NHS Airedale, Bradford and Leeds

	Agenda Item: PU2012/90	
DATE OF BOARD MEETING: 26 July 2012	**Category of Paper** **Tick(✓)**	
Executive Director Lead: Philomena Corrigan, Director of Delivery & Service Transformation	**Decision and Approval**	
Paper Author: Graham Brown	**Position Statement**	✓
Paper Title: Corporate Performance, Quality and Safety Transition Proposal	**Information**	
	Confidential Discussion	

SUMMARY

1. This paper has the purpose of describing the processes to establish how CCGs in the ABL Cluster will deliver and manage corporate performance and quality matters.

2. The paper is set out in three sections. This section describes the process that will provide for the PCT Cluster to receive assurance from CCGs on performance and quality matters, with the purpose of enabling the PCT Cluster to discharge its performance obligations, as required by DH. Two appendices cover the processes that CCGs will use in managing the performance and quality agenda, covering Leeds CCGs and Bradford & Airedale CCGs.

3. The development of CCGs and the pathway to authorisation of them as fully accountable bodies requires them to take charge of many of the duties and responsibilities of the PCT. Performance and quality issues are a significant part of this. The PCT Cluster though will remain as the accountable body until the point of CCG authorisation is reached. This means that if CCGs take the responsibility of managing corporate performance and quality during the time leading up to full authorisation, they will have to provide both solid governance and robust assurance back to the PCT.

BACKGROUND

4. Presently, the performance and quality agenda is covered by a combination of monitoring, improvement reporting and active management. Performance and quality data is generated and flows towards compilation of a performance and quality report, which is interpreted and analysed and is then forwarded to Senior Management. At this stage active Performance Management and assurance mechanisms takes place through either the Contract Management Board or individual performance and quality meetings with providers. These processes are supported through reporting to the Trust Board formally bi-monthly, formal sub-committees, executive team meetings and informally to senior managers, often resulting in decisions to generate actions in response to adverse quality concerns and performance. During the remainder of 2012/13 performance reporting to the Board remains the responsibility of the Director of Delivery & Service Transformation who should gain assurance form the CCGs. Which in the case of key access standards (A&E 4 hour wait, 18 week RTT etc…) will be LTHT - Leeds West CCG;

BTHT – Bradford Districts CCG; and Airedale Hospital – Airedale, Wharfedale & Craven CCG

5. In the immediate and medium term future, performance and quality management and governance arrangements are set to be more diversified, in that there are a greater number and range of bodies becoming involved. The process surrounding decisions on actions in response to poor performance and quality issues needs to clearly communicated

6. It also means that processes will have to be established that bridge the gap between the present and the future states, ensuring that sufficient grip is maintained on performance and quality matters. The main risks in not delivering this are that performance and quality issues go unchallenged, and the PCT reputation is damaged, and that the CCG authorisation process could be delayed. To do nothing though, by maintaining central PCT control is also damaging, in that the CCGs would find it extremely difficult to gain authorisation, if they have not taken control of this key element of their future work

PROPOSALS

7. The proposals in this section of the paper are described in strategic terms. They are intended to provide a clear statement describing the relationship between the local CCGs and the PCT Cluster. The main aim is to ensure that as the accountable body, the Cluster PCT, in delegating responsibility for performance and quality management matters to CCGs, receives robust assurance that performance and quality remains on track. Where performance and quality in any area is not positive, the PCT Cluster will need to be assured that the appropriate action is being taken.

8. The key principles are that:

- This arrangement will be in place until CCG authorisation is gained, or March 31 2013,. The arrangements detailed here will take immediate effect.
- Performance and quality reporting on the NHS Operating Framework 12/13, the NHS Outcomes Framework and quality dashboard (when launched) will be undertaken by CCGs. This will be delivered through support to CCGs from staff currently within the Cluster with the appropriate CCG staff and under CCG direction.
- Performance and quality reporting and management of matters outside the Operating Framework and Outcome Framework will be under the control of CCGs directly and do not directly form part of this programme.
- CCGs will provide, through monthly meetings at the collaborative level and joint monthly CCG/Cluster EMT meetings, written assurance to the PCT Cluster (using the performance and quality reports as evidence, amongst other things), on all corporate performance and quality matters.
- CCGs will take the chair and leadership of all provider contract management bodies. This will be on the basis of the lead CCG for specific contracts.
- CCGs will take the chair and leadership of provider quality and safety forums.
- CCGs will direct and lead the processes around determining the actions to be taken where performance and quality is not at the required level, in conjunction with service providers.
- Agreed performance remedial actions and any associated plans will be presented within the collaborative contacting framework contractual

penalties, task and finish groups for urgent issues and escalation to CQC if required,

- The PCT Cluster will provide challenge back to CCGs, where performance and quality is adverse or where there is a risk that it will be in the future. The forum for this will be EMT and the bi-monthly Trust Board meeting.
- CCGs will be required, as part of this challenge process, to ensure that they provide evidence of the required 'grip' of individual performance and quality issues, through a clear audit trail of actions and responses to instances of adverse performance.

9. Appendix 1 and 2 describe how the CCGs will organise how the performance and quality issues and addressed across the health economy.

SAFEGUARDING

10. Safeguarding functions will be delegated to CCGs in Bradford and Airedale, however it will remain with the Cluster Director of Quality and Nursing in Leeds until such time the Executive/ senior nurse for West, South and East and North is in post. This is time limited as recruitment for the CCG nurses are imminent.

NURSING LEADERSHIP AND NURSING/CARE STANDARDS

11. Likewise, in the absence of the Executive /Senior Nurse in Leeds, nursing leadership and nursing/care standards will remain with the Cluster Director of Quality and Nursing, supported by CCG aligned staff , for example the Clinical Quality Manager and Head of CHC. In Bradford and Airedale, the current quality and nursing team will be managed on an interim basis by designated CCGs, to maintain business continuity, in the first instance and until new CCG structures are put in place.

12. Effective working relationships between the CCGs in Leeds and the current cluster nurse will need to be agreed so as not to fragment the assurance on the totality of the quality agenda.

RECOMMENDATIONS;

13. The Board are ask to:

(a) **endorse** the implementation of the following actions:

i. Staff currently undertaking performance monitoring and management functions being managed on an interim basis by designated CCGs to maintain business continuity
ii. Staff currently undertaking functions related to quality and safety being managed on an interim basis by designated CCGs to maintain business continuity
iii. Safeguarding staff in Bradford and Airedale PCT being managed on an interim basis by designated CCGs to maintain business continuity
iv. Safeguarding staff in Leeds PCT remaining under the leadership of the Director of Nursing for the PCT cluster until substantive appointments are mage to the CCGs Director of Nursing role
v. The cluster PCT receiving a report to EMT monthly detailing performance, quality and safety indicators and actions
vi. The Trust Board also receiving a report detailing performance and quality issues and action plans from the CCGs
vii. The Accountable Officers of each attending EMT monthly and the Trust Board when scheduled for the remaining of the transition period.

Appendix 1

Leeds CCGs: Corporate, Quality and Performance Management Framework

1. Summary and Introduction

This report sets out proposals for CCGs to develop a system with the purpose of managing performance reporting and monitoring, quality reporting and the reporting of outcomes during and beyond the transition.

The structure will describe how the NHS Operating Framework 2012/13 will be delivered and reported throughout the year, but as importantly, it will set out a process to preparing for implementing the NHS Commissioning Outcomes Framework from 2013/14 and broader quality assurance mechanisms required.

In addition the proposed approach would;-

I. provide assurance that its statutory duties are being met and that CCGs are effectively both contributing to delivery of NHS indicator targets and that they take full ownership of the full scope of commissioning responsibilities.

II. provide CCGs with evidence of their collaborative commissioning governance arrangements for the CCG authorisation process

III. prepare CCGs for implementing the NHS Commissioning Outcomes Framework in 2013/14 and other quality assurance measures such as those in the NQB quality dashboard (soon to be launched)

IV. confirm the performance and quality indicators for reporting and for broader governance functions.

It is important that the reports and infrastructures proposed here should be seen as developmental which will also allow flexibility to adapt to meet the needs of CCGs whilst ensuring appropriate assurance to the cluster executive and Board that CCGs are fulfilling their delegated responsibilities.

It is clear that CCGs will also have their own reporting format and arrangements to support their local member Practices and local priorities for improved patient experience and broader quality improvement, which this structure can complement and combine with if required.

2. Background

PCTs are accountable for high quality services and targets agreed with the SHA for delivering the Operating Framework during 2012/13 and broader

quality outcomes. However, during this year, CCGs are also required to demonstrate their contribution to performance delivery, quality, and that robust systems and processes are in place to support authorisation. At the point of authorisation it is clear that CCGs will become fully responsible for performance delivery and securing high quality care for the population within the overall duties required of commissioning organisations. This includes effective clinical, corporate and financial governance.

The Leeds CCGs have been demonstrating their ability to take on performance management functions in partnership with the Cluster PCT, for example in chairing the Health and Social Care Transformation Board. This proposal builds on that experience, enabling CCGs to further demonstrate their readiness to take on the responsibility for performance and other commissioner duties such as quality - patient experience, clinical effectiveness and patient safety (including safeguarding).

3 Collation of Performance and quality intelligence:

City wide and CCG-level indicators, whether addressed by the Collaborative Forum or individual CCGs, would in the future be compiled by the Commissioning Support Service, which would also produce a commentary to accompany detailing actions. In the interim it is proposed that staff undertaking the functions of Performance, quality, corporate and clinical governance and information are aligned to Leeds West CCG.

4 CCG Governing Body

Initially, performance and quality data will need to be collated and reported, but as CCGs develop local commissioning priorities new indicators will be added.

Each CCG Governing body will receive a monthly report which will cover;

1) All indicators which were previously presented to the Cluster Board broken down to either City wide or CCG level,

2) Narrative explanation on the actions being taken to address the performance issues,

3) Quality standards and measures that are not covered by the national performance systems, including – workforce data, professional standards, complaints; serious incidents, patient & public involvement. This will also include key external report such as regulatory activity by CQC and monitor.

CCGs will also receive monthly reports on resource and reform indicators, including QIPP service transformation milestones.

Appendix 1

In the interim these performance reports will continue to be collated by staff in the quality, governance and performance function of the PCT and aligned on an interim management basis to Leeds West CCG until the Commissioning Support Service is established.

5 The role of Contract Management Boards;

Each CCG is taking responsibility for leading provider Contract bundles as listed below;

North CCG – LYPT
West CCG – LTHT
South/East CCG – Leeds Community healthcare Trust, third sector, nursing homes

Each Accountable Officer will chair the Contract Management Board which will discuss activity, finance, performance, quality and patient safety. Representation from respective CCGs is achieved by attendance at the Provider Management Groups which meet monthly.

6 Other systems

The recently released NHS Performance Framework has to be implemented by non-FT hospital trusts and has to be included in contract performance monitoring. A similar system also applies to FTs, but this is managed by Monitor.

Other national and city wide performance and quality requirements will almost certainly need to be mapped to the proposed reporting systems. This includes for example, the Leeds City Council led Children's Outcome Framework, where joint planning and monitoring for shared LA & CCG indicators might be through the Children's Trust Board or the Health & Wellbeing Board and also contribution to the statutory Leeds Safeguarding Children's Board (LSCB) and equivalent for adults, Safeguarding Adults Board (SAB). The CCGs will also support the delivery of public health measures and innovations, specifically where these read across to the Commissioning Outcomes Framework.

7 The role of the CCG Collaborative Commissioning Forum

The Collaborative Commissioning Forum would oversee collaborative commissioning arrangements in relation to performance and quality issues, and ensure that effective risk management strategies are being deployed across the system. It would consult with CCG Clinical Senates and other professionals on strategic and planning issues arising from performance and quality improvements, for example where patient pathways and experience of care need to be improved. It would not replace or duplicate the accountability or

responsibility of individual CCG Governing Bodies . All performance indicators will be reported at the CCG level, unless there is a justification for not doing this.
The main purpose of the Forum is to ensure that city wide issues are discussed collaboratively to ensure the strategic or political consequences of proposed decisions are agreed and understood. In a health economy as large as Leeds this is crucial.

The Forum would be chaired by CCG Accountable officers. Chairs of provider contracting and quality groups will invited, if required, to consider areas of risk flagged in their commentary.

It is envisaged that the Forum would address performance and quality issues where:

I. Provider-level specific data only is available, and where that is not disaggregated at CCG level

II. Citywide benchmarks need to be agreed

III. Data to support performance delivery is only available at Leeds whole city level

IV. Quality assurance and improvements are required across providers

8 CCG level performance activity and patient experience - GP practice indicators

There may be cases where outcomes data is readily available at CCG but not at member Practice level. Examples of this type include mental health crisis resolution/home treatment. There may be opportunities to use GP level data to compare with national definitions and therefore allow benchmarking, comparison and further analysis to seek improvements in the care pathways.

9 Shared local authority (and Public Health) and NHS outcome indicators

Public health mortality and morbidity outcome indicators form part of the Joint Strategic Needs Assessment (JSNA).

Public health analysts compile the public health and morbidity and mortality reports on behalf of CCGs and Leeds City Council. CCGs will offer commentary on their plans, as they contribute to jointly held indicators, and it is proposed this will be provided by the lead CCG where they hold the lead contracting responsibility. CCGs will need to work with PH to ensure a dovetailing of measures across health and public health – for example harm and avoidable deaths, infection prevention and control, and public safety.

Appendix 1

Indicators relevant to services for children and young people would be reported to and assured by the Children's Trust Board (CTB) and Leeds Safeguarding Children's Board (LSCB).

10 Preparing for the NHS Commissioning Outcomes Framework for 2013/14

The Commissioning Outcomes Framework, to be issued later this year, will replace the NHS Operating Framework for the planning round for 2013/14, as it applies to commissioning bodies within the NHS. It is anticipated that indicators within the Operating Framework that presently map across to the NHS Outcomes Framework indicators will feature in the NHS Commissioning Outcomes Framework.

It is clear that much further development work will be required in year to:

I. develop data collection and reporting once the DH publishes fuller technical guidance where it is absent

II. provide CCGs with a baseline and benchmark for anticipated NHS Commissioning Outcome Performance which can be used when identifying priorities and targets for plans for 2013/14, as well as subset data that might be included in GP practice level reports.

III. constantly review performance reports for consistency of approach and alignment with the NHS Commissioning Outcomes Framework for 2013/14

IV. analysis of indicator subset data and target setting for 2013/14 will require support from the Cluster PCT/CSS commissioning, public health information analysts, CCG commissioning clinical and management leads.

Appendix 2

Bradford & Airedale CCG Corporate, Quality and Performance Reporting & Management

1. The shadow accountable officers of the 3 CCGs have the following arrangements in place to support the discharge of delegated responsibilities from the Airedale, Bradford and Leeds Cluster Board during the transitional period. These will continue to evolve and develop.

CCG Shadow Governing Body

2. CCG Boards have been meeting on a monthly basis to receive a copy of an integrated performance report that covers:

- All national performance indicators (including quality) for the PCT statutory body(previously reported to the cluster board)
- A CCG tailored report setting out those indicators that can be specifically attributed to individual CCGs
- A CCG finance report describing the year to date financial position and a forecast for the year. This reconciles back to the overall financial position of the PCT. A CCG consolidated report will be sent to the cluster on a monthly basis.

3. At this monthly meeting performance issues are discussed and remedial action plans for non delivery explored and challenged.

4. In addition, specific discussions have taken place about quality matters. As part of the development of our governance arrangements each CCG is reviewing how it reports on and provides assurance in respect of performance and quality.

Bradford City and Bradford Districts

5. Subject to agreement through the Councils of Representatives for both CCGs, the governance arrangements have been reviewed and from August Bradford City and Districts CCGs will have a properly constituted shadow governing body that will start meeting monthly in public. The minutes of these meetings and the performance scorecard will be sent to the cluster on a monthly basis. At this meeting the Audit and Governance Committees, Remuneration Committees and Quality Committees will be formally established.

Airedale, Wharfedale and Craven CCG

6. The governance arrangements for AWC are currently being reviewed. Subject to approval by the Council of Members on 28th June, there will be a properly constituted Governing Body as well as an Executive Group. Performance will be formally reported to the Governing Body which will meet in public bimonthly. The Executive will meet on a monthly basis and to review and manage any performance issues. Further assurance around the delivery of both finance and performance will be facilitated by a finance and performance committee which will meet monthly. The minutes of these meetings and the performance scorecard will be sent to the cluster on a monthly basis.

Contract Management Arrangements

7. CCG leads have chaired the Contract Management Boards for both acute Trusts for over a year with other PCT support staff present. These arrangements will continue. The service development group and quality and performance groups are chaired by CCG support staff with CCG managerial and clinical representation.

8. As part of each organisations' development process these arrangements are being kept under review. The 'don't throw the baby away with the bathwater' principle applies to all issues under review.

Collaborative Arrangements

9. CCGs have agreed a programme of collaboration to provide further assurance around the delivery of a number of priority areas that cut across the 3 CCGs. In order to facilitate collaborative working the CCGs meet together on a monthly basis at the collaborative commissioner forum (terms of reference agreed). The overall purpose of the forum at present is to share intelligence, shape joint strategic direction and provide a collective commissioner voice on major service issues. Any formal decision making is referred back to each CCG.

The forum has established a programme of work to ensure that collaboration works operationally. This is particularly important for contracts where each CCG has a major interest such as Bradford District Care Trust. This may result in a formal set of management arrangements to support collaboration.

Financial Performance Management

10. The financial position for the PCT is coordinated and managed by the shadow CFO for the 3 CCGs. The overall PCT position is reported on a monthly basis to the GP collaborative meeting. These minutes are sent to the Cluster on a monthly basis. In addition, the financial position of individual CCG is reported to CCG's boards described in point 1 above.

11. Current robust budgetary management arrangements will continue which includes regular budget holder meetings and monthly meetings between the CFO and senior finance managers.

QIPP

12. A Bradford and Airedale wide QIPP meeting takes place on a fortnightly basis. The meeting is chaired by the CFO from the 3 CCGs with membership made up of senior managers from all PCT current functions plus 3 GPs - 1 from each of the 3 CCGs. The group is responsible for overseeing the delivery of the QIPP plan for 2012/13 and will start to plan for future QIPP Plans.

Other meetings

13. CCG staff and clinicians are involved in a range of regular 1:1 meetings with provider colleagues to provide further assurance around the delivery of our performance targets and the wider strategy. These include meetings between CCG CFO:Trust DOFs, CCG CFO: Trust directors of performance, Trust MDs: CCG lead GPs, CCG AO: Trust CEOs, CCG lead nurse:Trust DNs.

Authored by Helen Hirst, Interim

Bradford & Airedale CCG responsibility matrix

	CCG overall Lead	Lead Contracting manager	Lead Performance Manager	Lead Clinician
Contracting				
Airedale Hospital	**Jane H**	**Sue P**	**Kerry W**	**Phil P**
BTHFT	**Jane H**	**Cathy B**	**Kerry W**	**Andy W**
BDCT	**Jane H**	**Ali Jan H**	**Kerry W**	**C Harris/A Khan/B Kennedy**
Yorkshire Clinic	**Jane H**	**Sue P**	**Kerry W**	**Phil P**
Eccleshill & Yorkshire Eye	**Jane H**	**Cathy B**	**Kerry W**	**A Khan**
Other IS	**Jane H**	**Cathy B**	**Kerry W**	**Andy W**
YAS	**Jane H**	**Cathy B**	**Kerry W**	
Continuing Care	**Nancy O'N**	**Ali Jan H**		**See note**
Out of hours	**To be determined – current arrangements to continue**			**See note**
Prescribing	**To be determined – current arrangements to continue**			**See note**
Safeguarding	**Liz Allen**	**As above**	**As above**	**See note**
Patient safety	**Liz Allen**	**As above**	**As above**	**See note**
Patient experience	**Liz Allen/Fiona Stephens**	**As above**	**As above**	**See note**
Quality assurance	**Liz Allen/Kerry Weir**	**As above**	**As above**	**See note**
Prof standards and workforce assurance	**Liz Allen**	**As above**	**As above**	**Liz Allen**
Serious incident performance management	**Liz Allen**	**As above**	**As above**	**See note**

Note: there are a range of clinical leads covering all these areas