaken before the end of October which the Committee will receive a report on at the next Committee meeting.

3.0 RECOMMENDATION

3.1 The Board is asked to receive the update from the Remuneration and HR Committee for assurance noting the decisions taken under delegated authority.

Mrs S Cartwright
Director of Organisational Development, Transformation and Human Resources
October 2018
# Remuneration Committee and Human Resources Committee

**Date of Committee:** 27th September 2018  
**Report:** Remuneration Committee Annual Report 2017/18  
**Agenda item No:** 7.0

<table>
<thead>
<tr>
<th><strong>Title of Report:</strong></th>
<th>Remuneration Committee Annual Report 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose of Report:</strong></td>
<td>To present the Annual Report 2017/18 from the Remuneration Committee and provide assurance that the Committee has discharged its responsibilities and met its terms of reference.</td>
</tr>
<tr>
<td><strong>Author of Report:</strong></td>
<td>Mrs Alice McGee, Head of HR and OD</td>
</tr>
<tr>
<td><strong>Management Lead:</strong></td>
<td>Mrs Steph Cartwright, Director of Organisational Development, Transformation and Human Resources</td>
</tr>
<tr>
<td><strong>Clinical Lead:</strong></td>
<td>Dr David Hegarty, Chairman</td>
</tr>
<tr>
<td><strong>Key Points:</strong></td>
<td>The report summarises the Committee’s work during the year and confirms that it has discharged all its responsibilities for overseeing all aspects of the CCG’s arrangements for remuneration and HR.</td>
</tr>
<tr>
<td><strong>Recommendation:</strong></td>
<td>The Committee is asked to receive the report for assurance.</td>
</tr>
<tr>
<td><strong>Financial Implications:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>What Engagement Has Taken Place:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Any Conflicts of Interest Identified in Advance:</strong></td>
<td>None</td>
</tr>
</tbody>
</table>
| **Action Required:** | Decision  
Approval  
Assurance |
1.0 INTRODUCTION

The Remuneration Committee has been established in accordance with the CCG’s Constitution. This Annual Report summarises the activities of the Remuneration Committee for the financial year 2017/18 setting out how it met its Terms of Reference.

2.0 RESPONSIBILITIES

As set out in the Terms of Reference, the remit of the Committee is:

- to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS scheme.

- to make recommendations to the Governing Body in relation to HR policy and to oversee HR within the group.

3.0 PRINCIPAL REVIEW AREAS

There are two key areas that the Committee has oversight of: Remuneration and Human Resources.

3.1 REMUNERATION

- **Pay Award 2017/18 for Staff on Agenda for Change Contracts** – the committee considered the national pay award for 2017/18 and considered the application of a local pay award. The committee awarded a local non-consolidate pay award for all CCG staff on Agenda for Change terms and conditions.

- **Very Senior Manager Pay Award 2017/18** – in June 2017 the Committee considered the 2016/17 pay award for employees on VSM contracts and the 2017/18 cost of living award. The Committee approved the performance related pay award for 2017/18 in relation to performance against agreed individual and organisational objectives and awarded a non-consolidated cost of living award for 2017/18 in line with the decision for all CCG staff.

- **Clinical Leads Term of Office** – following concerns being raised by clinical executives about the term of office they were engaged on, the Committee considered the types of clinical leadership, clinical executives and GP Governing Body members in the organisation and the most appropriate contracts. The Committee agreed that all elected positions would be engaged on Office Holder contracts, and that all appointed positions would be engaged on fixed term employment contracts with the exception of Lay Members who would remain on Office Holder contracts. Throughout 2017/18 the committee ensured actions to move engaged GP’s onto the correct contract were implemented with regular updates and assurance throughout the year.

- **Executive Shared Resources** – in February 2018 and October 2017 the remuneration of the Chief Accountable Officer and the Chief Finance and Operating Officer were considered in
relation to the support and time provided to Walsall CCG. The remuneration was time limited and approved as exceptional circumstances.

- **Review of Pay Decisions** – in February 2018 the committee undertook a review of all pay decisions made since March 2013. The committee considered the decisions, the national guidance and the rationale for all decisions to ensure it remained assured of the decisions made.

- **Review of Director Terms and Conditions** – throughout 2016/17 the committee reviewed the terms and conditions of the CCG Directors including comparable roles within neighbouring CCG’s. The committee supported and approved the change of Director pay through Agenda for Change job evaluation process.

### 3.2 HR

- **Workforce Dashboard** – throughout the year the CCG has experienced some high levels of sickness which has been managed proactively and reduced throughout the year to below the industry average of 3%. There have been issues with the presentation of PDR and mandatory training data, due in part to staff not recording information on ESR, but the position has improved as the year progressed. This issue must continue to be monitored.

- **Occupational Health and Staff Counselling** – in August 2017 the Committee approved the staff support services that were re-procured following a decision in February 2017. The new service started in November 2017.

- **Union Recognition Agreement** – in February 2018 the Committee approved the CCG union recognition agreement to ensure that full engagement with staff before issues come to the Committee.

- **Staff Survey** – In October 2017 the Committee considered the questions of the staff survey, including more detailed questions on some of the areas of concern from previous years. The survey took place during December 2017 and January 2018 and the committee received the results and action plan in April 2018.

- **Primary Care and MCP Development** – throughout the year the committee received regular updates on the MCP and primary care development including providing a view on structure development, ensuring the impact on staff was fully considered and that conflicts of interest were managed.

- **HR Policies** – in line with the CCG cycle of reviewing HR policies, the committee considered and approved a number of updated HR policies in 2017: Agency Interim Policy; Lone Working Policy; Long Term Service Award; On-Call Payment Policy; Pay Protection Policy; Restricted Honours Policy; Smoke Free Policy; Staff Movement Policy; Substance Misuse Policy; Induction Policy; Stress Management Policy; Off-Payroll workers; Study Leave; Overpayments and Underpayments Policy; Sanctions and Redress; Equality and Inclusion Policy; Annual Leave Policy; PDR Policy; 360 Degree Feedback Policy; Retirement Policy.

- **Work Plan** – In February 2018 the committee approved the work plan for the committee for the following year (2018/19) to ensure all key actions and responsibilities were fully planned throughout the year.

- **TUPE Transfer** – the committee approved the TUPE transfer and the principle of consulting with staff post transfer to move to CCG terms and conditions, including the CCG local pay award. The transfer took place on 1st April 2018.

- **Consultant Pharmacist** – in line with the national policy for creating and appointing Consultant Pharmacist the committee approved the principle of the CCG creating a Consultant Pharmacist post, subject to a formal panel decision.
- **EPRR** – to ensure compliance with EPRR regulations the committee approved a Non-Executive Director as the named Lay member for EPRR on behalf of the CCG.

- **Chief Operating Officer** – as a result of the joint strategic officer arrangements with Walsall CCG the committee approved in principle the creation of a temporary senior post to ensure the CCG remained able to deliver its objectives. Following interview, the scope of the post was changed to a Programme Manager to take the lead on the CCG QIPP agenda.

- **2012/13 National Insurance and Tax** – the committee were informed of an issue identified that affected a number of staff in the CCG following an error made by payroll in the PCT for tax year 2012/13. The committee were provided with regular updates and approved a plan of action for resolving this for staff where possible.

4.0 **MEMBERSHIP AND ATTENDANCE RECORD**

The Committee has at least six members from its governing body, made up of:

- A lay member acting as Chair of the Committee (except when matters of lay member remuneration and/or terms of service are considered, at which time the Chair will be taken by one of the 2 GP members of the Committee)
- 2 further lay members, one of which will act as Vice-Chair
- The governing body member holding the position of secondary care specialist doctor
- 2 elected governing body GP members

The committee invites a number of additional officers to attend each meeting to provide expertise and management views. The attendance regularly includes; Chief Accountable Officer; Chief Finance and Operating Officer; Chair of the CCG; Director of Organisational Development, Transformation and HR; Staff Side Representatives; HR team colleagues.

During 2017/18 the Committee met 6 times with attendance recorded in the attached appendix. An assessment will be made of the cost of the operation and administration of the Committee throughout the year. This will be based upon the attendance of individuals as shown in the attached appendix and the cost will be calculated based on the average hourly cost of each individual at an estimated 3 hours per Committee. The cost for 2017/18 will be provided at the committee meeting.

Due to the complexity of membership and subject matter of the Committee, there have been times when the Chairmanship of certain parts of the agenda has been taken by the officers of the CCG, namely the Chief Accountable Officer and Chief Finance Officer.

5.0 **CONCLUSION**

In conclusion, the Committee is of the opinion that it has discharged its responsibilities for overseeing all relevant forms of Remuneration and Human Resources.

6.0 **RECOMMENDATION**

The Committee is asked to accept the report.
<table>
<thead>
<tr>
<th>NAME</th>
<th>ROLE</th>
<th>05/04/17</th>
<th>07/06/17</th>
<th>09/08/17</th>
<th>04/10/17</th>
<th>06/12/17</th>
<th>07/02/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr S Wellings</td>
<td>Lay Member for Governance and Committee Chair</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Dr C Handy</td>
<td>Lay Member for Quality and Safety</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs J Jasper</td>
<td>Lay Member – Patient and Public Involvement</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Dr Ruth Tapparo</td>
<td>Elected GP Board Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr A Johnson</td>
<td>Interim Secondary Care Doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Attendance</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mr M Hartland</td>
<td>Chief Operating and Finance Officer</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Mrs S Cartwright</td>
<td>Director of Transformation and HR</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Mrs A McGee</td>
<td>Head of HR and OD</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mr S Stanier</td>
<td>HR &amp; OD Lead</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Mr P Maubach</td>
<td>Chief Executive Officer</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr J Cahill</td>
<td>Staff Side representative</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Dr David Hegarty</td>
<td>Elected GP Board Member and CCG Chair</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
DUDLEY CLINICAL COMMISSIONING GROUP BOARD

Date of Board: 8 November 2018
Report: Urgent Decision made under Section 3.8 of the CCG’s Standing Orders
Agenda item No: 8.4

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Urgent Decision Taken under Section 3.8 of the CCG’s Standing Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>This report is to notify the Board of an Urgent Decision taken under Section 3.8 of the CCG’s Standing Orders</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr Paul Maubahc, Chief Executive Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr David Hegarty, Chair</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

- Under Section 3.8 ‘Emergency powers and urgent decisions’ of the CCGs Standing Orders (Appendix C of the CCG’s Constitution), the Governing Body has the power to make an urgent decision. This can be exercised by the Accountable Officer and the Chair after having consulted at least two elected GP representative members.

- The exercise of this power must be reported to the next formal meeting of the Governing Body for formal ratification.

- On the 8 October 2018, at the Board Development Session, Dr David Hegarty (Chair), Mr Paul Maubahc (AO), Dr Rebecca Lewis (Elected GP) and Dr Fiona Rose (Elected GP) approved an amendment to the Primary Care Commissioning Committee’s Terms of Reference under this Standing Order.

- This was to add the Head of Membership Development as a nominated representative (voting) for the Chief Nurse as follows: ‘Chief Nurse (or their nominated representatives, the Head of Quality Assurance in relation to Quality and Safety matters or The Head of Membership Development in relation to Primary Care matters)’

- This was to ensure that the Chief Nurse is represented at the Primary Care Commissioning Committee in all matters in her absence.

**RECOMMENDATION:**

1) The Governing Body is asked to formally ratify the use of this power

**FINANCIAL IMPLICATIONS:**

None

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

None

**ANY CONFLICTS OF INTEREST DECLARED:**

None

**ACTION REQUIRED:**

- Decision
- Approval
- Assurance
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 8 November 2018  
**Report:** Finance, Performance and Business Intelligence Committee Report  
**Agenda item No:** 9.1

<table>
<thead>
<tr>
<th>TITLES OF REPORT:</th>
<th>Finance, Performance and Business Intelligence Committee Report</th>
</tr>
</thead>
</table>
| PURPOSE OF REPORT:| To advise the Board of key issues discussed at the Finance, Performance and Business Intelligence Committees on 30th August 2018 and 27th September 2018  
To inform the Board of an urgent decision taken under delegated authority at the Finance, Performance and Business Intelligence Committee on 25th October 2018 |
| AUTHOR OF REPORT: | Mr M Hartland, Chief Finance and Operating Officer  
Mr J Smith, Head of Financial Management – Corporate |
| MANAGEMENT LEAD:  | Mr M Hartland, Chief Finance and Operating Officer |
| CLINICAL LEAD:    | Dr R Tapparo, Clinical Executive for Finance, Performance and BI |

**KEY POINTS:**

- The CCG expects to meet all financial duties in 2018/19.
- The CCG reported a year to date underspend of £5,278,000 for August 2018 and expects to achieve its revised year end control total of £12,651,000 as agreed with NHS England.
- NHS Constitution standards are being achieved at headline level with the exception of A&E. There are also performance exceptions to note in relation to Ambulance Handovers, IAPT Access, Dementia and BCF.
- The Commissioning Development Committee (CDC) is forecast to overspend significantly against its delegated budget by £4.2m.
- Committee received updates on the Board Assurance Framework & Risk Register.
- The CCG has constructed a system bid of £8.4m over 2 years for financial support to complete the implementation of the MCP.
- Reports from the IT Strategy Group and Estates Strategy Group were received.
- Latest ETTF plan contains six schemes, two schemes for 2018/19 of £478,000 including IT provision for a remote desktop solution for GP’s and DDA improvements at Netherton HC and four schemes in 2019/20 amounting to £1.77m supporting the Estates Strategy in consolidating General Practice.

**Under its delegated authority the Committee:**

- Approved the revised IAPT and Primary Care Mental Health Team payment mechanism.
- Supported and approved the principle that in 2018/19 £180,000 followed the patient for each net discharge from the care of specialised services.
- Endorsed the procurement of Sense.ly to provide the application to support online consultations.
- Supported the recommendation to defer the drawdown of historic surplus from 2018/19 to be drawn in 2019/20.

**RECOMMENDATION:**

The Board is asked to:

- Receive the report for assurance
- Note the decisions taken under delegated authority
- Formally ratify the Committee’s decision in respect of the CCG’s drawdown of its historic surplus
<table>
<thead>
<tr>
<th><strong>FINANCIAL IMPLICATION:</strong></th>
<th>As outlined in report and key points above</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHAT ENGAGEMENT HAS TAKEN PLACE:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:</strong></td>
<td>None</td>
</tr>
</tbody>
</table>
| **ACTION REQUIRED:** | Decision  
✓ Approval  
✓ Assurance |
1.0 INTRODUCTION

The report summarises the key issues discussed by the Finance, Performance and Business Intelligence Committees at its meetings on 30th August and 27th September 2018.

It also advises the Board of an urgent decision in respect of the CCG’s overall control total made by the Committee at its meeting on October 25th.

2.0 KEY INDICATOR SUMMARY

The table below identifies the CCG’s latest performance against key financial and performance indicators for 2018/19. This represents July performance information and August financial information. It is followed by exception reporting and an explanation of key issues where required.
### NHS Constitution / Statutory Finance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying Recurrent Surplus</td>
<td>M</td>
<td>(1,677) YTD</td>
<td>(2,107)</td>
<td>(2,107)</td>
<td>(5,031)</td>
<td></td>
</tr>
<tr>
<td>Programme Spend</td>
<td>M</td>
<td>159,748</td>
<td>195,366</td>
<td>195,366</td>
<td>472,755</td>
<td></td>
</tr>
<tr>
<td>Running Cost Spend</td>
<td>M</td>
<td>2,248 YTD</td>
<td>2,812</td>
<td>2,812</td>
<td>6,802</td>
<td></td>
</tr>
<tr>
<td>Programme Surplus</td>
<td>M</td>
<td>(4,217) YTD</td>
<td>(5,257)</td>
<td>(5,257)</td>
<td>(12,651)</td>
<td></td>
</tr>
<tr>
<td>Running Costs Surplus</td>
<td>M</td>
<td>0</td>
<td>(22)</td>
<td>(22)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>QIPP</td>
<td>M</td>
<td>(6,395) YTD</td>
<td>(7,516)</td>
<td>(7,516)</td>
<td>(16,989)</td>
<td></td>
</tr>
</tbody>
</table>

### Other Key Finance & Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency</th>
<th>Target/Threshold</th>
<th>Latest Period</th>
<th>Direction</th>
<th>YTD</th>
<th>FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimise breaches - zero tolerance target</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>All patients who have operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days</td>
<td>M</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>No urgent operation should be cancelled for a second time</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Care Programme Approach (CPA): patients followed up within 7 days</td>
<td>Q</td>
<td>≥95%</td>
<td>95.83%</td>
<td>95.83%</td>
<td>95.83%</td>
<td></td>
</tr>
<tr>
<td>IAPT Access: Number of people who receive psychological therapies</td>
<td>M</td>
<td>(1.58% &gt;19%)</td>
<td>1.15%</td>
<td>3.56%</td>
<td>17.81%</td>
<td></td>
</tr>
<tr>
<td>IAPT Recovery: Pts completing treatment who are moving to recovery</td>
<td>M</td>
<td>≥50%</td>
<td>42.90%</td>
<td>37.25%</td>
<td>47.20%</td>
<td></td>
</tr>
<tr>
<td>Early Intervention Psychiatry (EIP): Maximum 2 week wait</td>
<td>M</td>
<td>≥50%</td>
<td>66.7%</td>
<td>93.33%</td>
<td>60.32%</td>
<td></td>
</tr>
<tr>
<td>C.Difficile (DGFT): Reported monthly but measured annually</td>
<td>M</td>
<td>≤28</td>
<td>2</td>
<td>9</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>MRSA (DGFT): Zero tolerance</td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

## Cancer Waits (2 Weeks)

- Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP
- Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)

## Cancer Waits (31 Days)

- Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers
- Maximum 31-day wait for subsequent treatment where that treatment is surgery
- Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen

## Ambulance

- Change in national reporting from Sept-17 - Red ambulance calls resulting in an emergency response must have a mean average <7 mins
- Ambulance Handovers: Breaches over 45 mins and less than 60 mins
- Ambulance Handovers: Breaches over 60 mins
### 3.0 STATUTORY FINANCIAL DUTIES

The Committee was advised that the CCG had an annual budget at August 2018 of £492.2m. This reflected the notified allocation from NHS England and CCG anticipated allocations. At this point in time, the CCG was underspent by £5.3m and is forecast to achieve a surplus on its Revenue Resource Limit of £12.7m meeting the revised control total agreed with NHS England. This reflects the increase of £2,647,000 in the in-year surplus the CCG was requested to achieve at the end of 2017/18 financial year from the release of the 0.5% non-recurrent reserve and category M drug price concessions.
Capital budgets, cash limits and the CCG’s programme and administration expenditure targets are all expected to be achieved.

At a summary level there are three distinct areas of expenditure within the CCG, for which budget responsibility has been delegated to appropriate Committees. These are commissioning expenditure (Commissioning Development Committee - CDC), running/staffing costs and reserves (Finance, Performance and Business Intelligence Committee) and primary care commissioning/membership development (Primary Care Commissioning Committee).

Whilst the Finance, Performance and Business Intelligence Committee retains oversight of the financial position of the organisation and advises the Board regarding any mitigating actions that may need to be taken, the clinical and management leads of appropriate Committees are responsible and accountable for financial performance of their delegated portfolio.

The table below identifies the financial position to date by Committee;

<table>
<thead>
<tr>
<th>Committee</th>
<th>Annual Budget £m</th>
<th>Year to date Budget £m</th>
<th>Year to date Actual £m</th>
<th>Year to date Variance £m</th>
<th>Forecast Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Development Committee</td>
<td>416.4m</td>
<td>172.3m</td>
<td>174.8m</td>
<td>2.5m</td>
<td>4.2m</td>
</tr>
<tr>
<td>Finance, Performance &amp; BI Committee</td>
<td>17.9m</td>
<td>7.1m</td>
<td>4.6m</td>
<td>(2.5m)</td>
<td>(4.2m)</td>
</tr>
<tr>
<td>Primary Care Commissioning Committee</td>
<td>45.2m</td>
<td>18.8m</td>
<td>18.8m</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Surplus</td>
<td>12.7m</td>
<td>5.3m</td>
<td>-</td>
<td>(5.3m)</td>
<td>(12.7m)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>492.2m</strong></td>
<td><strong>203.5m</strong></td>
<td><strong>198.2m</strong></td>
<td><strong>(5.3m)</strong></td>
<td><strong>(12.7m)</strong></td>
</tr>
</tbody>
</table>

Based on month 5, the Clinical Development Committee (CDC) is forecast to overspend its delegated budget by £4.2m.

The table below illustrates the main areas contributing to the forecast overspend being reported against CDC.

<table>
<thead>
<tr>
<th>Area</th>
<th>Annual Budget £m</th>
<th>Year to date Budget £m</th>
<th>Year to date Actual £m</th>
<th>Year to date Variance £m</th>
<th>Forecast Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Electives</td>
<td>72.8m</td>
<td>30.3m</td>
<td>30.4m</td>
<td>0.1m</td>
<td>0.2m</td>
</tr>
<tr>
<td>Electives</td>
<td>44.4m</td>
<td>18.5m</td>
<td>18.9m</td>
<td>0.4m</td>
<td>1.1m</td>
</tr>
<tr>
<td>Outpatients</td>
<td>45.7m</td>
<td>19.1m</td>
<td>18.9m</td>
<td>(0.2m)</td>
<td>(0.3m)</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>19.0m</td>
<td>7.9m</td>
<td>8.2m</td>
<td>0.3m</td>
<td>0.7m</td>
</tr>
<tr>
<td>Learning Disabilities (LD), Adult Mental Health (MH)</td>
<td>9.2m</td>
<td>3.9m</td>
<td>4.3m</td>
<td>0.4m</td>
<td>0.5m</td>
</tr>
<tr>
<td>Funded Nursing Care (FNC)</td>
<td>4.5m</td>
<td>1.9m</td>
<td>1.8m</td>
<td>(0.1m)</td>
<td>(0.1m)</td>
</tr>
<tr>
<td>Other, including Prescribing</td>
<td>220.9m</td>
<td>90.6m</td>
<td>92.2m</td>
<td>1.6m</td>
<td>2.1m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>416.5m</strong></td>
<td><strong>172.2m</strong></td>
<td><strong>174.7m</strong></td>
<td><strong>2.5m</strong></td>
<td><strong>4.2m</strong></td>
</tr>
</tbody>
</table>

The latest position has been discussed at the CDC and Finance, Performance and Business Intelligence Committees and rectification plans are being monitored and reviewed for each of the overspending items above (excluding FNC where the rate is nationally agreed).

The forecast overspending described above at this point does not result in a breach of the CCG’s financial duties. To mitigate the over-performance the CCG is required to utilise its reserves and identify additional QIPP opportunities in year.

It is vital that spending is robustly managed during the year in order to meet the CCGs duty to achieve the control total set by NHS England.

This will be achieved by:-

- Development of rectification plans in relation to main overspending areas should they arise.
- Continual reviews of all discretionary spend.
- Continued adoption of robust financial governance measures.
- Progress with the achievement of 2018/19 QIPP schemes and develop additional schemes to mitigate the risk of any shortfall in achievement of original plans.
The Board will be kept informed of progress.

4.0 **NHS CONSTITUTION STANDARDS/CCG ASSURANCE**

The CCG has met all but one of the NHS Constitution standards in July 2018, the exception being A&E 4 hour waits.

4.1 **A&E 4 Hour Waits**

A&E waits failed to achieve the 95% national standard in July 2018, with 87.65% of patients admitted, transferred or discharged within 4 hours. A remedial action plan is in place with the Trust which aims to recover the 95% standard by March 2019 in line with national guidance.

4.2 **Cancer Waits (62 Days)**

DGFT recovered the national standard of 85% in July with performance of 85.36%. Contractual action remains in place with the provider with an action plan and recovery timescale agreed with the CCG.

5.0 **PERFORMANCE EXCEPTION REPORTING**

5.1 **Ambulance Handovers**

Both 45 and 60 minute handover breaches improved in August to 53 and 44 respectively. Ambulance handovers form part of the system wide Urgent Care Action plan, which is overseen by the A&E Delivery Board.

5.2 **IAPT Access**

IAPT Access continues to underperform against the national standard, challenged further by the increase from 16.8% to 19% of estimated prevalence (equivalent to 6,468 people accessing the service throughout the year). The June position has been confirmed as 390 against a trajectory of 539 (for Q1 an access rate of 3.56% against the national ambition of 4.75%).

A new payment approach is currently being discussed with the trust utilising the information obtained through the national workforce toolkit and NHSE IST.

In relation to the other key IAPT measure for Recovery; this was confirmed as 42.9% in June, not meeting the 50% national standard.

5.3 **Dementia Diagnosis**

The dementia diagnosis rate increased slightly to 63.29% in August compared to 63.25% in July, equivalent to 2,671 people on the Dementia register.

There was an increase of 6 people on the register and the prevalence figure increased to 4,220 in August compared to 4,213 in July.

The target is to achieve 66.7% of the prevalence recorded on the Dementia register.

6.0 **QIPP 2018/19**

The CCG QIPP target for 2018/19 stands at £16.99m, equating to 3.5% of the CCG’s total resource allocation. The forecast achievement against these plans is £16.99m which is on target for 2018/19.

Overall, the schemes were on track to achieve their forecast target, though the position was tighter this month compared to last month. Some of the schemes were rated as red or amber and it was particularly important to make progress on the A&E indicators.

7.0 **LOCAL INDICATORS**

7.1 **Better Care Fund (BCF)**

There are a number of conditions the health economy must meet to achieve performance within the Better Care Fund (BCF) plan. The BCF plan is managed on a quarterly basis, with the CCG reporting on non-elective admissions and Delayed transfers of care. Both of these areas are performing under plan and meeting the target with performance for July continuing to show a strong position.
8.0 OTHER ITEMS DISCUSSED

8.1 Combined Board Assurance Framework and Risk Register
The risks assigned to the Committee were reviewed and accepted.

8.2 IAPT Financial Impact Update
A report was presented to the Committee detailing the final proposals and implications of a revised IAPT payment mechanism. The proposal is to move from the current block payment arrangement to a cost per case mechanism which aligns with the current IAPT performance measures. The new tariff arrangements will lead to an increase in cost in 2018/19 if the trajectory is achieved. However, this will be offset by any underperformance in activity for the Primary Care Mental Health Team. These new arrangements will be in place from 1st October 2018 and will include a cap and collar arrangement which mitigates the risk of the change for both the CCG and the provider. **The Committee approved the revised IAPT and Primary Care Mental Health Team payment mechanism.**

8.3 Black Country Transforming Care Programme
The Committee received a report originally presented to the Joint Commissioning Committee on the allocation of resources transferred from NHSE to the Black Country TCP to fund costs associated with patients/clients with a learning disability discharged from the care of specialised services.

£3.6m had been transferred from specialised services to the Black Country TCP for 62 specialised services patients. This was currently sitting with Sandwell and West Birmingham CCG, which was hosting the TCP resource and is to be distributed to the CCGs. The process defined by NHSE for 2018/19 was that £180,000 (based on average cost) would be allocated to each CCG for each net discharge from specialised services into community care.

One of the key assumptions with the resource transfer was that the CCG would receive the benefit/risk should future costs be higher/lower. At this stage in the year, Dudley was expecting to be a net gainer due to the encouraging progress being made to transfer patients from specialised services to community care.

**The Committee supported and approved the principle that in 2018/19 £180,000 followed the patient for each net discharge. It also agreed that each CCG would operate a pool/risk-share to support the principles outlined in the report.**

8.4 MCP progress update
The Committee received an update on the work the CCG had been carrying out on a system bid for financial support to complete the implementation of the MCP.

The request was for £8.4m funding over two years. There were three elements to the bid, with recommended funding sources. These were;
(i) £2.02m for the CCG to continue the procurement/ISAP process;
(ii) £4.37m for mobilisation and development of the MCP and the separation of DGFT, the expectation was that this could be funded by NHS Improvement as the CCG and DGFT were unable to fund this, and
(iii) £2m NHSI/NHSE capital to fund the costs of business intelligence infrastructure and single point of access/communications hub. The capital bids would require STP support as they would be using STP funding.

The Committee confirmed that it would not support the use of its funding for the separation of the Trust and the paper was currently with DGFT for agreement before publication.

Additionally the CCG proposed to make a request to NHSE/NHSI for the ISAP process to be decoupled from the Foundation Trust separation process as the expectation was that the separation would not be completed by the end of this financial year. This was to allow DGFT to continue to work on the operational issues within the Trust. DGFT had not yet confirmed this approach.

8.5 A&E Delivery Board
The A&E Delivery Board dashboard report for September was presented to Committee for information. The report highlighted general improvement in four hour waits with the trust meeting the 90% recovery standard on two separate weeks; the trust still plan on meeting the 95% national
standard by the end of quarter 4 18/19. There had been no significant changes in attendance outcomes over the last 12 months, with between 32-40% of all attendances being discharged.

9.0 REPORTS FROM GROUPS ACCOUNTABLE TO THE COMMITTEE

9.1 IT Strategy Sub-Committee
The Committee received an update on the issues discussed by the IT Strategy Group and noted good progress on implementing projects within the strategy. The main issues for the Board to note were the majority of the roll out of CCG laptops would be completed by the end of September 2018; the actions in progress in respect of the IT security framework; actions taken following data loss at one practice; an update on NHS Digital security alerts; discussion on the IT risks and issues register; a position statement provided on CAS alerts relating to Docman 7; the potential replacement of fax machines; an update on on-line consultation and the decision to procure Sense.ly; updates provided on current IT projects, including desktop refresh, Local Digital Roadmap (LDR), the second phase of the POD, and an update on Single Point of Access.

In respect of the CAS alerts, NHS England (NHSE) had alerted CCGs and GP practices to an incident where some records received by NHS mail had not been processed and not transferred into the patient record because of an error within Docman. The IT team was trying to assess the clinical risk for the CCG and Dudley GPs.

Over the last few months, the CCG had been considering its position with regard to on-line consultation. The CCG had received external funding and had been advised to use the framework to procure this. However, Sense.ly, which is a current provider to Dudley, already had this functionality. A satisfactory technical assessment had confirmed this functionality. At the suggestion of Sandwell and West Birmingham CCG, Dudley had also tested the system used by that organisation. The view was that it was not as effective as the Sense.ly product and was considerably more expensive. The Sub-Committee therefore stood by its original decision to procure Sense.ly. The Committee supported this view.

9.2 Estates Strategy/Operational Group
The Committee received an update on the issues discussed by the Estates Operational Group and discussed a number of items in relation to the current year work programme as part of the Health Infrastructure Strategy. The main issues for the Board to note are continual review of space utilisation across the Dudley Health Economy; the review of statutory compliance across the primary care and community estates; the appointment of Hempsons solicitors to work on the agreement of a lease with Community Health Partnerships and agreement to follow a similar joint process in respect of NHS Property Service leases; an update on the three priority areas – Opportunities of Corbett Lower Site, future use of Ridge Hill inpatient unit and Bushey Fields Hospital; the business cases for Kingswinford and Lye were delayed pending confirmation of the Local Authority’s intention regarding the community centre on the Kingswinford site and confirmation of the MCP’s requirements in both schemes and consideration of a premises improvement grant from Wychbury Medical Practice.

9.2.1 Capital Investment Opportunities
The Committee was informed that the Local Estates Forum, established as part of the STP structure, had met to discuss a number of premises issues including current capital investment opportunities.

Under the National Estates and Technology Transformation Fund (ETTF) process, each STP region had been allocated a funding pot, with the Black Country budget totalling £4.0m in 2018/19 and £4.3m in 2019/20. The budget is managed by NHS England local team, with prioritisation and assurance of schemes taking place at an STP level. The latest ETTF plan contains six Dudley CCG schemes, two schemes for 2018/19 amounting to £478,000 and include IT provision for a remote desktop solution for General Practice and DDA improvements at Netherton HC. Four schemes form part of 2019/20 plans with a total value of £1.77m all supporting the Estates Strategy in consolidating General Practice, alongside a number of STP wide IT schemes with a total value of £1.8m in which Dudley CCG is a stakeholder.

In addition to the ETTF, funding of £2.65m (2018/19) and £2.36m (2019/20) has also been secured by the STP for a Health System Led Investment (HSLI) programme in Provider Digitalisation. A prioritisation matrix produced by the Black Country LDR group was used to prioritise Provider Bid submissions resulting in DGFT’s population health system of £1.4m ranking third against 2018/19 funding schemes and being recommended for submission to NHS England.
10.0 ADDITIONAL ITEM FROM FP&BI COMMITTEE HELD ON 25 OCTOBER 2018

At its meeting held on 25th October the Committee considered an urgent request from NHS England for the CCG to consider deferring its planned drawdown of £960,000 from its historic surplus from 2018/19 to 2019/20. The reason is twofold: this mechanism will enable NHS England to facilitate the request from the CCG and partners to access the CCG’s surplus to fund commissioner elements of the request to regulators for MCP support; and also it contributes to the overall balance of the NHS budget. The CCG would be able to drawdown double the deferral, ie cumulative surplus of £1.92m in 2019/20, as a minimum.

As part of its consideration the Committee was advised that Walsall CCG had recently agreed to repay the £1m it had received from Dudley CCG through the risk pool arrangement in previous years in 2018/19. This had not been built into Dudley CCG’s financial plans for 2018/19. After some deliberation the Committee agreed to support NHS England’s request to defer the drawdown of Dudley CCG’s historic deficit to 2019/20. The main factors in the Committee’s decision was the unplanned availability of £1m from Walsall CCG and the ability to secure funding in 2019/20 that would support the financial risk surrounding the mobilisation of the MCP.

The Board is requested to formally ratify the Committee’s support to the deferral of £960,000 CCG drawdown of its historic surplus.

11.0 DECISIONS TAKEN UNDER DELEGATED POWERS

Under delegated powers the Committee endorsed and approved the following:-

- Approved the revised IAPT and Primary Care Mental Health team payment mechanism
- Supported and approved the principle that in 2018/19 £180,000 followed the patient for each net discharge from the care of specialised services.
- Endorsed the procurement of Sense.ly to provide the application to support on-line consultations.
- Supported the recommendation to defer the drawdown of historic surplus from 2018/19 to be drawn in 2019/20.

12.0 RECOMMENDATION

The Board is asked to receive the report for assurance, note the decisions taken under delegated powers and formally ratify the Committee’s decision in respect of the CCG’s drawdown of its historic surplus.

Mr M Hartland
Chief Finance and Operating and Officer
November 2018
TITLE OF REPORT: Report of the Commissioning Development Committee

PURPOSE OF REPORT: To note matters considered by the Commissioning Development Committee

AUTHOR OF REPORT: Mr Neill Bucktin – Director of Commissioning

MANAGEMENT LEAD: Mr Neill Bucktin – Director of Commissioning

CLINICAL LEAD: Dr Jonathan Darby – Clinical Executive

KEY POINTS:
1. QIPP Programme to date is £160,000 behind its delivery target, the year-end target is still on track.
2. Financial over-performance of £5.12m related to emergency, ED and day case activity at Dudley Group NHS Foundation Trust and learning disability inpatient activity.
3. Repeat Prescribing POD telephony arrangements now approved and roll out taking place.
4. Revised policy on NHS Continuing Healthcare approved following legal advice, as a basis for patient and public engagement.
5. Internal audit report received on commissioning arrangements giving significant assurance.
6. Further report to be considered on proposed “well leg” service.
7. Support given to Dudley MBC’s Physical Activity Strategy.

RECOMMENDATION: That the matters considered by the Commissioning Development Committee be noted.

FINANCIAL IMPLICATIONS: None arising directly from this report

WHAT ENGAGEMENT HAS TAKEN PLACE: None

ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: None

ACTION REQUIRED: Decision Approval ✓ Assurance
1.0 PURPOSE OF REPORT

1.1 To advise the Board of matters considered by the Commissioning Development Committee

2.0 BACKGROUND

2.1 The Commissioning Development Committee met on 17 October 2018. This report advises the Board of the matters considered.

3.0 QIPP 2018/19 – PROGRESS REPORT

3.1 The Committee has considered progress against the 2018/19 QIPP Programme. Whilst the programme to date is £160,000 behind its delivery target, the year-end target is still on track. The main areas contributing to current under performance relate to emergency care. In particular, the anticipated reduction in emergency activity transferring from ED to the UTC has not materialised.

4.0 FINANCE AND PERFORMANCE 2018/19

4.1 An over performance of £5.12m is currently forecast. This relates to emergency admissions, ED attendances and day cases at Dudley Group NHS Foundation Trust which has been offset by under-performance at other acute providers. In addition there is over-performance in relation to learning disabilities inpatients which should be offset through the implementation of the Transforming Care Programme.

4.2 Whilst performance in relation to the IAPT access target remains a challenge, targets relating to the BCF schemes are being met.

5.0 MEDICINES MANAGEMENT

5.1 A review of medicines and device related Datix entries has demonstrated that Datix is being used by 7 practices and the Urgent Treatment Centre. It is anticipated that it will be available to all practices during the autumn. The aim is to inform learning and improve the safe use of medicines through the root cause analyses of incidents as they occur.

5.2 An audit of the prescribing of Direct-Acting Oral Anti-Coagulants (DOACs) has demonstrated the need for practices to prescribe, rather than referring to the anticoagulation clinic. This requires a redesign of services such that only Warfarin and non-valvular atrial fibrillation (NVAF) causes should be referred to the anticoagulation clinic.

5.3 As a result of an audit relating to Gram-negative Blood Stream Infections, the Area Clinical Effectiveness Sub-Committee has requested visits to a number of practices focussing on the improvement of anti-microbial stewardship.

5.4 The Committee has noted that the Repeat Prescribing POD now covers 8 practices. Telephony arrangements have now been finalised and the roll out programme can be implemented further.

6.0 NHS CONTINUING HEALTHCARE CHOICE AND RESOURCE ALLOCATION POLICY

6.1 The Board will recall a legal challenge made by the Equality and Human Rights Commission (EHRC), regarding the legality of the CCG’s policy in relation to NHS Continuing Healthcare. This challenge related to the financial threshold in the existing policy. Commissioning of NHS Continuing Healthcare packages in the home has always been limited such that, based upon the
equivalent costs of a care home placement, a package at home will not be commissioned if it exceeds that cost by more than 20%.

6.2 The existing policy, alongside those of other CCGs, has now been reviewed with appropriate legal advice. A revised policy has been approved by the Committee which retains the threshold, whilst describing more clearly how the policy needs to be implemented in the context of the CCG’s responsibilities to commission healthcare for the whole population and the need to allocate resources appropriately to fulfil those responsibilities.

6.3 The policy will now be the subject of patient and public engagement and the Committee will consider a further report on the outcome in December 2018.

7.0 INTERNAL AUDIT REPORT - COMMISSIONING ARRANGEMENTS

7.1 The Committee has received a report on the outcome of an internal audit review of commissioning arrangements. The report gave an assurance level of “significant assurance”. Three issues were identified for further action:-

- ensuring meetings of the Committee were quorate;
- monitoring arrangements in relation to the National “Must Dos”;
- the identification of the financial implications of any service de-commissioning.

8.0 COMMISSIONING A WELL LEG SERVICE

8.1 The Committee has considered a report on the potential development of a well leg service for patients with a healed leg but have remaining risk factors and do not meet the criteria for existing services. A further report will be considered in due course.

9.0 PHYSICAL ACTIVITY STRATEGY 2018/2023

9.1 The Committee has supported Dudley MBC’s Physical Activity Strategy. The strategy has been developed in accordance with the goals of the Joint Health and Wellbeing Strategy:-

- promoting healthy weight;
- reducing the impact of poverty;
- reducing loneliness and isolation.

9.2 The strategy is based upon three priorities for delivery:-

- mobilising the community, working with local groups and clubs;
- making Dudley a place in which it is easy to be active, in a safe and pleasant environment;
- encouraging people to see being physically active as the norm – the “way we do things” in Dudley.

9.3 This strategy will inform much of the MCP’s future approach to prevention

10.0 RECOMMENDATION

10.1 That the matters considered by the Commissioning Development Committee be noted.

Mr N Bucktin
Director of Commissioning
October 2018
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Meeting:** 8 November 2018  
**Report:** Report from the MCP Procurement Project Board  
**Agenda item No:** 10.2

<table>
<thead>
<tr>
<th><strong>TITLE OF REPORT:</strong></th>
<th>Multi-Specialty Community Provider (MCP) Procurement – Report of the Procurement Project Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To provide an update to the Governing Body in relation to the procurement and mobilisation of the MCP</td>
</tr>
<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Mr N Bucktin – Director of Commissioning</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mr N Bucktin – Director of Commissioning</td>
</tr>
<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr D Hegarty – Chair</td>
</tr>
</tbody>
</table>

**KEY POINTS:**
1. Transition Board has approved an interim leadership team structure  
2. Outcome of discussions with Clinical Senate awaited  
3. Proposal to make initial submission for ISAP Checkpoint 2 being considered by NHS England and NHS Improvement  
4. Internal audit review has provided “significant assurance”  
5. Comments made to NHS England in relation to the proposed Integrated Care Provider (ICP) contract  
6. Work taking place on proposed new CCG organisation

**RECOMMENDATION:**
1. That the matters considered by the Procurement Project Board be noted  
2. That consideration be given to making a submission for Checkpoint 2 of the Integrated Support and Assurance Process (ISAP) in the light of any advice received from NHS England/NHS Improvement

**FINANCIAL IMPLICATIONS:**
None arising directly from this report

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
None

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:**
1. GP Board members – partners to the bidding partnership and potential integration partners to the MCP  
2. Executive directors – potentially affected by the future configuration of the CCG as a commissioning body

**ACTION REQUIRED:**
- Decision  
- Approval  
- Assurance
1.0 PURPOSE OF REPORT

1.1 To note matters considered by the MCP Procurement Project Board

2.0 BACKGROUND

2.1 The Governing Body has established the MCP Procurement Project Board as the means for managing the procurement of the MCP. This report covers issues considered by the Project Board at its meetings on 8 and 24 October 2018.

3.0 TRANSITION BOARD

3.1 The Transition Board continues to meet and agreement has been reached on the make-up of the Transitional Leadership Team. Arrangements are being made to recruit to this team. A separate report from the Transition Board is included on this agenda.

4.0 CLINICAL SENATE REVIEW

4.1 Representatives from the Project Board and the bidding partnership met with representatives of the West Midlands Clinical Senate on 19 September 2018. The Senate representatives received a presentation on the development of the MCP clinical model, its associated outcomes and the clinical governance arrangements for the MCP organisation.

4.2 This meeting was positive and comments have been fed back from Senate representatives which have been responded to formally. The key test from this perspective that applies to the Integrated Support and Assurance Process (ISAP) is whether the proposals are “clinically sound, evidence based and feasible”. Confirmation is now being sought that this test has been passed.

5.0 ISAP

5.1 Discussions have taken place with regional and national representatives of NHS England and NHS Improvement to review the position in relation to ISAP Checkpoint 2 and the FT Transaction Review/Separation. This focussed on 3 issues:-

- Clinical Senate Review (see above);
- financial support for the Transaction Review/Separation;
- timetable for the process.

5.2 Following the discussion in relation to financial support, a bid has been submitted to both NHS England and NHS Improvement for suitable resources and the outcome is awaited.

5.3 The meeting was presented with a timetable based upon a contract “go live” date of 1 April 2020. This included the initial submission of documentation relating to the commissioner elements of ISAP Checkpoint 2, as previously considered by the Governing Body, in advance of the related Transaction Review materials. NHS England and NHS Improvement representatives have agreed to consider this and a response is awaited. ISAP Checkpoint 2 could not begin formally until the outstanding judicial review appeal (due to be considered in the Court of Appeal on 21/22 November 2018) and the consultation on the Integrated Care Provider Contract has concluded.

5.4 A number of further items are awaited from the bidding partnership. These items and the timescale for their production provided by the partnership is awaited. A further update on any response received from
NHS England and NHS Improvement in relation to ISAP and from the bidding partnership will be made to the meeting.

6.0 INTERNAL AUDIT REVIEW

6.1 An internal audit review of the process to date has been carried out and this will be considered by the Audit & Governance Committee in December 2018. The report found “significant assurance”. The auditors have been asked to clarify whether there are any specific recommendations to be pursued.

7.0 PROPOSED INTEGRATED CARE PROVIDER (ICP) CONTRACT

7.1 The Project Board has considered the proposed ICP contract. A response has been made to the consultation process. The proposed contractual form is welcomed in terms of how it provides an effective means of facilitating an integrated care model designed to deliver a set of outcomes. A response has been made to the national consultation process, this has included a specific discussion with colleagues from the New Care Models Team on how we would wish to utilise the contract to facilitate an incentivised means of population health management.

8.0 FUTURE CCG ORGANISATION

8.1 Further consideration has been given to the future configuration of the CCG in the light of the activities currently carried out by the CCG which will transfer to the MCP and the style of commissioning organisation required to operate alongside the MCP once the contract is operational. This matter is the subject of a separate report in the private section of this agenda.

9.0 RECOMMENDATION

9.1 That the matters considered by the Procurement Project Board be noted.

9.2 That consideration be given to making a submission for Checkpoint 2 of the Integrated Support and Assurance Process (ISAP) in the light of any advice received from NHS England/NHS Improvement.

Neill Bucktin
Director of Commissioning
October 2018
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 8 November 2018  
**Report:** Integrated Commissioning Executive  
**Agenda item No:** 10.3

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Report of the Integrated Commissioning Executive</th>
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<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To note matters considered by the Integrated Commissioning Executive</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr Neill Bucktin – Director of Commissioning</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr Neill Bucktin – Director of Commissioning</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr Jonathan Darby – Clinical Executive</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

1. Continued good performance in relation to Better Care Fund (BCF) metrics  
2. Improved Better Care Fund (iBCF) schemes reviewed  
3. Benefit of these schemes and funding streams to be identified

**RECOMMENDATION:**

That the matters considered by the Integrated Commissioning Executive be noted

**FINANCIAL IMPLICATIONS:**

None arising directly from this report

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

None

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:**

None

**ACTION REQUIRED:**

- Decision Approval
- ✓ Assurance
1.0 PURPOSE OF REPORT

1.1 To note matters considered by the Integrated Commissioning Executive

2.0 BACKGROUND

2.1 The Integrated Commissioning Executive is the body responsible for governing the Section 75 Agreement between the CCG and the Council for the Better Care Fund (BCF). This report sets out those matters considered by the Executive at its meeting on 5 September 2018.

3.0 BCF PERFORMANCE METRICS

3.1 The Executive have noted a consistent performance in terms of meeting the BCF metrics:

- a reduction in non-elective admissions;
- a reduction in admissions to nursing and residential care;
- an increase in the proportion of patients still at home 91 days after discharge;
- a reduction in delayed transfers of care.

4.0 FINANCIAL PERFORMANCE

4.1 The Executive have noted that the BCF is over performing in terms of expenditure on some elements of community services. This is being addressed through the contract monitoring process with Dudley Group NHS Foundation Trust.

5.0 IMPROVED BETTER CARE FUND (iBCF)

5.1 The Board will recall that additional resources were made available to Councils through the iBCF to be included with the BCF pooled fund. The Executive has reviewed the operation of the specific schemes funded non-recurrently from this element of the pooled fund. The main highlights being:

- 87.5% of people seen by the Emergency Response Team have not been admitted following an initial hospital attendance;
- 10% of people identified as requiring 24 hour care upon discharge have been returned to their own home;
- the number of average weekly discharges has increased;
- promotion of single handed care has resulted in a 16.24% reduction in hours for packages of care.

5.2 The commissioning of these services on a recurrent basis features in the CCG’s commissioning intentions. Further work on the benefit of the schemes and the associated sources of funding will now be addressed to inform the CCG’s financial planning.

6.0 RECOMMENDATION

6.1 That the report of the Integrated Commissioning Executive be noted.

Neill Bucktin
Director of Commissioning
October 2018
### DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Board:** 8 November 2018  
**Report:** Report from the Primary Care Commissioning Committee  
**Agenda Item No:** 11.1

<table>
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<tr>
<th>TITLE OF REPORT:</th>
<th>Report from the Primary Care Commissioning Committee</th>
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<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board on key issues discussed at the meetings of the Primary Care Commissioning Committee on 28 September 2018 and 19 October 2018. To present the Committee’s revised Terms of Reference for formal ratification</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs J Robinson, Primary Care Contracts Manager</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
</tbody>
</table>

#### KEY POINTS:
- The Committee:
  - Received assurance from the Primary Care Operational Group (PCOG) that there were no contractual breaches to be issued
  - Approved an extension to the APMS contract with QOF Doc, operating as High Oak Surgery
  - Accepted the application from Three Villages Medical Practice to close the Wollaston branch surgery
  - Received for assurance information in relation to the Central Alerting System sent to GP practices relating to Docman 7
  - Received for assurance the Quality and Safety Report
  - Noted the reported financial position
  - Considered and accepted the current risk register ratings
  - Approved amendments to the Terms of Reference of The Primary Care Operational Group
  - Approved amendments to the Terms of Reference of The Primary Commissioning Committee for ratification by the Governing Body noting the addition of the Head of Membership Development as Deputy to the Chief Nurse.
  - Approved the process for Commissioning Performance and QIPP practice visits

#### RECOMMENDATIONS:
- The Board is asked to note for assurance the issues discussed, and decisions taken by the Primary Care Commissioning Committee
- The Board is asked to formally ratify the Committee’s revised Terms of Reference

#### FINANCIAL IMPLICATIONS:
- The budget delegated to the Committee is £45,175,000

#### WHAT ENGAGEMENT HAS TAKEN PLACE:
- NHS England
- CQC
- Member practices
- Local Medical Committee
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<th>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE</th>
<th>No conflicts of interest identified</th>
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<tr>
<td>ACTION REQUIRED:</td>
<td>Decision</td>
</tr>
<tr>
<td></td>
<td>✓ Approval</td>
</tr>
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<td></td>
<td>✓ Assurance</td>
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</table>
1.0 INTRODUCTION

1.1 This report summarises the key issues discussed at the Primary Care Commissioning Committees held on 28 September 2018 and 19 October 2018.

PRIMARY CARE CONTRACTING

1.2 Committee received assurance from the Primary Care Operational Group (PCOG) that there were no contractual breaches to be issued.

High Oak Surgery

1.3 Committee agreed to extend the Alternative Provider Medical Services (APMS) contract with QOF Doc, operating as High Oak Surgery until 31 March 2020. The item was taken in private session due to private information detailed in the report.

1.4 The extension of the contract was proposed to be consistent with the expected timeline for the mobilisation of the MCP contract. The MCP is expected to assume full operational arrangements for the provision of primary medical services for those patients registered with the practice with effect from the 1 April 2020.

Three Villages Medical Practice - Closure of the Wollaston branch

1.5 Committee received the application from Three Villages Medical Practice to close the branch surgery at Wollaston.

1.6 To provide a greater opportunity for patients to attend, the meeting was held at The Amblecote Christian Centre, there were approximately 40 members of the public and public representatives in attendance.

1.7 Committee reviewed the comprehensive application and the practice spoke about the rationale for consolidating the 2 sites to bring all of the services together at Stourbridge Health and Social Care Centre (SH&SCC).

1.8 The CCG received a ‘Save Our Surgery’ petition with 872 signatures, formally handed to the CCG Accountable Officer.

1.9 The key points from the engagement and the PPC Action Group submission included, but not limited to, lack of suitable local public transport, lack of parking at SH&SCC, concerns about the stability of the pharmacy in Wollaston, loss of phlebotomy services, loss of Sunday access, access to appointments at SH&SCC, the PPG run tea party and effect on the well-being of elderly patients and that the proposal was perceived as being a business decision.

1.10 The Chair gave members of the public the opportunity to ask questions that had not already been covered. CCG representatives and the senior partner of Three Villages Medical Practice provided responses to the questions posed.

1.11 Committee considered the application and all documentation in accordance with the delegation agreement, NHS Regulations, NHS England policy and the CCG process for closing branch surgeries. The NHS England representative confirmed that Dudley CCG has a robust process for the closure of branch surgeries and informed Committee that they were satisfied that the CCG had fulfilled its statutory obligations and had considered the application in line with NHSE policy and guidance.
1.12 The voting members of the Committee unanimously formally accepted and approved the branch closure application.


2.0 CENTRAL ALERTING SYSTEM – DOCMAN 7

2.1 Committee received information in relation to the Central Alerting System (CAS) to GP practices relating to Docman 7.

2.2 Docman software is used by practices to automate the movement of documents and letters arriving by NHSmail into the Docman system for filing to the patient record. Once processed the email is automatically moved from the NHSmail inbox into a deleted folder. Where a file transfer fails, and the document is not moved into Docman then an alert is created.

2.3 CAS communication has been issued by NHS England to alert the CCG and GP practices to the issue where the file transfer has failed and where systems may not have not been in place to identify the alert and manage any unprocessed records that do not transfer automatically.

2.4 The issue affects GP practices across England using Docman version 7 software with Electronic Document Transfer (EDT) enabled; all Dudley GP practices are affected.

2.5 There are a number of tasks that practices have been required to complete including installation of software (made available by Docman) to identify any unprocessed records and undertaking a clinical risk assessment.

2.6 There are workload implications arising from this issue and practices across the Country are seeking funding; a national decision is yet to be taken.

2.7 Committee received assurance that no high risk harm has been identified and that this matter was also being managed through the IT Strategy Group.

3.0 QUALITY

3.1 The Quality and Safety report to the Board will set out in more detail those areas pertinent to primary care.

4.0 FINANCE

4.1 A break-even position is forecast in respect of delegated co-commissioning and core CCG budgets.

4.2 Committee noted the reported financial position.

5.0 RISK REGISTER

5.1 Risks assigned to Committee were reviewed and updated.

6.0 TERMS OF REFERENCE (TOR)

6.1 Committee approved minor changes to the TOR of the Primary Care Operational Group.

6.2 Committee was advised of the action taken by the Board under Emergency Powers on 8 October 2018 (reported at item 8.4 of the agenda). This was that the nominated representatives for the Chief Nurse at the Committee were the Head of Quality Assurance in relation to Quality and Safety matters and the Head of Membership Development in relation to Primary Care matters.

6.3 Committee approved the revised Terms of Reference.
6.4 The revised Terms of Reference of The Primary Commissioning Committee with the amendments shown in red are presented for formal ratification by the Board.

7.0 COMMISSIONING PERFORMANCE AND QIPP PRACTICE VISITS

7.1 The Governing Body agreed a membership engagement plan in May 2018. The plan included engagement on commissioning performance and QIPP taking place at 3 levels: the practice, the locality and the borough.

7.2 Committee received a report setting out how General Practice will be engaged in the management of their commissioning performance and delivery of QIPP, the information provided to practices, the actions required and reporting of engagement.

7.3 Committee approved the process and reporting arrangements.

8.0 RECOMMENDATIONS

8.1 The Board is asked to note for assurance the issues discussed, and decisions taken by the Primary Care Commissioning Committee on 28 September 2018 and 19 October 2018.

8.2 The Board formally ratify the revised Terms of Reference of the Committee (Appendix 1)

Mrs J Robinson
Primary Care Contracts Manager
October 2018

ENCLOSURE: Appendix 1 – Revised Terms of Reference
Governing Body’s

Primary Care Commissioning Committee

Terms of Reference – Version 2.6

AMENDMENT HISTORY

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<thead>
<tr>
<th>VERSION</th>
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<th>AMENDMENT HISTORY</th>
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<tbody>
<tr>
<td>V1.0</td>
<td>December 2014</td>
<td>First Draft of PCC TOR</td>
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<td>V1.0</td>
<td>May 2015</td>
<td>Presented to Board for approval</td>
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<tr>
<td>V2.0</td>
<td>October 2016</td>
<td>Governance Team reviewed with PC Team</td>
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<td>V2.1</td>
<td>November 2016</td>
<td>Further changes made to the nominated representatives &amp; quoracy</td>
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<td>V2.2</td>
<td>November 2016</td>
<td>Further changes made in relation to referencing – move to V2.3</td>
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<td>V2.3</td>
<td>December 2016</td>
<td>Further changes made following Committee in November.</td>
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<tr>
<td>V2.4</td>
<td>May 2017</td>
<td>Lay Member for Patient &amp; Public Engagement made a Voting Member of the Committee</td>
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<tr>
<td>V2.5</td>
<td>February 2018</td>
<td>Slight amends following NHS England review</td>
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<tr>
<td>V2.6</td>
<td>September 2018</td>
<td>Amendment to Chief Nurse nominated representative and reference included regarding 75% attendance.</td>
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REVIEWERS
This document has been reviewed by:

<table>
<thead>
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<th>DATE</th>
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<tbody>
<tr>
<td>Paul Lewis-Grundy</td>
<td>May 2015</td>
<td>Governance Manager</td>
<td>V1.0</td>
</tr>
<tr>
<td>Emma Smith</td>
<td>October 2016</td>
<td>Governance Support Manager</td>
<td>V2.0</td>
</tr>
<tr>
<td>Julie Robinson</td>
<td>October 2016</td>
<td>Primary Care Contracts Manager</td>
<td>V2.0</td>
</tr>
<tr>
<td>Daniel King</td>
<td>November 2016</td>
<td>Director Membership Development &amp; Primary Care</td>
<td>V2.1</td>
</tr>
<tr>
<td>Sue Johnson</td>
<td>November 2016</td>
<td>Deputy CFO</td>
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APPROVALS
This document has been approved by:

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<th>BOARD/COMMITTEE</th>
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<tr>
<td>V1.0</td>
<td>Dudley CCG Board</td>
<td>May 2015</td>
</tr>
</tbody>
</table>
NB: The version of this policy posted on the intranet must be a PDF copy of the approved version.

Please note that any changes to these Terms of Reference must be done in line with the Terms of Reference Development Guidance. Changes must be agreed at Committee and ratified through the Governing Body. The Governance Team must be included in any revision to ensure that the statutory duties are unaffected and in line with the CCGs Constitution.
Primary Care Commissioning Committee – Terms of Reference

1. Introduction & Purpose

1.1. The Primary Care Commissioning Committee (the ‘Committee’) is established in accordance with paragraph 6.7.1(f) of NHS Dudley Clinical Commissioning Group’s (CCG) constitution. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and will have effect as if incorporated into the constitution. The Committee terms of reference will be reviewed annually. Any changes to the terms of reference will be approved by the Governing Body.

1.2. The Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

1.3. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these terms of reference to NHS Dudley CCG. The delegation is set out in Schedule 1.

1.4. The CCG has established the NHS Dudley CCG Primary Care Commissioning Committee (“Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.5. It is a committee comprising representatives of the following organisations:

- NHS Dudley CCG; and
- The Office of Public Health, Dudley Metropolitan Borough Council
- A representative from NHS England will also be in attendance

2. Membership

2.1. Each member of the Committee as defined in Schedule 3 shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. The aim of the Committee will be to achieve consensus decision-making wherever possible.

2.2. The voting membership will include all independent members of the governing body except the Chief Officers excluding the Chief Accountable Officer; and the Public Health representative. That is:

- Lay member for Governance (Chair)
- Lay member for Quality & Safety (Vice Chair)
- Lay member for Patient & Public Engagement
- Secondary Care Specialist Doctor
- Chief Operating & Finance Officer (or their nominated representative the Deputy Chief Finance Officer)
- Chief Nurse (or their nominated representatives, the Head of Quality Assurance in relation to Quality and Safety matters or The Head of Membership Development in relation to Primary Care matters)
- Public Health representative

2.3. All voting members of the Committee (or formally nominated deputy) will be required to attend
75% of meetings in a 12 month period.

2.4 The Chair of the Committee will be appointed by the Governing Body. Unless there are any material reasons for not doing so this person will be the Governing Body lay member responsible for governance matters. Where the latter is not the case the material reasons must be documented.

2.5 The Vice Chair of the Committee will be appointed by the Committee members.

2.6 Other people that will normally be in attendance (members but non-voting) will include a:

- HealthWatch representative
- Health and Wellbeing Board representative
- Patient Opportunity Panel representative
- LMC representative
- LPC representative
- GP Lay Member
- Head of Membership Development & Primary Care

2.7 Governing Body elected GPs, Clinical Executives, NHS England representation, other GP members or employees of the CCG (not already listed in the membership) will be in attendance for those agenda items that the Committee membership has deemed appropriate for their input. This will be in an advisory and non-voting capacity. The CCG’s “Registering Interests and Managing Conflicts of Interest Policy” will be observed and complied with at all times.

3. Secretary

3.1 A named individual will be responsible for supporting the Chair in the management of the Committee’s business and for drawing members’ attention to best practice, national guidance and other relevant documents as appropriate.

4. Quorum

4.1 A meeting of the Committee will be quorate provided that at least 4 voting members are present of which:

- One must be either the Chair or Vice-Chair of the Committee
- One must be the Chief Operating & Finance Officer or Chief Nurse or their nominated representatives as stated in the membership section

5. Frequency of meetings

5.1 The Committee will formally meet on a monthly basis. There may be a need for the Committee to meet informally from time to time. Any informal meetings will support the work of the Committee and will have no delegated decision-making authority.

5.2 Meetings of the Committee shall:

a. Be held in public, subject to the application of section 2.1

b. the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest be reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
6. Authority & Statutory Framework

6.1 The Committee will be directly accountable for the commitment of the resources / budget delegated to the CCG by NHS England for the purpose of commissioning primary care medical services. This includes accountability for determining appropriate arrangements for the assessment and procurement of primary care medical services, and ensuring that the CCG’s responsibilities for consulting with its GP members and the public are properly accounted for as part of the established commissioning arrangements.

6.2 For the avoidance of doubt, the CCG’s Scheme of Reservation & Delegation, Standing Orders and Prime Financial Policies will prevail in the event of any conflict between these terms of reference and the aforementioned documents.

Statutory Framework

6.3 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6.4 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.5 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act, including:

   a) Management of conflicts of interest (section 14O);
   b) Duty to promote the NHS Constitution (section 14P);
   c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
   d) Duty as to improvement in quality of services (section 14R);
   e) Duty in relation to quality of primary medical services (section 14S);
   f) Duties as to reducing inequalities (section 14T);
   g) Duty to promote the involvement of each patient (section 14U);
   h) Duty as to patient choice (section 14V);
   i) Duty as to promoting integration (section 14Z1);
   j) Public involvement and consultation (section 14Z2).

6.6 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those functions set out below:
   
   * Duty to have regard to impact on services in certain areas (section 13O);
   * Duty as respects variation in provision of health services (section 13P).

6.7 The Committee is established as a committee of the Governing Body of NHS Dudley CCG in accordance with Schedule 1A of the “NHS Act”.

6.8 The CCG (and Committee) is subject to directions made by NHS England or by the Secretary of State for Health.

7. Remit Duties and Responsibilities

Operation of the Committee

7.1 The Committee will operate in accordance with the CCG’s Standing Orders and “Registering Interests and Managing Conflicts of Interest Policy”. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent
circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify. The reasons for calling a meeting at short notice will be recorded in the minutes of the meeting.

7.2 GPs and patients are represented in the committee through the inclusion of non-voting members from the LMC; Healthwatch and the Patient Opportunity Panel.

7.3 Members of the Committee have a collective responsibility for the operation of the Committee.

7.4 The Committee may delegate tasks to such people, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the CCG’s relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

7.5 The Committee may call experts, as required, to attend meetings and inform discussions.

7.6 Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Constitution, and comply with Section 8 of the Constitution: Standards of Business Conduct and Managing Conflicts of Interest.

7.7 Following each meeting, the Committee will present its minutes to NHS England and report to the governing body of the CCG (including the minutes of any sub-committees to which tasks have been delegated under paragraph 7.4 above).

7.8 The Committee will also comply with any reporting requirements set out in the CCG Constitution.

Procurement of Agreed Services

7.9 The procurement arrangements will be set out in the delegation agreement (Schedule 1 and Schedule 2 to this Terms of Reference) between NHS Dudley CCG and NHS England.

Decisions

7.10 The Committee will make decisions within the bounds of its terms of reference.

7.11 The decisions of the Committee shall be binding on NHS England and NHS Dudley CCG where they are within the bounds of the terms of reference.

Role of the Committee

7.12 The Committee has been established in accordance with the above statutory provisions to enable decisions on the review, planning and procurement of primary care services in Dudley, under delegated authority from NHS England.

7.13 In performing its role the Committee will exercise its management of the functions in accordance with the agreement between NHS England and NHS Dudley CCG.

7.14 The functions of the Committee are undertaken in the context of continually improving the quality of care provided to patients within the resources available. This is underpinned by equality of access to services, increased efficiency, productivity, value for money and to minimise bureaucracy.

7.15 The Committee will have at its heart three key principles, of shared ownership, shared responsibility and shared benefits to create jointly the best healthcare for the registered patients of Dudley.

7.16 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.
7.17 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Improvement Schemes" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

7.18 The CCG will also carry out the following activities:

a) To plan for sustainable primary medical care services in Dudley;
b) To review primary medical care services in Dudley with the aim of further improving the care provided to patients;
c) To co-ordinate the approach to the commissioning of primary care services generally;
d) To manage the budget for commissioning of primary medical care services in Dudley.

Geographical Coverage

7.19 The Committee will be responsible for commissioning primary care medical services coterminous with the geographical boundaries of NHS Dudley CCG.

Partnership

7.20 The Committee will be responsible for working with other statutory and voluntary agencies to maximise the benefits from investment in primary care services for the people served by the CCG.

8. Managing Conflicts of Interest

8.1 Conflicts of interest are a common and sometimes unavoidable part of the delivery of healthcare. The CCG is required to manage any conflicts of interest through a transparent and robust system. Members of the Committee are encouraged to be open and honest in identifying any potential conflicts during the meeting. The Chair of the Committee will be provided with the latest Declaration of Interest register at each meeting and will be required to recognise any potential conflicts that may arise from themselves or a member of the meeting.

8.2 It is imperative that CCGs ensures complete transparency in any decision-making processes through robust record-keeping. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes; who has the interest, the nature of the interest and why it give rise to a conflict; the items on the agenda to which the interest relates; how the conflict was agreed to be managed and evidence that the conflict was managed as intended.

9. Relationship with the Governing Body

9.1 The Committee is accountable to the governing body to ensure that it is effectively discharging its functions.

9.2 For the next meeting of the governing body following each meeting of the Committee, the Chair of the Committee will provide a written summary of the key matters covered by the meeting, including any action or decisions reserved for the governing body.

9.3 A report from of each meeting of the Committee will be presented to the next meeting of the
governing body for information by the Chair of the Committee.

10. Review of Committee Effectiveness

10.1 The Committee will annually self-assess and report to the governing body and NHS England on its performance in the delivery of its objectives.

10.2 The Committee’s terms of reference will be reviewed annually.

10.3 Any changes to the terms of reference will be approved by the governing body.
Schedule 1 – Scheme of Delegation

Appendix D - Scheme of Reservation and Delegation of the CCG Constitution

Schedule 2 – Delegated Commissioning Functions

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (“Local Improvement Scheme” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

Delegated commissioning arrangements exclude individual GP performance management (medical performers’ list for GPs, appraisal and revalidation). NHS England will retain responsibility for the administration of payments and list management.
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<th><strong>TITLE OF REPORT:</strong></th>
<th>Locality Feedback – September and October 2018</th>
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<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To advise the Board of themes emerging from discussions held at Locality meetings in September and October 2018</td>
</tr>
<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Mr D King, Head of Membership Development and Primary Care Dr Richard Gee, GP Engagement Lead</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mrs C Brunt, Chief Nurse</td>
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<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr R Gee, GP Engagement Lead</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

This report summarises the topics and themes emerging from the locality meetings for the month of September and October 2018. All localities received presentations on the following:

- Elective Care Commissioning Update
- Business Continuity Plans
- Dudley Quality Outcomes for Health

All localities discussed:

- The locality performance position using the Primary Care Analysis Tool (PCAT)
- The prescribing performance position
- The way in which extended access is operating within the locality
- Practice specific issues and sharing best practice

All October meetings localities will discuss:

- Primary care workforce data audit
- Integrated plus
- Thrive to work initiative

**RECOMMENDATION:**

1) The Board is asked to note the locality feedback for assurance

**FINANCIAL IMPLICATIONS:**

None

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

Dudley and Netherton locality
Sedgley, Coseley and Gornal locality
Halesowen and Quarry Bank locality
Stourbridge, Wollescote and Lye locality
Kingswinford, Amblecote and Brierley Hill locality

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:**

None

**ACTION REQUIRED:**

- Decision
- Approval
  - Assurance
1.0 INTRODUCTION
The CCG stakeholder survey results were discussed with GP members at the member’s event in May 2018. As a result GP members proposed a number of actions that were presented and agreed at the Governing Body in May 2018 as part of a membership engagement action plan. One component of the action plan was that there would be direct feedback from locality meetings into the Governing Body.

This report summarises the themes emerging from the locality forum meetings that took place in September and October 2018.

2.0 SUMMARY
The main items and themes emerging from locality discussions in September as follows:

2.1 Elective Care Commissioning Update
Mark Curran, Commissioning Manager for Planned Care and Dr Abrar Malik, Clinical Lead attended the locality meetings to discuss a range of commissioning initiatives as follows;

- Minor Eye Service goes live from October. The referral criteria and service description was discussed.
- Peer to peer review is working well especially for locum referrals. The process for recording peer to peer using templates was discussed.
- Paper switch off – the practices were reminded that all Consultant referrals will only be accepted electronically with effect from October 2018.
- Advice and guidance – practices received update on specialties now available and plans to ensure that 75% of all specialties are available by 2019. GPs were encouraged to provide feedback on the effectiveness of advice and guidance to the CCG via Mark Curran.
- Commissioning plans for the first contact physiotherapists was discussed – Dudley are the first CCG to be implementing the scheme in the Black Country.
- Commissioning plans for a community based service for joint injections were discussed – the Consultant Rheumatologists have been involved in developing the service specification. A capacity review is being undertaken in primary care.

2.2 Business Continuity Plans
Phil Cowley, Senior Finance Manager attended the locality meetings to discuss the business continuity arrangements within the localities. As part of the plans, the CCG has audited alternative service locations whereby a practice should have at least one location, ideally two, with nearby practices for the continuity of service provision. All practices agreed to review and report back to Phil Cowley by the end of October.

2.3 Dudley Quality Outcomes for Health Framework
Rob Franklin, Performance Manager attended the locality meetings to present the comparative performance of each practices against all the indicators within the Dudley Quality Outcomes for Health Framework. The comparative performance is now uploaded on to the Intranet each month and practices were provided with guidance on how to access this information.

2.4 Performance
All localities discussed the PCAT tool analysis and prescribing performance. All localities received updates from a member of the practice based pharmaceutical public health team – identifying areas for the locality practices to improve their prescribing efficiencies.

2.5 GP Engagement Lead Update
Dr Richard Gee sought feedback from all the localities on the following two issues
- Whether GPs were experiencing any improvement in emergency assessments diverting GP requests into the Emergency Department. The feedback and general view amongst localities is that there has been no noticeable improvement.
To consider a request from the Healthcare Forum on practices’ views regarding making nurse led appointments and flu clinics available for online booking. The feedback and general view amongst localities was it was difficult to avoid inappropriate booking of such appointments, even when practices had provided supporting information on which patients were appropriate for the slots. Dr Gee to feedback to Healthcare Forum and seek their suggestions on what actions could be taken to reduce inappropriate use of the slots.

2.6 October Locality Meetings
At the time of writing the report, the locality meetings for October had not taken place but the following items have been included for discussion

- **Primary Care Workforce Data Audit Results**
  To discuss the outcome of the primary care workforce data collected as part of the GP engagement scheme in each locality. This follows on from the members meeting in October focussed specifically on workforce initiatives within primary care, and the opportunities presented by the MCP in developing new roles that support the work of General Practice and the locality Integrated Care Teams (ICTs).

- **Integrated Plus**
  There is variation in the use of integrated plus across localities – the locality link workers will be attending the locality meetings along with the GP locality lead to discuss the referral information, understand the variation in referrals across practices and look at ways in which referrals can be increased.

- **Thrive to Work**
  Anita Hallbrook, Programme Director is attending the locality meetings to explain the service and the way in which GPs are able to identify patients and refer in for support. The CCG will be searching and identifying patients from EMIS and providing information to all GPs and practice managers at the next round of locality meetings, and through the Dudley Practice Management Alliance.

3.0 **RECOMMENDATION**
The Board is asked to receive the report for assurance.

Mr D King
Head of Membership Development and Primary Care
October 2018
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<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<td>Freedom of Information</td>
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<td>FTE</td>
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FYE Full Year Effect
FYFV Five Year Forward View
GDPR General Data Protection Regulations
GGI Good Governance Institute
GMS General Medical Services
GOWM Government Office for the West Midlands
GP General Practitioner
GPAQ General Practice Assessment of Quality
GPFV GP Forward View
GPwSI GP with Special Interest
GU Genito-urinary
GUM Genito-urinary Medicine
H&QB Halesowen and Quarry Bank (Locality)
HCAI Healthcare Associated Infections
HCF Healthcare Forum
HEE Health Education England
HENIG Health Economy NICE Implementation Group
HF Heart Failure
HFMA Healthcare Financial Management Association
HIAO Head of Internal Audit Opinion
HIC Health Improvement Centre
HIS Health Infrastructure Strategy
HIV Human Immunodeficiency Virus
HPA Health Protection Agency
HPS/S Health Promoting Schools / Service
HPU Health Protection Unit
HR Human Resources
HSC Health and Safety Commission
HSCQC Health and Social Care Quality Centre
HSE Health and Safety Executive
HSMC Health Services Management Centre
HT Home Treatment
HV Health Visitor
HWBB Health and Well-being Board
IAF Improvement Assessment Framework
IAPT Improved Access to Psychological Therapies
IC Infection Control
ICAS Independent Complaints Advocacy Service
ICE Integrated Commissioning Executive
ICNA Infection Control Nurses Association
ICO Integrated Care Organisation
ICP Integrated Care Provider
IFR Individual Funding Request
IG Information Governance
IOSH Institute of Occupational Safety and Health
ISAP Integrated Support Assurance Process
IT Information Technology
IUCD Intrauterine Contraceptive Device
JCAB Joint Clinical Advisory Board
JCC Joint Commissioning Committee
JD Job Description
JSNA Joint Strategic Needs Assessment
KAB Kingswinford, Amblecote and Brierley Hill (Locality)
KLOE Key Lines of Enquiry
KPI Key Performance Indicators
LAA Local Area Agreement
LAC Looked After Children
LACYP Looked After Children and Young People
LAT Local Area Team
LD Learning Disability
LDP Local Delivery Plan
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<th>Full Form</th>
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<td>PCDSG</td>
<td>Primary Care Development Steering Group</td>
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<td>PCSP</td>
<td>Personalised Care &amp; Support Plan</td>
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<tr>
<td>PDF</td>
<td>Portable Document Format</td>
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<td>PDR</td>
<td>Personal Development Review</td>
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<tr>
<td>PDS</td>
<td>Personal Dental Services</td>
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<tr>
<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
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<tr>
<td>PDU</td>
<td>Professional Development Unit</td>
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<tr>
<td>PE</td>
<td>Pulmonary Embolism</td>
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<tr>
<td>PEAK</td>
<td>Database holding the main registered details of patients and associated referral, contact, caseload, outpatient, inpatient, MH Act and clinic information.</td>
</tr>
<tr>
<td>PEAT</td>
<td>Patient Environment Action Team</td>
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<td>PEPP</td>
<td>Pooled Budget External Placement Panel</td>
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<td>PFI</td>
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<td>PHB</td>
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<td>PHE</td>
<td>Public Health England</td>
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<td>PHSO</td>
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<td>PID</td>
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<td>PIN</td>
<td>Prior Information Notice</td>
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<td>PMLD</td>
<td>Profound and Multiple Learning Difficulties</td>
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<td>Primary Medical Services</td>
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<td>Patient Opportunity Panels</td>
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<td>Patient Participation Group</td>
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<td>Pre-Qualification Questions</td>
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<td>Public Service Agreement</td>
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<td>Personal and Social Health Education</td>
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<td>PSIAMS</td>
<td>Personal Social Impact Action Measurement System</td>
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<td>Percutaneous Transluminary Coronary Angioplasty</td>
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<td>PWB</td>
<td>Personal Wheelchair Budget</td>
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<td>Q&amp;A</td>
<td>Questions and Answers</td>
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<td>Quality &amp; Safety</td>
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<td>Quality Improvement Board</td>
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<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
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<td>QMAS</td>
<td>Quality Management and Analysis System</td>
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<td>QOF</td>
<td>Quality and Outcome Framework</td>
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<td>QPDT</td>
<td>Quality and Practice Development Teams</td>
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<td>RACPC</td>
<td>Rapid Access Chest Pain Clinic</td>
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<td>RAG</td>
<td>Red, Amber Green (rating)</td>
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<td>RAS</td>
<td>Respiratory Assessment Service</td>
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<td>RCA</td>
<td>Root Cause Analysis</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<td>Race Equality Scheme</td>
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<td>Russells Hall Hospital</td>
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<td>RIDDOR</td>
<td>Reporting of Injuries, Diseases and Dangerous Occurrences Regulations</td>
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<td>RMO</td>
<td>Responsible Medical Officer</td>
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<tr>
<td>RRL</td>
<td>Revenue Resource Limit</td>
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</table>
RTT  Referral to Treatment
SAP  Single Assessment Process
SAR  Safeguarding Adult Reviews
SAR  Subject Access Request
SCG  Sedgley, Coseley and Gornal (Locality)
SCIE  Social Care Institute for Excellence
SCR  Serious Case Review
SDMP  Sustainable Development Management Plan
SDU  Sustainable Development Unit
SEPIA  Mental health computer system
SFBH  Standards for Better Health
SFI  Standing Financial Instructions
SI  Serious Incident
SIC  Statement of Internal Control
SLA  Service Level Agreement
SoMe  Social Media
SPA  Single Point of Access
SQPR  Service Quality Performance Review
SQRM  Safeguarding Quality Review Meeting
SRE  Sex and Relationship Education
SRG  System Resilience Group
SSD  Social Services Department
SSDP  Strategic Services Development Plan
STI  Sexually Transmitted Disease
STP  Sustainability and Transformation Plan
STRW  Support, Time & Recovery Worker
SWL  Stourbridge, Wollescote and Lye (Locality)
SWOT  Strength, Weakness, Opportunity and Threat
TB  Tuberculosis
TCT  Transforming Care Together
TIA  Transient Ischaemic Attack
TP  Teenage Pregnancy
TPT  Teenage Pregnancy Team
TTO  To Take Out
UCC  Urgent Care Centre
UCSCs  Urgent Care Sensitive Conditions
UHBT  University Hospital Birmingham Trust
Vaccs & Imms  Vaccinations and Immunisations
VSM  Very Senior Manager
WAN  Wide Area Network
WCC  World Class Commissioning
WIC  Walk in Centre
WMAS  West Midlands Ambulance Service
WMCA  West Midlands Combined Authority
WMHTAC  West Midlands Health Technology Advisory Committee
WMSCG  West Midlands Strategic Commissioning Group
WMSssa  West Midlands Specialised Services Agency
WTE  Whole Time Equivalent
YHC  Young Health Champion