Chair: Ms J Crombleholme
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NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group Governing Body
Part 1

A G E N D A

The next meeting of the NHS Stockport Clinical Commissioning Group Governing Body will be held at Regent House, Stockport at 8.30am on 30 March 2016.

	Agenda item	Report	Action	Indicative Timings	Lead
1	Apologies	Verbal	To receive and note	08.30	J Crombleholme
2	Declarations of Interest	Verbal	To receive and note		
3	Approval of the draft Minutes of the meeting held on 9 March 2016	Attached	To receive and approve		J Crombleholme
4	Actions Arising	Attached	To comment and note		J Crombleholme
5	Notification of Items for Any Other Business	Verbal	To note and consider		J Crombleholme
6	Patient Story	Video		8.40	J Crombleholme
7.	Month 11 Financial Position	Attached	To discuss	8.50	M Chidgey
8.	CCG Financial and Operational Plans	Attached	To approve	8.55	M Chidgey / T Ryley
9.	Integrated Commissioning • Pooled Budget • Section 75 Agreement • Establishment of Health and Care Integrated Commissioning Board • Integrated Commissioning function and approach • Provider Arrangements	Attached	To approve	9.25	G Mullins
9.	Any Other Business	Verbal		9.55	J Crombleholme
	Date, Time and Venue of Next meeting The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 27 April 2016 at Regent House, Stockport. Potential agenda items should be notified to stoccg.gb@nhs.net by 1 April 2016				

NHS
Stockport
Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT REGENT HOUSE, STOCKPORT
ON WEDNESDAY 9 MARCH 2016
PART 1

PRESENT

Ms J Crombleholme	Lay Member (Chair)
Mrs G Mullins	Chief Operating Officer
Dr D Kendall	Consultant member
Dr J Higgins	Locality Chair: Heatons and Tame Valley
Mr J Greenough	Lay Member
Dr P Carne	Locality Chair: Cheadle and Bramhall
Dr C Briggs	Clinical Director for Quality and Provider Management
Mr M Chidgey	Interim Chief Finance Officer
Dr A Johnson	Locality Chair: Marpeth and Werneth (Vice-Chair)
Dr R Gill	Chief Clinical Officer
Dr L Hardern	Locality Chair: Stepping Hill and Victoria
Dr A Firth	Locality Vice-Chair : Stepping Hill and Victoria
Dr V Owen Smith	Clinical Director for Public Health
Mrs K Richardson	Nurse Member

IN ATTENDANCE

Mr R Roberts	Director for General Practice Development
Mr T Ryley	Director of Strategic Planning and Performance
Mrs L Latham	Board Secretary and Head of Governance
Mrs S Carroll	Healthwatch
Dr D Jones	Director of Service Reform

APOLOGIES

Cllr J Pantall	Stockport Metropolitan Borough Council

175/15 APOLOGIES

Apologies were received from Cllr Pantall

176/15 DECLARATIONS OF INTEREST

J Crombleholme made a new declaration that she had been appointed as a Board Member of 'Coaching Inside and Out' which provided coaching support to female offenders and those at risk of offending.

M Chidgey declared a pecuniary interest with regard to Item 16 Remuneration Committee Report, the nature of the interest being that it related to the remuneration for the Interim Chief Finance Officer role for which he had recently been appointed as post holder.

R Gill, V Mehta, C Briggs, L Hardern, J Higgins, A Johnson and P Carne declared a pecuniary interest with regard to Item 15 – General Practice Development Scheme, the nature of the interest being that their Practices had been in receipt of monies as part of the scheme.

The Chair indicated that with regard to all declarations, all individuals could partake in the discussion to which the items related.

177/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 13 JANUARY 2016

The minutes of the meeting held on 13 January 2016 were agreed as a correct record of the meeting subject to the following amendments:

- Sue Carroll from Healthwatch be shown as in attendance

178/15 ACTIONS ARISING

The following updates on actions were provided:

- 12112015 Safeguarding– This matter had been responded to and could be removed from the log.
- 13012016 Patient Story – Completed and to be removed from the action log
- 13012016 Locality Chairs – Primary Care workforce matters would be fed into the design and decision making processes of Stockport Together and the action could be removed from the log.
- 13012016 Chief Operating Officer's Report – The detail of the operational elements of Primary Care Delegated Commissioning were being considered by the CCG's Management Team and the action could therefore be removed from the log.
- 13012016 Board Assurance Framework – The action had been completed and could be removed from the log.
- 13012016 Public Sector Equality Duty Report – The matter regarding the data collection had been responded to and could be removed from the log.

179/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

V Owen Smith requested that an item of any other business be added to highlight the launch of the Public Health England Campaign 'One You.'

180/15 PATIENT STORY

The Governing Body watched a patient story from a lady who had been diagnosed with Clostridium Difficile and described the impact on her physical health and mental well-being. She explained the impact of taking antibiotics on her symptoms and management of the condition and the support she had received from her GP, infection control disease nurse and partner. She explained that she had been advised to avoid wherever possible in future taking antibiotics and noted that it may leave her with real choices about treatments depending on her future health. She urged GPs and other clinicians to

think carefully before prescribing antibiotics, in particular the different types available and length of the course and patients to consider the potential impact of antibiotics and other alternatives available.

It was clarified that the patient had been left vulnerable to the infection as a result of being prescribed a certain type of antibiotics. V Owen Smith noted that the message around prescribing at the end of story could be, if edited used to discuss issues with clinicians who prescribe. She noted that any local activity around the use of antibiotics could be linked to Public Health England campaigns ahead of Winter 2016.

P Carne explained that a number of development schemes had taken place within primary care to provide GP's with the knowledge around which antibiotics should be prescribed. However it was noted that in other areas such as nursing homes and dentists, the guidance was not always as well followed. V Mehta noted that dental prescribing data was particularly difficult to access.

V Mehta highlighted data around the number of cases of Clostridium Difficile in Stockport and the processes in place to review learning around individual cases. He also noted that prescribing data indicated the GP's in Stockport were, when compared with other areas prescribing antibiotics appropriately. It was also noted that requests from out of area secondary care prescribers into general practice as part of discharge and outpatient processes were actively reviewed by GPs to ensure prescribing was appropriate and in line with local views.

Resolved: That the Governing Body:

1. Notes the content of the patient story and requests that thanks be passed on to the patient for sharing their views.
2. Requests that any further messages around patient expectation in relation to antibiotic prescribing to be locally distributed be aligned with national Public Health England campaigns as appropriate.

181/15 STRATEGIC IMPACT REPORT

The Governing Body considered a report which outlined the activity against the CCG's strategic and operational plans. T Ryley outlined the continued improvement against plan in the areas of non-elective surgery and prescribing and areas of worsening performance against plan which included elective activity. He highlighted that there was variation across localities with Marple and Werneth demonstrating that growth across the system could be controlled at General Practice level. Governing Body sought areas of best practice which could be shared across Localities. A Johnson explained that Locality Meetings were used to openly share information and performance data around referrals and admissions

J Greenough sought assurance around the correlation between prescribing figures and the finance report and in particular referral information for ophthalmology to organisations with Any Qualified Provider (AQP) status. M Chidgey agreed to review the content of both reports and ensure consistency in data.

V Mehta reported that the data relating to dermatology and urology did not correlate with what GP Members were experiencing within their practices. M Chidgey noted that some data capture issues had been experienced at the provider and he would include an update in the Strategic Impact Report to be considered at the April meeting.

C Briggs noted that any data relating to dermatology would need to be captured so as to consider the pilot underway in 10 practices relating to dermascopes.

A Johnson reported that dieticians would get prescribing rights from 1 April 2016 and requested that this be considered as part of prescribing arrangements and budgeting.

Resolved: That Governing Body:

1. Notes the content of the Strategic Impact Report.
2. Notes that the next version of the report will include information relating to dermatology and urology data capture by the Provider
3. Requests that dietician prescribing rights be considered as part of CCG prescribing management and budgeting.

182/15 FINANCE REPORT

The Governing Body considered the current financial and forecast positions of the CCG as a month 10 of the 2015/16 financial year. M Chidgey explained that the CCG was on track to deliver the end of year planned surplus of £1.75m however this had largely been achieved through non-recurrent means which would not be available in future years.

He highlighted the statutory duties as shown in Table 1 of the report, in particular linked to delivery of a financial surplus and QIPP.

J Greenough commented on the areas in which the CCG had made savings and the challenges of making savings in areas of less control such as AQP organisations which fell outside the remit of Stockport Together. M Chidgey explained that the economy plan would not require all providers to be part of the Multi-Speciality Community Provider (MCP) and it would be importance to balance the need for patient choice alongside the issues of demand and referral management.

In response to questioning, M Chidgey explained that ISCATS had been commissioned from Care UK at Greater Manchester level.

Resolved; That Governing Body:

I. Note the financial position for 15/16 which is:-
(iii) Year-to-date - As at 31st January an actual £1,459k surplus as per plan.
(iv) Forecast Outturn 15-16 – delivery of planned surplus of £1.75m.
II. Note the additional net risk totalling £0.28m not reflected within the forecast position
(Ref – Table 8).

III. Note that the forecast position reflects the retention of £0.9m performance fund held in Better Care Fund (BCF) to offset the cost of Non Elective (NEL) activity above planned BCF levels.

IV. Note the additional recurrent cost pressures of £9.7m arising in 2015/16 are treated as carry forward spend commitments into 16/17 and is a first call against 2016-17 growth funding and as a result it will be extremely challenging to deliver all NHS England business rules in 2016/17.

182/15 PERFORMANCE REPORT

G Mullins presented the Resilience and Compliance report covering NHS Constitutional Targets statutory duty and compliance up to December 2015. She highlighted that reductions in elective performance had meant that the target around Referral to Treatment times had not been met and that the emergency department target still remained very challenging. It had been considered at a meeting of the Council's Health Overview and Scrutiny Committee in February and would be further discussed at a Tripartite meeting between the CCG, NHS Stockport Foundation Trust and Stockport Council and Monitor and NHS England. She highlighted for Members the complaints figures reported within the period and the work underway to review reporting processes.

C Briggs noted that the Systems Resilience Group (SRG) continued to take a systems based approach to the challenges across the urgent care system and were meeting weekly. Work was underway to review the impact of SRG schemes over winter including extra community bed capacity which had been provided. An external report provided to Stockport Foundation Trust was currently being reviewed in light of the recommendations proposed and actions arising.

A discussion took place regarding emergency department staffing and the impact of night time dips in performance on the following daytime operations. M Chidgey noted that whilst factors such as industrial action, capping of locum and agency rates and overall workforces issues may have impacted on emergency department performance, this should be seen within the context of significantly worsening performance. The potential impact of NHS 111 on emergency department attendances and ambulatory admissions was discussed.

S Carroll explained some data which underpinned use of NHS 111 and anecdotal evidence around delayed discharge from hospital due to timing of consultant ward rounds and prescription issue. C Briggs noted that this issue had been recognised by the Foundation Trust and was being considered.

The Governing Body considered the difficulties in resolving emergency department performance challenges over a number of years and the resource which had been invested. A discussion took place regarding the balance in investing in emergency department performance which had proved challenging to improve against investment in other areas where greater ability for effecting change and transformation existed. C Briggs noted that the wider issues of patient flow across the system, processes, leadership and culture and communication were integral to whole system transformation.

In light of the Stockport Together Programme, C Briggs highlighted that the urgent care work had been viewed as a dependent priority to be undertaken after other key system design work. T Ryley explained that learning from other Vanguard sites had indicated that system redesign could significantly reduce patient hospital stays if the overall strategic and long term system modelling was undertaken well.

Resolved: That the performance report be noted.

183/15 QUALITY REPORT

M Chidgey provided a brief summary of the recent work of the Quality Committee. In particular he highlighted good progress on the achievement of TIA standard had been sustained and that the unresolved quality impact of CIP had been a focus of the ongoing contract negotiations. The failure to meet performance standards by NHS 111 had been progressed through the issue of a performance notice. In response to assurance sought by the Committee, information about how capacity gaps will be addressed for Looked After Children would be considered. District Nurse capacity and Gastroenetrology follow up would remain on the issue log.

NHS 111 performance was discussed and it was noted that signposting information had been re-displayed as part of the system to reduce the numbers of enquiries regarding service information and access. It was noted that the number of out of area placements for learning disability and mental health patients was small with a large number at high probability of early moving.

T Ryley acknowledged the district nursing challenge in light of the Stockport Together work on neighbourhoods and the importance of designing new models of care on the basis of workforce availability. C Briggs noted that it was important that the Quality Committee continued to monitor quality impact on district nursing at the current time. K Richardson noted that a new Nursing Strategy would be published on 1 May 2016.

Resolved: That the Governing Body note the report.

184/15 LOCALITY CHAIRS UPDATE

The Governing Body received updates from the Locality Chairs about work recently undertaken as follows:

Cheadle and Bramhall – P care reported that the recent Locality Meeting had considered the review of the first year of operation of the GP Development Scheme and had welcomed the discussion on the CCG's Strategic Plans. Issues which had arisen from the Multi-Disciplinary Team meetings included boundary issues with social care and IT issues. R Gill noted that the different populations served by social care and health would be discussed by the Greater Manchester Joint Commissioning Board with a proposal that consistency be achieved by building on the GP registered list.

Marple and Werneth – A Johnson noted that the two neighbourhoods had adapted different work approaches to fit the resident populations and the roles of the CCG Locality Meetings, Neighbourhood Meetings and Viaduct as the GP Federation were being discussed.

Stepping Hill and Victoria – L Hardern reported that the Locality had welcomed the positive feedback from the GP Development Scheme Review. Workforce and recruitment issues were causing significant issue in the locality, in particular access to support to help accelerate staff training. Of the two neighbourhoods, one had gone live with Multi-Disciplinary Team Meetings and the other would commence work soon.

Heatons and Tame Valley – J Higgins explained that across the Locality there was a strong appetite to get involved in shaping the future, in particular the staffing of the multi-disciplinary team and flexibility to utilise the workforce to work around the needs of patients within the particular localities. T Ryley explained that the Multi-Disciplinary Team approach was in its first iteration and learning from all areas would be used to develop an approach to locality budgeting which would be the basis for workforce planning and design.

A discussion took place regarding existing estates issues across primary care and the resource required both locally and across Greater Manchester to manage and resolve workforce challenges to staff both current and new models of care. R Gill noted that Healthier Together included a workforce stream.

Resolved: That the update of the Locality Chairs be noted.

185/15 REPORT OF THE CHAIR

J Crombleholme introduced A Rolfe who would be the new Executive Nurse member of the Governing Body from 1 April 2016 and reported that M Chidgey had been appointed as the Interim Chief Finance Officer from 1 March 2016.

She reported that a Part 2 meeting of the Governing Body had taken place to consider a Safeguarding matter.

186/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted the key elements within the report including the Delegation Agreement and Memorandum of Understanding which were in place to govern Primary Care Delegated Commissioning from 1 April 2016 and the continued development of the CCG's Strategic Plans. She noted that the activity and finance had been aligned between the CCG and Stockport Foundation Trust and discussions were ongoing with NHS England around the Business Rule Requirements.

The Governing Body was informed that the Value Proposition linked to the Vanguard Project had been submitted and would be determined at Greater Manchester level. The integrated commissioning arrangements with the local authority were noted to be progressing well with the draft Section 75 Agreement being finalised and a recent positively received governance workshop between Board Members.

In response to questioning M Chidgey reported that the CCG had a good understanding of its initial performance against the proposed new CCG Assurance Framework. He also explained the processes and expertise which underpinned the CCG's procurement activity and that arrangements would be reviewed for informing the Governing Body of the commencement and outcomes of procurement activity.

Resolved: That the Governing Body:

1. Notes the updates provided.

187/15 REPORT OF THE CHIEF CLINCIAL OFFICER

R Gill provided an overview of the Greater Manchester Strategic Plan and its importance in ensuring the continued developments in health and social care address the key issues of variability in health care, poor health outcomes, high spend and inconsistency in provider and commissioner form. He also noted the importance of enabler workstreams including IM&T, estates and workforce. T Ryley noted that the plan was integral to determining bids submitted for the Greater Manchester Transformation Fund and therefore it was important to ensure that the activities of the Stockport Together Programme were consistent with the Strategic Plan. He indicated that the local approach to finances in Stockport, including challenges and benefits had been reviewed collaboratively across partners which was not in total alignment with the Strategic Plan approach. The importance of tracking evaluation and performance metrics both regionally and locally was noted. D Jones noted the importance of evaluation and learning with regard to Devolution and noted that whilst the University of Manchester were already engaged in an evaluation of Devolution the GM Strategic Plan did not refer to the importance of evaluating the strategy and its implementation. R Gill indicated that evaluation would be an important element of the work.

R Gill provided an update on the arrangements for the commissioning of specialised services in Greater Manchester in 2016/17 and the associated financial delegations. He noted that work would be undertaken to review the services being commissioned and determine which would be best delivered

on a Greater Manchester footprint. V Owen Smith sought assurances about the public health strategic involvement in specialist commissioning. R Gill agreed to seek confirmation at regional level. The funding level for Stockport in relation to specialist commissioning was noted.

The Governing Body considered the implementation of the Healthier Together Programme within the South East Sector and the work currently underway. R Gill noted that the funding required for the South East Sector implementation had not yet been agreed but that all partners would need to consider appropriate resourcing as part of their core business.

The complexity of tracking the multiple local, sub-regional and regional partnerships was discussed by Members. T Ryley explained that it was important that the Governing Body could be assured that transformational change was on track to deliver the standards and outcomes required with a continued focus on patient care.

Resolved: That the Governing Body:

1. Note the Greater Manchester Strategic Plan
2. Endorse the continued approach to the arrangements for the commissioning of specialised services within Greater Manchester
3. Note the establishment of Governance Arrangements for the South East Sector

188/15 Governance Matters

Committee Terms of Reference

The Governing Body considered the revised Terms of Reference as proposed by the CCG's Committees following review in light of the changes to the governance structure implemented in January 2016.

V Mehta sought confirmation about the membership of the Primary Care Joint Committee as aligned to the operational elements of the delegations the CCG would undertake from 1 April 2016.

Resolved: That the Governing Body:

Approves the Terms of Reference for the following Committees:

1. Finance and Performance Committee
2. Quality Committee
3. Remuneration Committee
4. STAMP
5. Primary Care Commissioning Committee (to be in place from 1 April 2016)

Governing Body Forward Plan 2016/17

T Ryley presented the proposed Governing Body Forward Plan for 2016/17 and highlighted the balance between meetings in public and the need to formulate strategy and consider matters in a more developmental way. He noted that the Plan would continue to be adapted in-year to ensure issues arising could be dealt with by the Governing Body.

Resolved: That the Governing Body approves the Forward Plan for the 2016/17 year.

189/15 COMPLIANCE REPORT

T Ryley introduced the report and highlighted in particular the legal and statutory duties of the CCG relating to information governance and management. He highlighted the proposal so submit the Information Governance Toolkit at Level 2 and drew Members' attention to the action plan indicated in the report.

Resolved: That Governing Body:

1. Notes the contents of this report
2. Notes that the CCG is aiming to achieve Level 2 of IG toolkit and will submit documentation in support of this self-assessment
3. Notes the specific actions and deadlines for completion in the 16/17 Improvement Plan.

190/15 GENERAL PRACTICE DEVLEOPMENT SCHEME

V Mehta highlighted the outcomes and best practice examples arising from the first year's operation of the GP Development Scheme. He noted that Practices had been asked to put forward proposals for schemes which would support the delivery of some high level outcomes with a focus on prevention and long term sustainability of general practice. He explained that the full financial benefit had not yet been realised due to the delays in some of the schemes starting due to staff recruitment timescales. He highlighted the link between investment and performance data around management of long term conditions, emergency department attendance and prescribing and the anecdotal feedback from Practices about the wider positive impact. Improvements in patient feedback were also noted to be very positive.

The Governing Body considered the innovation which had been seen through the scheme and the importance of building on successful projects and sharing the learning. It was noted that some elements could be delivered at neighbourhood level.

V Mehta noted that discussions about how the scheme could be further developed in the future were emerging and it was important to ensure that the aspiration and link to the CCG's Strategic Plan were clear.

Members of the Governing Body endorsed the positive impact of the scheme and in particular the innovation which been seen and the significant progress made within the first year. S Carroll noted the robust process which had been put in place to approve schemes submitted by practices. J Crombleholme reminded Governing Body GP Members of conflict of interest regarding the decision, highlighting in particular the basis on which funding would be made recurrent, including the 81p return on monies invested to date.

T Ryley noted that the Scheme had required significant resource and hard work to ensure its implementation and success and that the delivery of benefits for patient care should remain the key focus of the evaluation. He noted that the learning from the scheme and best practice examples should form a key part of the development of the Neighbourhood Models as part of the Stockport Together Programme. In addition, he explained the learning from another Vanguard site around the training and use of Care Co-Ordinators could also be used locally.

A Johnson noted that the scheme was a positive example of achieving the right balance between testing things out, innovation and a proportionate approach to reporting outcomes.

Resolved: That Governing Body:

1. Notes the report and approves the funding for the scheme becoming recurrent from 16/17 onwards.

191/15 REPORTS FROM COMMITTEES

- Finance and Performance Committee – P Carne provided an overview of the work undertaken by the Committee at its January and February meetings. In particular he noted the review of the General Practice Development Scheme and the continued approach to reviewing the performance and delivery of QIPP Schemes.

- Audit Committee – J Greenough highlighted the recent Audit Committee Effectiveness Review which had been undertaken and the action plan arising which would be discussed with the Governing Body Chair in the coming weeks.

- Remuneration Committee – J Greenough reported on the recent meeting of the Committee at which recommendations had been proposed for the remuneration of the Interim Chief Finance Officer role.

  Resolved: That Governing Body:

  1. Notes the arrangements being proposed to ensure the CCG meets the requirements for the appointment of a Chief Finance Officer for an interim period.
  2. That the Interim Chief Finance Officer role be remunerated at Agenda for Change Band 9 based on the duties as outlined in the revised Job Description considered by the Remuneration Committee.
  3. That the interim arrangements be put in place for 6 months whilst arrangements to recruit to the position permanently are explored.

(The meeting ended at 12.26pm)

Public Questions

The following questions were raised by members of the public in attendance at the meeting:

1. What was the outcome of the changes to the community mental health team structure undertaken by Pennine Care?

M Chidgey agreed to provide an update as part of the minutes of the meeting.

2. What was the level of return on investment for the GP Development Scheme?

V Mehta noted that for every £1 invested there had been a return of 81p. He explained that due to some delays in schemes getting up and running data had not been available for the whole year.

3. Is there a clearer copy of the Joint Strategic Needs Assessment (JSNA) Document?

V Owen Smith reported that a new JSNA website was being built and would be live from the end of March. This would ensure all data is fully accessible and can be viewed clearly.

4. Does the CCG know the split of commissioning responsibility between the CCG and Greater Manchester as a result of the Devolution Arrangements?

R Gill highlighted the paper on specialist commissioning which had been considered as part of the agenda and the additional commissioning responsibilities which would be undertaken by the CCG from 1 April 2016 for primary care medical services.

NHS Stockport Clinical Commissioning Group
9 March 2016

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
09 03 2016 (1)	Patient Story To link prescribing of antibiotics into the proposed GP led campaign on patient behaviour change. To align any local messages to relevant Public Health England Campaigns in due course.	180/15	April 2016	 V Owen Smith V Owen Smith
09 03 2016 (2)	Strategic Impact Report To include in the next version of the report narrative around the performance of the provider for urology and dermatology treatments. To investigate the potential impact of dietician prescribing rights coming into force from 1 April 2016.	181/15	April 2016	 M Chidgey R Roberts

09 03 2016 (3)	Chief Operating Officer's Report To review the processes for keeping the Governing Body appraised of procurement activity planned and underway and informing them of the outcome.	186/15	April 2016	G Mullins
09 03 2016 (4)	Chief Clinical Officer's Report To seek clarification about the strategic public health support available as part of the Greater Manchester approach to specialist commissioning.	187/15	April 216	R Gill

NHS
Stockport
Clinical Commissioning Group

Finance Report February 2016 – Month 11

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

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Executive Summary

What *decisions* do you require of the Governing Body?
1. **Note** the year-to-date surplus of £1,604kk which is line with plan. 2. **Note** that the CCG is forecasting to deliver the planned surplus of £1.75m which has only been achieved through in-year non-recurrent benefits 3. **Note** as a result of the CCG is carrying forward a deficit of £8.7m, delivery against all NHS England business rules in 2016/17 will be extremely challenging. 4. **Note** that there are no significant risk which would prevent delivery of the CCG's planned surplus of £1.75m
Please detail the key points of this report
• Reported YTD surplus (£1,604k) and forecast outturn surplus (£1,750k) are as per plan. • Main areas of cost pressure continue to be within the Acute Sector (Elective and Outpatient) and Prescribing. • There are no significant risk which would prevent delivery of the CCG's planned surplus of £1.75m
What are the likely impacts and/or implications?
Delivery against statutory financial duties and financial performance targets.
How does this link to the Annual Business Plan?
As per 2015/16 Financial Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Governing Body only
Clinical Executive Sponsor: Ranjit Gill
Presented by: Mark Chidgey
Meeting Date: 30th March 2016
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Report of the Interim Chief Finance Officer as at 29th February 2016

1. Statutory Financial Duties and Performance Targets

In holding the CCG to account, NHS England requires the CCG to deliver its statutory duties and financial performance targets for 2015/16 as approved by the Governing Body at the start of the financial year. Progress on delivery of these statutory duties and performance targets are monitored monthly and the CCG's performance is detailed in Table 1 below:

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty	Performance YTD (Mth 11)	Performance Forecast
Revenue (Appendix 1 Table 1)	Not to exceed revenue resource allocation		
Running Costs (Appendix 1 Table 1)	Not to exceed running cost allocation		
Capital – *(Note: The CCG has not received a capital allocation in 2015/16)*	Not to exceed capital resource allocation	**N/A**	**N/A**

Area	Performance Target	Performance YTD	Performance Forecast
Revenue (Appendix 1 Table 1)	Deliver a Recurrent Surplus		
Revenue (Appendix 1 Table 1)	Deliver a 0.5% in-year surplus		
Cash (Appendix 1 Table 9)	Operate within the maximum drawdown limit		
Business Conduct (Appendix 1 Table 8)	Comply with Better Payment Practices Code		
QIPP (Appendix 1 Table 10)	Fully deliver planned QIPP saving		

2. Financial Performance as at 29th February 2016 and Forecast Outturn

The CCG has reported a YTD surplus of £1,604k in line with plan and forecasting to deliver its planned surplus of £1.75m. However, members should note that delivery of the planned surplus has only been achieved through in-year non-recurrent benefits and as a result the CCG is carrying forward a **c£8.7m** deficit into 2016-17.

The current deficit is a result of:

- Non delivery of recurrent CIP (mainly elective activity and prescribing) **£6.0m**
- Impact of ETO partially funded non recurrently **£1.4m**
- Full Year Effect (FYE) of charging for Allied Health Professions (AHP's) **£0.8m**
- Prescribing over performance **£0.6m**
- Other over/(under) performance (**£1.4m).**

The main areas of over performance are acute elective (Trauma & Orthopaedics and Ophthalmology) and outpatient activity (Dermatology, Trauma & Orthopaedics and Cardiology General Medicine) as well as prescribing.

The CCG's forecasted recurrent position has **deteriorated by £0.7m** since month 9 (December 15). The forecasted recurrent position as at month 9 is the month on which the CCG's 16/17 financial plan is based, therefore any recurrent deterioration in the CCG's financial position against this baseline will be a call against the contingency set aside in 2016-17.

Risks

There are no significant risks which would prevent the delivery of the CCG's planned surplus of £1.75m.

As a result of the CCG is carrying forward a deficit of £8.7m delivery against all NHS England business rules in 2016/17 will be extremely challenging.

Recommendations

The Governing Body is asked to:-

I. **Note** the year-to-date surplus of £1,604kk which is line with plan.

II. **Note** that the CCG is forecasting to deliver the planned surplus of £1.75m which has only been achieved through in-year non-recurrent benefits

III. **Note** as a result of the CCG is carrying forward a deficit of £8.7m, delivery against all

NHS England business rules in 2016/17 will be extremely challenging.

IV. **Note** that there are no significant risk which would prevent delivery of the CCG's planned surplus of £1.75m

Mark Chidgey
Interim Chief Finance Officer
29th February 2016

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	Y
Page numbers	N	Service Changes: Public Consultation Completed and Reported in Document	n/a
Paragraph numbers in place	Y	Service Changes: Approved Equality Impact Assessment Included as Appendix	n/a
2 Page Executive summary in place (Docs 6 pages or more in length)	n/a	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	n/a
All text single space Arial 12. Headings Arial Bold 12 or above, no underlining	Y	Change in Service Supplier: Procurement & Tendering Rationale approved and Included	n/a
		Any form of change: Risk Assessment Completed and included	n/a
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	n/a

Appendix 1

MONTH 11 FINANCIAL DASHBOARD

RAG Rating Key:

G	Potential risk of overspend: less than or equal to £0
A	Potential risk of overspend: between £0 and £250k
R	Potential risk of overspend: Over £250k

TABLE 1

Month 11 Financial Position - as at 29th February 2016

	YTD (Mth 11) Plan £000s	YTD (Mth 11) Actual £000s	YTD (Mth 11) Var £000s	YTD (Mth 11) Var %	Forecast 15/16 Plan £000s	Forecast 15/16 Actual £000s	Forecast 15/16 Var £000s	Forecast 15/16 Var %	RAG RATING	Recurrent Budget £000s	Recurrent Commitment £000s	Recurrent Variance (Favourable) / Adverse £000s
Revenue Resource Limit (RRL)												
Confirmed	(344,316)	(344,316)	0	0.0%	(378,328)	(378,328)	0	0.0%	G	(374,047)	(374,047)	0
In Year	(7,740)	(7,740)	0	0.0%	(8,444)	(8,444)	0	0.0%	G	(1,348)	(1,348)	0
Total RRL	**(352,056)**	**(352,056)**	**0**	**0.0%**	**(386,772)**	**(386,772)**	**0**	**0.0%**	G	**(375,395)**	**(375,395)**	**0**
Net Expenditure												
Acute	204,558	207,715	3,157	1.5%	223,738	226,878	3,140	1.4%	R	221,804	227,634	5,830
Mental Health	29,081	28,776	(305)	(1.0%)	31,721	31,322	(399)	(1.3%)	G	31,103	30,867	(236)
Community Health	32,735	32,465	(270)	(0.8%)	35,786	35,718	(68)	(0.2%)	G	35,711	35,721	10
Continuing Care	15,874	15,283	(591)	(3.7%)	17,126	16,466	(660)	(3.9%)	G	15,009	15,009	0
Primary Care	11,379	10,779	(600)	(5.3%)	12,563	11,777	(786)	(6.3%)	G	10,073	9,973	(100)
Other	6,092	4,053	(2,039)	(33.5%)	7,803	5,741	(2,062)	(26.4%)	G	2,636	3,398	762
Sub Total Healthcare Contracts	**299,719**	**299,071**	**(648)**	**(0.2%)**	**328,737**	**327,902**	**(835)**	**(0.3%)**	G	**316,336**	**322,602**	**6,266**
Prescribing	44,609	45,954	1,345	3.0%	48,664	50,164	1,500	3.1%	R	48,664	50,164	1,500
Running Costs (Corporate)	5,567	5,077	(490)	(8.8%)	6,750	5,952	(798)	(11.8%)	G	6,424	6,424	0
Reserves (Ref: Reserves Summary)	557	0	(557)	(100.0%)	871	1,004	133	15.3%	G	2,748	4,876	2,128
Total Net Expenditure and Reserves	**350,452**	**350,102**	**(350)**	**(0.1%)**	**385,022**	**385,022**	**0**	**0.0%**	G	**57,836**	**61,464**	**3,628**
TOTAL (SURPLUS) / DEFICIT	**(1,604)**	**(1,954)**	**(350)**	**21.8%**	**385,022**	**385,022**	**0**	**0.0%**	G	**(1,223)**	**8,671**	**9,894**

TABLE 2

Acute Contract Performance		Year to Date			Forecast	
Top 6 Acute Commissioning contracts & AQP/IS	Annual Budget	Budget	Actual	YTD Variance - Overspend /	Forecast Outturn	Forecast Variance - Overspend /
	£'000	£'000	£'000	£'000	£'000	£'000
Stockport FT	144,302	132,277	131,967	(310)	143,836	(466)
University Hospitals of South Manchester FT	25,490	23,365	23,752	387	25,899	409
Central Manchester University Hospitals FT	18,706	17,147	17,396	249	18,844	138
Salford Royal FT	5,670	5,197	5,515	318	5,979	309
East Cheshire NHS Trust	2,259	2,071	1,980	(91)	2,165	(94)
Tameside Hospital FT	1,084	997	1,150	153	1,252	168
AQPs/IS	11,328	10,384	12,830	2,446	14,031	2,703
Other	14,899	13,120	13,125	5	14,872	(27)
Total Acute	**223,738**	**204,558**	**207,715**	**3,157**	**226,878**	**3,140**

ACUTE

TABLE 3

PoD

Forecast variance to plan at Mth 11 based on Mth 10 Activity Data (SLAM) (£000)	Top 6 Acute Commissioning Contracts & AQP/IS								
PoD	SFT (£000)	UHSM (£000)	CMFT (£000)	Salford Royal (£000)	East Cheshire (£000)	Tameside (£000)	AQP / IS (£000)	Other Providers (£000)	Total (£000)
Elective	(83)	30	98	(69)	(55)	0	2,433	111	2,465
Drugs & Devices	604	0	380	(100)	19	25	0	(8)	920
Outpatients	442	38	(41)	575	(42)	(6)	270	13	1,249
Non Elective	670	301	(364)	(4)	(11)	46	0	(39)	599
Non Elective (Excess bed days)	(840)	106	69	0	(13)	18	0	(14)	(674)
Macular	0	14	265	0	0	0	0	0	279
Fertility	0	0	61	0	0	0	0	4	65
Maternity	(127)	0	152	0	(8)	1	0	(7)	11
A&E	32	63	(11)	23	(2)	10	0	(8)	107
Critical Care	(648)	(203)	181	(60)	(28)	62	0	(61)	(757)
Other PoDs	(516)	60	(652)	(56)	46	12	0	(18)	(1,124)
Total Mth 11 Forecast Variance	(466)	409	138	309	(94)	168	2,703	(27)	3,140

PRESCRIBING

TABLE 4

Forecast Reserves Summary

	Reserves Held Mth 11	Commits Mth 11 onwards	Forecast Bals Year End
Amounts Held in CCG Reserves	**£000s**	**£000s**	**£000s**
Investments - National	1,267	0	(1,267)
Investments - Greater Manchester	1,144	0	(1,144)
Contingency	313	0	(313)
In-Year Allocations	1,361	1,004	(357)
CIP - Not embedded in budgets	(3,214)	0	3,214
Total Reserves	**871**	**1,004**	**133**

TABLE 5

Forecast spend against in year allocation (NHS Eng Requirement)	£000s
2015-16 Allocation	(386,772)
Less: Brought forward 2014-15 Surplus	4,281
Forecast 2015-16 Expenditure	385,022
Forecast (under)/over-spend against in year allocation	2,531

TABLE 6

Top Five Increases in Prescribing Spend by Drug Type	Jan 14 - Dec 14 (£000s)	Jan 15 - Dec 15 (£000s)	Change (£000s)	Change in Spend (%)	Change in No. Items (%)
Endocrine System	6,217	6,867	650	10.5%	26.6%
Cardiovascular System	5,993	6,522	529	8.8%	22.5%
Central Nervous System	10,315	10,743	428	4.1%	25.9%
Nutrition And Blood	2,576	2,963	387	15.0%	25.0%
Appliances	1,270	1,416	146	11.5%	38.3%

TABLE 10

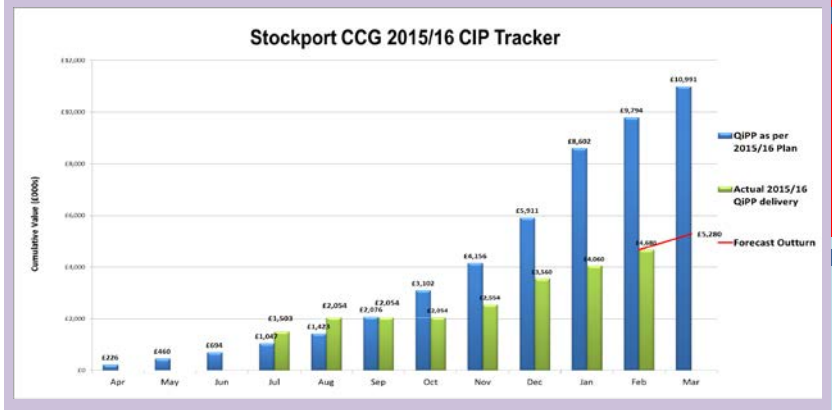


TABLE 7

Risks not in the financial position

There are no significant risks which would prevent the delivery of the CCG's planned surplus of £1.75m.

TABLE 9

Cashflow Summary - Month 11	£000s
Cash Limit for the Year	385,412
Cash drawn down YTD	349,126
Remaining cash	36,286
Actual cash drawn down (%)	90.6%
Expected cash drawn down (%)	91.7%

TABLE 8

Public Sector Payment Policy (PSPP) - Measure of Compliance

The Public Sector Payment Policy target requires CCG's to aim to pay **95%** of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.	February YTD Number	February YTD £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	9,523	59,721
Total Non-NHS Trade Invoices Paid Within Target	9,308	58,247
Percentage of Non-NHS Trade Invoices Paid Within Target	97.74	97.53
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,312	238,732
Total NHS Trade Invoices Paid Within Target	2,218	238,256
Percentage of NHS Trade Invoices Paid Within Target	95.93	99.80
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	11,835	298,453
Total NHS Trade Invoices Paid Within Target	11,526	296,503
Percentage of NHS Trade Invoices Paid Within Target	97.39	99.35

We will continue to monitor our performance against the 95% 'Public Sector Payment Policy' (PSPP) target of invoices paid within 30 days of invoice. Performance is measured based on both numbers of invoices and £ value.

Appendix 2

NHS STOCKPORT CCG BALANCE SHEET as at 29th February 2016 (Month 11)

	Opening Balances 1.4.15 £000s	Closing Balances 29.02.16 £000s	Movement in Balances £000s	Forecast B/S 31.3.16 £000s
Non-current assets:				
Property, plant and equipment	14	9	(5)	10
Intangible assets	0	0	0	0
Trade and other receivables	0	0	0	0
Total non-current assets	**14**	**9**	**(5)**	**10**
Current assets:				
Cash and cash equivalents	43	7	(36)	50
Trade and other receivables	1,363	3,134	1,771	1,388
Inventories	0	0	0	0
	1,406	**3,141**	**1,735**	**1,438**
Non-current assets classified "Held for Sale"	0	0	0	0
Total current assets	**1,406**	**3,141**	**1,735**	**1,438**
Total assets	**1,420**	**3,150**	**1,730**	**1,448**
Current liabilities				
Trade and other payables	(20,923)	(24,215)	(3,292)	(21,000)
Provisions	(883)	(649)	234	(399)
Borrowings	0	0	0	0
Total current liabilities	**(21,806)**	**(24,864)**	**(3,058)**	**(21,399)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(21,714)**	**(1,328)**	**(19,951)**
Non-current liabilities				
Trade and other payables	0	0	0	0
Provisions	0	0	0	0
Borrowings	0	0	0	0
Total non-current liabilities	**0**	**0**	**0**	**0**
Total Assets Employed:	**(20,386)**	**(21,714)**	**(1,328)**	**(19,951)**
FINANCED BY:				
TAXPAYERS' EQUITY				
General fund	(20,386)	(21,714)	(1,328)	(19,951)
Revaluation reserve	0	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(21,714)**	**(1,328)**	**(19,951)**

NHS
Stockport
Clinical Commissioning Group

CCG Financial and Operational Plan 2016/17

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Tel: 0161 426 9900
Fax: 0161 426 5999
Text Relay: 18001 + 0161 426 9900
Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
To approve the 2016/17 Operational plan To approve the 2016/17 Financial plan including the Income and Expenditure Budget. To delegate authority to vary this plan, within agreed parameters, to the Chief Finance Officer.
Please detail the key points of this report
1. This operational plan is for year 3 of the CCGs 5 year strategic plan. The strategic aims remain consistent. 2. The financial plan enables the CCG to move into recurrent surplus. 3. The pace of implementation of the plan is dependent upon the timing and level of Vanguard funding received (£13.3m). In approving this plan the key factors for the GB to consider from a compliance perspective are:- 4. The in-year surplus of 0.5% is below the NHS business rules expectation of 1%. 5. All national constitution standards are planned to be achieved with the exception of the A&E 4 hour target.
What are the likely impacts and/or implications?
The opportunity to transform both commissioning and provision in Stockport. The risk that the required pace and depth of change are not met with consequent impact on finance, quality and performance.
How does this link to the Annual Business Plan?
The operational and financial plans are fundamental elements.
What are the potential conflicts of interest?
The plan includes both direct and indirect investment relating to GP practices.
Where has this report been previously discussed?
Finance & Performance Committee
Clinical Executive Sponsor: Ranjit Gill
Presented by: Mark Chidgey
Meeting Date: 30th March 2016

Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Operational Plan 2016/17

1 Introduction & Process

1.1 The attached CCG operational plan for 2016/17 represents year 3 of a 5 year strategy. The plan describes a position where significant progress has been made but very significant challenges remain.

1.2 With the approval of the Governing Body, the CCG will submit the final version of this plan to NHS England on 11th April 2016.

Due to the changes brought about by devolution NHSE will not assure the plan in isolation but as one element of the single Greater Manchester plan.

Stockport CCG is then accountable to Greater Manchester for delivery of the Stockport elements of the Greater Manchester plan.

2 Operational Plan Summary

2.1 **Structural Change** There are three key changes which either impact on or are driven by the plan:-

- Devolution to Greater Manchester means that the planning footprint moves from Stockport to Greater Manchester. The GB have been briefed on implications for governance, accountability and assessment.

- Section 75 pooling of budgets with Stockport MBC signals a significant step forward in the ability of the Stockport system to consistently commission services that meet both health and social care need. The detail of this is provided within the next agenda item.

- The Multi Speciality Community Provider, envisioned as part of our Vanguard proposal, is moving towards reality. A single provider board has been established with an MOU between the parties drafted and progressing towards agreement. This gives Stockport the opportunity to be at the forefront of delivering the Five Year Forward View.

2.2 **Programmes of Change** As this is year 3 of a 5 year strategy then we have already established; the programmes of change, the projects within these (see page 32 of attachment) and the capacity and capability to deliver. The approach, capacity and values are summarised as “Stockport Together”.

- The economy’s ability to deliver change at the pace and crucially the depth required is significantly dependent upon approval of the Vanguard value proposition by Greater Manchester..

- Redistribution of resources into primary and community has been an explicit priority throughout the strategy. Of the £8.4m planned CCG investment then more than 50% of this is into Primary Care and Mental Health services:-

- Primary care investment is into Information Technology and, following evaluation and approval by GB last month, recurrent funding for the GP development schemes.

- The CCG has stated its commitment to Parity of Esteem on many occasions and is now demonstrating this commitment with an increase of 5.9% in Mental Health funding. This will deliver improvements in quality, access and performance.

2.3 **Performance** All of the national constitution standards are planned to be achieved. The exception to this is the Emergency Department 4 hour standard. The transformation elements required for sustainable delivery will not be fully in place for winter 2016 and this is reflected within the trajectory. ***Submitting a plan whereby a national standard is not being achieved places a significant risk on assurance.***

2.4 Capacity and Demand The assumption within the plan is that the investment into neighbourhoods (£5.5m from within Better Care Fund) will enable demand growth into Stockport Acute to be managed. The risks and opportunities of this within a capitation contract are a key element of the ongoing contract negotiation with Stockport FT and the Provider Board.

Demand outside of the emerging MCP providers is assumed at up to 3%.

3 Financial Plan Summary

3.1 2015/16 has been a challenging year for the Stockport economy and Stockport CCG. Both Stockport NHS FT and NHS Stockport CCG end the year in recurrent deficit. This reflects the structural system deficit identified as part of the South Sector review.

3.2 In 2016/17 the CCG will receive an increase in allocation of 5.9%. This compares with an average national settlement of 3.7%, whilst most GM CCGs will receive around 3%. The financial strategy and operational plan presented today aim to balance the pace of a significant transformation programme with achieving financial resilience.

3.3 The combination of an existing structural deficit and the NHS wide challenges set out in the FYFV mean that Stockport is and will continue to be a high risk economy with regards to financial sustainability. Within Stockport Together there has been a specific focus on aligning financial plans and a focus on achieving financial balance across the system rather than just within individual organisations. As a result a new relationship, approach and set of behaviours are forming between organisations.

3.4 At the conclusion of this paper a position is set out is that within the proposed plan is an inherently high level of financial risk to the CCG. It is precisely for this reason that the operational plan sets out a continuation of the existing strategy of:-

- Commissioning on a capitation basis for outcomes.
- Integrating provision into an Mutlispecialty Community Provider, with the combined ability to deliver an agreed outcomes framework within the capitation budget.
- Implicit within the above, a shift of resources and capacity into primary and community services.

4 Business Rules

4.1 The NHS financial business rules to be met are set out in the table below:-

Business Rule	Greater Manchester	Stockport	Notes
Maintain carried forward 15/16 surplus less agreed drawdown control total target.	✓		£14.8m control total for GM.
0.5% Commissioner contingency reserve.		✓	Included within plan
Deliver recurrent surplus.		✓	Achieved at 1%.
Deliver 1% surplus in year.	✓	!	The plan is to maintain our surplus at 0.5%.
1% non committed system risk reserve.		✓	Included within plan but results in £4m unidentified CIP.

4.2 Due to the change in planning footprint, the requirement for achieving business rules is now set at a Greater Manchester level. Within Greater Manchester there is an expectation that each organisation will also individually achieve the business rules.

4.3 In working with GM CCGs to ensure that the business rules are met, the focus and challenge has been on why Stockport CCG, with the level of growth that we have received, is not planning to achieve a 1% surplus:-

- The waterfall chart (attachment page 18) illustrates how growth has been utilised. It has allowed the CCGs recurrent position to move significantly from the £8m recurrent deficit reported in 2015/16 to a £4m recurrent surplus in 2016/17. This recurrent surplus includes, a yet to be identified, CIP of £0.9m.

- We have compared our position with that of an equivalent CCG that receives only average growth, has no structural deficit to manage and is able to access their full 1% surplus from 2015/16. After these and other non-recurrent factors, then Stockport has an additional challenge to meet in the range of £4.5m-£6.5m.

- The requirement to set aside an uncommitted 1% system risk reserve is a significant challenge to every CCG. At this stage it can only be achieved by setting an unidentified, non-recurrent CIP of c£4m.

4.4 The outcome of the above factors is that the plan we are submitting includes a surplus of 0.5% as opposed to the expected 1%. The rationale behind this recommendation is that the cumulative CIP risk would be too great to represent a credible financial plan. This is illustrated in the table below:-

CIP	Value £m	Comment	Include in Plan
Identified schemes	£11.5m	The elements and level of risk within this are comparable with that of the majority of CCGs	Yes
Unidentified recurrent	£0.9m	All CCGs will have an element of unidentified CIP	Yes
Unidentified non recurrent	£4.4m	This is a very significant challenge for all CCGs. Based on consistent planning, risk, mandation and emerging guidance. Thefore this is not a differential risk.	Yes
Additional 0.5% surplus to achieve 1% in-year.	£2m	Given that there is £5.3m of unidentified CIP above, then a further £2m is extremely high risk and is near certain to result in the CCG failing to achieve the target surplus.	No

5 Developments not included within the financial plan

5.1 As the CCG is restricted to only reporting on notified allocations received by the CCG there are a number of relevant issues that currently sit outside of the plan. The significant issues are:-

Better Care Fund – From within the BCF and from additional funding provided by SMBC, the investment in the Neighbourhood model is planned to increase from £2m in 15/16 to £5.5m in 16/17.

Primary Care Access – Funding for the extension of primary care access that was initiated in 15/16 has not yet been formally notified and so is not included within the CCG financial plan. This initiative will continue.

Vanguard value proposition – As stated above the Stockport economy has requested £13m of funding to progress at pace with the MCP and Neighbourhood model. We are awaiting an outcome from Greater Manchester on this and in advance of this neither income nor expenditure has been included within the CCG plan.

6 Financial Risks

6.1 As highlighted above, until the Structural deficit across the South Sector is addressed then the Stockport economy will continue to be high risk financially. Explicit risks within the plan are:-

Risk / Mitigation	Value	Mitigation approach
0.5% Contingency	(£2m)	Uncommitted contingency / benefit available against in year risks.
PbR activity growth.	£5m	£5.5m investment through BCF in neighbourhood model. Progress on capitation contracts with emerging MCP providers.
Prescribing price / volume growth.	£2m	Reduction in CIP from £3m to £2m. Continuation of prescribing support to primary care. Increased co-ordination of primary / secondary prescribing through MCP / provider board.
Unidentified CIP	£5m	Early identification of £1m recurrent requirement. Communication and negotiation with GM and GM partners on 1% requirement and priorities.
Readmissions	£2m	NHSE are considering amending the rules on this and as a consequence it is possible that it becomes a cost pressure to CCGs in 16/17. All of the Stockport funding is contractually committed in community based schemes. Negotiation with SFT and other Trusts, in particular with regards to System Resilience.

6.2 Whilst the above risks cannot be aggregated, it is clear that the financial plan includes a significant net risk for NHS Stockport CCG.

7 Contract Negotiation

7.1 Contract negotiation has progressed well with Stockport NHS Foundation Trust. Activity and price has been agreed for the 15/16 outturn at 16/17 prices. The final stages of the negotiation are now to agree the risks and opportunities for each party for variances from this activity level.

7.2 Contract proposals received from other NHS providers have in the main been for activity levels significantly above the 15/16 outturn. The CCG response is that we will consistently contract at the 15/16 outturn level.

Recommendations

The Governing Body is asked to:-

1) **approve** the Operational Plan for 2016/17.

2) **approve** the Financial Plan for 2016/17 (appendices 1-3 attached)

3) **Note** that as a result of the above there will be additional scrutiny from Greater Manchester and NHSE on the Stockport economy due to:-

    - A forecast surplus of 0.5%.

    - An ED 4 hour trajectory which is below the national constitution standard.

4) **Delegate** to the CFO the ability to vary this plan resulting from:-
    - Final contract negotiation outcome.
    - Revised national guidance.
    - Changes to agreements between Greater Manchester CCGs.

    Any changes to the plan to be supported by both the Chief Operating Officer and Chief Clinical Officer and subsequently reported to the next meeting of the Governing Body.

5) **Support** the management team in:-
    - prioritising the early delivery of the existing CIP projects.
    - rapidly expanding this to address the remaining unidentified CIP.
    - Reviewing objectives for teams and individuals and to align these with delivery of the above objectives and the operational plan.

Mark Chidgey
Interim Chief Finance Officer &
Director of Provider Management

23rd March 2016

Financial Budget for Approval 2016/17

Appendix 1

	2016-17		
	Recurrent	**NR**	**In Year**
Funding			
Prior year allocation	(363,122)		(363,122)
Growth	(21,966)		(21,966)
Sub-Total	**(385,087)**		**(385,087)**
Running costs	(6,450)		(6,450)
BCF allocation (Social Care)	(5,987)		(5,987)
Primary Care Co-Commissioning	(35,279)		(35,279)
Prior year (surplus) / deficit		(1,750)	(1,750)
Total Funding (A)	**(432,803)**	**(1,750)**	**(434,553)**
Expenditure			
Opening expenditure	383,383		383,383
Pre-commitments			
Remove previous year CQuIN	(5,391)		(5,391)
Current year CQuiN			
Recurrent commitments	**377,992**		**377,992**
Pre-commitments / Primary Care	33,962		33,962
Inflation	11,154		11,154
Tariff deflator	(4,411)		(4,411)
Demand	8,802		8,802
Recurrent investments	6,711		6,711
Current year CQuiN	6,833		6,833
BCF contribution			
BCF costs transfer			
Non-recurrent expenditures / (benefits)			
Contingency (0.5%)		2,173	2,173
Non-recurrent investment		5,945	5,945
Total Expenditure (B)	**441,044**	**8,117**	**449,161**
CIP Planned Delivery (C)	(12,216)	(4,389)	(16,604)
Net Expenditure (B+C = D)	**428,828**	**3,729**	**432,557**
Budget (surplus) / deficit (A+D = E)	**(3,975)**	**1,979**	**(1,996)**
Recurrent Targets			
Recurrent surplus target	(3,975)		
C/f budget (surplus) / deficit	(3,975)		
Recurrent undelivered CIP	(0)		
Total recurrent CIP required	**(12,216)**		
In-year Targets			
In-year surplus target			(1,996)
In-year surplus achieved			(1,996)
Undelivered CIP			0
Total CIP required			**(16,604)**

Income & Expenditure Budget for Approval 2016/17

Appendix 2

Income		
Allocation	**Plan 2016/17 £000s**	**Total**
Prior year allocation	£363,122	
Growth	£21,966	
Sub-Total	£385,087	
Running costs	£6,450	
BCF allocation (Social Care)	**£5,987**	
Primary Care Co-Commissioning	£35,279	
Prior year (surplus) / deficit	£1,750	
Total Funding (A)	**£434,553**	**£434,553**

Expenditure		
Service areas	**Plan 2016/17 £000s**	**Total**
Hospital services	£235,877	
Mental Health	£33,872	
Community Health	£36,114	
Continuing Health Care	£15,921	
Primary Care	£10,644	
Prescribing	£51,023	
Primary Care Co- Commissioning	£34,751	
Other Programmes	£6,553	
Corporate	£6,450	
1% Non Recurrent Uncommitted	£4,264	
Contingency	£2,173	
Unidentified QIPP	-£5,085	
Total	**£432,557**	**£432,557**

Planned Surplus (0.5%)		**£1,996**

Summary of CIP and Investments

Appendix 3

CIP

Initiative	Saving	Risk Level
Estates (Kennedy Way)	£0.2m	●
Prescribing	£2.0m	●
Continuing Healthcare growth	£0.6m	●
Stockport Together / Vanguard	£4.2m	●
Re-procurements	£0.5m	●
Non-recurrent Income		
Quality Premium	£0.3m	●
Balance Sheet	£0.5m	●
Amended Planning Assumptions		
BCF Risk Fund	£0.9m	●
CQUIN reduced to 95%	£0.4m	●
Slippage / pessimism bias	£1.5m	●
Reserves w/o from 15/16	£0.4m	●
Unidentified CIP (Recurrent)	£0.9m	●
Unidentified CIP (Non Recurrent)	£4.2m	●
Total	**£16.6m**	

Investments

Initiative	Investment
Primary Care	
GP Development Scheme	£1.5m
GP IM&T	£0.8m
GP Premises	£0.1m
Mental Health	
Mental health Parity of Esteem	£1.6m
CAMHS Transformation Plan	£0.6m
Access	
Additional capacity for RtT target	£1.0m
Additional Cancer demand	£0.3m
Impact of NICE guidance	£0.5m
Other	
St Anne's Hospice - usage	£0.2m
Weight Management	£0.2m
Greater Manchester Strategic Levy	£0.8m
CHC – national scheme	£0.8m
Total	**£8.4m**

Financial Plan 2016/17-2020/21

Appendix 4

	2016-17			2017-18			2018-19			2019-20			2020-21		
	Recurrent	NR	In Year	Recurrent	NR	In Year	Recurrent	NR	In Year	Recurrent	NR	In Year	Recurrent	NR	In Year
Funding															
Prior year allocation	(363,122)		(363,122)	(385,087)		(385,087)	(392,819)		(392,819)	(400,642)		(400,642)	(408,993)		(408,993)
Growth	(21,966)		(21,966)	(7,731)		(7,731)	(7,823)		(7,823)	(8,351)		(8,351)	(15,092)		(15,092)
Sub-Total	**(385,087)**		**(385,087)**	**(392,819)**		**(392,819)**	**(400,642)**		**(400,642)**	**(408,993)**		**(408,993)**	**(424,085)**		**(424,085)**
Running costs	(6,450)		(6,450)	(6,434)		(6,434)	(6,420)		(6,420)	(6,407)		(6,407)	(6,395)		(6,395)
BCF allocation (Social Care)	(5,987)		(5,987)	(6,089)		(6,089)	(6,192)		(6,192)	(6,297)		(6,297)	(6,404)		(6,404)
Primary Care Co-Commissioning	(35,279)		(35,279)	(37,887)		(37,887)	(39,157)		(39,157)	(40,384)		(40,384)	(41,985)		(41,985)
Prior year (surplus) / deficit		(1,750)	(1,750)		(1,996)	(1,996)		(4,073)	(4,073)		(4,173)	(4,173)		(4,259)	(4,259)
Total Funding (A)	**(432,803)**	**(1,750)**	**(434,553)**	**(443,229)**	**(1,996)**	**(445,225)**	**(452,411)**	**(4,073)**	**(456,484)**	**(462,081)**	**(4,173)**	**(466,255)**	**(478,869)**	**(4,259)**	**(483,128)**
Expenditure															
Opening expenditure	383,383		383,383	428,828		428,828	439,175		439,175	448,279		448,279	457,864		457,864
Pre-commitments															
Remove previous year CQuIN	(5,391)		(5,391)	(6,833)		(6,833)	(6,907)		(6,907)	(7,089)		(7,089)	(7,277)		(7,277)
Current year CQuIN															
Recurrent commitments	**377,992**		**377,992**	**421,995**		**421,995**	**432,269**		**432,269**	**441,189**		**441,189**	**450,587**		**450,587**
Pre-commitments / Primary Care	33,962		33,962												
Inflation	11,154		11,154	9,364		9,364	8,309		8,309	8,494		8,494	11,859		11,859
Tariff deflator	(4,411)		(4,411)	(4,576)		(4,576)	(4,713)		(4,713)	(4,854)		(4,854)	(5,000)		(5,000)
Demand	8,802		8,802	9,545		9,545	9,864		9,864	10,196		10,196	10,565		10,565
Recurrent investments	6,711		6,711	0		0	0		0	0		0	0		0
Current year CQuIN	6,833		6,833	6,907		6,907	7,089		7,089	7,277		7,277	7,536		7,536
BCF contribution															
BCF costs transfer															
Non-recurrent expenditures / (benefits)															
Contingency (0.5%)		2,173	2,173		2,226	2,226		2,282	2,282		2,331	2,331		2,416	2,416
Non-recurrent investment		5,945	5,945		3,989	3,989		4,006	4,006		4,090	4,090		4,241	4,241
Total Expenditure (B)	**441,044**	**8,117**	**449,161**	**443,235**	**6,215**	**449,451**	**452,818**	**6,289**	**459,107**	**462,302**	**6,421**	**468,723**	**475,548**	**6,656**	**482,204**
CIP Planned Delivery (C)	(12,216)	(4,389)	(16,604)	(4,060)	(4,239)	(8,299)	(4,540)	(2,256)	(6,796)	(4,437)	(2,290)	(6,727)	(1,047)	(2,440)	(3,488)
Net Expenditure (B+C = D)	**428,828**	**3,729**	**432,557**	**439,175**	**1,976**	**441,152**	**448,279**	**4,033**	**452,311**	**457,864**	**4,132**	**461,996**	**474,500**	**4,216**	**478,716**
Budget (surplus) / deficit (A+D = E)	**(3,975)**	**1,979**	**(1,996)**	**(4,053)**	**(20)**	**(4,073)**	**(4,133)**	**(41)**	**(4,173)**	**(4,217)**	**(42)**	**(4,259)**	**(4,369)**	**(43)**	**(4,411)**
Recurrent Targets															
Recurrent surplus target	(3,975)			(4,053)			(4,133)			(4,217)			(4,369)		
C/f budget (surplus) / deficit	(3,975)			(4,053)			(4,133)			(4,217)			(4,369)		
Recurrent undelivered CIP	(0)			(0)			0			0			0		
Total recurrent CIP required	**(12,216)**			**(4,060)**			**(4,540)**			**(4,437)**			**(1,047)**		
In-year Targets															
In-year surplus target			(1,996)			(4,073)			(4,173)			(4,259)			(4,411)
In-year surplus achieved			(1,996)			(4,073)			(4,173)			(4,259)			(4,411)
Undelivered CIP			0			0			0			0			0
Total CIP required			**(16,604)**			**(8,299)**			**(6,796)**			**(6,727)**			**(3,488)**

Operational Plan

NHS
Stockport
Clinical Commissioning Group

2016/17

Our 5 Year Plans

NHS Stockport Clinical Commissioning Group

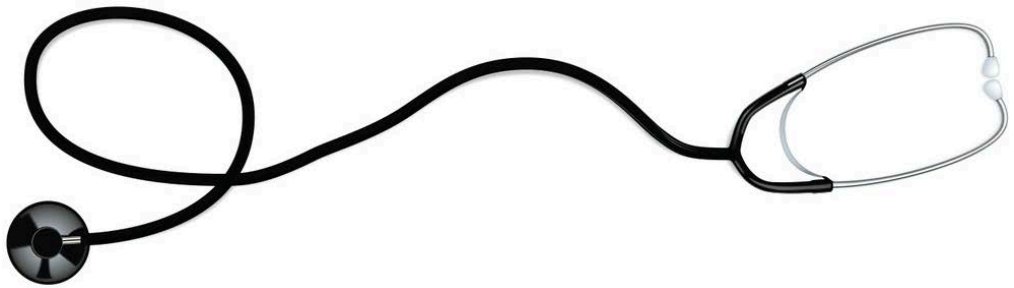
Our 5 Year Vision for Stockport

With our partners across the health and social care economy of Stockport, our vision is to provide a truly joined up, high quality, sustainable, modern and accessible health and care system.

The effective use of technology and data will help us to understand people and their health and care needs better and to provide the right advice and support to help them stay healthy for as long as possible.

Preventing disease or the impact of disease will be core to our services. When ill or experiencing one or more conditions the local services will work together with people to help them remain at home and independent without requiring a visit to or stay in hospital or residential care.

As a result of this work, people will be less likely to die young of treatable disease adding 1,000 years of life to the population of Stockport over the next five years, reducing health inequalities in the borough.



Our Strategic Aims

1. Transform the experience of children and adults with long-term and complex physical and mental health conditions
2. Increase the clinical cost effectiveness of elective treatment and prescribing
3. Ensure better prevention and early identification of disease leading to reduced inequalities and improved mortality
4. Improve the quality, safety and performance of local services in line with national and local expectations
5. Create a more sustainable primary care led and less hospitalised health care system

Our Strategic Objectives

1. Reduce unplanned hospitalisation by 17%
2. Improve the health related quality of life for people with long-term conditions to best in class
3. Improve access to mental health services, increasing IAPT services to 20% and extending young people's services up to the age of 25
4. Improve the efficiency of the elective system, including outpatients, by up to 30%
5. Reduce the number of avoidable hospital deaths
6. Increase patient satisfaction with all services to the top quartile
7. Reduce the umber of years of life lost to causes amenable to healthcare by 1000
8. Narrow the gap in life expectancy across Stockport to single figures

This Operational Plan sets out our continuing efforts to deliver these aims and objectives during year 3 of our 5 year strategy.

Wider Context

NHS Stockport Clinical Commissioning Group

Our plans sit within the wider context of changes at a national, regional and local level.

The NHS Five Year Forward View

This operational plan sets out what NHS Stockport CCG will do in 2016/17 to deliver the NHS's five year transformation plan to improve quality; standards for patients; to reduce health inequalities; to restore and maintain financial balance.

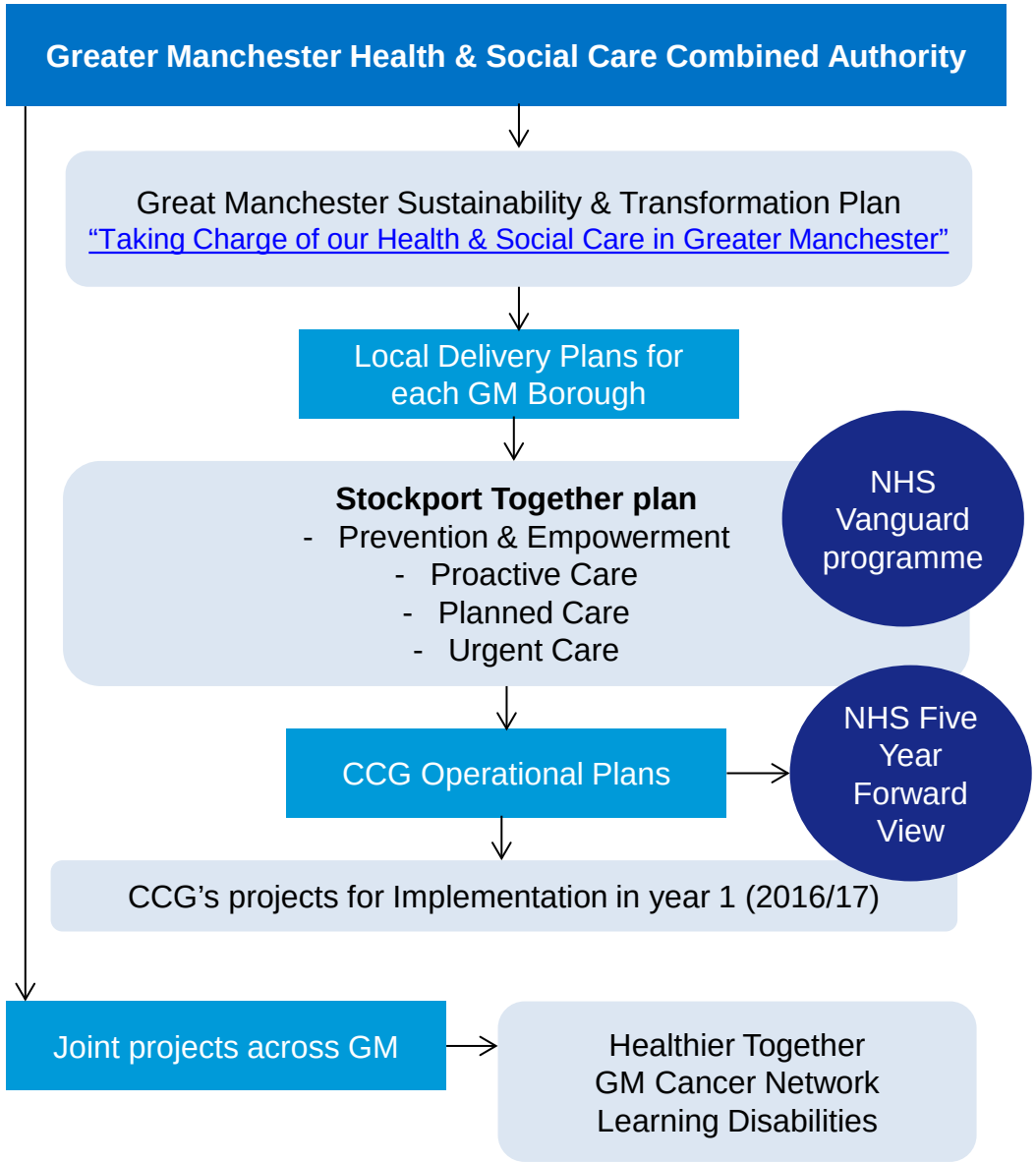
NHS Stockport CCG has been selected as a Vanguard site, to pilot a Multi- Speciality Community Provider (MCP) model of care which will help us bring about these changes at pace and offer a blueprint for other CCGs to adopt.

Stockport Together

With our partners across the health and social care economy of Stockport, our vision is to provide a truly joined up, high quality, sustainable, modern and accessible health and care system. The operational plan is year one of our Stockport Together plans for this new system, under an MCP model.

Devolution in Greater Manchester

NHS Stockport CCG is an active partner in the devolved health and social care partnership for Greater Manchester, with our Chief Clinical Officer sitting on their Strategic Partnership Board. The 'Stockport Together' plan is the locality plan which will form our part of the Greater Manchester 5 year strategy – our local STP, including shared projects such as Healthier Together.



Project Plan

NHS Stockport Clinical Commissioning Group

Delivery of our strategic plans will be through the continuation of our existing projects under the CCG's eight Strategic Programmes. Project plans have been refreshed to respond to new NHS requirements and developments in the Stockport Together (Vanguard) and GM-Devo (STP) programmes. It should be noted that the CCG does not see these three elements as mutually exclusive, but as layers of one cohesive approach.

Programme		Project	Programme		Project
Urgent Care	UC1	Single Point of Access	New Models of Care	NMC1	Stockport Together
	UC2	Reform Acute ACS Pathway Project		NMC2	Better Care Fund
	UC3	Systems Resilience Group		NMC3	Co-commissioning
Proactive Care	PRC1	Care Planning Project		NMC4	Healthier Together
	PRC2	Care Homes Management		NMC5	Estates
	PRC3	Community Falls		NMC6	Workforce & OD
	PRC4	End of Life Care	Quality	Q1	Francis, Berwick & Winterbourne
	PRC5	Modern Model of Integrated Care		Q2	Harm-Free Care
	PRC6	Review Intermediate Tier		Q3	Early Diagnosis of Cancer
	PRC7	Patient Education		Q4	Accountability & Assurance Framework
	PRC8	GP Development Scheme		Q5	Mental Capacity Act
Parity of Esteem	PE1	IAPT		Q6	Clinical Effectiveness
	PE2	CAMHS		Q7	Patient Experience
	PE3	ASD & ADHD		Q8	NICE Guidance
	PE4	Dementia Care		Q9	Patient Choice
	PE5	RAID		Q10	Prescribing Quality
	PE6	Severe & Enduring Mental Health		Q11	Research & Innovation
	PE7	Personal Health Budgets	Prevention	P1	Health Chats
Planned Care	PLC1	Maximise Adherence with EUR		P2	Access to Lifestyles
	PLC2	New EUR Thresholds		P3	Immunisation & Vaccination Uptake
	PLC3	Optimise Care Pathways		P4	Screening Uptake
	PLC4	Reduce GP Referral Variation		P5	Know Your Numbers
	PLC5	Improving Value for Money	Technology	T1	Digital Services
	PLC6	Long-Term Conditions Variation		T2	Integrated records
	PLC7	Consultant-Connect		T3	Clinical Systems Maturity
QIPP / CIP	See page 13 for full list of QIPP / CIP plans				

044

Progress to date

NHS Stockport Clinical Commissioning Group

Over the first two years of our Strategic Plan we saw significant progress in a number of areas, including:

Creating a more Sustainable, Primary Care-Led System

- development of the Stockport Together Partnership to transform health and social care;
- received national Vanguard status for our new model of care;
- no longer have half-day closures in any GP Practice in Stockport
- funded 145 additional opening hours each week in General Practice
- recruited 7 pharmacists to work part-time in Primary Care;
- Patient Education sessions in General Practice

Transforming the Experience of Patients with Long-Term Conditions

- tailored Care Plans for c 4,500 people with multiple healthcare needs to better manage their conditions (2% of over 18s);
- piloted an integrated neighbourhood team to help manage complex health and social care needs for the most vulnerable adults in the borough;
- real-time tests for asthma patients in Primary Care using video consultations;
- Care coordinators were recruited by 6 practices to manage LTCs

Reducing Unplanned Hospitalisation

- piloted the NWAS Pathfinder Service to treat people on the spot rather than taking people to A&E unnecessarily;
- worked with local care homes to train their staff;
- reassigned GP cover to care homes to improve capacity and set up GP ward rounds, reducing unnecessary admissions to hospital of care home residents;

As a result…

- ED attendances have flat lined in Stockport compared to an increase of 2.2% nationally
- 277 less people were admitted to hospital with a Long Term Condition (LTC)
- 102 less admissions to hospital for people with COPD
- 202 less people admitted to hospital from a care home setting
- 6 practices have employed care coordinators - data suggest a reduction in readmissions within 30 days
- 7 additional pharmacists were recruited to work in Primary Care, taking the load off GPs and allowing them to spend more time with patients with long-term conditions
- over 50% of GP practices have increased LTC capacity through extended hours under the scheme
- Stockport practices are performing within the top quartile nationally for management of Long-Term Conditions

Progress to date

NHS Stockport Clinical Commissioning Group

Improving Access to Mental Health Services

- increased local access to IAPT services from just 8% to the national standard of 15%;
- Stockport has already met the NHS's new NHS 18 week IAPT standard that came into force in April this year and making progress on the 6 week waiting time standards;
- extended access to CAMHS services from 16-18 years;
- set aside investment to commission additional community capacity for children and young people with eating disorders;
- has continued to invest in our Rapid Access service (RAID) to support mental health needs in urgent care services;
- worked with the Local Authority to open a residential scheme for adults with learning disabilities;
- supported the transfer of care from a hospital placement to the community for adults with learning disabilities and autism;

Ensuring Better Prevention

- over 2,000 downloads of a new Stockport health and care app;
- a successful hypertension campaign which saw 1,794 people tested and over a third referred to their GP for further action;
- trained over 30 non-clinical staff to take BP readings;
- ran a COPD awareness campaign, testing the 'lung age 'of around 1,000 residents;
- invested in patient education courses for people with type 1 diabetes;
- we started training health and social care staff across Stockport to have *Health Chats* supporting healthy lifestyle changes;

Improving the Efficiency of the Elective System

- worked with our GP Practices to improve the quality of referrals, reducing the number of people referred who don't need any treatment or follow-up;
- launching a new scheme allowing GPs access to consultant advice before making referrals;
- reviewed 11 out-patient clinics and 27 pathways, resulting in the discharge of just over 1,000 patients from secondary care;
- all practices now offer online booking and access to records;
- following up from views in patient surveys, practices have reviewed phone protocols and introduced an admin email account to reduce DNAs

Improving the Quality, Safety & Performance of Local Services

- redesigned urgent surgery provision across Greater Manchester with Healthier Together;
- invested £875,000 in a new community IV service and £960,000 in Rapid Response services to support people out of hospital.

Improving Patient Experience

- an End of Life Care pilot which successfully tripled the percentage of patients (from 30-90%) who were able to die in the place of their choosing;
- improved satisfaction ratings in General practice by up to 6% on last year – with ratings above the England average

In light of these achievements and new requirements from the NHS, this document sets out our continued programme of change 1 April 2016 – 31 March 2017.

Activity Baseline

NHS Stockport Clinical Commissioning Group

Activity Baseline

Forecast Outturn for 2015/16 is a profiled forecast based on Month 8 SUS data (November 2015). This is in line with planning at our main provider, to ensure consistency in planning figures.

Over 2015/16 the CCG has made significant progress, through a range of QIPP schemes, in reducing the rate at which demand rises. As a result, work is underway with our local foundation trust to move in 16/17 from PbR to a capitation contract based on population outcomes.

2015/16 Forecast Outturn by Provider	EM2: Consultant Led First Outpatient Attendances (Total activity)	EM3: Consultant Led Follow-Up Outpatient Attendances (Total activity)	EM4: Total Elective Admissions (Spells) (Total Activity)	EM5: Total Non-Elective Admissions (Spells) (Total Activity)	EM6: Total A&E Attendances
Central Manchester	8977	28107	4726	2568	8540
East Cheshire	1079	2713	439	239	882
IS providers – BMI	2287	6430	1876		
IS Providers – Other	3615	2919	398		
Other NHS Providers	2659	1523	1160	1326	3030
Pennine Acute	229	507	68	97	546
Salford Royal	7914	14569	648	240	748
South Manchester	12641	34305	5379	4684	10263
Stockport	64856	151827	25338	37340	70945
Tameside	574	1169	177	229	947
WWL	158	540	124	24	37
ALL PROVIDERS	**104,989**	**244,609**	**40,333**	**46,747**	**95,938**

Performance

NHS Stockport Clinical Commissioning Group

Constitutional Targets

The CCG aims to ensure that local patients benefit from the best quality care, meeting and surpassing targets set out in the NHS Constitution. Performance on these targets is monitored monthly by the Governing Body, Where standards slip, the CCG's Quality Committee works with service providers to develop improvement plans. Where issues are sustained contractual measures may be used, including financial penalties. Similarly, performance indicators and financial incentives are used to prioritise key areas for local people. The improvement programmes set out in this plan are also aimed to reduce demand on services and improve capacity to deliver high quality care.

NHS standards	Target	Q3	Improvement led by
A&E waits **12 hour trolley waits**	95% 0	**82.1%** **0**	Stockport System Resilience Group
Category A ambulance calls	75% 75% 95%	**74.7%** **70.1%** **92.9%**	GM Urgent Care Network
Referral to Treatment times	92%	**91.9%**	Stockport System Resilience Group
Diagnostic waiting times	99%	**97.6%**	Manchester System Resilience Group

NHS standard	Target	Q3	Improvement led by
Cancer waits (2 wks)	93% 93%	**97.0%** **94.9%**	Stockport Cancer Board
Cancer waits (31 days)	96% 94% 98% 94%	**98.6%** **97.6%** **100%** **100%**	Stockport Cancer Board
Cancer waits (62 days)	85% 90%	**87.4%** **100%**	Stockport Cancer Board
Mental Health 18 week access	95%	**96.5%**	Pennine Care Commissioning CCGs
52 week waits	0	**3**	Stockport System Resilience Group
Mixed Sex accommodation	0	**0**	Quality Committee
Urgent ops cancelled twice	0	**0**	Quality Committee
C-Difficile	7	**30**	Quality Committee
MRSA	0	**3**	Quality Committee

Improvement Trajectories

NHS Stockport Clinical Commissioning Group

Improvement Trajectories

For our main acute service provider, Stockport NHS FT, the following improvement trajectories have been considered by the Stockport Systems Resilience Group and submitted to NHS Improvement.

Referral to Treatment Times

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total pts waiting	19,846	19,900	19,900	19,950	20,000	20,100	19,950	19,900	19,850	19,800	19,900	19,900	19,800
Patients > 18 weeks wait	1572	1,560	1,540	1,550	1,580	1,600	1,550	1,500	1,450	1,450	1,500	1,450	1,400
Performance (%)	92.1	92.2	92.3	92.2	92.1	92.0	92.2	92.5	92.7	92.7	92.5	92.7	92.9

Baseline data = end of January 2016 submission data
Assumptions - profile will follow previous years seasonal trend

Cancer 62 day wait

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total patients seen	40.5	55	48	46	47	42	46	47	56	42	44	55	57
> 62 day patients	2	8	5	5	6.5	6	6	7	7	5	6.5	8	7
Performance (%)	95.1	85.5	89.6	89.1	86.2	85.7	87.0	85.1	87.5	88.1	85.2	85.5	87.7

Baseline data = December 2015
Assumptions - 1.Treatment values have been used as opposed to patients seen - to account for GM reallocation policy
2. Total treatment activity will match this years

Improvement Trajectories

NHS Stockport Clinical Commissioning Group

Diagnostics

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total pts waiting	4,253	4,350	4,570	4,850	5,000	4,560	4,000	4,300	4,280	4,352	4,330	4,250	4,220
Pts waiting < 6 weeks	4,249	4,346	4,565	4,845	4,995	4,556	3,986	4,296	4,276	4,348	4,327	4,241	4,213
Performance	99.9	99.9	99.9	99.9	99.9	99.9	99.7	99.9	99.9	99.9	99.9	99.8	99.8

Baseline data = January 2016
Assumptions - Assume similar waiting list size and performance next year.

ED – 4 hour wait

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total attendances	7,803	7,600	7,800	7,800	8,000	7,500	7,700	8,000	7,800	7,800	7,800	7,500	7,800
Pts waiting < 4 hrs	2,068	1,500	1,200	850	800	500	375	375	375	500	500	500	375
Performance	73.5	80.3	84.6	89.1	90.0	93.3	95.1	95.3	95.2	93.6	93.6	93.3	95.2

Financial Baseline

NHS Stockport Clinical Commissioning Group

Financial Baseline

The table below sets out how funding was spent by sector in 2015/16 .

Service areas	Forecast Exp 2015/16 £000s	% of Budget
Hospital services	£226,238	59.17%
Mental Health	£31,394	8.21%
Community Health	£35,633	9.32%
Continuing Health Care	£16,436	4.30%
Primary Care (Incl. Prescribing)	£60,516	15.83%
Other Programmes	£6,184	1.62%
Corporate	£5,932	1.55%
Total	**£382,333**	**100.00%**

The above 2015/16 forecast outturn is based on month 9 finance data which is based on the month the 8 activity (November) data as activity information is reported 1 month in arrears. The CCG is carrying forward an underlying deficit of c£8m into 2016/17.

CCG Budget 2016/17

For 2016/17 NHS Stockport CCG has received an **5.9%** uplift in funding , giving a budget of **£391.1 million**, plus the Primary Care Medical allocation £35.3m for in line with level 3 co-commissioning delegation plus running costs of £6.45m plus return of 2015/16 surplus £1.75m. Therefore in 2016/17 the CCG will receive a total allocation of £434.6 million

As a challenged health economy, with substantial financial pressures across the system, the focus of this uplift must be on meeting NHS Constitutional targets. Our financial strategy for 2016/17 is entirely aligned to the Stockport Together ambition in our Sustainability and Transformation Plan (STP).

Business Rules

In 2016/17 CCGs have a requirement under NHS England business rules to make a 1% surplus; to set aside a further 1% for non-recurrent uncommitted investment; and a 0.5% contingency fund. However, as a result of carrying forward a c£8m deficit into 2016/17 and the need to deliver against national priorities the CCG is unable to meet the 1% surplus business rule and is planning to deliver a 0.5% surplus. The CCG recognises that this will lead to a further assurance process and additional scrutiny in respect to the CCG plans.

National Priorities

In 2016/17 the CCG will invest in additional capacity to improve our performance around Mental Health; Referral to Treatment Times (RTT); Cancer; Urgent Care; and Learning Disabilities.

Investment

In 2016/17 the CCG's investments will be specifically directed at achieving national 'Must-Dos'. Further investments in our cross-economy transformation programme – Stockport Together – will be funded through our Better Care Fund; the Vanguard programme; and the Greater Manchester Transformation Fund – separate to our 2016/17 allocations.

Quality, Innovation, Productivity & Prevention

To deliver against national priorities as well as meeting the NHS business rules will result in requiring a £16.6m QIPP programme . Our QIPP plans set out measures that will deliver both recurrent (£12.4m) and non-recurrent (£4.4m) savings, allowing us to invest in lasting change and move the health economy into a recurrent surplus. The CCG will benchmark its existing spend across all services, using the Right Care approach and the Lord Carter Review to identify further opportunities for efficiencies.

NHS Requirements

NHS Stockport Clinical Commissioning Group

In December 2015, NHS England issued new planning guidance, including a range of new challenges for CCGs. Much of this challenge has been absorbed into out existing plans:

NHS Requirement	CCG / Stockport Together Plans	Anticipated Additional Pressure
Seven Day Working • Consultant Cover and diagnostics access at weekends (25% of country by Mar 2017) • Enhanced Primary Care Access (20% of population by March 2017)	Healthier Together Clinical Effectiveness GP Development Scheme GM Primary Care Strategy GP Federation	HT was due to be funded from the GM risk share investment. The plan funds the GP Development scheme on a recurrent basis In-year allocation for 7 day services
Sustainability & Transformation Plan	Stockport Together	PMO costs to be funded through Vanguard funding as detailed within the Value Proposition submitted 8 Feb
Return system to financial balance • Lord Carter provider productivity programme • Agency Spend cap • Right Care Programme	FT projects (CIP / Sustainability Fund) Clinical Effectiveness Francis, Berwick project VfM re-procurements GP referrals LTC variation Outpatient review	This is a major financial risk to Providers and their ability to access the Sustainability & Transformation Fund and, therefore, a risk to system financial balance. The plan assumes that the CCG receives required funding as detailed within the Vanguard value proposition.
Plan to address the Sustainability & Quality of General practice	GP Development Scheme GP referrals project LTC Variation project Proactive Care programme Workforce development projects Neighbourhood teams GP Federation Digital Services Clinical Systems Maturity	The plan funds the GP Development scheme on a recurrent basis Investment in Primary Care estate to enable delivery of schemes ***a full break down of CCG spending on Primary Care can be found on P24***

NHS Requirements

NHS Stockport Clinical Commissioning Group

NHS Requirement	CCG / Stockport Together Plans	Anticipated Additional Pressure
Urgent Care • Access Standards for A&E • Category A Ambulance waits	Systems Resilience Group ACS pathways Front end of A&E	SRG budget of £1.9m fully committed. NWAS investment of £0.5m made in 2015/16. Need to ensure benefits of investment are fully realised in 2016/17 Full resource implications unknown until Stockport Together develop Urgent Care business plan.
Referral to Treatment	Quality projects Constitution projects Consultant connect	Will require us to commission additional capacity (c.1,500 electives) at a cost of c**£1m** to meet the 92% target and ensure future sustainability by reducing the growing backlog.
Cancer standards	Quality projects Constitution projects Early diagnosis project	Will require additional capacity for diagnostics and 2 week waits costing c**£250k**
Mental Health access • 50% target for Early Intervention in Psychosis • 95% IAPT 18 week target • 75% IAPT 6 week target • 66.7% dementia diagnosis rate	Early Intervention in Psychosis IAPT project Dementia Care project	investment of £2.2m in line with the Parity of Esteem business rule
Learning Disabilities	GM plans Winterbourne View project ASD & ADHD	Investment of £400k set aside
Improvements in Quality	Harm-free care project Accountability framework Clinical effectiveness project Patient Experience project	No cost implications from these projects

Activity Forecast

NHS Stockport Clinical Commissioning Group

Planning Assumptions

The CCG starting point assumes a maximum risk of 3% of growth across all services. This has then been adjusted for:-

- the impact of changes that are already in place (eg ED attends have reduced with a significant reduction in admissions from care homes – this is linked to our efforts in primary care, care homes, social care and community services development).
- the impact of policy, for example with regards to cancer.

We acknowledge that growth will happen, given the changing demographics and health needs in our community. But while need may increase, demand will be limited by better protocols and supply will be managed through use of the independent sector at a better cost to the taxpayer.

Over the past two years Stockport has undertaken a huge amount of work with our partners to reduce unnecessary referrals into secondary care and to create effective community services that pull people out of hospital, reducing length of stay. We are starting to see the impacts of this work at Stockport FT, with reductions in both electives and non-electives but changes to electives are primarily a result of capacity constraints.

We will continue to develop our existing deflection schemes across the health & social care economy, including:

- Improved referral management
- Stronger application of 'fit for treatment' thresholds
- Increased proactive care to reduce the use of urgent care services
- Better management of emergency presentations at ED to reduce unnecessary admissions to hospital
- Reduction in prescribing waste.

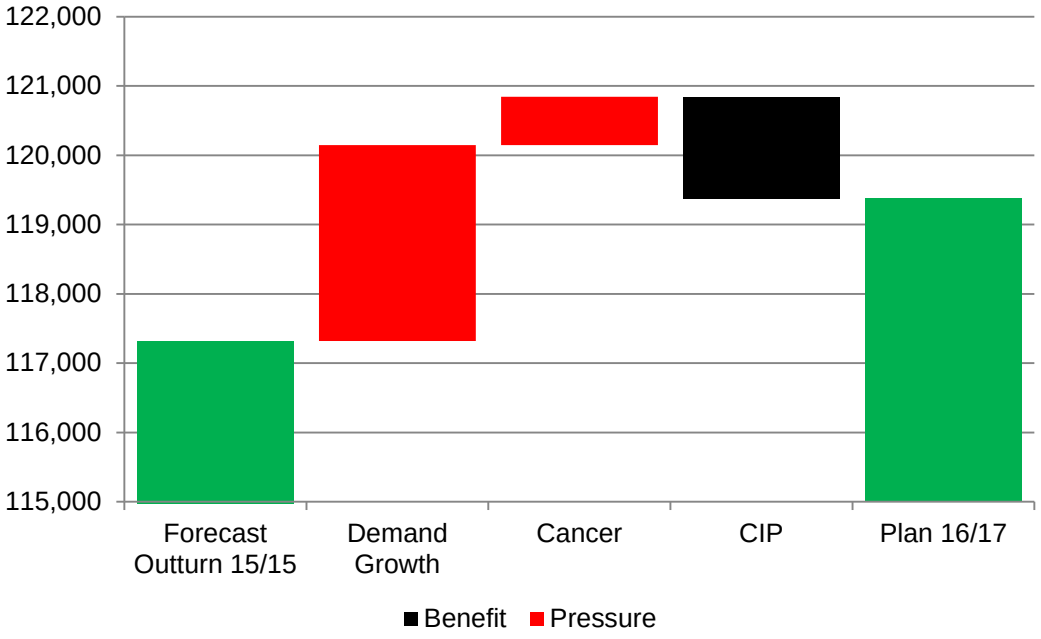
Code	Activity	2015/16 Activity (Forecast Outturn)	2016/17 Activity (Plan)	Growth Assumption (%)
E.M.1	Total Referrals (All Specialties)	125,898	129,300	2.7%
E.M.2	Consultant Led First Outpatient Attendances (Total Activity)	104,085	106,862	2.7%
E.M.3	Consultant Led Follow-Up Outpatient Attendances (Total Activity)	260,270	266,573	2.4%
E.M.4	Total Elective Admissions (Spells) (Total Activity) [*Ordinary Electives + Daycases]*	40,817	41,835	2.5%
E.M.5	Total Non-Elective Admissions (Spells) (Total Activity)	46,510	46,797	0.6%
E.M.6	Total A&E Attendances	97,277	98,036	0.8%
E.M.13	Endoscopy Activity	12,486	13,110	5.0%
E.M.14	Diagnostic Activity excluding Endoscopy	142,160	152,111	7.0%
E.M.16	Cancer Two Week Wait Referrals	9,941	10,638	7.0%
E.M.17	Cancer 62 Day Treatments following an Urgent GP Referral	710	759	7.0%

Activity Forecast

NHS Stockport Clinical Commissioning Group

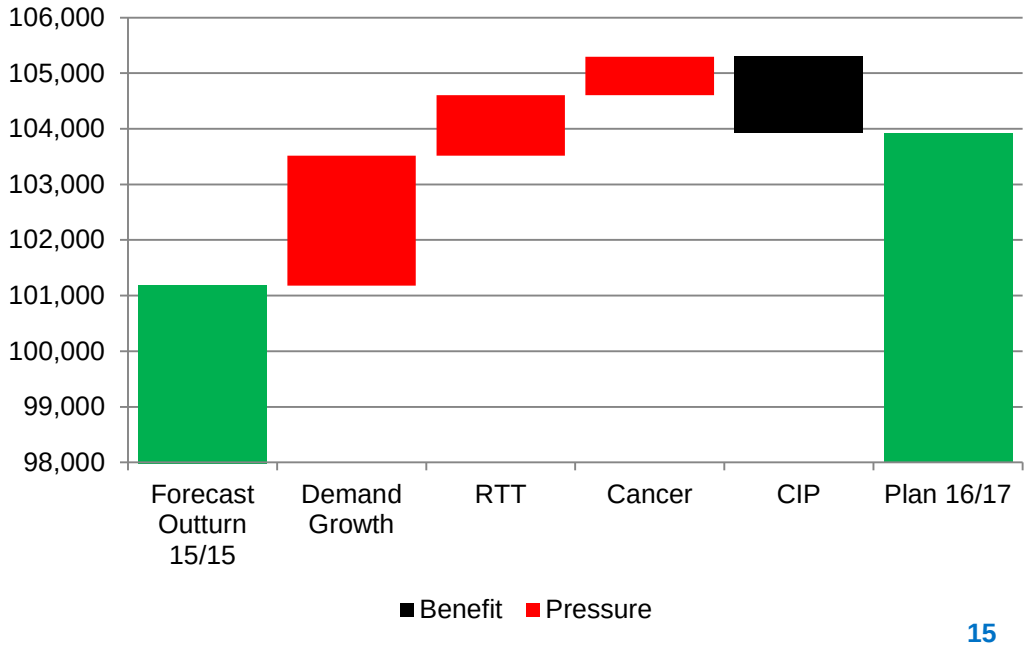
EM7: Total Referrals

As stated above, we anticipate a maximum risk of 3% growth across all providers. In line with national Must-Do policies, we are factoring in additional growth around Cancer. Our CIP reflects the difference between our plan for 16/17 and growth trends. This will be addressed through continued work in GP referral management, proactive service development through our BCF and Vanguard. We have also just piloted a consultant connect programme, which will provide access for GPs to discuss patients with consultants and make the best call re referrals. It is expected that this will remove unnecessary referrals and improve the quality of referrals, reducing consultant-consultant referrals in the acute.



EM8: Consultant-led First Outpatient Attendances

Again, we anticipate a maximum risk of 3% growth across all providers, given our negotiations with Stockport FT for a block contract based on 0% growth, which reflects local progress in referral management work with GP practices and investments in proactive community services. In line with national Must-Do policies, we are factoring in additional growth around Cancer and RtT. This would be additional commissioned work to reduce backlogs and improve performance on targets.

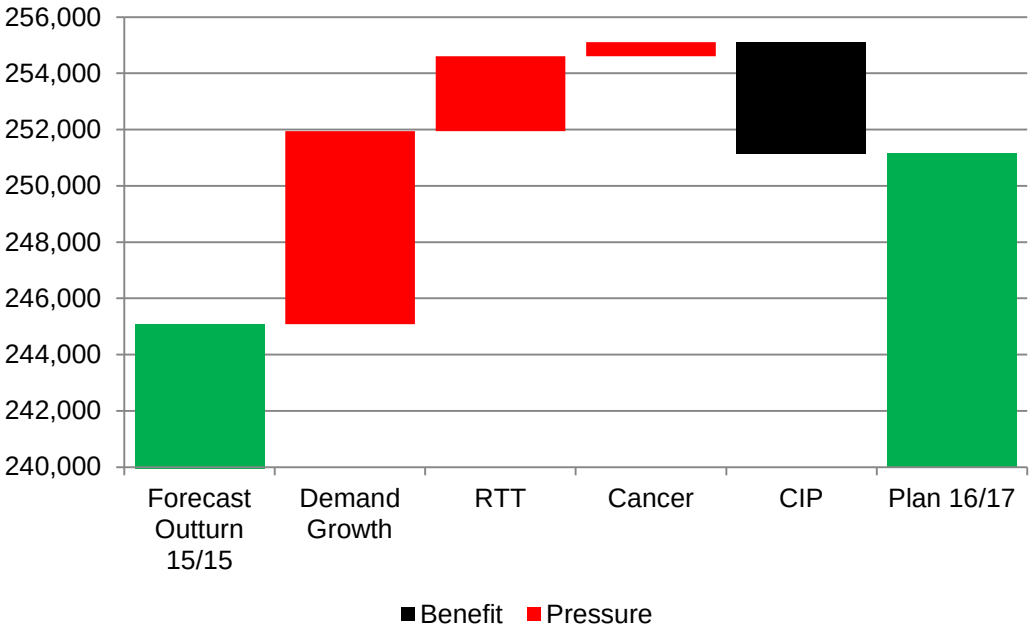


Activity Forecast

NHS Stockport Clinical Commissioning Group

EM9: Consultant-led Follow-Up Outpatient Attendances

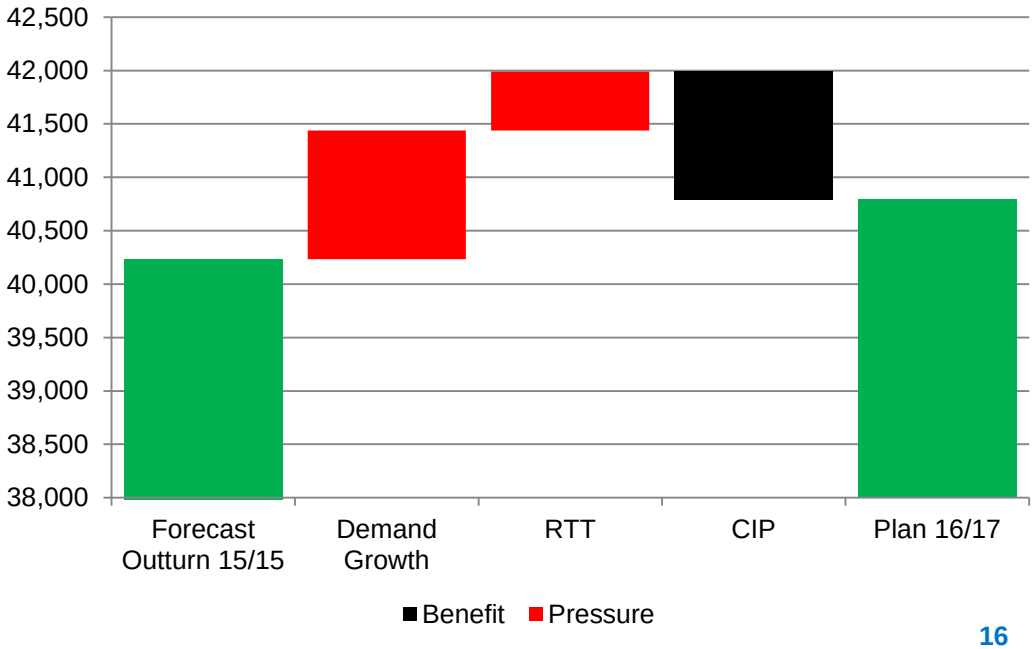
Again, we are expecting growth of 3%. We have factored in additional activity for Cancer and RtT national policy changes. Our CIP will be tackled through our investments in primary and community services to pick up follow-ups in the community. Through our Vanguard site, we have agreed with the local Trust that around 40% of follow-up appointments will be undertaken out of hospital.



EM10: Total Elective Admissions

As above, we expect around 3% growth and have budgeted for additional capacity around RtT in line with national policy.

As mentioned in the narrative above, we expect the majority of growth (planned at 2.5% for electives) to happen through private providers such as the BMI and Optegra, where there is more capacity.

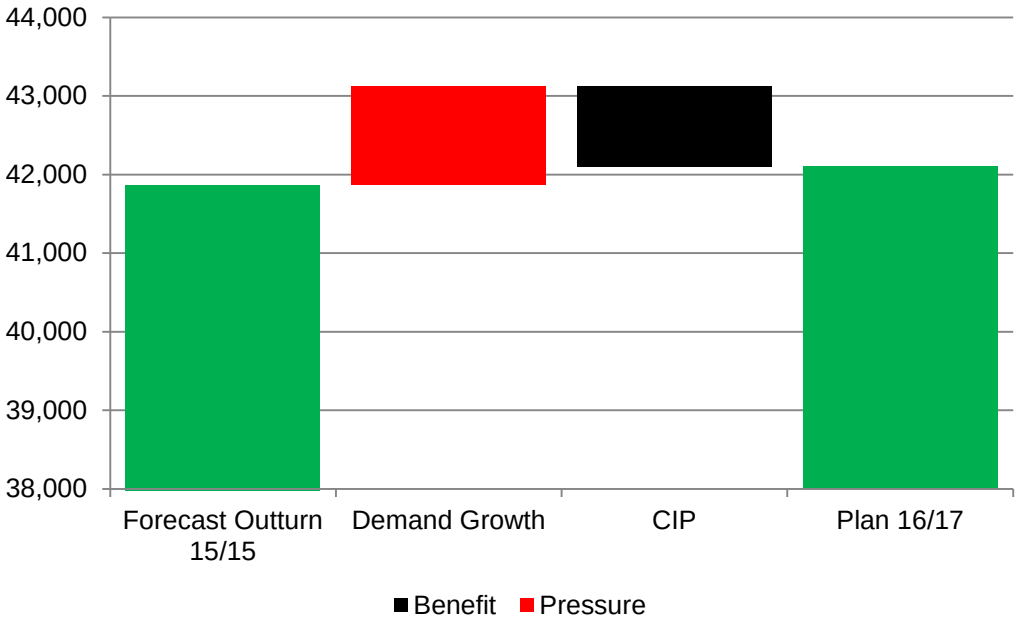


Activity Forecast

NHS Stockport Clinical Commissioning Group

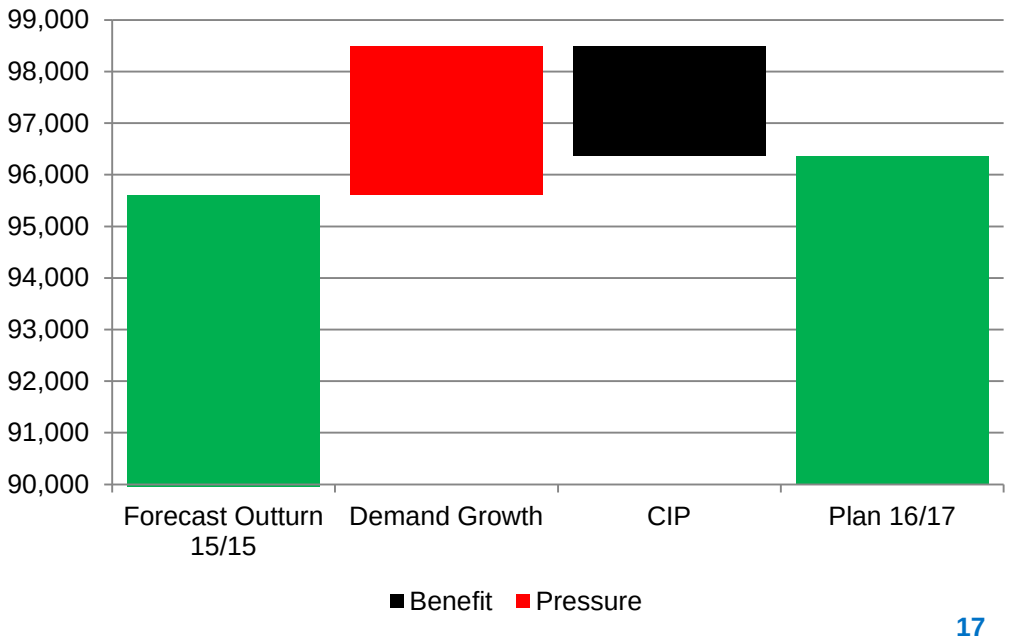
EM11: Total Non-Elective Admissions

Over the past two years investments in local transformation have started to realise a reduction in ED attendances, particularly from care homes, where patients have traditionally been more likely to be admitted. Our CIP reflects the fact that the vast majority of our patients are seen at Stockport FT, with whom we are negotiating a capitated block contract based on 15/16 activity – planning for 0.6% growth in NELs. We expect this growth to be higher at other providers, where there is no MCP in development. Work will continue in primary and community care to prevent non-elective attendances, and work will be undertaken to support the Trust to improve its internal processes and reduce the rate of admissions through the ED, where the trust is an outlier nationally.



EM12: Total A&E Attendances

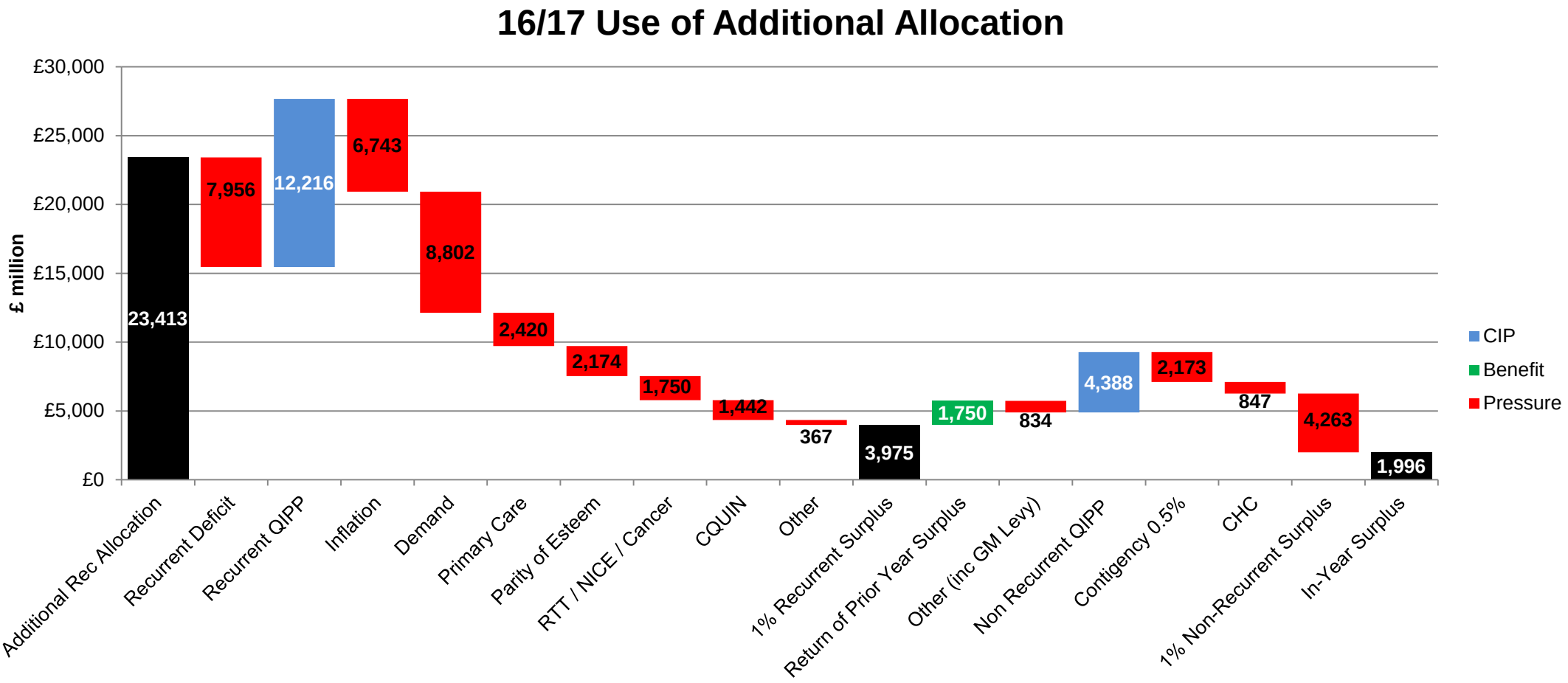
Again, we expect a maximum risk of 3% growth across the board. However, progress in our local schemes to improve proactive community services, develop GP care plans for vulnerable patients, support care homes with GP ward rounds and integrate the health and social care offer in the community have already resulted in reduced ED attendances at Stepping Hill Hospital from Stockport-registered patients. Our CIP reflects the fact that the vast majority of our registered patients attend the local acute, where we are negotiating a contract to flatline growth.



Use of 16/17 allocation

NHS Stockport Clinical Commissioning Group

The waterfall chart below shows the additional allocation that the CCG will receive in 2016/17, and how our financial planning suggests it will be applied to various pressures. The blue 'QIPP' figures show the savings the CCG must make in order to deliver all of the NHS business rules and planning requirements (Must-Dos). It is estimated that this would require the CCG to make savings of £16.6m to deliver a 0.5% in-year surplus. The diagram below includes the impact of the Primary Care services which the CCG will co-commission from 2016/17 onwards.



QIPP Plans

NHS Stockport Clinical Commissioning Group

Quality Innovation Productivity & Prevention

Given the changing demographics and health needs in Stockport, the CCG believes we must invest in long-term change that will create a sustainable system to meet local needs going forward. However, change comes at a cost.

NHS Stockport CCG has worked closely with our partners across the Stockport Health economy (Stockport NHS Foundation Trust, Stockport Council and Pennine Care) to develop a new, sustainable model of care that aims to prevent ill-health, and manage existing conditions in the community, reducing the reliance on emergency hospital care. Our joint plans take a five year approach, acknowledging that the financial benefits of this model will not be realised in the first two years.

Over the first two years, our efforts to manage referral variation and reduce unnecessary follow-up appointments have resulted in the stemming of growth. These schemes will continue to support the ongoing transformation of our health economy.

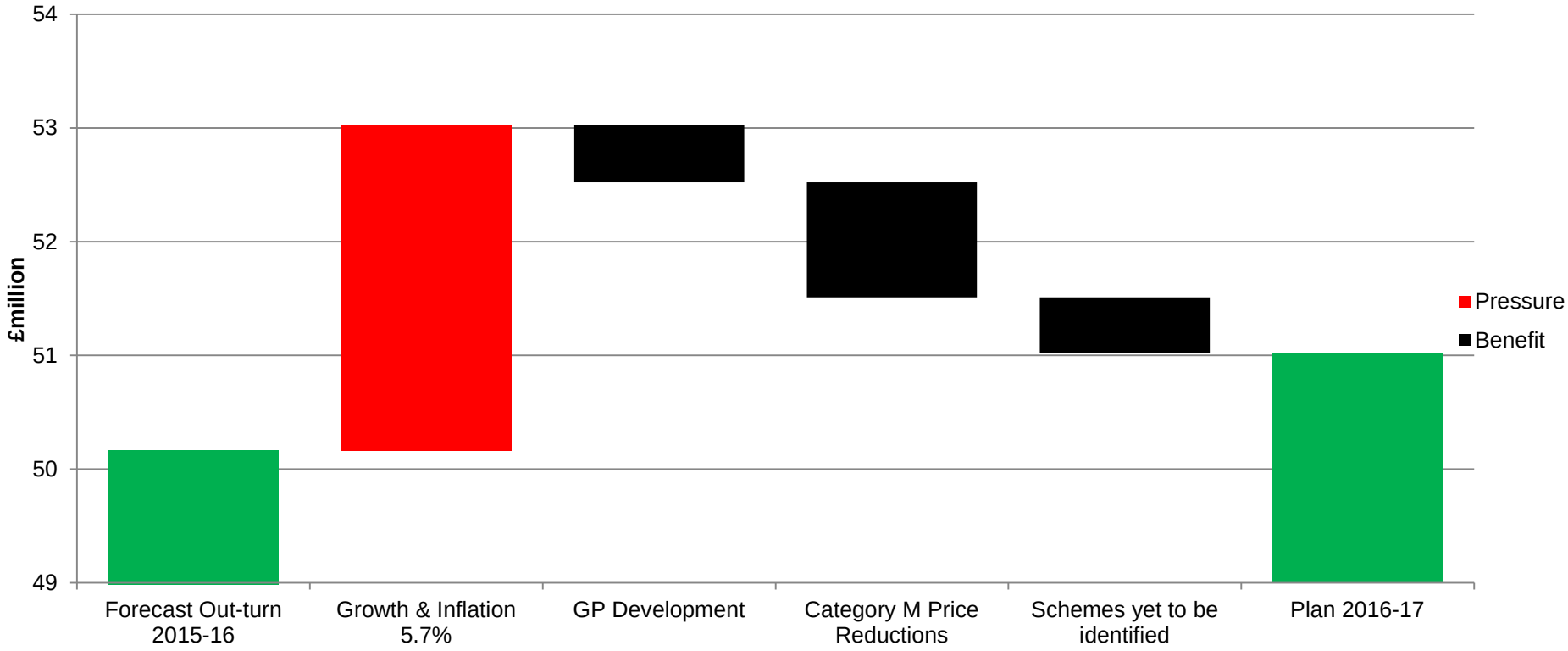
Our QIPP plans for 2016/17 include work to further reduce the cost of prescribing and financial income from last year's work on the Quality Premium.

Work will be taken to review areas of significant growth locally , such as dermatology and ophthalmology. In addition, work will be undertaken across Stockport Together to assess the recently refreshed Commissioning for Value Packs to identify further areas of efficiency and quality improvements using the Right care approach.

Initiative	Saving	Risk Level
Estates	£0.2m	●
Prescribing	£2.0m	●
Continuing Healthcare growth	£0.6m	●
Stockport Together / Vanguard	£4.2m	●
Re-procurements	£0.5m	●
Non-recurrent Income		
Quality Premium	£0.3m	●
Balance Sheet	£0.5m	●
Amended Planning Assumptions		
BCF Risk Fund	£0.9m	●
CQUIN reduced to 95%	£0.4m	●
Slippage / pessimism bias	£1.5m	●
Reserves w/o from 15/16	£0.4m	●
Unidentified CIP (Recurrent)	£0.9m	●
Unidentified CIP (Non Recurrent)	£4.2m	●
Total	**£16.6m**	

QIPP Plan

Stockport has a strong record of achievement in medicines management, through work with both our GP practices and Trust colleagues. Over 2016/17 our Medicines optimisation team intend to continue this work to deliver a QIPP of £2m. £0.5m of this QIPP programme will come from our GP Development Scheme, which has started to deliver savings from the past two year's work. A further £1m will be realised through price reductions in Category M drugs. The final £0.5m QIPP saving will be delivered by schemes identified by the Medicines Optimisation team.



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Investments

NHS Stockport Clinical Commissioning Group

Schedule of Investments

Given the changing demographics and health needs in Stockport, the CCG believes we must invest in long-term change that will create a sustainable system to meet local needs going forward. However, change comes at a cost.

NHS Stockport CCG has worked closely with our partners across the Stockport Health economy (Stockport NHS Foundation Trust, Stockport Council and Pennine Care) to develop a new, sustainable model of care that aims to prevent ill-health, and manage existing conditions in the community, reducing the reliance on emergency hospital care. Our joint plans take a five year approach, acknowledging that the financial benefits of this model will not be realised in the first two years.

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Initiative	Investment
Primary Care	
GP Development Scheme	£1.5m
GP IM&T	£0.8m
GP Premises	£0.1m
Mental Health	
Mental health Parity of Esteem	£1.6m
CAMHS Transformation Plan	£0.6m
Access	
Additional capacity for RtT target	£1.0m
Additional Cancer demand	£0.3m
Impact of NICE guidance	£0.5m
Other	
St Anne's Hospice - usage	£0.2m
Weight Management	£0.2m
Greater Manchester Strategic Levy	£0.8m
CHC – national scheme	£0.8m
Total	**£8.4m**

Right Care

NHS Stockport Clinical Commissioning Group

Right Care

While the CCG was not part of the first wave of this programme, the Right Care approach is already embedded into the work of the CCG through:

- our clinically-led Vanguard programme – Stockport Together
- and Greater Manchester's Healthier Together Programme

both of which adopt the general principles of the Right Care approach by

- using benchmarking data to identify variation in terms of outcomes and cost (Phase 1 – where to look)
- harnessing clinical engagement as a means of identifying what to change (Phase 2 – what to change)
- Using the principles of effective quality improvement to undertake a process of change, backed by ongoing clinical engagement and strong clinical leadership (Phase 3 – How to change)

Over 2016, NHS Stockport will continue to work with partners across the local health and social care economy to assess the refreshed Commissioning for Value packs and feed any new plans or changes into our work across Stockport Together, GM-Devo and Greater Manchester's Healthier Together programme.

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Right Care

NHS Stockport Clinical Commissioning Group

Commissioning for Value Packs

The NHS's Commissioning for Value packs compare the CCG with the 10 CCGs who have the most similar populations to Stockport:

- NHS Southend CCG
- NHS Wakefield CCG
- NHS Trafford CCG
- NHS St Helens CCG
- NHS Wirral CCG
- NHS Dudley CCG
- NHS North Tyneside CCG
- NHS Rotherham CCG
- NHS Solihull CCG
- NHS Warrington CCG

They then identify a range of areas where:

- the CCG spends more than its comparators
- the CCG has worse outcomes than its comparators.

This allows us to highlight the top priorities for transformation and improvement.

NHS Stockport CCG's highlighted areas for improvement are set out in the table below.

Over April and May, the CCG will work with colleagues in public health, business intelligence, finance, as well as clinicians from primary care, community services, mental health, acute care and the local authority to understand the reasons for these differences and develop transformation programmes to implement change.

Spend & Outcomes	Outcomes	Spend
Gastro-intestinal	Trauma and Injuries	Gastro-intestinal
Trauma and Injuries	Gastro-intestinal	Circulation
Neurological	Mental Health	Trauma and Injuries
Mental Health	Neurological	Respiratory
Cancer	Cancer	Neurological

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Better Care Fund

NHS Stockport Clinical Commissioning Group

Better Care Fund

NHSE guidance indicates CCG required investment into a Better Care Fund (£19.3m for Stockport - £18.5m in 15/16) with the local authority.

The table below sets out how this funding is currently allocated.

Better Care Fund Schedule	Value (£m)
Adult Social Care Protection	7.621
Stockport Together Investment	3.575
Reablement	1.204
Rapid Response	0.960
Carers	0.670
Step Up / Step Down Beds	0.650
Complex Equipment	0.630
Care Homes	0.500
GP Enhanced Care	0.475
Mental Health – RAID	0.400
Mental Health – Adult ADHD / ASD	0.200
People Powered Health	0.210
Community Falls Service	0.150
Staff Capacity	0.150
Expanded Patient Education	0.115
Dementia	0.050
IM&T	0.033
NEL Contingency (P4P)	0.917
Total 15/16	**18.510**
GP Development	0.785
Total 16/17	**19.295**

Section 75

In addition, Stockport CCG and our partners at Stockport Council have taken the step of increasing our integrated commissioning work through an extended Section 75 agreement which will pool our shared resources for health and social care services aimed at the over 65 population.

The purpose of this work is to increase the integration of services to deliver a seamless offer to the people of Stockport and, at the same time, reduce unnecessary waste through duplication of services and processes.

The venture will be governed by a new integrated commissioning board of 3 local Councillors and 3 CCG Board members.

In 2016/17 we will be pooling in excess of £200m through a section 75 agreement. It is intended that the CCG will host the commissioning functions and the Council will host finance.

Primary Care

NHS Stockport Clinical Commissioning Group

Delegated Commissioning

As of 1 April 2016, NHS Stockport CCG will partner with NHS England to co-commission Primary Care services.

In 16/17 the Primary Medical allocation is £35.3m inclusive of a 3.6% uplift. As with the CCG budget, we must set aside 1% for non-recurrent investment held as uncommitted and a 0.5% contingency.

The table below sets out the proposed Primary Care budget 2016/17

Primary Care Budget 16/17	£000's	£000's
Allocation		
Allocation including 3.6% uplift		(35,279)
Less Commitments		
Contract Baseline 15/16	33,962	
Uplift (2.8%)	950	
Premises Investment	50	
1% Non Recurrent Investment*	352	
0.5% Contingency*	176	35,490
Primary Care Planned (Surplus) / Deficit		211

- NHS England Business Rules

Transformation

Our Strategic Aim is to shift provision of care in Stockport from the current, reactive system which is dominated by secondary care services, to a preventative and proactive approach supporting people to live well and manage their health in the community. To do this, we have recognised that we will need to build capacity in Primary Care. Since the CCG's creation on 1st April 2013 considerable investment has been made into Primary Care and the table below sets out the investment the CCG has made, and is planning to make to date. Primary Care investment will be made through Stockport Together programmes subject to receiving the funding requested within the Vanguard value proposition.

Additional Primary Care Investment 2013/14 – 2016/17	£000's
GP Development Scheme (£10 per patient)	3,000
Includes	
- Pharmacy Advisors in Practices	
- Care Homes Ward Rounds	
- Intermediate Care GP contracts	
- Capacity to target LTC, COPD, Asthma, Hypertension etc	
GP IM&T	870
GP Premises	50
GP Referral Management	300
Primary Care 7 Day Access	701
Neighbourhood GPs	200
Total	**5,121**

Mental Health

NHS Stockport Clinical Commissioning Group

Parity of Esteem

Achieving parity of esteem between services for mental and physical health has been a key programme of the CCG's 5 year strategy. In order to deliver parity of esteem the CCG will be investing £2.5m into mental health services.

The CCG intends to use this investment to tackle growing demand for services; to meet the new national targets; and to improve the quality of local services. The table below sets out how this uplift in Mental health spending has been factored into our plans.

Proposed Investments	£000's
Inflation	330
LD Investment	400
IAPT	173
Early Intervention in Psychosis	435
Comprehensive MH Liaison Service / RAID	238
Crisis Care	144
1:1 observations (safer staffing)	200
CAMHS	584
Total Proposed Investments	2,504

Mental Health Targets

Over the past two years significant investment has gone into improving our mental health access.

During 2016/17 additional processes will be developed with our mental health provider Pennine Care to support the achievement of our access targets for IAPT services, including effective waiting list management processes. In particular, an emphasis will be placed on the effectiveness of the service by looking not only at access into the service, but their achievement of recovery rate targets and improvements in patient experience of the service.

Progress on our targets for Early Intervention in Psychosis will be supported through additional investment into the required NICE care packages and increased capacity in the core team.

Further Investment

Work will continue to improve staffing levels, Child and Adolescent Mental Health Services, Crisis Care and Learning Disability services.

A full break down of our work can be found on the following slides.

Mental Health

NHS Stockport Clinical Commissioning Group

Objective	Issue	Quality Impact	Plans	Investment	Priority Level
Safer Staffing	Lack of funding for 1:1 observations. General improvements in ward-based care Female PICU capacity in area	Increased morbidity and acuity on inpatient wards. Increased risk for patients and staff. Female patients requiring PICU sometimes transferred out of area, resulting in poorer experience	Undertake review of acute care pathway to address safer staffing requirements and improve quality and patient experience	£200,000	High
Improve Crisis Care	Lack of skills and capacity to deliver the right care in a crisis. Commission Street Triage and Sanctuary.	Poor patient experience	Recruit 2.0 WTE mental health practitioners (Band 6) Commission Sanctuary	£109,000 £35,000	High Medium
CMHT	New care model in process of being implemented.	Managed through implementation.	(a) monitor quality impact of the new care model (b) support recovery through partnership working with LA & 3rd sector	£-	Medium
Dementia diagnosis rates	Prevalence has been maintained but Stockport's performance has deteriorated slightly based on data received in September	Delayed diagnosis will result in delayed treatment, which will impact on a person's outcomes	Continue to deliver dementia plans	No new investment	Medium
Transformation of CAMHS	Local CAMHS transformation plan has been approved by NHS England	Improvements in child and adult mental health services	Deliver transformation plan with ring-fenced NHSE funding	£584,466*	High
Improvements in Learning Disability & challenging behaviour services	Absence of local 'at risk' register. Lack of specialise residential accommodation for people with LD and challenging behaviour.	Patient safety for people with a Learning disability. Ongoing support not always provided in right setting	GM Fast Track Plan Short-term acute LD beds in GM Specialist residential accommodation	£400,000	High

Mental Health

NHS Stockport Clinical Commissioning Group

Objective	Issue	Quality Impact	Plans	Investment	Priority Level
IAPT improvements: • Achieve recovery rates	Additional processes required	Effectiveness of the service is not being realised due to under achievement of the recovery target	Work with Pennine Care to develop processes	N/A	High
• Achieve IAPT access standards	Need to establish effective waiting list management process and patient tracking. Capacity to maintain a sustainable waiting list position of approximately 4 weeks	Poor patient experience. Risk of people's condition deteriorating while waiting to access treatment	Recruit 3.0 WTE	£173,000	High
Early Intervention Psychosis – achievement of national targets	Lack of dedicated medical in-put Lack of capacity for CBT for psychosis More capacity required in the core team	Poorer outcomes for people with severe mental illness as all NICE compliant components are not available	Enhance team to deliver targets with: 1.5WTE CBT 5.0 Care co-ordinators 1.0 Consultant 1.0 Medical secretary 0.5 Team admin. Includes non-pay and overheads	£435,000	High
Comprehensive MHLS	Low staffing numbers covering the ED Capacity of the team to respond to post-overdose/self-harm presentations limited Limited medical in-put to the team Cover for additional acute wards	Poor patient experience while waiting in ED and on the ward for assessment Inequitable position as MHLS is not available across the acute hospital Availability of skilled staff to undertake robust assessment at earliest opportunity	4.0 WTE Mental health practitioners Band 6 0.5 medical input 1.0 Administration	£238,000	High

CCG Assessment Framework

NHS Stockport Clinical Commissioning Group

New Framework for CCGs

NHS Stockport CCG is committed to being an open and accountable organisation.

The new Assessment Framework for CCGs sits well with our own plans to transform the local health and care system to improve local health outcomes, to reduce inequalities, to improve quality of our care services and to develop a sustainable system that delivers better value for taxpayers.

In addition, the framework acknowledges our leadership role in the local health and social care economy, with measures to assess areas where we do not have contractual responsibility but are working closely with colleagues in social care and public health to build an integrated system that understands the overlap between services and creates services that meet the holistic needs of our shared service users.

The CCG Assessment Framework will form a strong basis for measuring our progress through this period of transformation. This high level picture will support us in determining the impacts –both planned and unintended – of our change agenda so that we can ensure continuous improvement for the people of Stockport.

A range of improvement and transformation projects are already underway through our operational plans; our cross-economy Stockport Together programmes; and our work as part of a devolved heath and care system in Greater Manchester, which speak to the improvements we want to see under the Framework. These projects have been mapped to the domains of the Assessment Framework and its clinical priority areas in the table opposite.

Domains	Projects
Better Health	Prevention & Empowerment Proactive Care Planned Care Urgent Care
Better Care	Quality projects Healthier Together Better Care Fund
Sustainability	QIPP & CIP plans Stockport Together's Capitated contracting approach
Leadership	Stockport Together programme Workforce development Collaborative Leadership Development programme
Clinical Areas	**Projects**
Mental Health	IAPT CAMHS RAID Early Intervention in Psychosis Mental Health Liaison in Neighbourhoods
Dementia	Dementia diagnosis project Proactive Care & Care planning Carers support
Learning Disabilities	Heys Court Out of Area Placements Personal Health Budgets
Cancer	Early Diagnosis Screening programmes RtT improvement projects GM Cancer Board
Diabetes	Expert patients Proactive Care
Maternity	Smoking cessation Breast feeding initiation Patient Experience & Contract KPIs

Contracts

NHS Stockport Clinical Commissioning Group

Contracting Round

Stockport's Health and Social Care Partners have been working over the past year as part of Stockport Together to develop a new Multi-Speciality Community Provider model of care. This model involves a radical change not only in our provider model (the MCP) but in how we as commissioners contract.

The CCG and its partners recognise that the old payment system focussed too much on activity and cost, rather than rewarding quality and outcome achievement. Our aim is to move towards an integrated health and social care commissioning function that contracts for outcomes with an integrated provider, or MCP.

In 2016/17 we intend to move from the current Payments by Results to a capitation based agreement with each of those providers who are expected to form the MCP going forward. Our contracting objectives for 16/17 are to minimise economy deficit through a focus on reducing costs not redistributing them; and to maximise progress towards a full MCP and outcomes framework.

Negotiations are based on a continuation of the level of activity in 2015/16, recognising the impact of our ongoing QIPP schemes, aimed at reducing unwarranted variation and demand.

The longer-term aim is to move to a single outcome-based contract with a single MCP provider operating as a *single entity*. The future contract will use weighted capitation to take a whole-population approach to commissioning services for Stockport people. Over 2016/17 the CCG and its delivery partners will further develop our Outcomes Framework.

2016/17 CQUIN

Through the Commissioning for Quality and Innovation payment framework (CQUIN) we will offer acute providers the opportunity to earn up to 2.5% of their annual contract value by achieving improvements in:

- Lessons learned – promoting a safety culture
- identification and early treatment of sepsis
- care of patients with acute kidney injury
- care bundles
- effective discharge management
- Outcomes framework .

Our community services contract will focus on rewarding progress towards the development of our Multi-Speciality Community provider (MCP). As such, the Community CQUIN will prioritise:

- Clinically led expert reference groups
- Data collection to support evidence-based improvement and data sharing among MCP partners.

Key Performance Indicators

The following KPIs will be prioritised within the contract:

- Urgent care
- Stroke
- Safeguarding
- Serious Incidents
- Discharge
- Access.

Risk

NHS Stockport Clinical Commissioning Group

Approach

A comprehensive risk management process plays a crucial role in the successful management of the CCG's portfolio of activities. All projects have been risk assessed and linked to the CCG's Board Assurance Framework and Operational Risk Register by themes.

Risks are assessed monthly and reported to the CCG's executive team, with regular reporting of the Strategic Risks to the Governing Body in its Board Assurance Framework.

Where the risk can be valued in financial terms this will be done. Appropriate mitigation strategies will be developed to minimise the impact of the individual risk or maximise opportunity.

The risk assurance framework will cover a range of risks relating to delivering the programme but also the operational risks inherent within the solutions themselves.

Given the overlap of projects between the CCG's operational plans and the joint-transformation programmes across Stockport Together, work has been undertaken to map all CCG and Stockport Together risks and ensure a common understanding across the patch.

The CCG recognises that the key risk is that of deliverability: work will be undertaken to prioritise teams to focus on the delivery of change set out in this plan.

Risk Themes

To provide for a holistic and cross cutting approach to the management of risk and opportunity within the CCG, risks are grouped by theme and include both potential risks and opportunities for the organisation. management of risk and opportunity.

Theme	Risk Appetite	Rationale
Quality	Moderate	We will ensure the provision of high quality services to our patients and will only rarely accept risks which threaten that goal.
Safety	Low	We hold patient and staff safety in the highest regard and will seek to minimise any risks
Financial Resilience	Moderate	We will stay within set financial limits and will accept risks that may cause financial loss only where the benefits merit the risk
Compliance	Low	We will comply with all legislation relevant to NHS Stockport CCG and will not accept any risk that would result in non-compliance
Reputation	Moderate	We will maintain high standards of conduct and will accept only risks where the benefits merit the risk
Innovation	High	We encourage a culture of innovation within NHS Stockport CCG
Partnerships	High	We will work with other organisations to ensure the best outcome for patients and are willing to accept the risks associated with a collaborative approach
Organisational Development	Moderate	We will work to ensure that the CCG continues to develop in terms of its workforce, culture, governance and structure to meet the requirement to be an agile organisation able to work at pace and will accept the risks associated with this approach.

5 Year Plan

NHS Stockport Clinical Commissioning Group

Sustainability & Transformation Plan

In 2016/17 all NHS organisations are required to develop a Sustainability and Transformation Plan (STP), setting out how we will address:

- The health & wellbeing gap
- The care and quality gap
- The funding and efficiency gap.

The geographic footprint for our STP is that of Greater Manchester. “Taking Charge of our Health & Social Care in Greater Manchester” - GM’s five year plan for sustainability and transformation - can be found at: http://www.gmhealthandsocialcaredevo.org.uk/assets/GM-Strategic-Plan-Final.pdf

The Plan is backed by ten locality plans – one for each borough of Greater Manchester. In Stockport, the Stockport Together plan is the locality plan for the economy and the Multispecialty Community Provider (MCP) element (Vanguard) is an element of the Stockport Together Plan.

Stockport Together is a change programme designed to deliver better outcomes and more sustainable services across the local health and social care economy. It will achieve its aims by focusing on neighbourhoods: building on an analysis of the capacity, resilience and needs of the local population to create a radically improved range of clinical and social interventions. The programme will bring health and care professionals into a new set of relationships with each other and with local people, removing inappropriate boundaries between primary and secondary care and between community providers. It will place much of the control of resources in the hands of those best placed to use them to greatest effect: clinicians, professionals and the community.

Programmes of Change

To address the outcomes, quality and sustainability challenge effectively we must change the way in which services are delivered. We have undertaken this work to date under 4 programme areas:

- Prevention & Empowerment
- Proactive Care
- Planned Care
- and Urgent Care.

STOCKPORT TOGETHER

Together, these transformation programmes will allow us to shift the emphasis from hospital care after a person becomes unwell, to preventing ill-health and supporting people to live well, managing their health as close to home as possible, taking the burden off the specialist acute sector to deliver high quality, once-in-a-lifetime care when necessary.

As such, Healthier Together will deliver improvements in health and wellbeing, improve the quality of care and ultimately tackle the funding and efficiency gap by delivering a sustainable model of healthcare to meet the growing and changing needs of our population.

As part of the Greater Manchester Plan, we will work across the area to reduce variation and improve quality across the acute and specialist commissioning sectors, contributing to the triple aim outlined above of better health and better quality within our financial resources.

NHS
Stockport
Clinical Commissioning Group

Development of Integrated Commissioning

Approval of Section 75 documents

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
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Stockport
SK4 1BS

Tel: 0161 426 9900 **Fax:** 0161 426 5999
Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
The CCG Governing Body is asked to consider the documents and give delegated authority to the Chief Operating Officer, in consultation with the Chief Clinical Officer to make any changes that are necessary to enable the above arrangements / documents to be implemented as a result of further discussions and negotiations with the Council.
Please detail the key points of this report
The purpose of this report is to recommend the section 75, and associated governance documents related to integrated commissioning, to the CCG Governing Body for formal ratification.
What are the likely impacts and/or implications?
The development of integrated commissioning is one of the CCGs strategic priorities. The increase in the pooled fund and move to integration of the commissioning function is an important key first step in this. The aim is that integration of plans and resources will support the development of new integrated models of delivery which are being planned and implemented under Stockport Together. It is proposed that in year one the CCG and Council manage their own financial risks, but over time we move to a shared risk management arrangement. It is also the intention that we more formally integrate the commissioning function over time.
How does this link to the Annual Business Plan?
Supports delivery.
What are the potential conflicts of interest?
The CCG will need to manage Conflicts associated with commissioning decisions made under these arrangements in accordance with national guidance and local policy.
Where has this report been previously discussed?
Directors Leadership Team
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 30th March 2016
Agenda item:

Development of Integrated Commissioning and Approval of Section 75 Document and

1. Introduction

1.1 Over the past months a number of reports relating to the Stockport Together programme for integrating health and social care have been presented to the CCG Governing Body.

1.2 The CCG Plan for 2016/17 includes a proposal that the CCG extends the existing pooled budget and commissioning arrangements with the Council, to include services for people aged 65+. This would increase the CCGs contribution to the pooled budget from £24.8m to £147.4. The aim is to integrate planning, budgeting and commissioning, enabling the combined resource can be deployed more effectively to improve health and care outcomes in the medium term. The reason for recommending that the increase in pooled and integrated arrangements focuses on the 65+ population initially is that this is the first priority for the Stockport Together change programme, with the development of integrated neighbourhood services. The intention is to extend the integrated arrangement to other population groups over the next few years, once we have tested and embedded the new commissioning arrangements.

1.3 The purpose of this report is to provide a further update on progress, recommend approaches to the formal governance and management arrangements for the pool and to present the formal section 75 agreement for approval.

2. Stockport Together

2.1 The Stockport Together partners continue to work closely together on the design and implementation of new delivery models aimed at achieving both the shifts in activity and overall cost reduction required to deal with what is a very significant financial challenge. A particular focus over the past few months has been on the plans for 2016/17, ensuring that all partners are sighted on the difficulties and opportunities faced by each other and how a more collective and integrated approach can be taken to the deployment of around £482m of health and care resources. The implications of the financial settlements and business rules for the CCG, the Council's financial plans and contract negotiations are currently being worked through to determine whether and how an overall financial balance can be achieved for the forthcoming year.

2.2 At the same time, plans are being progressed for making the radical changes needed over the next few years. In the recent submission

(value proposition) for further support from the 'Vanguard' programme of which Stockport is a major element a number of key features of Stockport Together were reiterated together with some illustrations of the progress being made. These are summarised below.

2.3 The partners are committed to a fundamental and wide-ranging programme of change in the way health and social care services are commissioned and delivered across Stockport. This change programme is designed to deliver better outcomes and more sustainable services across the local health and social care economy. The aims will be achieved by focusing on neighbourhoods: by building on an analysis of the capacity, resilience and needs of the local population to create a radically improved range of clinical and social interventions. The programme will bring health and care professionals into a new set of relationships with each other and with local people, removing inappropriate boundaries between primary and secondary care and between community providers. Much of the control of resources will be placed in the hands of those who will use them to greatest effect: clinicians, professionals and the community.

2.4 In order to achieve the ambition, Stockport Together partners have reached a number of agreements, the most notable of which is to adopt an integrated approach to system design and development. 2016/17 will be a transitional year as much detail still has to be agreed, but during this period, it is proposed that health and care commissioning will begin to be carried out as a single function. In parallel, the key provider partners intend to form a new, shadow organisation in which the GP Federation (Viaduct Health), Stockport Foundation Trust (acute and community services), Pennine Care and the Local Authority would have an equal stake, and within which the traditional competing priorities will be renegotiated and replaced by a collaborative alliance. The Stockport Together programme will oversee and co-ordinate this transformation and ensure that a single conversation about clinical and professional leadership, value for money and organisational structure takes the place of the traditional, fragmented contract negotiation process.

2.5 The partners will work in ways that ensure the consistent use of standardised interventions across the economy, and also actively support local innovation. The provider alliance will develop economy-wide leadership and governance alongside an approach which acknowledges the very different needs in the communities across Stockport. At a neighbourhood level, clinically led multidisciplinary teams will manage local resources. This approach will encourage the development of creative relationships with the third sector and providers of residential and domiciliary services: it will also support the use of rapid improvement cycles designed to make clinical pathways more efficient and bring the hospital closer to the community.

2.6 During the coming year it is also intended to explore the creation of an integrated support service for the new system, identifying the potential benefits of bringing together functions such as estates, finance, ICT and workforce development to improve efficiency and support the single focus of the new model of care.

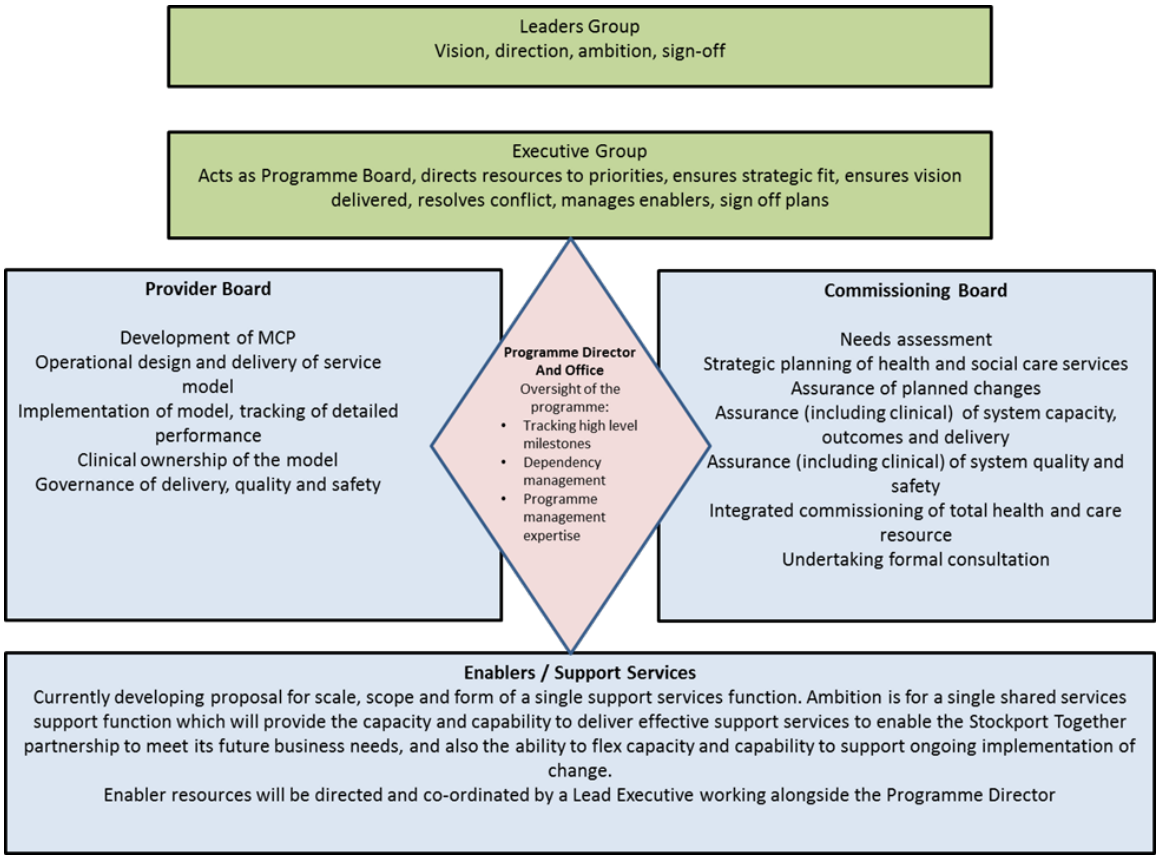
2.7 During 2015/16 considerable work has been undertaken to develop detailed design of the various service model elements. By April 2016 the first iteration of the Integrated Neighbourhood Service including multi-disciplinary and integrated teams will be established in all of the eight neighbourhoods of Stockport. All care homes and their residents have been aligned to a specific GP practice and weekly MDT's are now undertaken in each home led by the GP. Community based resources have been recruited to support care home work in each neighbourhood. Mental Health liaison posts will also be in place in each area by April.

2.8 Much of the necessary infrastructure and systems to support integrated work across the social care/health care interfaces has been put in place. For example, by April 2016 health and council buildings will have full Wi-Fi access; all GP practices and the Out of Hours service will be on a single electronic patient record system (EMIS) and procurement of the same system will have begun for community based services; there is a shared record in place, and the Stockport Health and Social Care App is in use and 30,000 people are signed-up to seeing their GP record on line.

2.9 A conceptual approach to population based commissioning for outcomes has been developed. The framework for an outcomes based contract exists based on population segmentation. Initial work on populating the framework has started and further expertise will be secured by April 2016. During 2016 a placed-based joint commissioning function will be established built from the CCG and Local Authority, along with a provider board made-up of Viaduct Health, Pennine Care NHS Foundation Trust, Adult Social Care and Stockport NHS Foundation Trust operating under a memorandum of understanding to operate as an alliance with an open book approach. As a core partner of this the GP Federation has developed further with its own business plan. Work is underway to make significant progress during the 2016/17 contract negotiations with Stockport NHS Foundation Trust towards a capitation contract based on outcomes.

2.10 The governance model for the Stockport Together programme has recently been revised to provide greater clarity and direction from senior managers within the partner organisations. The arrangements are illustrated in the diagram below. An Executive Group has been formed on which director level managers from the partner organisations meet each week, while the commissioning and provider boards enable a focus on the integration of those two distinct (but related) areas of business. A small central Programme Office will provide co-ordination and drive the overall programme and the enabler / support services grouping will

facilitate the deployment of sufficient resources to meet the programme's requirements.



2.11 Stockport Together is an integral element of the GM Health and Social Care Devolution work. Each "locality" in Greater Manchester has been required to develop a locality plan to support the development and implementation of the GM sustainability and transformation plan. Stockport Together, and in particular the Multi-Speciality Community Provider (MCP) development, is a significant and core component of the locality plan. The Greater Manchester transformation fund identifies five lots that reflect the strategic priorities of the conurbation for health and social care. Given the significant scale of Stockport's system level change the development of the MCP will support Greater Manchester to implement its strategic plan against three of these lots:

- Radical upgrade in population health and prevention
- Transforming care in localities, and
- Enabling better care

3. Integrated Commissioning

3.1 The CCG is asked to agree the governance, leadership, management and financial arrangements that will underpin the integrated commissioning and pooled budget arrangements for 2016/17.

Pooled Budget

3.2 The Council and the CCG have operated a pooled budget since 2009. For 2015/16 this stands at £51.682m and includes the following services / activities

- Learning Disability (£25.611m)
- Non-Acute Services (£6.072m)
- Better Care Fund (£18.510m)
- Continuing Health Care (£0.600m)
- Mental Health (£0.573m)
- Equipment Store (£0.316m)

The Council and the CCG have agreed in principle to the expansion of the pooled budget from 2016/17. Initially this would encompass the entire range of the Council's Adult Social Care and Public Health funds, together with CCG resources in relation to health services for people aged over 65 (i.e. non-elective and planned hospital care, community services and mental health services). Subject to final agreement, the net contributions from the two organisations to the new pooled budget for 2016/17 are likely to amount to between £220m and £240m, Agreement has been reached in principle with the CCG that the pooled budget should be hosted by the Council (this provision is incorporated into the draft Section 75 Agreement) and the CCG acting as commissioning lead. It is important to note that while the specific integrated commissioning arrangements illustrated below only apply to the pooled resources, it is the intention of partners to have the whole of the health care resource envelope in view.

3.2 Subject to agreement of the terms and conditions outlined below, the necessary arrangements being agreed and implemented, and confirmation of each partner's contribution, the Governing Body is being asked to agree that the following CCG budgets set out in Appendix Two are included in the pool. The Councils budgets to be included are set out in Appendix One.

3.4 At this stage it is considered inappropriate to consider or recommend any risk share arrangement which would see the CCG or Council taking on risks associated with the spending of each other's contribution. However it is anticipated that once the pooled budget and integrated commissioning arrangements are more established there will be opportunities to consider how resources may be redeployed and the related risks shared on an equal basis.

3.5 It is important for both organisations that pooled budget statements would be developed to include the outcomes that are being sought and that the appropriate level of expenditure detail would be available and

reported to members in a standard, consistent and understandable format. Any changes to the way in which resources are to be deployed and risk transfer effected need to be communicated to members and subject to their consideration. Work is underway to draft template financial and performance reports for discussion and ratification by the Health and Care Integrated Commissioning Board

Section 75 Agreement

3.6 The operation of the pooled budget is governed by a partnership agreement between the Council and the CCG, using powers granted under Section 75 of the National Health Service Act 2006. The existing agreement is being revised to reflect both the increased size and scope of the pooled budget and the emergence of more formal Stockport Together arrangements for jointly commissioning and providing health and social care services. The final drafting of the revised agreement will continue up to and beyond the time of the Executive meeting; therefore the Executive is being asked to give delegated authority to the relevant officers to finalise the agreement, ideally by 31 March.

3.7 The S75 Agreement is still a 'work in progress' and the latest draft is included as Appendix Four to this report. The Agreement sets out the vision, aims and objectives to be achieved through integrated commissioning of the pooled resources, and how the commissioning function itself will be governed, led and managed. The Agreement also describes the responsibilities of the partners and the functions and powers they are delegating and exercising through the Integrated Commissioning Board (see below). The arrangements for the operation of the pooled budget are detailed and the role and responsibilities of the proposed Health and Care Integrated Commissioning Board covered. The draft agreement will be subject to further revision as plans are finalised and further legal issues are clarified for both the Council and the CCG. If there are any significant changes to the draft they will be shared with members prior to the Governing Body meeting. It has been suggested by the Council that a final version will be made available for consideration at the CRMG Scrutiny Committee's meeting on 12 April.

Health and Care Integrated Commissioning Board

3.8 Responsibility for the existing pooled budget is delegated to the Health and Wellbeing Integrated Commissioning Board. The Board is made up of three Executive Councillors and three members of the CCG governing body. Following discussions between the Council and the CCG it is proposed to replace that board with a new Health and Care Integrated Commissioning Board (HCICB) as described in the draft S75 Agreement. The HCICB will therefore be accountable and responsible for the deployment and management of the pooled budget and the commissioning of services therefrom. As is the case now the work of the HCICB will run in parallel to that of the Health and Wellbeing Board; the

two groups will provide a distinct but complementary focus on making improvements to health and care outcomes.

3.10 Schedule 3 of the Section 75 Agreement contains the proposed governance framework and procedure rules for the HCICB and a draft of this is attached at Appendix 3. In drawing up these proposals particular attention has been paid to the following issues which are of special interest to elected members;

- Membership
- Transparency and access to information
- Administration
- Agenda management
- Business to be transacted and frequency of meetings
- Advice and support
- Relationship to partner constitutional arrangements and requirements

3.11 Both the relevant Executive Councillors and the CCG Governing Body members are keen for the business of the HCICB to be transacted in public and to be subject to appropriate scrutiny arrangements, including an opportunity for scrutiny to be undertaken by the relevant Council and CCG groupings in advance of decisions being taken by the Board. Further consideration is currently being given regarding the call-in provisions that would be appropriate to decisions that may or may not relate to statutory council functions.

3.12 When the documents were discussed at the Joint Scrutiny meeting, members made a number of comments including:

- Whether the title of the Board should include 'social care' – The Executive of the Council has been asked to consider this
- The composition of the board – confirmation was provided that the Board will be undertaking executive functions and that the Council's' representatives should therefore be the relevant Executive Councillors
- It was suggested at the scrutiny meeting that the governance specification (appendix three) should be amended to make it clear that the agendas and minutes of the Board will be published on the Council and CCG websites and that scrutiny committees will be given the opportunity to review and comment upon reports and proposals to be considered by the Board. These points have been addressed in the updated version included at appendix three
- Questions were asked regarding the frequency, time of day and location of Board meetings. This is something that will need to be discussed and agreed between the Council and the CCG.

- Comments were made on the proposal to only take public questions if they were received at least 24 hours before the meeting

Integrated Commissioning Function

3.13 Two key roles are identified as being essential to achieving the benefits from a more integrated approach to commissioning and pooled resourcing; they are the lead for commissioning and lead financial management roles. As the Council is hosting the pooled budget it is considered appropriate that the latter role should be undertaken by the Council's Borough Treasurer. Similarly, given that the majority of the budget and commissioning activity relates to the CCG it is proposed that a new senior position is established within the CCG to take overall responsibility for the commissioning of health and care services from the pooled budget. Both of these positions will be accountable to the HCICB.

3.14 Once appointed, the commissioning lead will establish integrated working arrangements which will bring together the capacity and capability necessary to maximise the opportunities to be gained from such an approach. The two leads will be responsible for providing the HCICB with regular reports on the commissioning outcomes and financial performance being achieved against plans and targets.

3.15 As can be seen from the diagram in paragraph 2.10 a commissioning function comprising officers from the Council and CCG has the responsibility for designing and implementing the integrated commissioning arrangements, and is being supported by key enabling resources, providing the required legal, finance, procurement and contracting expertise. A key priority for that group is to come up with a proposed spending plan for the pooled budget in 2016/17 and the contracts with providers which will enable service outcomes to be achieved within the resources available.

3.16 Looking ahead to 2017/18 and beyond, the officer group and then the HCICB will need to determine a procurement strategy and approach to contracting with the new provider model, i.e. the MCP referred to earlier in this and in previous reports. The Vanguard value proposition provides an idea of how that will be developed;

'We are developing a weighted capitation outcome based, whole population approach to commissioning services for Stockport people. This will eventually be in the form of a single outcome based contract with a single accountable care type organisation (ACO) either operating as a lead provider or as a single entity. The whole budget for health and social care will be made available to the ACO subject to delivering improvements in outcomes for the population. The ACO will either directly provide or will procure services that collectively deliver these outcomes whilst ensuring choice. The commissioners have agreed and

set out in a joint procurement strategy the approach, rules and timeframes including due diligence through shared design'.

'The Procurement strategy and commissioning intentions for 2016/17 set out an expectation that the four key providers would be required to work together in 2016/17 and prepare for a single contract approach for 2017/18. To put this in place the leaders from Viaduct Health, Stockport NHS Foundation Trust, Pennine Care NHS Foundation Trust, and Stockport Adult Social Care have formed a provider board. By April 2016 they will have in place a senior interim CEO level position and an MOU setting out how they will work together in the shadow year. The board includes executive level directors from each partner organisation'.

4. Integrated Provision

4.1 The Stockport Together programme has been working at two distinct levels in bringing forward design options to improve health and care delivery: the first focuses on changing the way things happen for people and in neighbourhoods (changing professional behaviour and culture); the second is concerned with creating a new, more adaptive and resilient organisational structure. The Provider Board, which comprises senior representatives of the partner provider organisations, has developed a work plan with two key, high level, milestones in respect of the options for organisational change. The first is to produce a Memorandum of Understanding which sets out the broad collaborative and financial arrangements to underpin joint working for the coming financial year, (during which the Accountable Care Organisation (ACO) referred to earlier operates in "shadow" form). The second is to identify and evaluate the realistic options partners could adopt to create the ACO in readiness to "go live" in April 2017. The first priority of the Provider Board is to ensure service continuity as we enter a transition phase over the coming months. The CCG needs to determine its role within the MCP, and whether any current functions should transfer to the MCP. The CCG will, via the Stockport Together programme, work with the partners to ensure that service outcomes are maximised by the best use of resources, acknowledging that in addition to planning for the future, there is an urgent problem to be faced in matching resources to increasing need and demand.

4.2 A draft Memorandum of Understanding (MOU) has been prepared to underpin the development of the MCP during 2016/17, which includes specific reference to the relationship between the provider partners and the commissioners.

4.3 The latest draft of the MOU is included at Appendix Five, noting that the appendices are still to be completed. It is based on principles developed by NHS England to support the creation of a formal Strategic Alliance, is not legally binding, and its purpose is simply to enable the partners to:

"express a convergence of will… and the agreement of a common line of action. It is intended to set out how the parties will work together…..to promote integrated services that deliver personalised care within an agreed cost envelope..."

It includes the following details:

- the commitments to joint working;
- schemes of delegation and adherence to partner governance;
- commitments to staff and organisational development;
- internal governance for the shadow organisation;
- services in the "core" shadow MCP, and those that are dependent on it;
- risk and reward share;
- contracts within and outside Stockport Together;
- organisational structure for both overarching, borough-wide services and neighbourhood working.

4.4 Service design to date has been developed around a number of principles, one of these is best summed up as "whatever can be devolved to neighbourhood should be devolved", another is "where there is a strong rationale – whether of outcome evidence or value - for creating a borough-wide service, this should be considered". The provider board is currently assessing the relative strengths of options for resource deployment according to the weight of evidence generated by these two principles.

1. Stockport Together Finances

1.1 Following the setting of the Authority's budget for 2016/17 the level of resources available to be contributed by the Council into the pooled budget for health and social care has been established as set out is paragraph 3.3 above. This includes the proceeds of the 'social care precept' and the £4.2m of one-off resources made available to smooth the transfer into the pooled budget and enable the phased implementation of the budget reductions needed to meet the underlying cash limit allocation included in the medium term financial plan (MTFP).

Members are fully aware of the Council's financial position in 2016/17 and the very challenging forecasts for 2017/18 and beyond. The Council will have to make further reductions to the underlying cash limit and therefore the contribution to the pooled budget; the Stockport Together partners understand and appreciate that position.

1.2 The CCG received an uplift in its baseline funding allocation of almost 6% for 2016/17, bringing it to £397.5m. However, a significant element of this growth was pre-committed against the brought forward deficit of c£8m. Over and above this, the need to meet NHS business rules means that the CCG has a recurrent CIP (Cost Improvement Programme) requirement of around £12.2m and, potentially, a further one-off requirement of some £4m. At the time of writing the CCG is in discussion with NHS England regarding its plan for 2016/17 and a final budget will be determined by the end of March.

1.3 The Stockport NHS Foundation Trust (FT) has been given the opportunity to benefit from just over £8m of one-off NHS Sustainability Funding in 2016/17, providing it can demonstrate that it will achieve a financial break-even for that year. The FT has agreed a programme of spending reductions amounting to around £15m and is seeking to identify what further measures would / could be taken to achieve the required break-even control total.

1.4 Once the health bodies have completed their budget exercises the Stockport Together partners have agreed to take an overview of the totality of the resources and planned spending. It is possible that further adjustments will need to be made during the year to achieve a balanced position overall. Any resulting implications within the pooled budget would of course have to be agreed by the HCICB.

1.5 Along with other localities Stockport is taking a longer term view of health and social care finances within the Borough. Based on a series of assumptions, resource and spending forecasts have been prepared for each of the partner organisations, overlain with the potential net benefits to be derived from the Stockport Together programme of investment to change the models of care, shift activity and reduce estimated costs. The overall level of resources available is currently projected to rise from around £482m in 2016/17 to some £521m by 20120/21. However, current projections, taking account of planned interventions and assumed efficiency savings, suggest that spending could exceed those figures by between £39m and £47m per annum from 2017/18, including the impact of 'like for like' reductions in the Council's contribution to the pooled budget. This illustrates the scale of the challenge facing

Stockport Together and confirms the need to take a much more integrated approach to the commissioning and provision of health and care services.

1.6 It is to be hoped that the submission for Vanguard funding for 2016/17 and 2017/18 will be successful, especially as that money is now included within the Greater Manchester Transformation Fund. It is likely that significant levels of further investment will be needed, both capital and revenue, in order for the aim of clinical and financial sustainability to be achieved in Stockport and across Greater Manchester.

2. Conclusion and Recommendations

2.1 Against a very challenging backdrop the Stockport Together partners are working hard together to develop the new and radical arrangements needed to achieve their individual and collective aspirations. This report has a particular focus on the proposals for integrated commissioning, and outlines a series of financial, governance, leadership and organisational measures that are proposed.

2.2 The Governing Body is asked to note the progress that has been made on these matters.

2.3 The Governing Body is asked to approve the approach to the Integrated Commissioning of health and social care set out in the report and, subject to any further changes that may be made in discussions with health partners, the following :

- the CCGs contribution to the pooled budget with the Council for 2016/17 as set out in Appendix Two;
- the revised Section 75 Partnership Agreement with the Council (Appendix Four)
- the establishment and operation of the Health and Care Integrated Commissioning Board (HCICB) as set out in Appendix Three
- the Integrated Commissioning arrangements described in paragraphs 3.13-3.16

6.4 Furthermore, the Governing Body is asked to give delegated authority to the Chief Operating Officer in consultation with the Chief Clinical Officer to make any changes that are necessary to enable the above arrangements / documents to be implemented as a result of further discussions and negotiations with Council partners.

STOCKPORT METROPOLITAN BOROUGH COUNCIL

NHS Stockport Clinical Commissioning Group

DATED

Stockport Clinical Commissioning Group (1)

and

Stockport Metropolitan Borough Council (2)

SECTION 75 PARTNERSHIP AGREEMENT

For the creation of a pooled fund and shared commissioning arrangements Integrated Health and Social Care Service in Stockport

These arrangements include use of Section 75 powers to establish Pooled Fund and Lead Commissioning arrangements

Responsible Officers:

On behalf of NHS Stockport Clinical Commissioning Group

(Accountable Officer)

On behalf of Stockport Council

(Insert name and role of responsible officers for the purpose of this Agreement)

(The Council's Responsible Officers)

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Schedule 1 *(to follow)*

Schedules describing the services to be provided under integrated commissioning arrangements.

Schedule 2 *(to follow)*

Pooled Budgets

Schedule 3 *(to follow)*

HCICB Governance specifications

Schedule 4 *(to follow)*

Conflicts of Interest Principles

Schedule 5 *(to follow)*

Governance Diagram

Summary of Agreement

Since 2009, both Stockport Council and the NHS commissioning organisations in Stockport have had a commitment to integrated commissioning arrangements for the commissioning of health and social care services using pooled budget arrangements.

From 2015/16, these arrangements also included a Better Care Fund (BCF).

Pooled budgets between Social Care and Health are designed to cut across organisational boundaries, to improve the health and well-being of people in Stockport and to provide better value for money.

Both Stockport Council and Stockport Clinical Commissioning Group have now agreed to extend these integrated commissioning arrangements through the commissioning of a larger scale integrated health and social care service using a single pooled budget.

1. **Parties:**

(1) **NHS STOCKPORT CLINICAL COMMISSIONING GROUP** of 7th Floor, Regent House, Heaton Lane, Stockport SK4 1BS (**"the CCG"**);

(2) **STOCKPORT METROPOLITAN BOROUGH COUNCIL** of Town Hall, Stockport, SK1 3XE (**"the Council"**)

2. Introduction

2.1 The purpose of this agreement is to put in place the arrangements required to govern and manage integrated commissioning arrangements aligned with a new pooled budget. It will establish the Health and Care Integrated Commissioning Board (HCICB) as the vehicle through which both parties will discharge their commissioning responsibilities in respect of the pooled funds. The agreement applies to the defined health and social care services supplied to the residents of the Metropolitan Borough of Stockport and to patients registered with the GP Practices within the Stockport area and whose medical services contracts are managed by the CCG. This agreement builds on and supersedes arrangements entered into by previous Section 75 agreements but is to be regarded as an entirely new arrangement.

2.2 Stockport's 2015/16 Better Care Fund plan was submitted in September 2014. In October 2014, NHS England reviewed the plan and it was 'approved with support.' Following the submission of further evidence, this was formally updated Stockport was notified of its 'full approval' status in December 2014. The parties have noted that the BCF monies included within the pooled funds are subject to a pre-condition that they are deployed through a S75 pooled fund agreement.

3. The Stockport Together Vision

3.1 The Parties have a shared vision of a timely transformation towards an integrated approach to the provision of health and social care services in Stockport, and believe that significantly extending the pooling of financial resources and both co-ordinating and integrating their commissioning activities through the medium of the HCICB will help facilitate the best use of resources to support the local resident and patient population.

4. Section 75 Document Purpose

The purpose of this Section 75 agreement is to:

1. Set out the Pooled Fund arrangements, including provision for the new services set out in Schedule 1

2. Record the commissioning philosophy that will underpin the commissioning of health and social care services through the HCICB and the transitional arrangements.

3. Describe the new expanded role of the HCICB in the administration of the Pooled Fund and to make formal arrangements for its procedures and actions.

4. Make any necessary arrangements to ensure that the commissioning and planning of the defined functions takes place on the basis of and by reference to evidence-based information and standards, and uses up-to-date service specifications and recognised and authoritative clinical protocols implemented with suitable and expert medical and social care advice.

5. Describe the joint actions to be taken by the parties both through and outside the HCICB in order to commission health and social care services in an integrated way.

6. Regulate the relationships between the parties as exercised through the HCICB.

7. Provide for the development of formal commissioning arrangements by the parties through the HCICB.

8. Make arrangements for the provision of a secretariat and other supporting services for the HCICB.

9. Make the necessary delegation, governance, audit and regulatory arrangements to facilitate the purposes listed above.

5. Background to the Agreement

5.1 The Parties are organisations working to improve the health and care of people resident in the Stockport area and patients registered to GP practices within the same area. They believe that outcomes for their served populations can be greatly enhanced by closer working Partnership arrangements. Although the parties responsibilities nominally cover the same geographical area, they have different commissioning responsibilities to the registered population for health care services and to the resident population for public health and social care services.

5.2 The objective of the Partnership Arrangements is to improve the outcomes for health and social care users from commissioned services through closer working between the National Health Service and Local Government to the extent (from time to time and subject to the terms of this agreement) that it is lawful to do so and consistent with the obligations of the Parties to co-operate with each other in commissioning the care.

5.4 These Partnership Arrangements have been established pursuant to Section 75 of the Act and pursuant to the Regulations.

5.5 The Parties believe that the Partnership Arrangements proposed by this Agreement fulfil the objectives set out by the Stockport Health and Wellbeing Board within the Joint Health and Wellbeing Strategy, Stockport CCG's Strategic Plan, the NHS Constitution and Guidance in so far as it relates to local, regional and national requirements, the Council Plan and the Council's relevant Strategic Directorate Business Plans.

6. Definitions and Interpretation

In this Agreement, unless the context otherwise requires:

"**The Authorised Officers"** means the Responsible Officers of the Parties as specified in the introductory page of this Agreement

"**The Act**" means the National Health Service Act 2006

"**The Chief Officers**" means the Chief Clinical Officer of the Clinical Commissioning Group and the Chief Executive Officer of the Council

"**The Commencement Date**" means 1 April 2016

"**The Council**" means the Stockport Metropolitan Borough Council

"**The Council's Functions**" means such functions of the Council as may be necessary to provide the Services specified in Schedule 1(1)

"The Director of Integrated Commissioning" means the jointly appointed individual who will be the integrated commissioning lead on behalf of both parties and who shall have overall responsibility for the Joint Commissioning Board

"**The Financial Year**" means a twelve month period commencing on 1 April and terminating on the following 31 March

"**The Functions**" means together Stockport Clinical Commissioning Group Functions and the Council's Functions in so far as they relate to the agreement

"**The HSCA 2012"** means the Health and Social Care Act 2012

"**The HCICB"** means the Health and Care Integrated Commissioning Board

"The Health-Related Functions" shall mean the public health functions of the Council under the HSCA 2012 and any other functions that may be exercised by the Council in its commissioning or delivery of the Services specified in Schedule 1

"The Initial Term" means a period of one year terminating on 31 March 2017 and capable of extending thereafter on a year to year basis at the parties discretion and agreement for a maximum period of seven years from the date of this agreement and thereafter as agreed between the Parties by further negotiation

"The Joint Commissioning Board" shall mean the joint administrative arrangements made by the Parties to commission the integrated services agreed though the HCICB

"Commissioning Function Host" shall mean the CCG as the party responsibility for hosting the integrated commissioning arrangements

"Ancillary Service Commissioner" (ASC) shall mean the party that has been nominated in writing within an Ancillary Service Commissioning Agreement to be the lead commissioner of a service that falls within Schedule 1of this agreement but which the parties have agreed shall fall outside the HCICB integrated commissioning arrangements

"Ancillary Service Commissioning Agreement" shall mean an agreement made between the parties under Clause 7.10.8

"The MCP" means the Multispecialty Community Provider to be established by and with the agreement of the current principal providers of health and social care services within the area in which their services may be delivered and which may be commissioned by their agreement through the HCICB and which will undertake such integration activities as may be required.

"The NHS Functions" means those NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

"The Pooled Fund Host" shall mean the Council as the Party responsible for the accounting for and audit of the pooled fund established under this agreement

"**The Pooled Fund**" means such fund or funds of monies received from separate contributions by the Parties for the purposes of providing the specified services to be commissioned through the HCICB and which are set out in Schedule 1of this agreement

"**The Pooled Fund Arrangements**" means the arrangements agreed by the Parties for establishing and maintaining the Pooled Fund

"The Pool Fund Manager" will be the nominated officer(s) who will be accountable to the HCICB for the management of the Pooled Fund in accordance with the Pooled Fund Arrangements.

"The Individual Pooled Service Budgets" shall mean the budgets agreed between the Parties within the HCICB to provide the services specified in Schedule 1of this agreement from the Pooled Fund and which shall be administered by the Joint Commissioning Board

"The Individual Pooled Service Budget Managers" being officers with delegated responsibility (detailed in the annual budget report) for budgets and the commissioning of services within an Individual Pool Budget

"**The Parties**" means together Stockport Clinical Commissioning Group and the Council

"**The Partnership Arrangements**" means the arrangements jointly agreed by the Parties for the purposes of providing the Services pursuant to the Regulations and Section 75 of the Act

"Pennine Care" means Pennine Care NHS Foundation Trust

"Finance Lead" shall mean **the** Section 151 Officer of the Council

"**Stockport CCG**" means the Stockport Clinical Commissioning Group

Stockport CCG functions" means such of those functions as described in Schedule 3 as may be necessary to provide the Services

"Stockport FT" means Stockport NHS Foundation Trust

"**The Regulations**" means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No. 617 and any amendments and subsequent re-enactments

"**The Services**" means the services commissioned under this Agreement

"**The Service User**" means an individual in receipt of services commissioned under the agreement.

"**The Term**" means a period of means a period of seven years from the Commencement Date, plus any extended period as agreed by the Parties under clause 14.3;

"**The Stockport Area"** means the area within the Stockport Metropolitan Borough boundary in Greater Manchester. It includes areas in which GPs listed by the CCG are practicing and for which commissioning responsibilities exist for the registered population and also any area within the boundaries of the Metropolitan Borough of Stockport for which the Council has responsibilities and duties for those ordinarily resident

"Losses" means any and all direct losses, costs, claims, proceedings, damages, liabilities and any reasonably incurred expenses, including legal fees and disbursements

The headings in this Agreement are inserted for convenience only and shall not affect its construction and a reference to any Schedule or clause is to a Schedule or clause of this Agreement.

Words importing the singular number shall include the plural and vice versa and words importing the masculine shall include the feminine and vice versa.

"SOSH" means the Secretary of State for Health.

"Third Party Costs" means all such third party costs (including legal and other professional fees) in respect of each service as a Party reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

"Working Day" means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

All references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

Reference to the Parties shall include their respective statutory successors, employees and agents subject to the provision of Clause 20.

In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

Non-exhaustive lists: Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

Gender and persons :In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, Partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

Singularity: In this Agreement, words importing the singular only shall include the plural and vice versa.

"Staff" and "Employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

Mode of formal communication: Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Parties shall be in writing.

Money: Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

References to this Agreement within its text include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

7. Appointment of the Commissioning Function and Pooled Fund Hosts and their duties

7.1 Earlier Section 75 Agreements between the Parties established the Health and Wellbeing Integrated Commissioning Group (HWICB), consisting of representatives of the Parties in order to provide overall governance for the agreement, deployment, administration and management of resources between Stockport Council and Stockport CCG, and oversight of aligned resources, aligned to meet specified services by reference to agreed health and care priorities and outcomes identified from Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and the CCG Integrated Commissioning Plan and within the delegated scope of identified resource availability. Under the HWICB arrangements the Parties retained independence in their commissioning arrangements relating to the specified services.

7.2 The Parties propose to continue to build upon the previous model under this agreement, under which the parties will commission the services described in Schedule 1 of this agreement and the Health and Wellbeing Integrated Commissioning Board will be reconfigured and renamed the Health and Care Integrated Commissioning Board (HCICB). The HCICB will be subject to the rules for meetings, voting arrangements and procedural rules set out in Schedule 3 to this agreement. The HCICB will provide strategic direction in the areas of agreed joint financing and commissioning set out in this agreement, with delegated authority for the development and operation of integrated commissioning and service innovation in these areas, taking into account the wider strategic framework set by the Health and Wellbeing Board and the Joint Health and Wellbeing Strategy and within the strategic plans of the Parties, and informed by appropriate intelligence such as the JSNA. Integrated commissioning will initially take place by sharing the planning and commissioning arrangements and then commissioning services using separate contracts with providers through the HCICB. In time the Parties will move towards full integrated commissioning arrangements from the Pooled Fund under which the CCG will act as Commissioning Lead.

7.3 The parties will appoint NHS Stockport Clinical Commissioning Group acting through the HCICB as the host for the integrated commissioning arrangements (which such expression shall have a different meaning to the role of Lead Service

Commissioner referred to in this agreement) and Stockport Council as the host for the pooled fund. In order to facilitate these arrangements the following functions will be undertaken in the manner set out elsewhere in this agreement

7.3.1 To agree to, and oversee, the use of HSCA 2012 flexibilities for establishing and then operating pooled budgets and integrated commissioning between the Parties under the terms of this agreement.

7.3.2 To oversee the establishment of the Pooled Fund and then the establishment of lead commissioner arrangements through the HCICB, to administer the individual Pool Budgets (if appropriate) and to receive information from the Director of Integrated Commissioning (DIC), the Finance Lead and Individual Pool Budget Managers (where appropriate) with delegated responsibility for the access to an agreed level of funding from the Pooled Fund.

7.3.3 To approve the overall pooled budget, the component individual pool budgets and the required Party contributions to the Pool Fund.

7.3.4 To monitor the BCF in accordance with NHS England guidance, making use of recommended best practice templates and to report to the HCICB on a quarterly basis for sign off and in relation to any specific required annual returns.

7.3.5 To prepare proposals for managing the financial aspects of the Pooled Funds for consideration by both parties, including the initial separate management of the Parties contributions and then following the eventual pooling of the aligned resources the risk management arrangements associated with this.

7.3.6 To receive (as a minimum) quarterly information from the Pooled Fund Manager(s), to include both service and financial information, in a form to be agreed, to fulfil the Parties' performance management requirements.

7.3.7 To receive quarterly information from the officers to include both service and financial information, in a form to be agreed, to fulfil the Parties' performance management requirements.

7.3.8 To agree appropriate action resulting from the above reports where necessary.

7.3.9 To resolve disputes or where necessary to refer such to dispute resolution procedures.

7.3.10 To review the role and effectiveness of the integrated commissioning arrangements through achievement of planned objectives and targets, ultimately demonstrating improved outcomes for service users and making recommendations to the Council and CCG as to any amendment to its functions.

7.3.11 To report, on an appropriate basis, on the integrated commissioning arrangements to ensure appropriate reporting and accountability to the parent organisations.

7.3.12 To report to statutory bodies and other stakeholders by the inclusion of minutes on Parties' bodies agendas as appropriate and as agreed by each Party.

7.3.13 Any other purposes as may be deemed appropriate by the Parties and agreed as set out in this agreement

7.4 The Council through the HCICB will be the Pooled Fund Host with responsibility for accounting, audit and the financial reporting of the Pooled Fund and its collection, administration and for making payments out of it in relation to the performance of contracts agreed through the HCICB in relation to the relevant Pooled Service Budget and such part of the Pooled Fund that is represented by it.

7.5 Both parties will jointly appoint a Director of Integrated Commissioning (DIC), employed by the CCG who will be responsible for implementing the instructions and policies of the HCICB through integrated commissioning arrangements. The DIC will jointly report to the Chief Clinical Officer of the CCG and the Chief Executive of the Council through arrangements set out in this agreement. The DIC will by instruction from the HCICB determine delegation of financial responsibility for Pooled Service Budgets which will be managed by Individual Pooled Service Budget Managers who will commission all appropriate services on behalf of the Parties and provide appropriate information to the DIC, the Finance Lead, the HCICB and the Parties.

7.6 The commissioning contracts will initially be between the party with responsibility for commissioning of that service and the provider selected by the HCICB and subject to the integrated service delivery arrangements agreed within the HCICB. Following the establishment of full integrated commissioning arrangements through the

Pooled Fund, the contracting role may be undertaken by either Party or as otherwise provided for under this agreement.

8. Integrated Commissioning:

8.1 Introduction:

The commissioning arrangements set out in this agreement shall be the means by which the Parties co-operate in order to provide the services described in Schedule 1 to this agreement through integrated commissioning. This Agreement sets out the mechanism through which the Parties will work together in partnership through the HCICB. During the period of this agreement the Parties will co-operate with a view to introduce integrated commissioning through capitation and outcome based payments for services provided under the service contracts and the establishment of standard contracts and outcome assessment arrangements to support this.

8.2 Delegations:

With a view to working together in partnership (but not so as to create the legal relationship of partnership between them), in order to implement the integrated commissioning arrangements set out in this agreement and to make arrangements for the services to be provided under Schedule 1 the parties agree that:

8.2.1 The Council shall delegate to the CCG and the CCG agrees to exercise, on the Council's behalf, the Council's Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions, and

8.2.2 To the extent to which it may legally do so, the CCG shall delegate to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Council's Functions.

8.2.3 In the event that any delegation of powers by any of the Parties provide for under this agreement shall require obtaining the consent or approval of any Minister of the Crown, Government Department or any other body formally constituted for that (and other) purposes then the party required to seek such consent or approval shall use its best endeavours to do so and in a timely fashion, efficiently and without unreasonable delay.

8.2.4 The Parties shall only delegate such powers to each other as are required to implement the terms of this agreement and specifically reserve all other commissioning powers and functions to themselves.

8.3 Partial or incomplete delegations:

Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant service specification in Schedule 1 and the Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with those statutory constraints.

8.4 Integrated commissioning objectives:

The Parties shall seek to achieve the following objectives in the course of making the integrated commissioning arrangements under this agreement:

8.4.1 To continue to deliver the S75 services as covered by previous agreements and the defined services as have been specified in Schedule 1.

8.4.2 To deliver improved and improving service delivery efficiencies through the integrated commissioning arrangements.

8.4.3 To work with the main NHS and other service providers within the locality to facilitate the commissioning of services

8.4.4 To take any necessary steps to develop a future procurement strategy for the better integration of services by their provision through an MCP, which is to be established through other arrangements by a Provider Board composed of representatives of the 'fixed point' service providers already involved in the delivery of the services.

8.4.5 To introduce new service commissioning arrangements involving the use of capitation payments and outcomes assessment frameworks to be developed by the Parties during the period of this agreement.

8.4.6 To liaise and co-operate in the formulation of the Greater Manchester Strategic Sustainability Plan relating to its future proposals for the sub-regional provision of combined health and social care.

8.4.7 Where the Parties propose to add a new service to this Agreement a Scheme Specification for the new service shall be completed and agreed between the Parties.

8.4.8 The Parties shall not enter into a new Scheme Specification in respect of an additional service unless they are satisfied that the Individual Scheme in question will improve the health and wellbeing of the population of Stockport in accordance with this Agreement and by reference to the Outcomes Framework.

8.4.9 Each Party shall keep the other Party and the HCICB regularly informed of the effectiveness of the arrangements including the Better Care Fund and any overspend or underspend in the Pooled Fund.

8.5 Parties mutual responsibilities:

The Parties agree that their boards, their officers and employees, their controlled subsidiaries and any independent contractors retained by either of the Parties or their controlled subsidiaries shall work together for the purposes of undertaking integrated commissioning arrangements and achieving the objectives described in Clause 7.5 and in particular shall:

8.5.1 Co-operate with each other in the conduct of all activities relating to the objectives.

8.5.2 Make the necessary delegations as set out in Clauses 7.2 and 7.3, including any formal arrangements to give all necessary third party consents or notifications.

8.5.3 Make all and any agreed contributions into the Pooled Fund as set out in Schedule 1 promptly and without deductions for the purposes of providing the services.

8.5.4 Make any necessary arrangements to make payments from the pooled fund as may be required by the HCICB in order to provide the services that have been commissioned under this agreement.

8.5.5 Operate all their related activities and services in a manner that is compatible with the objectives set out in Clause 7.4 so far as they are not inconsistent with their other legal obligations or formal service delivery arrangements.

8.5.6 Operate the integrated commissioning arrangements and fulfilling all responsibilities relating to them as agreed in this agreement. Exercise candour in their dealings with each other and to conduct themselves transparently in any negotiations, including disclosing any reasonable prospect that there shall be a conflict of interest between them.

8.5.7 Exercise candour in their dealings with each other and conduct themselves transparently in any negotiations, including disclosing any reasonable prospect that there shall be a conflict of interest between them.

8.6 Legacy contracts, transition commissioning arrangements:

8.6.1 Both Parties agree that any contracts for the full or partial delivery of the services specified in Schedule 1(1) that are continuing at the date of this agreement and which are between the parties and other providers (legacy contracts) will be unaffected by this agreement.

8.6.2 After the date of this agreement any legacy contract will be deemed to fall within the integrated commissioning arrangements set out in Clause 7 and will be dealt with as part of the Pooled Fund arrangements set out in Clause 8. Subject to the continuation of the pre-existing commissioning arrangements and any contractual arrangements made under them.

8.7 Monitoring and review of the HCICB:

The Responsible Officers of the Parties shall from time to time agree joint arrangements to monitor and review the manner in which the HCICB exercises the delegated commissioning and regulatory powers set out in this agreement to ensure that they are exercised in compliance with the law and with the terms of this agreement and that the manner in which they are exercised is both effective and appropriate.

8.8 Joint integrated commissioning arrangements through the HCICB

8.8.1 Both Parties shall work in cooperation and shall endeavour to ensure that the services specified in Schedule 1 are commissioned with all due skill, care and attention through the HCICB arrangements.

8.8.2 Each Party shall be responsible for making payments to Providers from the Pooled Fund of all sums pursuant to the terms of the contract negotiated on behalf of that Party through the HCICB and the Joint Commissioning Board and for complying with the terms of that contract.

8.8.3 Both Parties shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification in Schedule 1 are commissioned through the HCICB within each Parties Financial Contribution in respect of that particular Service in each Financial Year.

8.8.5 Each Party shall keep the other Parties and the HCICB regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in the Pooled Fund.

8.8.6 The HCICB will report back to both the Parties in the event of any failure by either of them to make payments required by this agreement.

8.8.7 The parties will make any necessary reports to the Health and Wellbeing Board outside the terms of this agreement as may be required under Chapter 7 of the HSCA 2012.

8.9 Role of Joint Commissioning Board

The parties will commission the services specified in Schedule 1 through the strategic direction of the HCICB. The administrative work involved in implementing the decisions taken by the HCICB and in undertaking the commissioning arrangements for these services shall be under the overall direction of the Lead Commissioner through the Director of Integrated Commissioning. The parties may at their discretion after approval by the HCICB either make their own commissioning arrangements or instruct the Joint Commissioning Board to make such arrangements as may be required in relation to the services. The Joint Commissioning Board shall oversee the integrated commissioning arrangements operated between the parties for the purposes of implementing this agreement and

shall be an ad hoc administrative arrangement for which the Director of Integrated Commissioning shall have day-to-day operational responsibility. The parties may direct the Joint commissioning Board to issue contracts for the services in accordance with the strategic direction of the HCICB and, subject to any agreements between the parties as to the use of capitation and outcomes-related payments or in relation to costs under the Pooled Fund, such contracts shall be on such terms as are consistent with the directions of the HCICB as interpreted by the parties in relation to each contract.

8.10 Specific Functions of the Joint Commissioning Board:

Without prejudice to the generality of the Clause 8(9) above the Joint Commissioning Board shall undertake the following specific functions:

8.10.1 Undertake population health and social care needs assessments

8.10.2 Carry out strategic planning of health and social care services

8.10.3 Undertake assurance activity of planned commissioning changes

8.10.4 Exercise the consultation responsibilities of commissioners in planning for the redesign

8.10.5 Undertake assurance (including clinical assurance) of system capacity, outcomes and delivery

8.10.6 Undertake assurance (including clinical assurance) of system quality and safety

8.10.7 Establish the weighted capitation payment linked to an age cohort

8.10.8 Establish and oversee the operation of the outcomes framework

8.10.9 Establish the procurement strategy for the schedule of services as outlined in the agreement

8.10.10 Establish the acceptable provider forms and the scope of service delivery

8.10.11 Assess the provider response to the above in terms of:-

a. Level of payment and mix of cost / outcomes reward
b. Development plan / milestones for the provider form development in accordance with the procurement strategy

c. Sign off the value chain which links the outcomes framework with the providers own operating/development model

8.10.12 Oversee the development of an integrated commissioning resource to align expertise and capacity within both Parties

9. Pooled Fund:

9.1 The Parties agree as follows:

9.1.1 The Council will be the Pooled Fund Host with the responsibility for accounting and audit and the financial reporting of the overall pool being exercised by the Finance Lead.

9.1.2 The Director of Integrated Commissioning (DIC) will be the joint responsibility of the Chief Clinical Officer of the CCG and Chief Executive of the Council and will manage the operation of the Pooled Fund and the Pooled Services Budgets through the Joint Commissioning Board (the JCB) which will be jointly operated by the Parties under Clauses 8.9 and 8.10 of this agreement.

9.1.3 The DIC will determine delegation of financial responsibility to Individual Pooled Service Budget Managers who will work through the JCB to commission all appropriate services on behalf of the Parties and provide appropriate information to the Parties and the HCICB.

9.1.4 The Standing Orders and Standing Financial Instructions of the Party by which an Individual Pooled Service Budget Manager is employed shall apply to the management of each Individual Pooled Service Budget through the JCB under this Agreement. The CCG Governing Body and Council Executive should formally record this arrangement in their Standing Orders and Standing Financial Regulations.

9.1.5 The Parties will provide the HCICB, the DIC and the Individual Pooled Service Budget Managers with all the necessary financial and administrative support to enable the effective and efficient management of the Pooled Fund and any Individual Pooled Service Budget.

9.1.6 The Parties will create a clear identifiable accounting structure within their financial systems (e.g. a separate cost centre) to enable effective monitoring and reporting of the Pooled Fund and the budgets of the Individual Pooled Services and the DIC under instruction from the Finance Lead will be responsible for maintaining an overall accounting structure for the Pooled Fund.

9.1.7 The Individual Pooled Service Budget Managers will provide such information as is deemed necessary by the Parties to this Agreement, to the HCICB, to enable

effective performance management of the Services provided under this Agreement and any Pooled budget.

9.1.8 The DIC and the Individual Pooled Service Budget Managers will be accountable for managing their Pooled Service Budget and forecasting expenditure and will notify the nominated finance officers of each party who must report to the HCICB on the outputs and outcomes and the achievements of targets as set out in the service plans and objectives.

9.1.9 The DIC and the Individual Pooled Service Budget Managers will be responsible for the management of each specific Individual Pooled Service Budget within financial balance and will in conjunction with the JCB report any potential or actual variations to any Individual Pooled Service Budget and its potential effect upon the Pooled Fund, as soon as practicably possible to the HCICB, and in any event at the next meeting of the HCICB following identification of any such variation;

9.1.10 Individual Pooled Service Budget Managers will follow their own statutory accounting and audit arrangements. A year-end Memorandum Account showing income received, expenditure and any balance remaining shall be prepared by the Pooled Fund Host and sent to the Parties for inclusion in their statutory accounts.

9.1.11 The Parties shall comply, at all times, with HMRC guidance as updated from time to time on VAT in respect of the respective Pooled Service Budgets and their Statutory Finance Officers shall consult with HMRC to agree an appropriate scheme for recovery of VAT.

9.2 Operation of Pooled Budgets

9.2.1 The Parties will agree their contribution to the Pooled Fund as set out in Schedule 2 each year in accordance with this clause 9. The contributions for the Financial Year 2016/17 are as set out in Schedule 2 here to and will be used as a basis for agreeing future Financial Year contributions from the Parties. Such annual contributions will be evidenced in writing by insertion into the said Schedule 2 as an agreed amendment.

9.2.2 The Parties agree that annual Pooled Fund will be confirmed by 31 March for the following Financial Year. The Board will receive notice of planned contributions within one week of each Party agreeing their respective budgets.

9.2.3 The Lead Commissioner shall ensure that VFM is actively secured at all times in making payments from Individual Pooled Service Budgets to deliver the services set out in Schedule 1.

9.2.4 Any monies specifically allocated by the government for particular client groups, services or specific projects shall be put into the relevant Pooled Service Budget subject to such discretions that funding allocations allow to the HCICB. The HCICB shall approve the expenditure plans for such grants. The appropriate Individual Pooled Service Budget manager will ensure that the conditions of the grant are met. Where grants are put into relevant Pooled Service Budgets any underspends in the grant will be carried over to the next financial year unless this is not allowed by the conditions of the grant.

9.2.5 For the avoidance of doubt, all funding between the organisations supplied under this Agreement is included in each party's annual contribution to the Pooled Fund.

9.3 Contributions to the Pooled fund:

9.3.1 Annual contributions to the Pooled Fund will be calculated taking into account but not limited to

(i) recurrently rolled forward Funds from previous year
(ii) plus or minus agreed in-year changes where recurrent (overspends or underspends)
(iii) plus or minus agreed inflationary uplift
(iv) plus or minus planned and agreed changes, and
(v) minus planned and agreed efficiency requirements

9.3.2 The parties agree that these changes must not have a detrimental financial impact on either party unless specifically agreed with the party adversely affected and approved by HCICB.

9.3.3 Contributions agreed by Parties will be formally budgeted for prior to the start of the new financial year.

9.3.4 Where required, the organisation which is not hosting the Pool will pay its contribution to the Pooled Fund by 4 equal instalments on a fixed date agreed with the Pool Host in each year of this Agreement. As a minimum this will be an amount equal to the amount allocated in respect of its revenue expenditure budget for the

Services in question for the said Financial Year in which the payment is made. The amounts will be set out in Schedule 2.

9.3.5 The annual Pooled Fund will normally be calculated as the initial Pooled Fund for the previous year, plus any agreed in-year changes where it is decided these should be recurrent, plus any agreed inflationary uplift for the forthcoming year, plus any agreed planned changes for the coming year, plus any agreed efficiency requirements. The way in which such annual Pooled Fund will be determined shall be in accordance with the above provisions.

9.3.6 The contribution by the Council to the Pooled Fund shall be made upon the net figure after deductions for charges levied on Service Users, or any associated costs or expenses.

9.3.7 The parties recognise that there may be scope to develop the Partnership and to bring other budgets and services in addition to those specified in Schedule 1 into pooled or aligned arrangements from time to time and any such changes will be treated as variations to this agreement and will be evidenced in writing and Scheduled to this agreement.

9.3.8 The Pooled Fund shall only be used for the provision of Services agreed to fulfil the Aims and Outcomes of this Agreement as set out at Schedule 1 to this Agreement.

9.3.9 Changes forecast to the total level of agreed Pooled Fund expenditure for the year shall be reported to the next meeting of the HCICB and the HCICB shall agree appropriate action to contain expenditure within an individually agreed Individual Pooled Service Budget or to utilise a surplus, or exceptionally, where additional funding is thought to be required, shall submit a case of need to the Parties. Where additional funding is approved, the Parties will consider the appropriateness of continuing such level of funding as part of the Pooled Fund setting process for the following year.

9.3.10 Where an unforeseen overspend arises at the end of the Financial Year, the Parties will need to consider how best to fund this and its implications for future years. Parties have agreed that as a general principle overspends will not be tolerated and if this situation arises then actions will be approved in-year by the HCICB to avert this situation. In the event that overspends do arise then the nature of this will be

explicitly set out by the Individual Pooled Service Budget Manager and the source understood by the HCICB so that fair and appropriate action can be agreed to fund the pressure.

9.3.11 The HCICB will be responsible for negotiating any proposed arrangements for joint support in the instance of under or overspends in year within the overall spirit of Partnership arrangements and financial positions recognising that Parties retain statutory responsible for this element of the service. Such negotiated proposals must be agreed between the parties before they shall be implemented. Where recurrent pressures are identified then the HCICB will consider whether it is necessary to instruct the Individual Pooled Service Budget Managers to develop robust recovery plans.

9.3.12 Where there is a surplus in an Individual Pooled Service Budget then the Pool Host shall identify this for in-year financial management purposes, taken in wider context with all other Pooled Service Budgets, and any recurrent impact of this on future year's contributions. Any in-year surpluses identified should be made explicit in the reports so that the HCICB can understand this in the wider context of all Individual Pooled Service Budgets and give consideration to other options it feels are appropriate (such as applying this to other Pooled Service overspending areas or known pressures and/or carrying forward any surplus for the benefit of the service in future years or making an in-year repayment to the Parties based on percentage contributions). Where the surplus has a recurrent impact then Parties may propose options around retaining this for service investments or agreeing a recurrent deduction to party contributions which will be subject to review by the HCICB. Such agreement is to be indicated in writing in the minutes of the relevant meeting of the HCICB.

9.3.13 The Parties may not normally vary their annual contributions to the Pooled Fund during the course of the financial year to which the annual contribution applies. Any variations to the Parties' annual contributions must be recommended by the HCICB, having considered the wider context as outlined above, with such agreement indicated in writing in the minutes of the relevant meeting of the HCICB.

9.3.14 In the event of dispute or disagreement in relation to the liability or benefit for any overspend or underspend the matter may be referred by either Party in accordance with Clause 9.3.2.

9.3.15 The DIC shall present a quarterly and an annual report to the HCICB, which shall be provided to the relevant Parties and include income and expenditure received by or incurred from the Pooled Fund. Such reports shall include an item on potential overspend or underspend.

9.4 Financial accountability and risk sharing:

9.4.1 Each party will maintain its existing financial accountability and internal and external audit arrangements and shall bear its own risks in relation to the integrated commissioning arrangements. By way of clarification this means that the Council will follow its Financial Procedure rules and the CCG will follow its own Standing Financial Instructions and Standing orders as last approved by the CCG Governing Body.

9.4.2 The approach to bearing risks will remain under continuous review by both parties in line with the objectives of the agreement relating to integrated commissioning and the management of the Pooled Fund.

9.5 Pooled Fund: Overspend and underspend procedures

9.5.1 Subject to Clause 9.2, the HCICB shall manage expenditure from the Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

9.5.2 The Council as the host organisation of the Pooled Fund shall not be in breach of its obligations under this Agreement if an Overspend occurs provided that expenditure from the Pooled Fund has been in accordance with Permitted Expenditure, the Pooled Fund has been managed by it in compliance with the terms of this Agreement and that regular reporting of overspends and underspends has taken place in accordance with Clause 8.8.5

9.5.3 In the event that the DIC or any Pooled Service Budget Manager identifies an actual or projected variation then they must ensure that the HCICB is informed as soon as reasonably possible and the provisions of the relevant Service Specification are applied.

9.6 Non-financial contributions to the Pooled Fund; transfer of assets in lieu of money contributions

The Services Specifications in Schedule 1 and the relevant budgets in Schedule 2 shall set out any non-financial contributions (and the service or services to which they relate) of each Party including staff (including the Pooled Service Budget Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

9.7 Division of Pooled Fund into Individual Pooled Service Budgets (PSB's):

The Director of Integrated Commissioning following consultation with the HCICB shall establish suitable arrangements for the purposes of creating pooled service budgets for the individual services to be provide under this agreement to be operated in accordance with the financial governance arrangements set out in this agreement and the budgets set out in Schedule 2

9.8 Capital Expenditure

No part of the Pooled Fund shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of the Council. The CCG does not have a capital budget. If a need for capital expenditure is identified this must be agreed by the Parties.

10. Over-arching arrangements for the HCICB

10.1 Status of HCICB:

The HCICB shall be operated in accordance with the rules and procedure set out in Schedule 3. In the event that any legislative or regulatory change mandates amendment to this arrangement then this agreement will not be ended and the Parties will consult with each other and co-operate in order to identify any appropriate changes to the status of the HCICB and make any necessary changes to the arrangements set out in this agreement. Provided that if no new status or arrangements can be agreed then this Clause shall have no further effect in relation to any possible termination arrangements.

10.2 Relationship between HCICB and Joint Commissioning Board (JCB) arrangements

The HCICB shall be the principal source of strategic direction for the JCB through the Director of Integrated Commissioning (DIC)

10.3 Relationship between parties and HCICB, over-arching principle of financial probity

10.3.1 All Parties shall promote a culture of financial probity and sound financial discipline and control in relation to the arrangements set out in this Agreement. The Council as the host of the pooled fund shall arrange for the audit of the accounts of the Pooled Fund and shall require the relevant internal auditors to make arrangements to certify an annual return of those accounts as may from time to time be required under Section 28(1) of the Audit Commission Act 1998 or other applicable legislation of similar effect

10.3.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access by them to any document, information or explanation they require from any employee, member of the Parties in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

10.3.3 The Parties will at all times comply with Law and ensure good corporate governance in respect of each Party (including the Parties respective Standing Orders and Standing Financial Instructions).

10.3.4 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

10.3.5 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

10.4 Commercial confidentiality arrangements

Information shall be shared between the parties in accordance with the data sharing arrangements set out in Clause 9.17 below save that no commercially sensitive information shall be communicated between the parties in the course of the operation of the Joint Commissioning Board without the express agreement of the Director of Integrated Commissioning or some other officer of each of the parties appointed for that purpose

10.5 Shared data protection arrangements under the Data Protection Act (the 1998 Act), the Freedom of Information Act (the 2000 Act) and the Environmental Protection Regulations 2004 (the 2004 Act)

10.5.1 The Parties agree that they will each cooperate with each other to enable any Party receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Parties as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

10.5.2 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Party shall be in breach of Clause

26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

10.5.3 Any processing of data that is undertaken by the Parties, their servants, employees, agents or subcontractors in the course of this agreement shall comply with the Fair Data Processing principals set out in the 1998 Act and shall be in accordance with the over-arching data processing policy

10.6 Conflicts of interest

The Parties shall comply with the agreed principles for identifying and managing conflicts of interest.

10.7 Resolution of commissioning disputes between parties by mediation

10.7.1 In the event of a dispute between the Parties arising out of this Agreement, either Party may serve written notice of the dispute on the other Party, setting out full details of the dispute

10.7.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 10.7.1 at a meeting convened for the purpose of resolving the dispute

10.7.3 If the dispute remains after the meeting detailed in Clause 10.7.2 has taken place, the Parties' respective Authorised Officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

10.7.4 If the dispute remains after the meeting detailed in Clause 0 has taken place, then the Parties will attempt to settle such dispute by mediation in accordance with an independent mediation procedure as agreed by the Parties in compliance with this agreement. To initiate mediation, either Party may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to the Centre for Effective Dispute Resolution (CEDR) or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Party will terminate such mediation until

each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, Clause 14 of the Model Mediation Procedure will apply (or the equivalent Clause of any other model mediation procedure agreed by the Parties). The Parties will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

10.7.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Party's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

10.8. Director of Integrated Commissioning.

10.8.1 **Appointment of the Director of Integrated Commissioning (DIC)**

The DIC shall be recruited, appointed and employed by the CCG in accordance with its own recruitment policies and it shall be responsible for the DIC's day to day management.

10.8.2 **Arrangements relating to employment of the DIC:**

The Council will confer on the DIC such powers and responsibilities and make resources available sufficient to enable them to carry out their duties.

10.8.3 **DIC responsibility for Individual Pooled Service Budgets**

The DIC shall have day to day management of the pooled service budgets and shall report to the HCICB in relation to this responsibility.

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11 Liabilities and Insurance and Indemnity

11.1 Subject to Clause 8, if a Party ("First Party") incurs a Loss arising out of or in connection with this Agreement or in relation to the Services to be jointly commissioned under the terms of this agreement as a consequence of any act or omission of another Party ("Other Party") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the contract under which the Services are to be provided then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

11.2 Clause 11.1 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Party acting in accordance with the instructions or requests of the First Party, the HCICB or the DIC.

11.3 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause then the Party that may claim against the other indemnifying Party will:

11.3.1 As soon as reasonably practicable give written notice of that matter to the Other Party specifying in reasonable detail the nature of the relevant claim

11.3.2 Not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Party (such consent not to be unreasonably conditioned, withheld or delayed)

11.3.3 Give the other Party and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the indemnifying Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purposes of assessing the metis of and if necessary, defending the relevant claim.

11.4 Each Party shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

11.5 Each Party shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

12 Term of agreement:

This Agreement shall come into force on the Commencement Date and shall continue until it is terminated in accordance with its terms. The duration of the arrangements for each Individual Service shall be as set out in the relevant Scheme Specification in Schedule 1.

13 Continued co-operation between parties after end of agreement:

The Parties shall continue to co-operate with each other or their statutory successors following the termination of this agreement (for any reason) with a view to ensuring the continuity of delivery of the services, the continuation, renewal or re-procurement of the services, any commissioning arrangements relating to them and the continued provision of health and social care to the served populations.

14 Continuing contracts and liabilities arising from termination of agreement:

In the event that this agreement is ended then any contracts made under it will be deemed to continue as between the parties to that agreement and the parties will seek to co-operate under Clause 13 in relation to the arrangements made under such contracts.

15 Third party rights and contracts

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

16. Governing and Applicable law

16.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

16.2 Subject to Clause 23 (Dispute Resolution), the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection

with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

17 Complaints procedures

17.1 During the term of the Agreement, the Parties will develop and operate a joint complaints system. The application of a joint complaints system will be without prejudice to a complainant's right to use either of the Parties' statutory complaints procedures where applicable

17.2 Prior to the development of a joint complaints system or after the failure or suspension of any such joint complaints system the following will apply

17.3 Where a complaint wholly relates to one or more of the Council's Health Related Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council

17.4 Where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the CCG

17.5 Where a complaint relates partly to one or more of the Council's Health Related Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the CCG, in line with local joint protocol

17.6 Where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, and then the HCICB will set up a complaints subgroup to examine the complaint and recommend remedies. All complaints shall be reported to the HCICB

18 Review and variation

18.1 The Parties shall review the integrated commissioning arrangements six months prior to expiry of the Term.

18.2. Review will comprise the delivery of the NHS Functions and the health-related Functions, the extent to which the objectives of the integrated commissioning arrangements are met, compliance with and fulfilment of national and local

policies, financial arrangements and continuous improvement in quality of care through clinical governance.

18.3 The Parties may determine to renew the Partnership Agreement at the end of the Term.

18.4 The review and variation provisions in this Clause shall apply as a means of developing and refining the parties' respective functions in relation to the services and fulfilling the objectives of this Agreement.

18.5 If at any time during the term of this Agreement either party gives Notice to vary this Agreement, it shall be considered first by the HCICB for approval and then if approved will be recommended for approval by the other party. In the event of such mutual approval then a memorandum of agreement shall be prepared and executed by the parties and thereafter the variation shall be binding.

18.6 If the CCG or SMBC do not agree to the request to vary the agreement, then the variation shall not take place

19 Appointment of Legal Advisors

The parties shall in all circumstances where it is practicable to do so take a single advisor approach to seeking legal advice in relation to the implementation of this agreement, any dispute arising from it or any proposed change to or modification of its terms, such advice being commissioned through the DIC.

20 Appointment of Financial and Audit Advisors

At all times the Parties shall retain their own financial and audit advisors for their financial and governance arrangements but may make arrangements for a single advisor in relation to specific matters where it is practicable and desirable to do so, such advice being commissioned through the DIC.

21 Relationship between the Parties and Greater Manchester Strategic Partnership Board and Joint Commissioning Board in the event that they exercise parallel legal powers

The parties shall consult with each other in the event that either of the bodies exercises parallel legal powers in relation to the arrangements made under this agreement and shall seek to ensure that the exercise of powers or discretions in this

agreement are so far as possible compatible with the current policy of the relevant bodies for the purposes of the defined functions.

22 Responsibility for Public Statements and Press Releases

The parties shall co-operate when issuing any public statement or press release relating to the terms of this agreement or any activity undertaken under it or discretion exercised by reference to it to the intent that both parties agree such statement or release which should represent the agreed position of both parties in relation to such matters.

23 Entire Agreement

The terms herein contained together with the contents of the schedules constitute the complete Agreement between the Partners with respect to commissioning and supersede all previous communications, representations, understandings and agreement and any representation, promise or condition not incorporated herein shall not be binding on any Partner.

24 No Partnership or Agency

Nothing in this Agreement shall create or be deemed to create a legal partnership or the relationship of employer and employee or agent and principal between the Parties.

25 Invalidity and Severability

If any Clause or part of this Agreement is found by any court tribunal administrative body or authority of competent jurisdiction to be illegal invalid or unenforceable then that provision will to the extent required be severed from this Agreement and will be ineffective without as far as is possible modifying any other Clause or part of this Agreement and this will not affect any other provisions of this Agreement which will remain in full force and effect.

26 Counterparts

This Agreement may be executed in any number of counterparts or duplicates, each of which shall be an original, and such counterparts or duplicates shall together constitute one and the same agreement.

27 Notice

All formal Notices relating to this Agreement shall be given by hand, pre-paid first class post (or in accordance with the Postal Services Act 2000 if applicable) or facsimile transmission confirmed by pre-paid letter to the addressee at the address given below or such other address as the addressee shall have for the time being notified to the other Party giving the notice and such notice shall be deemed to have been delivered either upon delivery if by hand or if by letter at the expiration of forty eight (48) hours after posting or if by facsimile, upon receipt.

28 For the purposes of this agreement , the address of each Party shall be:

Council:
Chief Executive
Stockport Metropolitan Borough Council
Town Hall
Stockport
SK1 3XE

Clinical Commissioning Group:
Chief Clinical Officer
Stockport Clinical Commissioning Group
Regent House
Stockport
SK4 1BS

29 Force Majeure

Neither Party will be liable to the other for any delay in or failure to perform its obligations as a result of any cause beyond its reasonable control, including fire, natural disaster, flood shortage or delay of power, fuel or transport.

30 Termination

30.1 This agreement will commence on 1 April 2016 and run for one year. Thereafter it can be extended on a year to year basis at the parties' discretion and agreement for a maximum period of seven years.

30.2 This Agreement shall terminate upon the effluxion of time except where Clause 30.1 applies or the agreement is otherwise renewed on review by the parties.

30.3 In the event of dispute or disagreement relating to the terms and conditions of this Agreement, which cannot be resolved under this Agreement, then either Party may, by service of 6 months' notice in writing upon the other Party, terminate this Agreement.

30.4 In the event that the Agreement terminates, responsibility for the CCG's Functions exercised under the Agreement will be returned to the CCG and responsibility for the Council's Functions exercised under the Agreement will be returned to the Council.

30.5 Either Party may terminate the Agreement at any time with immediate effect in the event that:

(i) There is a change in law that materially affects the Partnership Arrangements made pursuant to this Agreement under the Regulations or renders performance of any Party's obligations (or the obligations of any other party towards that Party) ultra vires.

(ii) One of the parties is in material breach of its obligations under this Agreement, provided that where the breach is remediable, the non-defaulting Party shall require the defaulting Party to remedy the breach and if the defaulting Party so remedies the breach within one month, such breach shall not give rise to a right to terminate the agreement.

30.6 In the event of immediate termination of the agreement the Pooled funds, including underspends and overspends shall be returned to the Parties based on proportions of contributions to the Pool. In the event of assets being purchased from the pool, the Parties will provide proposals to the HCICB for how these will be dealt with prior to the termination of the agreement. If these proposals cannot be agreed that Parties will refer to the dispute procedure at Clause 10.7.

30.7 Termination of the Agreement shall be without prejudice to the rights, duties and liabilities of the Parties or any of them that have accrued prior to termination.

31. Transferability of agreement

In the event that any individual role or statutory function of any party that is a fundamental requirement for the effectiveness of this agreement shall be transferred to another organisation then:

31.1 The remaining Parties shall first seek to negotiate a continuation of this agreement with that organisation and if that shall not prove possible within a reasonable period (to be agreed between the Parties) then this agreement will be deemed to have ended due to supervening impossibility of performance.

31.2 Should either Party cease to exist or cease to be responsible for the defined functions then subject to any applicable ministerial direction or delegated legislation this agreement shall be deemed to continue with any other organisation that takes over substantially all its role or statutory function with the Stockport MBC borough boundaries.

Schedule Two

Pooled Budgets for 2016/17

Council

Supporting Adults Portfolio

Description	Spending / Budget Plan 2016/17 (£000)
Integrated Locality Service	24,710
Stability Services	4,652
Former YPD - Unallocated	384
Learning Disabilities	23,798
Mental Health	5,889
Strategy & Performance	949
Prevention	3,347
Allocation from contingencies / Other Adjustments	3,058
Total	**66,787**

Independence & Wellbeing Portfolio

Description	Spending / Budget Plan 2016/17 (£000)
Public Health Grant	16,488
Health & Wellbeing	1,461
Total	**17,949**

Summary

Description	Spending / Budget Plan 2016/17 (£000)
Supporting Adults Portfolio	66,787
Independence & Wellbeing Portfolio	17,949
Total	**84,736**

Pooled Budget: SMBC Spending / Budget Plan for 2016/17	£000
Supporting Adults Portfolio	
Integrated Locality Service	
Net residential & nursing	17,368
Non residential costs	16,574
Non residential income	(4,935)
Deferred income	(1,200)
CHC Income	(107)
Assessment staff	3,745
Extra Care Housing	915
Preventative Services	234
Miscellaneous	68
Recharge to BCF	(10,019)
Non Acute - Reablement	2,067
	24,710
Stability Services	
REaCH	2,358
Contact Centre	34
Equipment	329
Equipment Staff	795
Recharge to BCF	(1,957)
Non Acute - Intermediate Care	2,032
Equipment Service	921
Telecare	140
	4,652
Former YPD - Unallocated	
Tenancies	384
	384
Learning Disabilities	
Internal Tenancies	8,941
LDRC	195
External Tenancies	3,953
Purchasing Res & Nursing	4,448
Purchasing Non residential	7,579
CHC Income	(843)
Assessment Staff	696
Health Staff	1,016
Miscellaneous	131
Other income	(1,818)
Recharge to BCF	(500)
	23,798

Mental Health	
Purchasing	3,133
Staff	1,869
Preventative Services	114
Miscellaneous	71
Drug & Alcohol	418
Mental Health	284
	5,889
Strategy & Performance	
Information Management	1,034
Modernisation	712
Divisional Management	(2,814)
Day Care Services	2,111
Miscellaneous	(310)
Out of Hours	216
	949
Prevention	
Preventative Services	3,347
	3,347
Contingency / other adjustments	
Contingency / other adjustments	4,662
Contingency / Other Adjustments included in service areas above	(1,604)
	3,058
Total - Supporting Adults Portfolio	**66,787**

Independence & Wellbeing Portfolio	
Public Health	
Drug & Alcohol	2,848
Staffing & Programme Management	3,559
Intelligence	8
CYP	5,779
Mental Wellbeing	100
Healthcare	151
Sexual Health	2,512
Lifestyles	1,186
Communities	213
Health Protection	29
Older People	90
Physical Activity	13
	16,488
Health & Wellbeing	
Health Policy	316
Health Policy Grants	99
Safeguarding Adults	905
Contingency / other adjustments not included above	141
	1,461
Total - Independence & Wellbeing Portfolio	**17,949**
Total	**84,736**

Clinical Commissioning Group

Area of Expenditure	Existing Pooled Budget 15/16	Additional +65's based on 15/16 outturn	Total Proposed Pooled Budget based on 15/16 contract values and prices
	£000	£000	£000
Stockport FT (Acute & Community)	1,257	72,125	73,382
Pennine Care	1,300	6,142	7,442
GP	2,475	388	2,863
SMBC	18,392	2,541	20,933
MCP Providers	**23,424**	**81,196**	**104,620**
Independent Hosp	0	8,404	8,404
NHS Trusts	0	24,102	24,102
Care Homes / Domiciliary	600	6,698	7,298
Mastercall	0	1,295	1,295
Choice Providers	**600**	**40,499**	**41,099**
Hospices	0	815	815
Other	0	0	0
3rd SECTOR	520	102	622
Hospices & 3rd Sector	**520**	**917**	**1,437**
Other	**258**	**0**	**258**
Grand Total	**24,802**	**122,612**	**147,414**

Stockport FT - Acute	A&E	Elective Admissions	Out Patients	Urgent Admissions	Other	Total
	£000	£000	£000	£000	£000	£000
Accident & Emergency	2,818	0	0	392	26	3,236
Medicine	0	1,429	3,585	28,351	389	33,754
Surgery	0	4,241	3,169	3,461	122	10,993
Trauma & Orthopaedics	0	4,534	1,047	3,204	44	8,829
Other Specialties	0	1,162	635	9	467	2,273
ENT	0	389	591	105	13	1,098
Obstetrics	0	0	2	0	0	2
Ophthalmology	0	1,271	1,300	10	44	2,625
TOTAL	**2,818**	**13,026**	**10,329**	**35,532**	**1,105**	**62,810**

Stockport FT - Community Services	Total
	£000
Community Rehab	635
Continence Nurses	387
District Nursing	5,120
Nutrition & Diabetics	153
Orthotics	148
Palliative Care	1,104
Podiatry	1,095
Primary Care Physiotherapy	286
Tier 2 Services	896
Tissue Viability	237
Wheelchair Service	372
Other Community	139
Grand Total	**10,572**

Schedule 4

Conflicts of Interest Principles

Schedule 5

Governance Diagram

Appendix Three

Schedule Three

Health and Care Integrated Commissioning Board – Governance Specification

1. Overview

1.1 The name of the Board is the 'Health and Care Integrated Commissioning Board'

1.2 The Board shall discharge and exercise functions on behalf of NHS Stockport Clinical Commissioning Group and Stockport Metropolitan Borough Council insofar as they relate to the Section 75 Agreement entered into by both organisations.

1.3 The objectives of the Integrated Commissioning arrangements are outlined in Section 8.4 of the Section 75 Agreement.

1.4 The mutual responsibilities of both organisations are outlined in Section 8.5 of the Agreement.

1.5 The additional functions and powers to be delegated and exercised through the Board are outlined in Section 8.8 of the Agreement.

1.6 The Section 75 agreement also outlines the arrangements for monitoring and review of commissioning arrangements in Section 8.7

2. Schedule Purpose

2.1 This Schedule provides the governance framework in which the Health and Care Integrated Commissioning Board will exercise its functions.

2.2 The Procedure Rules govern the conduct of meetings of the Health and Care Integrated Commissioning Board and, except where expressly stated otherwise, take precedence over each organisation's existing Constitutional provisions.

2.3 The Health and Care Integrated Commissioning Board must seek the approval of both organisations to vary its Procedure Rules.

3. Membership

3.1 There will be six members of the Health and Care Integrated Commissioning Board, three appointed from each organisation.

3.2 For the Council the appointees will be Executive Councillors nominated by the Executive.

3.3 For the Clinical Commissioning Group the appointees will be Governing Body Members nominated by the Governing Body.

3.4 No appointee's membership will extend beyond their appointment or contract term with their respective organisation.

3.5 Membership will be reviewed annually by each organisation.

3.6 In addition to the Members of the Board, each organisation will nominate relevant Management Representatives who will act as advisors in support of the Health and Care Integrated Commissioning Board's work.

3.7 Any nominees of each respective organisation are governed by the provisions of their own organisation's Codes and Protocols.

4. Quorum

4.1 The quorum for a meeting of the Board shall be at least two members from each organisation.

5. Substitutions

5.1 Continuity of attendance at the Health and Care Integrated Commissioning Board is strongly encouraged.

5.2 Where nominated Members are unable to attend, each organisation will utilise existing mechanisms for substitution as laid down in their own Constitution.

6. Chair

6.1 Annually the Health and Care Integrated Commissioning Board will elect a Chair and Vice-Chair.

7. Leaving the Health and Care Integrated Commissioning Board

7.1 A member of the Board shall cease to hold office if:

7.1.1 He or she notifies the Board of a wish to resign;
7.1.2 He or she ceases to be an Executive Councillor of the Council or a member / employee of the CCG which appointed him or her
7.1.3 The CCG or the Council notifies the Board of their removal.

8. Interests of Board Members

8.1 A separate Conflicts of Interest Policy will be included as part of a separate schedule to the Section 75 Agreement.

9. Access to Information

9.1 The Health and Care Integrated Commissioning Board will hold its meetings in public unless considering information classified as 'exempt' or 'confidential' under Access to Information legislation or specific requirements of each organisation's Constitution.

9.2 The agendas, reports and minutes for meetings of the Health and Care Integrated Commissioning Board will be published on the websites of both organisations in accordance with each organisation's requirements

9.3 The Chair shall have discretion to regulate the behaviour of all members of the public and press who attend meetings in the interests of the efficient conduct of the meeting.

9.4 The conduct of the meeting is at the discretion of the Chair.

10. Sub-Committees

10.1 The Health and Care Integrated Commissioning Board may establish Sub-Committees and informal Working Groups to undertake elements of its work if required.

11. Administration

11.1 Organisational and secretarial support for the Board will be provided on a basis to be agreed by the organisations.

12. Meeting Frequency, Timing and Location

12.1 The Health and Care Integrated Commissioning Board will meet a minimum of four times a year.

12.2 Dates of meetings will be agreed a year in advance and incorporated into the Meetings Calendars of both organisations.

12.3 Consideration will be given to the timing and location of the meetings, recognising and reflecting the differing preferences and requirements of each organisation.

13. Agenda Management Processes

13.1 All prospective items of business for the Health and Care Integrated Commissioning Board shall be agreed by the Chair of the Board following consultation with the Director of Integrated Commissioning and the Lead Finance Officer.

13.2 At least five clear days in advance of a meeting, the responsible Secretary to the Board will arrange for publication of the papers on the pages of each organisation's website and for papers to be distributed to all Members of the Board and to any relevant supporting officers.

13.3 Any additional notices required to be served on any member of the Board shall be in writing and served by the Secretary of the Board either through electronic means or via post to their nominated address.

13.4 The minutes of the Board meeting will be published no later than X days after the meeting.

14. Business to be Transacted

14.1 Standing items for each meeting of the Health and Care Integrated Commissioning Board will include the following;

- Apologies for absence
- Declarations of Interest
- Public Questions to be submitted no later than 24 hours prior to the meeting
- Minutes of the last meeting
- Substantive items for consideration

14.2 The Chair may vary the order of business and take urgent items as specified subject to them meeting the requirements as outlined in the urgency procedure.

14.3 The Director of Integrated Commissioning and the Lead Finance Officer, and/or relevant lead commissioners and budget holders, will report to each meeting of the Health and Care Integrated Commissioning Board on their areas of respective responsibility.

14.4 In addition, nominated officers will provide finance and performance reports in a format determined by the Board on the use of pooled appropriate non-pooled resources and on commissioning activity.

15. Urgency Procedure

15.1 An item of business must not be considered at a meeting of the Health and Care Integrated Commissioning Board unless:

(a) A copy of the agenda including the item is displayed on the organisation's websites at least five clear days before the meeting:

(b) Where the meeting is convened at shorter notice from time to time or:

(c) By reason of special circumstances which shall be specified in the minutes that the Chair is of the opinion that the item should be considered at the meeting as a matter of urgency:

15.2 'Special circumstances' justifying an item being considered as a matter of urgency will relate to both why the decision could not be made at a meeting allowing the five clear days for publication and circulation of reports to Members and via the organisation's websites for public inspection.

16. Cancellation / Addition of Meetings

16.1 Meetings of the Health and Care Integrated Commissioning Board may, after consultation with the Chair be cancelled if there is insufficient business to transact or some other appropriate reason warranting cancellation.

16.2 The date of meetings may be varied after consultation with the Chair if it is required to aid the efficient transaction of business.

16.3 Additional meetings of the Health and Care Integrated Commissioning Board can be called subject to meeting the requirements of the Governance Schedule following consultation with the Chair.

17. Voting

17.1 In the event that matters cannot be determined by the Health and Care Integrated Commissioning Board through reaching consensus, each Member will be entitled to one vote.

17.2 All decisions of the Health and Care Integrated Commissioning Board will be approved on the basis of a simple majority voting in favour.

17.3 Where there is an equality of votes, the Members of the Board retain the right to request that the matter be referred back to the individual organisations for further consideration prior to the Chair having the right to exercise a second and casting vote

17.4 Where a matter is referred back to the individual organisations, timescales for reporting back to the Health and Care Integrated Commissioning Board must be agreed.

18. Minutes

18.1 At the next suitable meeting of the Health and Care Integrated Commissioning Board the Chair will move a motion that the minutes of the previous meeting be agreed as a correct record. The meeting may only consider the accuracy of the minutes.

18.2 Once agreed the Chair will sign the minutes.

19. Parties Existing Constitutional Requirements

19.1 No amendment may be made to this Schedule which would conflict with the legislative requirements or existing Standing Orders of either organisation.

19.2 Any amendments should be agreed by each organisation's existing Governance Structures (CCG Governing Body and Council Executive)

19.3 Each organisation is responsible for ensuring that the decisions of the Health and Care Integrated Commissioning Board are subject to the wider statutory and legal requirements of their organisations governance structures.

19.4 Decisions made by the Health and Care Integrated Commissioning Board will be subject to the Scrutiny and Call-In provisions as outlined in the Council's Constitution. This will include the relevant scrutiny committee(s) being given the opportunity to see and comment upon substantive reports before they are considered by the Board.

19.5 The right to see and comment upon substantive reports before they are considered by the Board will also be extended to the relevant Committees of the CCG's Governing Body.

20. Review Processes

20.1 The operation of the Health and Care Integrated Commissioning Board and its governance arrangements shall be subject to annual review in a format to be determined by the Board.

FINAL VERSION

MEMORANDUM OF UNDERSTANDING BETWEEN STOCKPORT TOGETHER PROVIDER MANAGEMENT BOARD PARTNERS FOR THE DEVELOPMENT OF A SHADOW MULTI-SPECIALTY COMMUNITY PROVIDER

1. Status and Purpose of the Memorandum of Understanding

1.1 This memorandum of understanding is made between the organisations set out below to express a convergence of will between the parties and the agreement of a common line of action. It is intended to set out how the parties will work together to form a Shadow Multi-Specialty Community Provider.

1.2 Provider organisations, to be together referred to in this Memorandum of Understanding as ''Provider participants'':

Stockport NHS Foundation Trust
Pennine Care NHS Foundation Trust
Stockport Metropolitan Borough Council
Viaduct Health

1.3 The provider participants are together referred to a 'we', 'us' and 'our' as the context requires. 'Participant' means any one of Us.

1.4 This memorandum of understanding is supported by a letter of intent from NHS Stockport Clinical Commissioning Group explaining how it will enable, facilitate and support the concept of the Shadow Multi-Specialty Community Provider.

2. Term

2.1 This memorandum of understanding will come into force on 1st April 2016 and will expire on 31st March 2017.

3. Background

3.1 The Provider Participants are providers of NHS-funded healthcare and social care services to the people who live in Stockport. For the purposes of this

agreement this applies to all patients registered with a Stockport GP for health services and all people resident within Stockport for social care services and the public health function.

3.2 This agreement is an integral part of our commitment, as participants in Stockport Together, to promote integrated services that deliver personalised care within an agreed cost base.

The full objectives of the Memorandum of Understanding are set out below.

4. Shadow Multi-specialty Community Provider objectives for 2016/17

4.1 The overall aim of the Shadow Multi-specialty Community Provider is to work in collaboration to innovate, improve quality, manage costs across the system and deliver practitioner led solutions. As Provider participants we will work to reduce hospital admissions and attendances and shift provision of care to a neighbourhood based approach. We will also start to instigate conversations with individuals and communities in a move towards being equal partners and having a different relationship with services.

4.2 To deliver this aim the Shadow Multi-specialty Community Provider will develop a work programme with two main objectives:

4.2.1 To support and align with the design entities within the Stockport Together programme and then take the approved business cases through to delivery

4.2.2 To make decisions on and accelerate change around current operational issues using a practitioner led approach

4.3 Some initial pieces of work around these objectives will include:

a. Aligning prescribing and achieving cost savings in medicines management
b. Operationalising a neighbourhood model that is practitioner driven and owned
c. Developing a Cross Provider Operational Winter Plan and put forward joint plans to the Systems Resilience Group
d. Designing and implementing a programme of Rapid Improvement Cycles
e. Designing an integrated leadership structure by end of Q1 to be in place by Q4

f. Developing options for and deciding on the preferred option to establish an MCP and move towards full model for 17/18
g. Working together to flexibly absorb growth across providers

5. Shadow Multi-specialty Community Provider purpose and remit

5.1 A Shadow Multi-speciality Community Provider is part of Stockport's Vanguard status; to develop and test out a replicable MCP as part of the New Models of Care set out in the Five Year Forward View. This agreement is formed in the context of Stockport's Locality Plan developed as part of Devolution Manchester.

5.2 Delivering benefits to the people of Stockport is key within this new provider form. The Vision Decision and Draft Design Decision Documents set out the detail of the benefits which will be delivered through Stockport Together and the Shadow Multi-specialty Community Provider. The high level benefits to people include;

- Healthy life expectancy in the most deprived areas improves so that mortality rates are 15% lower in five years
- The healthy life expectancy across Stockport to be at or above the national average
- To narrow the gap in life expectancy across the borough from 11 years to 9 years
- Individuals to have more healthy years as well as longer lives
- To reduce the years of life lost amenable to health care
- Reduction in mortality from preventable causes
- Individuals to have increased quality of life
- Fewer people in Stockport making risky or unhealthy lifestyles choices
- More people in Stockport making active and positive choices to improve their health and wellbeing Increased identification of people with needs
- Demonstrable system which is geared to enable self-care (optimise, maintain and sustain)
- More community capacity and increased empowerment
- More individuals to be self managing effectively
- Improved experience of joined up/ integrated working (staff and individuals)
- Improved experience of care

- Reduced emergency attendance/admissions for people on a Planned/Proactive Care pathway
- Reduction in A&E attendances and non-elective admissions
- Reduced reliance on ‘acute’-based Planned Care
- Reduction in out-patients and elective treatment
- To be 'best in class' for long-term condition outcomes

5.3 Provider Participants will work closely together to ensure that the services provided within the Shadow Multi-speciality Community Provider are person centred and the organisational blockers that may have previously prevented this from happening are removed.

5.4 We have agreed to form a Shadow Multi-specialty Community Provider to progress the work of Stockport Together and start to work together to establish and improve a financial, governance and contractual framework for the delivery of integrated health and social care in Stockport. Within the parameters of the Provider Management Board we will take decisions to accelerate change in the system and take a problem solving approach to issues. Provider participants will work together to recommend collective solutions to the Design Authority.

5.5 This Memorandum of Understanding sets out the key terms we have agreed with each other. Our remit is to work across all age ranges from age 18+ utilising our collective provider expenditure. One element of this remit is our commitment is to the over 65 age group and the agreed outcomes and indicators for the services contained within the Section 75 Partnership Agreement for the creation of a pooled fund and integrated commissioning arrangements for Health and Social Care Services in Stockport.

6. Shadow Multi-specialty Community Provider principles

6.1 Our commitment to working together

6.1.1 We recognise that the successful development of the MCP in shadow form will require strong relationships and the creation of an environment of trust, collaboration and innovation.

6.1.2 All provider participants recognise the importance of good formal and informal working relations with shared responsibility, while respecting differences, building trust and mutual respect, openness and honesty.

6.1.3 We will make decisions on the basis of our shared values and common purpose; delivering improved population health and care through our Shadow Multi-Specialty Community Provider and its alignment to the Stockport Locality Plan and our Vanguard status.

6.1.4 We will work collaboratively with the Integrated Commissioning Board to provide them with assurance around planned changes, system outcomes, delivery, quality and safety. All provider participants will work together to provide innovative and integrated solutions which meet the needs of the population of Stockport.

6.2 Our commitment to our services and our staff

6.2.1 Each of us will perform our respective obligations under our individual contracts with our commissioners. We acknowledge that the overall quality of our services will be determined by our collective performance and we will work together to discuss how we optimise this performance and share risk and rewards.

6.2.2 The staff working within the Shadow Multi-specialty Community Provider will retain their employment with their existing employer under their existing terms and conditions. The policies and procedures from each organisation continue to apply.

6.2.3 Our approach will be to deliver a practitioner led model with all practitioners having an equitable voice in developments. General practice will lead the clinical direction within the neighbourhoods via Viaduct Health.

6.2.4 Over the life of the Shadow MCP we will start to alter the provision of services based on the most effective use of staff, premises and resources and agree a full MCP form for 2017/18.

7. Shadow Multi-specialty Community Provider governance

7.1 We must communicate with each other and all relevant staff in a clear, direct and timely manner to optimise the ability for each of us, the Provider Management Board and Provider Senior Leadership Team to make effective and timely decisions to achieve the shadow MCP objectives.

7.2 We agree to be bound by the actions and decisions of the Provider Management Board carried out in accordance with this agreement. The Provider Management Board is constituted of:

Director of People, Stockport MBC
Director of Adult Social Care, Stockport MBC
Chief Operating Officer/Deputy Chief Executive, Stockport NHS Foundation Trust
Medical Director, Pennine Care NHS Foundation Trust
Chief Officer, Viaduct Health

7.3 The Terms of reference for the Provider Management Board are as follows;

- Leads the development of MCP – Form, governance, establishment as a legal entity
- Manages the delivery of a scoped and costed provider model
- Manages the governance, planning, design, resource deployment to deliver an agreed Provider Form
- Makes recommendations to the Exec Board on the Provider Form
- Co-designs the models of care programmes in collaboration with Partner organisations; the Commissioning Board and the Enablers to ensure there is system wide consensus:
- Collates recommendations to the Design Entities and Exec Board on the scope, scale and detail of the design
- Maintains clinical and professional ownership of the models of care
- Provides subject matter expertise
- Coordinates the capacity and capability to design and deliver the models of care programmes
- Coordinates time-limited activities (programme and project) to design models of care to the point of implementation
- Utilises business intelligence and analysis for process capture; and quantification and process change quantification.

- Leads the implementation of the new services, tracking detailed performance and delivery of KPIs and benefits.

7.4 The Provider Management Board is the group responsible for directing and leading the Shadow MCP

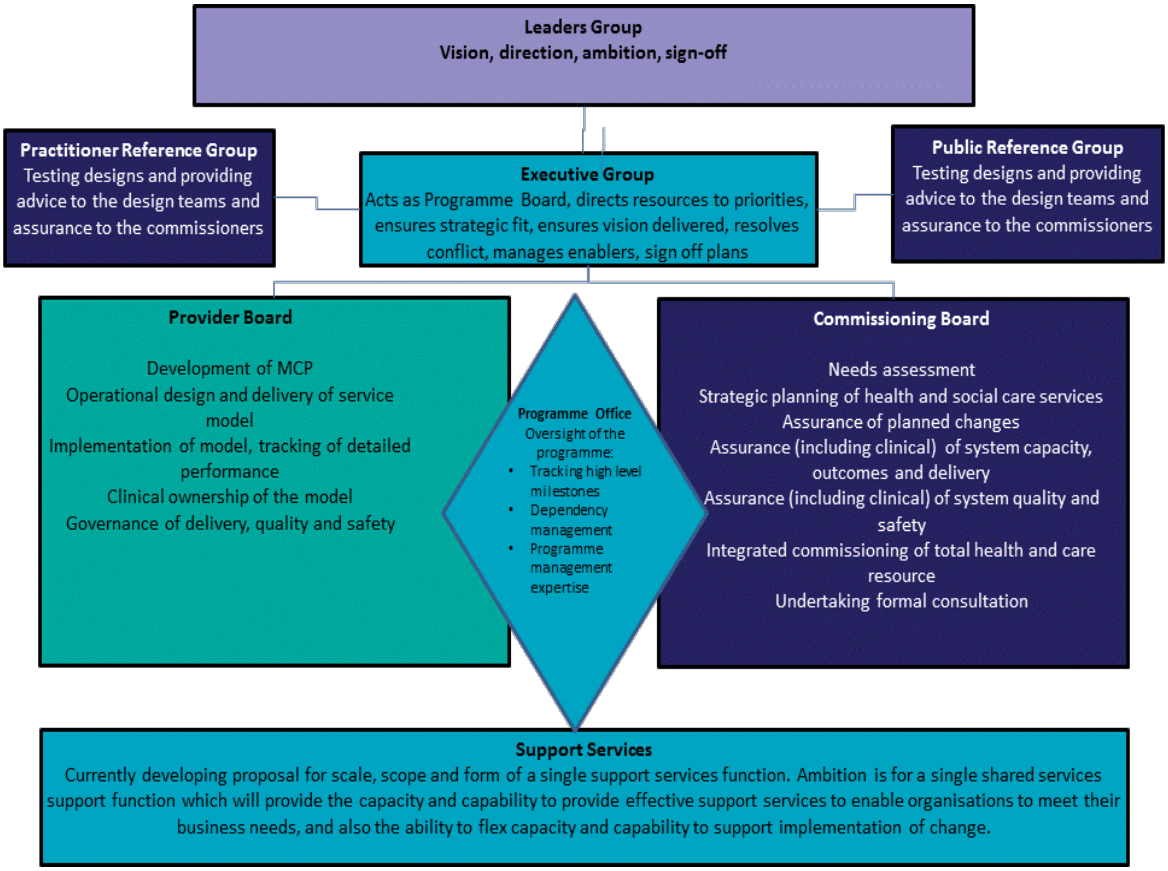
7.5 The Provider Senior Leadership Team is responsible for the implementation of the MCP model going forward and implementation of operational governance.

7.6 Members of the Provider Management Board are responsible for describing the decisions and scenarios in which they have the delegated authority to make a decision on behalf of their organisation and the decisions which they will require the agreement of their organisation's governing body (e.g. Board of Directors, Council Executive).

7.7 The Provider Management Board will be responsible for:

- The development of the full Multi-specialty Community Provider for 2017/18
- Operational design and delivery of the service model
- Implementation of the model, tracking of detailed performance
- Clinical ownership of the model
- Governance of delivery, quality and safety

7.8 In Q1 of 2016/17 the Provider Management Board will develop and agree a new leadership structure which will be in place before 31st March 2017.



8. Risk management

8.1 Service risk management

8.1.1 All provider participants covered by this agreement recognise that they remain accountable for the management of risks within their services in 2016/17 but will work together to identify and resolve risks together.

8.1.2 It is acknowledged that by starting to integrate services into a Shadow Multi-Specialty Community Provider form there is an inherent risk of dis-integrating some services from other services that they may have been integrated with previously. All provider participants commit to working together to understand and mitigate these risks.

8.2 Financial risk management

8.2.1 During the course of this agreement the partner organisations intend to:

a) Agree a process for sharing and mitigating financial risks in the system that avoids destabilising individual organisations
b) Agree a process for gain share for benefits that are not modelled as part of the Stockport Together design process
c) Develop a process of how to manage financial accountability and sustainability as the organisations move to a full Multi-Specialty Community Provider
d) Plan a collaborative response to operational system financial pressures in 2016/17
e) Work with commissioners to develop a plan for financial sustainability from 2017/18

9. Services in scope for this agreement

9.1 Provider participants have put forward a number of services to be considered 'in scope' and 'in view' of the Shadow Multi-specialty Community Provider. In scope are the services which will be directly affected and transformed via the Shadow Multi-specialty Community Provider in 2016/17 and in view services are those which will be impacted on as a result of changes agreed via the Shadow Multi-specialty Community Provider. Provider participants will ensure that the interface between the in scope and in view services is carefully managed.

9.2 For 2016/17, services 'in scope' consist of:

- Adult community nursing services
- Some adult specialist nursing services
- Adult community therapy services
- Adult social care services
- Intermediate tier services across both health and social care
- Older people's community mental health services

9.3 For 2016/17, services 'in view' consist of:

- Outpatient services
- Diagnostics
- Emergency Department

- Acute Medicine
- Frail Elderly Medicine
- Medicines Optimisation
- Primary Care Development

9.4 These services are detailed in appendix A and appendix B. Services not listed in appendix A and appendix B are considered 'out of scope' for the Shadow Multi-specialty Community Provider in 2016/17. Services for children and young people are considered out of the scope of this agreement in 2016/17.

9.5 Further work will be undertaken in year to agree the scope for services to be included in a full Multi-specialty Community Provider from 2017/18.

10. Key performance indicators

10.1 The provider participants in this Memorandum of Understanding remain responsible for delivering their statutory obligations and their own key performance indicators as defined by their own organisation, commissioners and regulatory bodies. All participants are committed, however, to work together to achieve these key performance indicators on a system basis.

10.2 During Q1 of 2016/17 the Provider Participants will sign off a performance and assurance framework for the current year and commence work to develop a future framework for a full Multi-specialty Community Provider.

11. Agreement and authorisation

On behalf of our constituent organisations we agree to the terms of this Memorandum of Understanding:

Signature		**Date**
	For and behalf of Stockport Metropolitan Borough Council	
	For and behalf of Stockport NHS Foundation Trust	
	For and behalf of Pennine Care NHS Foundation Trust	
	For and behalf of Viaduct Health	