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 11.00am on 9 December 2015

	Agenda item	Report	Action	Indicative Timings	Lead
1	Apologies	Verbal	To receive and note	11.00	J Crombleholme
2	Declarations of Interest	Verbal	To receive and note		
3	Approval of the draft Minutes of the meeting held on 11 November 2015	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 - Stoptober	Video		11.15	J Crombleholme
7.	Corporate Performance Reports a) Strategic Impact Report b) Finance Report c) Performance Report d) Quality Report	Written Reports	To receive, assure and note.	11.25	 Tim Ryley Gary Jones Gaynor Mullins Mark Chidgey
8.	Locality Chairs' Update	Verbal Report	To receive and note	11.50	Locality Chairs
9.	Report of the Chair	Verbal	To receive and note	12.00	J Crombleholme
10.	Report of the Chief Operating Officer to include the following: • Mid-Year Conference • Update re integrated	Written Report	To discuss and approve	12.10	G Mullins

	commissioning • Update re Stockport Together • Governance Review Implementation and Constitutional Changes				
11.	Report of the Chief Clinical Officer	Verbal Report	To Note	12:20	
12.	Reports from Committees • Clinical Policy Committee • QIPP Committee	Written reports	To note	12:30	Vicci Owen Smith Gaynor Mullins
13.	Any Other Business	Verbal		12:45	J Crombleholme
	Date, Time and Venue of Next meeting The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 13 January 2016 at 10:00 at Regent House, Heaton Lane, Stockport, SK4 1BS. Potential agenda items should be notified to stoccg.gb@nhs.net by 20 December 2015				

NHS Stockport Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT REGENT HOUSE, STOCKPORT
ON WEDNESDAY 11 NOVEMBER 2015
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 V Mehta	Clinical Director for General Practice Development
Dr P Carne	Locality Chair: Cheadle and Bramhall
Dr C Briggs	Clinical Director for Quality and Provider Management
Mr G Jones	Chief Finance Officer
Mrs K Richardson	Nurse Member
Dr A Johnson	Locality Chair: Marpeth and Werneth (Vice-Chair)
Dr R Gill	Chief Clinical Officer
Dr V Owen Smith	Clinical Director for Public Health
Dr A Firth	Locality Vice-Chair : Stepping Hill and Victoria

IN ATTENDANCE

Mr M Chidgey	Director of Quality and Provider Management
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 Gaskell	Lead Nurse – Safeguarding

APOLOGIES

Dr L Hardern	Locality Chair: Stepping Hill and Victoria
Dr D Jones	Director of Service Reform

123/15 APOLOGIES

Apologies were received from L Hardern and D Jones.

124/15 DECLARATIONS OF INTEREST

It was acknowledged the Item 7 – Proactive Care would impact on all Governing Body Members employed as General Practitioners. The interest was however not material and therefore did not need to be formally declared.

125/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 9 SEPTEMBER

The minutes of the meeting held on 9 September 2015 were approved as a correct record subject to the following amendments:

The attendance list be corrected to read: V Owen Smith

Page 5, sentence be amended to read 'M Chidgey confirmed that all providers were being equally monitored and reasons for overspend related to increased referrals.'

126/15 ACTIONS ARISING

The following updates on actions were provided:

- 08/07/15 Strategic Impact Report – Monthly provision of information to practices was now underway following a slight delay whilst data quality issues had been resolved. The overall development of the information provided as part of the report would remain under review and Locality Chairs would be provided with information for their areas in due course. It was noted that Practices had expressed willingness to share data within Neighbourhoods and Localities to enable benchmarking which would need to be incorporated into future data sharing agreements.
- 08/07/15 – Performance Report – The letter from the Systems Resilience Group would be discussed elsewhere on the agenda. The action could be removed.
- 09/09/15 – Planned Care Update – C Briggs explained that pace had picked up as part of the work being carried out through the Planned Care Board and the action could be removed.
- 09/09/15 – Performance Report – this action could be removed.
- 09/09/15 – Chief Operating Officers Report – Discussions were ongoing in relation to the Council's Budget Proposals for Children's and Adults Services. A meeting between the CCG and Children's Services had taken place with the Adults Services meeting date yet to be confirmed. The action could be removed and would be dealt with by the CCG's QIPP Committee.
- 09/09/15 Governance Review – this action could be removed.

127/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

Two items of any other business were highlighted as follows:

- Council Information Advice and Guidance Services
- Healthier Together Update

128/15 PATIENT STORY

The Governing Body heard a patient story from a lady in her 70s who had been diagnosed with breast cancer. She shared her experiences of the care pathway from the initial investigation, through the referrals process and to treatment. She outlined the support and information she had been provided with by all clinicians throughout the process and in particular praised nurses for their personal approach to care. She stressed the importance of those over 70 taking advantage of breast screening every 3 years and the positive outcome for her health as a result of early diagnosis.

In responding to the patient story, the Governing Body acknowledged the importance of patients feelings as part of treatment pathways and the importance of women over 70 years of age taking advantage of breast screening every 3 years. It was noted that seeking permission to play the video in GP Practices would seek to further remind people of the optional screening programme. A Johnson confirmed that Macclesfield Hospital was the designated specialist centre for breast cancer screening and patients were automatically referred there.

A visiting screening van would be located in the Brinnington area in the near future to try and increase screening uptake rates within the area which were significantly lower than other areas of Stockport. M Chidgey explained that the commissioning of the breast cancer pathway was split between 3 commissioners and as such, there was the potential for fragmentation although this had not been evidence in the patient story.

Resolved: That the Governing Body:

1. Requests that thanks be passed onto the patient for sharing their story along with a request that the video be shared and made available to GP practices to promote screening for over 70s.

129/15 PROACTIVE CARE UPDATE

V Mehta provided an overview of the activity being undertaken within the Proactive Care Programme including work with Care Homes, development of the neighbourhoods and the re-shaping of the intermediate tier. He highlighted the element of the report which was seeking the release of £400,000 of monies within the Primary Care Development budget to provide clinical GP leadership within the locality Multi-Disciplinary Teams to improve engagement and accelerate progress. R Gill explained that this kind of financial investment could contribute to Better Care Fund targets of reducing preventable emergency hospitalisation through better management of complex and long term condition cases. R Roberts noted that learning from the Spain and emerging activities in England supported the benefits of the proposed approach.

G Jones reminded Governing Body members of the CCG's current financial position and the turnaround status with recurrent exceeding the funding allocation received by the organisation. He explained that committing to recurrent spend within these circumstances needed to be scrutinised closely and that other financial support through the Better Care Fund, Stockport Together Programme and Section 75 pooled budget could be explored.

V Mehta explained that the investment supported the longer term sustainability of the Stockport economy and that GP clinical leadership was essential. V Owen Smith noted that the Vanguard monies could provide an opportunity to test the proposed model and assess the benefits as a pilot before committing monies recurrently. She also indicated that the lack of detail about the proposed model for 7 day working made contextual decision making more difficult.

A discussion about the lack of financial detail within the paper was took place, in particular detail about how the money sought would be spent. Board members agreed V Mehta noted that financial detail needed to be clarified but there also needed to be flexibility to utilise any monies across across Stockport to meet locality needs.

G Mullins noted explained that whilst she supported the direction of travel and the evidence that GP leadership would play a key role, she sought clarity about the funding required as part of the wide £4.5m investment in the redevelopment of the system model. R Roberts noted that short term funding would not assist with known recruitment problems in key areas of primary care and that whilst nurse

practitioners would play a key role, GP clinical leadership was required. V Mehta concurred with this view and explained that clinical and risk ownership was needed within the community settings to work collaboratively to prevent avoidable admissions.

C Briggs reminded the Governing Body that the move to commissioning for outcomes and the establishment of the Multi-speciality Community Provider would require more strategic clinical leadership from commissioners and as such, the Governing Body would need to balance that with the required detail to scrutinise decision making.

A Firth highlighted the iterative development of neighbourhood working and the need to have a robust financial underpinning to enable continued development.

T Ryley endorsed the strong view about the need for GP Clinical leadership within the community and suggested that the matter be considered as part of the development of the Stockport Together business case which would be finalised in January / December to cover the whole service redesign. This would be in addition to the second stage of the Value Proposition submission. He explained that to proceed at the current time without further financial detail and the work being incorporated as part of wider Stockport Together thinking may not provide the best financial value and patient impact sought by the CCG. G Jones supported this view and noted that this kind of development could be incorporated as part of essential double running costs funded through the Vanguard Programme and Stockport Together.

The Board concluded their discussion by returning to the CCG's current financial position and the importance of continually seeking to reduce recurrent spend and have total assurance that any decisions regarding investments to save would yield the financial or efficiency based benefits outlined. G Jones reminded the Board of the Turnaround status in which the organisation had been placed. V Mehta outlined the potential risks of not making the investment within the community but accepted that this needed to be balanced alongside the financial challenges of the CCG and the wider health economy in Stockport.

J Crombleholme summarised the discussions of the Governing Body, highlighting the unanimous support for the approach outlined in the report but caveated with an understanding of the CCG's current financial position and future challenges. She highlighted the importance of robust financial scrutiny of the investment of recurrent monies by the CCG and noted the need for these, at a time of immense change through Stockport Together to be set within the wider context of Stockport Together. She noted the clarity from the Governing Body regarding other potential funding opportunities for the scheme. T Ryley noted that the Proactive Care Programme Board would be developing this work which would link through to the wider Stockport Together Business Case.

Resolved: That the Governing Body:

1. Notes the update on the Proactive Care Work.
2. Does not support the request for £400,000 recurrent investment as outlined in the report and requests that the proposal be considered as part of the Stockport Together wider programme and overall Business Case.
3. Notes that the Business Care remains under development and will be considered by the Governing Body in December 2015 / January 2016 for approval.

130/15 STRATEGIC IMPACT REPORT

The Governing Body considered a report which outlined the activity against the CCG's strategic and operational plans. T Ryley explained that it was difficult in terms of the data to make direct links between cause and effect and that there was a lag between activity on the ground and data reporting so highlighted some caution in the interpretation of the data. The report did highlight particular performance as being above plan for GP first outpatient attendances and prescribing and accident and emergency attendances, long-term condition admissions and elective spells being better than plan. He noted that some data quality issues were still being resolved.

With regard to referral management issues, J Greenough suggested implementation of a referral management centre may provide an overall reduction. C Briggs noted that work was under way to look in detail at variation management and support practices to make appropriate referrals. A discussion took place regarding the Consultant Connect package and the importance of ensuring practices had access to accurate data and support to analyse it. In terms of referral management systems and centres, C Briggs noted that the focus needed to be on changing behaviour within primary care. As a result of reductions in consultant to consultant referrals it was noted that there was likely to be an increase in GP referrals.

The Governing Body discussed the continued challenge of trying to work with practices to understand referral variation and the need to enable regular communication between GPs and hospital consultants to ensure pre-referral discussions could take place. This was supported as a direction of travel. Hospital consultants working along GP practices as an additional layer of peer support for referral audits was noted as a positive suggestion which should be progressed. G Mullins reminded the Governing Body that whilst variation was important, there was also a need to work towards overall reductions in referrals given the CCG's challenging financial position. It was noted that a priority project of the CCG, referral variation would be considered at the QIPP Committee in November.

A Johnson noted that continued changes in NICE guidance meant that GPs could not manage many conditions without a referral to a specialist.

C Briggs reminded the Governing Body that the work on referral management needed to be considered as part of wider work across Planned Care and investment balanced in line with the CCG's current financial challenges. In summarising the Board's discussion, concern was noted regarding the variation in referrals across practices and the need to continue to look at ways referral levels could be flat-lined or reduced. It was noted that as part of the GP Development Scheme learning should be continually shared to ensure that work and learning across all areas, in particular which linked to referral management was made available.

Resolved: That Governing Body:

1. Notes the content of the Strategic Impact Report.
2. Notes the importance of ensuring the accuracy of data on which referral variation and management be considered and the need for continued help and support to practices in analysing and understanding their local information.
3. Supports work being undertaken to open up lines of communication between GPs and hospital consultants on referral matters and that an additional layer of peer support for referral audits in GP practices be investigated involving hospital consultants.

131/15 PERFORMANCE REPORT

G Mullins presented the Resilience and Compliance report covering NHS Constitutional Targets for August and September for statutory duty and compliance. She explained that the Quarter One assurance meeting had taken place in early November. The CCG had been given limited assurance on the basis of delivery against those Constitutional Targets shown as red in the report, in particular referral to treatment times and emergency department activity.

The Governing Body considered the letter from the Systems Resilience Group which provided limited assurance in terms of readiness for winter 2015/16 and highlighted the key risks to delivery. It was noted that the 4 hour emergency department target was challenging across the region. She highlighted the inclusion of 6 months complaints information.

Resolved: That the Governing Body note the report.

132/15 FINANCE REPORT (INCLUDING FINANCE ENVIRONMENT CONTROL ASSESSMENT)

The Governing Body considered the current financial and forecast positions of the CCG as at month 6 of the 2015/16 financial year in the new style dashboard reporting approach. G Jones explained that the year to date position showed a figure of £152,000 behind plan which meant an end of year forecast of £1m. Of the £1.75m surplus agreed with NHS England, only £672,000 had been forecasted for the end of the year. As a result of this, the CCG had been placed into financial turnaround and meetings had taken place with NHS England about the next steps arising from this. He noted that the recurrent position of £10.5m impacting in 2016/17 took the financial challenge overall to approximately £20m in that year. It was noted by the Governing Body had the initial financial surplus proposed to NHS England which was not accepted been agreed, the organisation's current financial position would have been forecasting at that level at Month 6.

The CCG's QIPP Committee had been regularly updated on the financial position and Cost Improvement Programmes and had been undertaking work to ensure the data was robust and that clinical thresholds were reviewed in line with the agreed Financial Recovery Plan.

In response to questioning, G Jones explained that the CHC legacy monies would not be returned to the CCG as had been previously anticipated as a decision had been made by NHS England to use them more widely across the system. Representations on the matter had been made by the CCG along with continued emphasis of the distance from the target funding of £10m for Stockport and its implications.

The Governing Body discussed the recent review of the QIPP Committee's activity and the refocussing of the Committee to cover a broader Finance and Performance remit with a view to making its work most robust and clinically focussed. G Mullins reported on the measures taken by the CCG to control discretionary spend and maintain controls over recruitment.

R Gill expressed the importance of continuing to ensure for the patients of Stockport that the CCG received the funding allocation to which it was entitled and the need to communicate the importance of proactive care and healthy lifestyles. The link between funding and GP referrals was noted and in particular the support required by GP Practices from the CCG when having difficult conversations about the appropriateness of referrals.

A discussion took place regarding the content of the Finance Environment Control Assessment and the self-evaluation process by which the document had been completed.

Resolved: That the Governing Body:

1. Notes the financial position for 15/16 which is reporting:- (i) As at Mth 6 a £423k YTD surplus which represents a £452k adverse variance against a plan of £875k (ii) a forecast surplus of £672k which represents a £1,078k underachievement against 15/16 plan of £1.75m.
2. Acknowledges that this forecast position assumes the delivery of £1,582k CIP achievement in returning a £672k surplus position.
3. Acknowledges the significant risk inherent in the delivery of the additional £1,078k savings requirement being taken forward by the QiPP Committee.
4. Notes the additional net risk totalling £1.75m not reflected within the forecast position (Ref – Table 8).
5. Notes that the CCG position reflects the retention of £0.9m performance Fund held in BCF to offset over performance in NEL activity.
6. Notes that the forecast position assumes the return of £1m underspend from the National CHC Risk Pool representing our pro-rata share of national underspend.
7. Notes the additional recurrent cost pressures of £10.5m arising in 15/16 being carried forward into 16/17 which is additional to the £9.4m CIP already planned for 16/17.
8. Approves the draft self-assessment checklist as submitted in August as the final submission.

133/15 QUALITY REPORT

M Chidgey provided a brief summary of the recent work of the Quality and Provider Management Committee including the assurance on the CIP Plans for NHS Stockport Foundation Trust. He noted that a significant focus of the recent meeting had been Safeguarding with those reports being presented to the Governing Body as part of a separate agenda item.

Resolved: That the Governing Body note the report.

134/15 LOCALITY CHAIRS UPDATE

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

Cheadle and Bramhall – P Carne reported that the work with care homes was ongoing and initial activity was proving positive. All practices within the Locality would be moving onto the same clinical system in the coming months and the Neighbourhood Working meetings had been completed. He outlined the different progress being made in Cheadle and Bramhall and the difficulties of working on cross borough issues, particularly outside Greater Manchester.

Marple and Werneth – A Johnson noted that the first neighbourhood meetings had taken place and practices were beginning to focus on moving work forward. Work with Care Homes was also reported as positive.

Stepping Hill and Victoria – A Firth explained that work with Care Homes was positive and that 5 of the 6 neighbourhood meetings had taken place. Engagement with some of the smaller practices and their attendance at meetings had been a focus.

Heatons and Tame Valley – J Higgins reported that relationships with Care Homes had developed well and practices had felt the work to be positive. A focus of the upcoming discussion at the next locality

meeting would be recruitment challenges. He noted there was an appetite for collaboration across the locality and use existing GP skills and specialisms across the area with the aim of sharing knowledge and potentially reducing referrals.

The Governing Body noted the high GP engagement at a recent Masterclass event and the focus on looking to the future and collaborating. V Mehta noted that a number of GP members had commented positively on the CCG's willingness to discuss 7 Day Working following the Annual General Meeting in September 2015.

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

135/15 REPORT OF THE CHAIR

J Crombleholme noted that she had nothing formal to report but explained that she would respond to the letter from the SRG jointly with the Chair of NHS Stockport Foundation Trust's Board.

136/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted the key elements included within the report and in particular the application which had been submitted to move to Level 3 Co-Commissioning. She noted that application had been supported by the NHS England Area Team. In highlighting the financial turnaround, she explained that it was essential that the CCG utilised the external perspective and challenge effectively as part of continued improvements and the review of processes and procedures. She noted that the Quarter 1 assurance meeting with NHS England had recently taken place and the information arising would be shared with Governing Body when available.

She informed Members of the process of revalidation for the CCG's nursing staff and it was highlighted that integrated commissioning arrangements would bring benefits to the process across the whole of the primary care system.

She thanked the team, including T Ryley for the work on Value Proposition which had secured Vanguard investment in Stockport of £3.98m. V Mehta sought confirmation about the activity submitted as part of the Value Proposition which could now not take place as the full amount requested had not been received. T Ryley explained that the main reduction had been due to no monies being secured for capital funding / estates nationally as part of the programme.

The Governing Body was informed that there had been some data reporting issues arising from the Arriva Patient Transport Services Contract.

Resolved: That the Governing Body:

1. Endorses the Co-Commissioning Programme
2. Notes the updates included as part of the report.

137/15 REPORT OF THE CHIEF CLINCIAL OFFICER

R Gill provided an overview of the arrangements for the governance arrangements underpinning Greater Manchester Devolution including the role of the Strategic Partnership Board and the Executive Group. He explained that there were no proposals to change the statutory accountability and funding flows to existing health organisations and local authorities and that the statutory responsibility for Devolution rested with the Greater Manchester Combined Authority (GMCA.)

The governance arrangements were noted to be in shadow and continually evolving, particularly the work with existing regulatory bodies. He outlined the role of the Strategic Plan in guiding the decision making as part of Devolution Governance. The outcome of the comprehensive spending review to be confirmed on 25 November 2015 and the Transformation Fund business case would be a key milestone in the development of the arrangements.

In response to questioning it was noted that the partnership was equal between social care and health as part of the arrangements and providers would be included as part of the Strategic Provider Board. Councillor Pantall noted that it was Stockport Council's intention to nominate the Leader of the Council to sit on the Strategic Partnership Board. V Mehta noted the challenge for individuals nominated to represent their organisations and wider professional groups effectively.

R Gill concluded by confirming that the work on the Strategic Plan had created consensus across Greater Manchester about the need for change and the pace at which it should be achieved and that final confirmation of the arrangements to operate from 1 April 2016 onwards would be required by Governing Body at a future meeting.

Resolved: That the Governing Body:

1. Supports in principle shadow governance arrangements as set out in the report.
2. Notes that the shadow structure will be in place from October 2015 and that the arrangements will be subject to review and development during the shadow period to ensure they are fit for purpose for Devolution in April 2016.
3. Notes that the in principle shadow governance arrangements had also been agreed by the Greater Manchester Combined Authority and Association of Greater Manchester Authorities.

138/15 SAFEGUARDING

C Briggs provided an overview of the reports submitted to the Governing Body covering the area of Safeguarding. She noted that the new accountability and assurance framework provided some ongoing challenges for the organisation, in particular due to capacity constraints.

S Gaskell sought the views of the Governing Body in prioritising assurance activity across providers and in particular those smaller organisations. The Governing Body supported a risk based approach to assurance, with active monitoring by the Quality Committee. Members were informed that recruitment for an Executive Nurse was ongoing to provide strategic leadership across safeguarding.

A discussion took place about the importance of ensuring that the views of safeguarding were fed into the preventative work of Stockport Together to ensure safeguarding responsibilities were met and opportunities were maximised to make services safer by preventing incidents. V Mehta noted the proposals for integrated commissioning arrangements provided the opportunity to explore how commissioners could collaborate in the area of safeguarding. G Mullins noted that as part of Greater Manchester Devolution work was being undertaken with regulators.

The Governing Body considered the 2014/15 Safeguarding Annual Report and the areas highlighted as priorities in year which included continued challenges around capacity, prevention and pressures across the whole safeguarding system. The report had been previously considered by the Quality and Provider Management Committee and assurance was provided by K Richardson as Chair that robust processes existing for monitoring and escalation of key issues to the Governing Body. Councillor

Pantall noted that the issue of Deprivation of Liberty Safeguards (DoLs) had been raised by Ann Coffey MP in Parliament.

A discussion took place regarding the Care Quality Commission Action Plan arising from the Inspection visit in December 2014. S Gaskell explained progress against those actions still outstanding, in particular those which had exceeded the timescales set and highlighted that evidence of embedding was being gathered before recommendations were fully closed off. She expressed concern at the delay in finalisation of the report.

R Gill highlighted the importance of ensuring that the new system model built safeguarding into its design and the positive benefits which could be achieved as a result of collaborative working between GP Practices, community nurses etc

Resolved: That Governing Body:

1. Acknowledges that the updated framework has placed additional requirements on the CCG in respect to safeguarding.
2. Notes the actions that will need to be put in place to ensure that the CCG is compliant with the new regulations.
3. Confirms that the 2014/15 Annual Safeguarding report provides assurance that the CCG is meeting its safeguarding responsibilities.
4. Acknowledges the gaps / risks in the system and the actions in place to address then.
5. Acknowledges the progress that has been made against the actions listed in the CQC Action Plan and the actions in place to complete those which remain outstanding.
6. Notes the domestic homicide update.

139/15 RISK MANAGEMENT STRATEGY

T Ryley provided an overview of the refreshed Risk Management Strategy and noted the importance of ensuring that a culture of risk leadership was embedded across the organisation. The Governing Body was informed that the Strategy built on the current arrangements and incorporated partnership risk and management of opportunity in addition to providing for greater internal consistency and moderation.

He explained that the Audit Committee had considered the Strategy and endorsed it.

Councillor Pantall commented that it was important when managing risk that organisations learned from the wider system.

Resolved: That the Governing Body approves the Risk Management Strategy.

140/15 REPORTS FROM COMMITTEES

R Roberts provided an overview of the work of the Clinical Policy Committee. V Owen Smith drew Governing Body Member's attention to the delegation requested in paragraph 3.6 of the report which sought approval for a change in process for the CCG authorisation of new Greater Manchester EUR policies which would improve expediency in terms of implementation.

J Greenough provided an overview of the recent Audit Committee meeting which focussed on commencing the process to re-appoint the external auditor from 1 April 2016 onwards, actions arising from the Internal Audit Review of Corporate Governance including succession planning for board

members and the amber assessment of the CCG in relation to counter-fraud. He highlighted the Committee's recent approval of its Annual Report.

Resolved: That Governing Body:

- Notes the update on the falls/Osteoporosis pathway
- Notes CPC response to new national NICE guidance: NG17 Type 1 diabetes in adults
- diagnosis and management.
- Notes the decision made by CPC regarding its requirements for NICE compliance
- reporting.
- Notes CPC have endorsed the GMMMG recommendation listed under section 3.4.
- Notes CPC have endorsed the GMMMG NOAC guidance.
- Approves the change in process for new Greater Manchester EUR policies.
- Notes the updated costing summary for NICE TA's.
- Notes the work of the Audit Committee, including the Annual Report.

141/15 ANY OTHER BUSINESS

- R Gill reported that the Claim for Judicial Review against the Healthier Together Process had been granted approval to proceed with the hearing scheduled for mid-December 2015.

- Councillor Pantall explained that the Council was undertaking a review of its Information Advice and Guidance Services. The work was in its early stages and was focussing around developing the digital offer and reviewing the need for face to face services across a number of areas. He asked that any views of Governing Body members be shared with him directly following the meeting.

(The meeting ended at 12.52pm)

Public Questions

The following question was raised by a member of the public in attendance at the meeting:

'What commissioning has been done so far by the Strategic Partnership Board, what is planned and how will transparency be maintained?'

R Gill responded to explain that the arrangements were evolving and it was the intention that the meetings would be held in public. He explained that no formal decisions had been made yet but there were some good examples of some regional collaboration in areas like diabetes prevention.

NHS Stockport Clinical Commissioning Group
11 November 2015.

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
08072015	**Strategic Impact Report** That work be undertaken through the CCG's Business Intelligence Team to ensure Locality Chairs were provided with overview data to support work within their areas and as part of the development of Neighbourhoods.	126/15	January 2016	Mark Chidgey
12112015	**Proactive Care** Consideration be given to seeking the required investment of £400,000 from the Vanguard Monies be given and considered by the Programme Board as part of the development of the Business Case	129/15	December 2015	Roger Roberts
12112015	**Report of the Chair** That a joint response be provided by the CCG and NHS Stockport Foundation Trust to the letter of the System's Resilience Group Chair and shared with the Governing Body Members after submission.	135/15	December 2015	Jane Crombleholme

12112015	**Chief Operating Officer's Report** Information arising from the Quarter 1 assurance meeting be shared with Governing Body Members as soon as it became available.	136/15	December 2015 / January 2016	Gaynor Mullins
12112015	**Safeguarding** That the Stockport Together Programme incorporates safeguarding considerations into the design of new models of care.	**138/15**	January 2016	Tim Ryley

NHS
Stockport
Clinical Commissioning Group

Strategic Impact Report

Performance against key indicators in operational plan

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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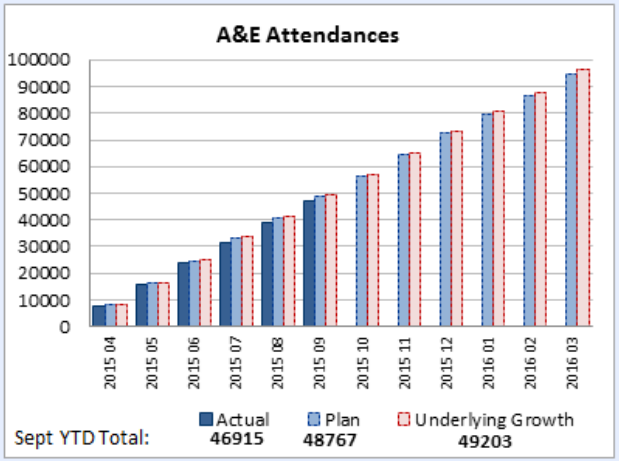
Executive Summary

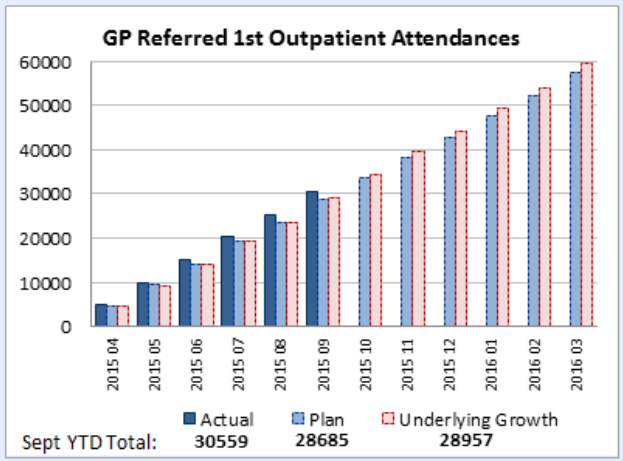
What *decisions* do you require of the Governing Body?
The Governing Body are not asked to make any specific decisions but should note the content of this report when considering the finance report and QIPP.
Please detail the key points of this report
- There are a number of areas where the CCG is having an impact greater than planned – A&E attendance, Direct GP admissions, Care Home admissions, elective procedures, non-GP referred outpatients, and admissions where primary cause of admission is a long-term condition. Many of these are closely linked to the GP Development scheme aims and changes in admission processes at SFT. - Total non-elective admissions**,** GP 1st Outpatients and Prescribing cost all remain above plan. - There remain a few issues with data quality**.** - GP 1st outpatients are more accurately a measure of hospital activity than actual GP referrals for which they are only a proxy; but growing 18 week pressures suggest it is a reasonable assumption to assume growth in referrals. - Direct cause and effect between specific actions and strategic outcomes are not clear and hypotheses should be treated cautiously. - Variation between practices and localities remains high though some of this is a feature of the planning processes.
What are the likely impacts and/or implications?
The cumulative effect of the gains and under-performance is a contribution to the financial pressure.
How does this link to the Annual Business Plan?
These are the key strategic measures of the effectiveness of the combined work set out in the plan to shift to a more sustainable economy
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors meeting
Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 9th December 2015
Agenda item:

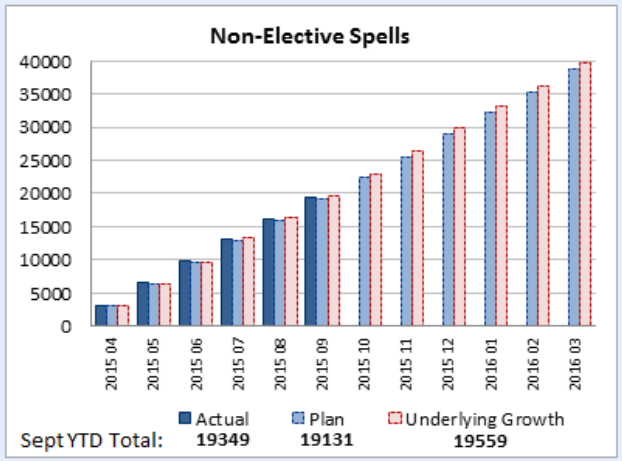
Stockport Level Strategic Impact Report

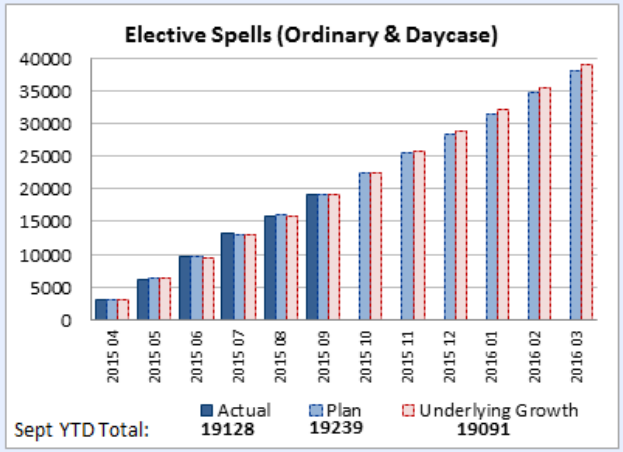
NHS Stockport Clinical Commissioning Group

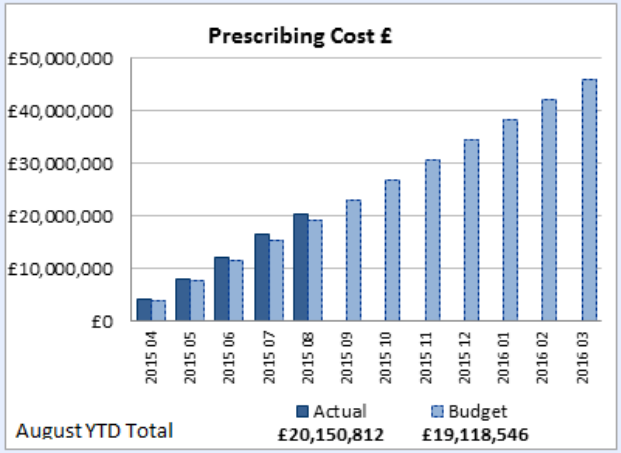
Stockport Level Cumulative Charts 2015/16

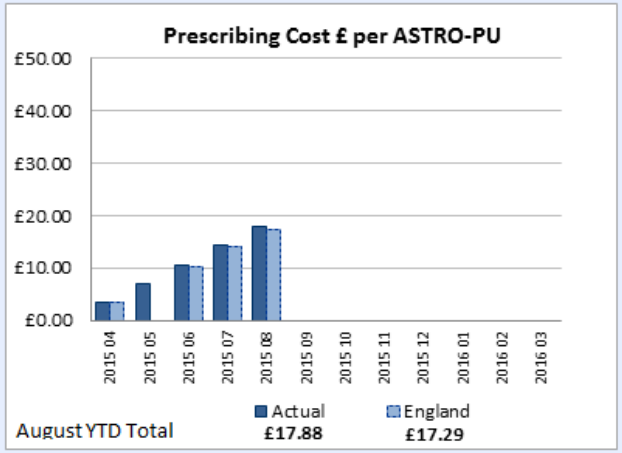












General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	Stkpt	Stkpt	
Practice Name	All Stockport		
GP Partnership			
Prescribing Name		Map:	
		Tel reception:	

List Size	
Mar 2015	304218
Mar 2014	298743
Mar 2013	296314
Weighted list 31/10/14	297723

		2015-16 Plan YTD Apr-Sep	2015-16 YTD Apr-Sep	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		48767	46915	-1852	-3.8%		**-3.8%**	**-3.8%**
Ambulance Conveyance Rate		82.0%	80.4%					
Non-Elective Admissions								
All Non-Elective Admissions		19131	19349	218	1.1%		**1.1%**	**1.1%**
Occ Bed Days per 100,000 [1]		30482	28881	-1600	-5.3%		**-5.3%**	**-5.3%**
GP Direct Admissions		3242	3191	-51	-1.6%		**-1.6%**	**-1.6%**
LTC	**Register**							
CHD Admissions	11666	484	423	-61	-12.6%		**-12.6%**	**-12.6%**
HF Admissions	2627	245	250	5	2.1%		**2.1%**	**2.1%**
COPD Admissions	6494	260	157	-103	-39.7%		**-39.7%**	**-39.7%**
Asthma Admissions	19327	90	86	-4	-4.9%		**-4.9%**	**-4.9%**
Diabetes Admissions	13981	69	68	-1	-1.3%		**-1.3%**	**-1.3%**
LTC Admissions	54095	1149	984	-165	-14.3%		**-14.3%**	**-14.3%**
AF Admissions	5416	296	217	-79	-26.6%		**-26.6%**	**-26.6%**
Care Home Admissions		1037	932	-105	-10.1%		**-10.1%**	**-10.1%**
Referrals								
GP Referred 1st OPA		27908	29065	1157	4.1%		**4.1%**	**4.1%**
Dermatology		2863	3201	338	11.8%		**11.8%**	**11.8%**
ENT		3083	3326	243	7.9%		**7.9%**	**7.9%**
General Medicine		4451	4828	377	8.5%		**8.5%**	**8.5%**
General Surgery		5242	5475	233	4.4%		**4.4%**	**4.4%**
Obstetrics & Gynaecology		2011	1911	-100	-5.0%		**-5.0%**	**-5.0%**
Opthalmology		2129	1848	-281	-13.2%		**-13.2%**	**-13.2%**
Paediatrics		1282	1360	78	6.1%		**6.1%**	**6.1%**
Rheumatology		648	588	-60	-9.3%		**-9.3%**	**-9.3%**
Trauma & Orthopaedics		3647	4026	379	10.4%		**10.4%**	**10.4%**
Urology		1536	1513	-23	-1.5%		**-1.5%**	**-1.5%**
Other Specialties		1015	989	-26	-2.6%		**-2.6%**	**-2.6%**
Other Referred 1st OPA		18418	17819	-599	-3.3%		**-3.3%**	**-3.3%**
GP Referred 1st OPA								
Other Specialist Medicine [2]		779	1494	715	91.8%		**91.8%**	**91.8%**
Planned								
Elective Admissions		19241	19128	-113	-0.6%		**-0.6%**	**-0.6%**
Prescribing (Apr-Jul)		3155855	3288277	132422	4.2%		**4.2%**	**4.2%**

1 - Occ Bed Days per 100,000 compares 2015/16 actual with 2014/15 actual rather than with plan
2 - There is a data excess for Neurology which is being investigated with Salford Royal FT

Cheadle and Bramhall Locality

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	C&B	C&B	
Practice Name	Locality: Cheadle and Bramhall		
GP Partnership			
Prescribing Name		Map:	
		Tel reception:	

List Size	
Mar 2015	88686
Mar 2014	87458
Mar 2013	86787
Weighted list 31/10/14	81230

		2015-16 Plan YTD Apr-Sep	2015-16 YTD Apr-Sep	Variance	<---------- %Variance ----------> Practice		Locality	Stkport
Urgent								
A&E Attendances		12728	12185	-543.1328	-4.3%		-4.3%	-3.8%
Non-Elective Admissions								
All Non-Elective Admissions		4835	5069	234.341083	4.8%		4.8%	1.1%
Occ Bed Days per 100,000		11714	10676	-1038	-8.9%		-6.3%	-1.7%
GP Direct Admissions		761	808	47.1247038	6.2%		6.2%	-1.6%
LTC	**Register**							
CHD Admissions	3221	138	106	-32.468672	-23.4%		-23.4%	-12.6%
HF Admissions	668	71	78	7.44098126	10.5%		10.5%	2.1%
COPD Admissions	1214	57	32	-24.654203	-43.5%		-43.5%	-39.7%
Asthma Admissions	5184	15	18	3.18378158	21.5%		21.5%	-4.9%
Diabetes Admissions	4080	16	10	-6.150753	-38.1%		-38.1%	-1.3%
LTC Admissions	14367	297	244	-52.648865	-17.7%		-17.7%	-14.3%
AF Admissions	1753	85	70	-15.109487	-17.8%		-17.8%	-26.6%
Care Home Admissions		221	229	8.38655252	3.8%		3.8%	-10.1%
Referrals								
GP Referred 1st OPA		8428	9240	811.714961	9.6%		9.6%	4.1%
Dermatology		970	1118	148.171668	15.3%		15.3%	11.8%
ENT		944	1054	109.757183	11.6%		11.6%	7.9%
General Medicine		1442	1695	252.993834	17.5%		17.5%	8.5%
General Surgery		1548	1653	105.203139	6.8%		6.8%	4.4%
Obstetrics & Gynaecology		527	562	35.4981936	6.7%		6.7%	-5.0%
Opthalmology		616	537	-79.050387	-12.8%		-12.8%	-13.2%
Paediatrics		357	444	87.1639151	24.4%		24.4%	6.1%
Rheumatology		175	195	20.3296455	11.6%		11.6%	-9.3%
Trauma & Orthopaedics		1083	1193	110.026329	10.2%		10.2%	10.4%
Urology		453	476	22.9712341	5.1%		5.1%	-1.5%
Other Specialties		314	313	-1.3497918	-0.4%		-0.4%	-2.6%
Other Referred 1st OPA		4992	4718	-274.36821	-5.5%		-5.5%	-3.3%
GP Referred 1st OPA								
*Other Specialist Medicine		264	517	253.41129	96.1%		96.1%	91.8%
Planned								
Elective Admissions		5496	5520	24.1616178	0.4%		0.4%	-0.6%
Prescribing (Apr-Jul)		789309	815241	25932	3.3%		3.3%	4.2%

*There is a data excess for Neurology which is being investigated with Salford Royal FT.

Heaton & Tame Valley Locality

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	H&TV H&TV
Practice Name	Locality: Heatons and Tame Valle
GP Partnership	
Prescribing Name	Map:
	Tel reception:

List Size	
Mar 2015	79407
Mar 2014	76720
Mar 2013	75750
Weighted list 31/10/14	78283

		2015-16 Plan YTD Apr-Sep	2015-16 YTD Apr-Sep	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		13012	12492	-520.39709	-4.0%		-4.0%	-3.8%
Non-Elective Admissions								
All Non-Elective Admissions		4990	5217	226.739415	4.5%		4.5%	1.1%
Occ Bed Days per 100,000		14003	11349	-2654	-19.0%		-13.2%	-1.7%
GP Direct Admissions		852	832	-19.62665	-2.3%		-2.3%	-1.6%
LTC	Register							
CHD Admissions	2853	102	102	-0.2507762	-0.2%		-0.2%	-12.6%
HF Admissions	653	57	62	5.1499376	9.1%		9.1%	2.1%
COPD Admissions	1965	70	46	-24.468064	-34.7%		-34.7%	-39.7%
Asthma Admissions	5112	26	20	-6.2731882	-23.9%		-23.9%	-4.9%
Diabetes Admissions	3495	17	21	4.18522551	24.9%		24.9%	-1.3%
LTC Admissions	14078	273	251	-21.656865	-7.9%		-7.9%	-14.3%
AF Admissions	1181	64	51	-13.102218	-20.4%		-20.4%	-26.6%
Care Home Admissions		324	293	-30.864418	-9.5%		-9.5%	-10.1%
Referrals								
GP Referred 1st OPA		6806	6995	188.557863	2.8%		2.8%	4.1%
Dermatology		686	696	9.71189768	1.4%		1.4%	11.8%
ENT		772	861	88.8608737	11.5%		11.5%	7.9%
General Medicine		1000	1070	69.7190213	7.0%		7.0%	8.5%
General Surgery		1290	1379	89.2049461	6.9%		6.9%	4.4%
Obstetrics & Gynaecology		541	485	-55.939134	-10.3%		-10.3%	-5.0%
Opthalmology		540	511	-28.932102	-5.4%		-5.4%	-13.2%
Paediatrics		328	330	1.64134951	0.5%		0.5%	6.1%
Rheumatology		181	130	-51.018379	-28.2%		-28.2%	-9.3%
Trauma & Orthopaedics		847	934	87.3063861	10.3%		10.3%	10.4%
Urology		374	344	-30.342565	-8.1%		-8.1%	-1.5%
Other Specialties		247	255	8.3455684	3.4%		3.4%	-2.6%
Other Referred 1st OPA		4759	4680	-78.641174	-1.7%		-1.7%	-3.3%
GP Referred 1st OPA								
*Other Specialist Medicine		195	323	128.436133	66.0%		66.0%	91.8%
Planned								
Elective Admissions		4768	4694	-74.254549	-1.6%		-1.6%	-0.6%
Prescribing (Apr-Jul)		845679	902852	57173	6.8%		6.8%	4.2%

*There is a data excess for Neurology which is being investigated with Salford Royal FT.

Marple & Werneth Locality

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	M&W	M&W	
Practice Name	Locality: Marple & Werneth		
GP Partnership			
Prescribing Name		Map	
		Tel reception:	

	List Size
Mar 2015	56691
Mar 2014	56354
Mar 2013	56045
Weighted list 31/10/14	57367

		2015-16 Plan YTD Apr-Sep	2015-16 YTD Apr-Sep	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		8558	7928	-629.68345	-7.4%		-7.4%	-3.8%
Non-Elective Admissions								
All Non-Elective Admissions		3572	3386	-185.8338	-5.2%		-5.2%	1.1%
Occ Bed Days per 100,000		15720	11183	-4537	-28.9%		-28.0%	-1.7%
GP Direct Admissions		625	507	-118.39649	-18.9%		-18.9%	-1.6%
LTC	**Register**							
CHD Admissions	2587	109	94	-15.105613	-13.8%		-13.8%	-12.6%
HF Admissions	500	45	51	5.73251432	12.7%		12.7%	2.1%
COPD Admissions	1295	46	26	-20.450004	-44.0%		-44.0%	-39.7%
Asthma Admissions	3779	17	15	-2.0673896	-12.1%		-12.1%	-4.9%
Diabetes Admissions	2537	9	20	10.7853344	117.0%		117.0%	-1.3%
LTC Admissions	10698	227	206	-21.105158	-9.3%		-9.3%	-14.3%
AF Admissions	1211	62	40	-21.651714	-35.1%		-35.1%	-26.6%
Care Home Admissions		222	192	-29.55597	-13.3%		-13.3%	-10.1%
Referrals								
GP Referred 1st OPA		5146	5092	-53.50017	-1.0%		-1.0%	4.1%
Dermatology		478	594	115.901734	24.2%		24.2%	11.8%
ENT		515	513	-2.2947229	-0.4%		-0.4%	7.9%
General Medicine		837	834	-3.3767757	-0.4%		-0.4%	8.5%
General Surgery		1011	975	-35.635742	-3.5%		-3.5%	4.4%
Obstetrics & Gynaecology		332	342	9.74518582	2.9%		2.9%	-5.0%
Opthalmology		442	308	-134.43648	-30.4%		-30.4%	-13.2%
Paediatrics		211	215	4.38925563	2.1%		2.1%	6.1%
Rheumatology		121	104	-16.674356	-13.8%		-13.8%	-9.3%
Trauma & Orthopaedics		711	746	34.9629741	4.9%		4.9%	10.4%
Urology		293	305	12.323675	4.2%		4.2%	-1.5%
Other Specialties		194	156	-38.404919	-19.8%		-19.8%	-2.6%
Other Referred 1st OPA		3571	3300	-271.43166	-7.6%		-7.6%	-3.3%
GP Referred 1st OPA								
*Other Specialist Medicine		121	258	136.550096	112.4%		112.4%	91.8%
Planned								
Elective Admissions		3753	3730	-22.774193	-0.6%		-0.6%	-0.6%
Prescribing (Apr-Jul)		615666	640627	24961	4.1%		4.1%	4.2%

*There is a data excess for Neurology which is being investigated with Salford Royal FT.

Stepping Hill and Victoria Locality

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	SH&V	SH&V	
Practice Name	Locality: Stepping Hill & Victoria		
GP Partnership			
Prescribing Name		Map:	
		Tel reception:	

	List Size
Mar 2015	79434
Mar 2014	78211
Mar 2013	77732
Weighted list 31/10/14	80843

		2015-16 Plan YTD Apr-Sep	2015-16 YTD Apr-Sep	Variance	<---------- Practice	%Variance Locality	----------> Stkport
Urgent							
A&E Attendances		14469	13381	-1087.7867	-7.5%	-7.5%	-3.8%
Non-Elective Admissions							
All Non-Elective Admissions		5734	5569	-165.2467	-2.9%	-2.9%	1.1%
Occ Bed Days per 100,000		15451	12812	-2639	-17.1%	-14.5%	-1.7%
GP Direct Admissions		1004	1039	34.7826855	3.5%	3.5%	-1.6%
LTC	**Register**						
CHD Admissions	3005	134	117	-17.230191	-12.8%	-12.8%	-12.6%
HF Admissions	806	72	57	-15.171101	-21.0%	-21.0%	2.1%
COPD Admissions	2020	87	49	-37.722046	-43.5%	-43.5%	-39.7%
Asthma Admissions	5252	32	32	-0.3150157	-1.0%	-1.0%	-4.9%
Diabetes Admissions	3869	27	16	-10.731434	-40.1%	-40.1%	-1.3%
LTC Admissions	14952	352	271	-81.169788	-23.0%	-23.0%	-14.3%
AF Admissions	1271	85	55	-29.763392	-35.1%	-35.1%	-26.6%
Care Home Admissions		271	217	-54.0389	-19.9%	-19.9%	-10.1%
Referrals							
GP Referred 1st OPA		7528	7654	126.30335	1.7%	1.7%	4.1%
Dermatology		729	758	29.2843565	4.0%	4.0%	11.8%
ENT		851	895	43.6283524	5.1%	5.1%	7.9%
General Medicine		1171	1222	50.8454723	4.3%	4.3%	8.5%
General Surgery		1394	1456	62.2476593	4.5%	4.5%	4.4%
Obstetrics & Gynaecology		612	522	-89.72188	-14.7%	-14.7%	-5.0%
Opthalmology		531	489	-41.594659	-7.8%	-7.8%	-13.2%
Paediatrics		386	369	-17.339039	-4.5%	-4.5%	6.1%
Rheumatology		172	158	-14.045387	-8.2%	-8.2%	-9.3%
Trauma & Orthopaedics		1006	1139	132.917216	13.2%	13.2%	10.4%
Urology		416	386	-29.970516	-7.2%	-7.2%	-1.5%
Other Specialties		260	260	0.0517751	0.0%	0.0%	-2.6%
Other Referred 1st OPA		5096	4986	-109.55895	-2.2%	-2.2%	-3.3%
GP Referred 1st OPA							
*Other Specialist Medicine		199	358	158.526476	79.5%	79.5%	91.8%
Planned							
Elective Admissions		5224	5135	-89.132876	-1.7%	-1.7%	-0.6%
Prescribing (Apr-Jul)		892195	891347	-848	-0.1%	-0.1%	4.2%

*There is a data excess for Neurology which is being investigated with Salford Royal FT.

NHS Stockport Clinical Commissioning Group

Finance Report October 2015 – Month 7

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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Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?

1. **Note** the financial position for 15/16 which is reporting:-

   (i) **Year to date** - As at 31st October an actual £598k surplus compared to plan surplus of £1,021k - shortfall of £423k

   (ii) **Forecast 15-16** - a forecast surplus of £1,101k compared to planned surplus for 15-16 of £1.75m – shortfall £649k

2. **Acknowledge** that the forecast surplus of £1,101k assumes achievement of £756k additional CIP measures.

3. **Acknowledge** that the additional £649k savings requirement to deliver the £1.75m planned surplus is being taken forward by the QiPP Committee.

4. **Note** the additional net risk totalling £1.67m not reflected within the forecast position (Ref – Table 8).

5. **Note** that the forecast position reflects the retention of £0.9m performance Fund held in BCF to offset over performance in NEL activity.

6. **Note** that the anticipated return of £1m from underspending national CHC legacy risk pool has now been removed from our forecast as it is highly unlikely that this underspend will be returned to CCGs in 15-16.

7. **Note** the additional recurrent cost pressures of £9.6m arising in 15/16 are treated as carry forward commitments and as such increase the total savings requirement in 16/17 to c£19.1m.

Please detail the key points of this report

- Actual surplus reported as at Mth 7 (YTD) of £598k which is £423k below plan.
- Actions are being taken forward by the QiPP Committee to address the £649k forecast variance to plan which will enable the CCG to deliver its £1.75m planned surplus.
- Main areas of cost pressure continue to derive within the Acute sector (especially AQP/IS) and Prescribing.
- Additional risks with a most likely financial impact of £1.67m have been identified although not factored into the financial position at this stage.

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: Gary Jones
Meeting Date: 9th December 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Report of the Chief Finance Officer as at 31st October 2015

1. Introduction

This report should be read in conjunction with the 'Dashboard' (Appendix 1) which summarises the financial position of the organisation on 'one page'. This report will highlight the key factors that are impacting on the CCG's financial position and ability to deliver against its statutory financial duties.

This report provides an update on:-

1. The financial position both (i) year to date as at 31st October 2015 and (ii) forecast outturn 15/16
2. Key risks not included within the financial position
3. Underlying recurrent financial position
4. Recurrent pressure arising 15/16 and carried forward into 16/17.

2. Statutory Financial Duties and Performance Targets

In holding the CCG to account, NHSE requires the CCG to deliver its statutory duties and financial performance targets for 15/16 as approved by the Governing Body at the start of the financial year. Progress on delivery of these targets is monitored monthly on the areas and our performance is contained in Table 1 below:

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty	Performance YTD (Mth 7)	Performance Forecast
Revenue (Dashboard Table 1)	Not to exceed revenue resource allocation		
Running Costs (Dashboard 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	Deliver a Recurrent Surplus		
Revenue (Appendix 1 Table 1)	Deliver a 0.5% in-year surplus		
Cash (Appendix 1 Table 10)	Operate within the maximum drawdown limit		
Business Conduct (Appendix 1 Table 9)	Comply with Better Payment Practices Code		
QIPP (Appendix 1 Table 11)	Fully deliver planned QIPP saving		

3. Year to Date (Mth 7) & Forecast Financial Position (Ref – Appendix 1 Table 1)

3.1 YTD surplus of £598k which is £423k below plan i.e. planned for £1,021k surplus at Month 7. In year overspends are being impacted by increases in Elective activity, Outpatients, Any Qualified Provider (AQP) / Independent Sector (Trauma & Orthopaedics, Cataracts & WET AMD) and increased prescribing spend as set out in Table 7.

3.2 The CCG is currently forecasting an outturn position of £1,101k surplus against a planned surplus of £1.75m, the forecast variances are set out by Provider [Appendix 1 Table 2] and by Point of Delivery [Appendix 1 Table 3].

Acute:

3.3 Key risk areas within Acute are AQP/IS contracts which are forecast to overspend by £2.5m. The main areas of overspend within the following areas:

- BMI - Elective contract activity, predominantly within Trauma & Orthopaedics
- Optegra - Cataracts and AMD
- ISCATS – The budget for this contract was set based on 10 months to January 2016; however this contact has now been extended into 2016-17.

3.4 The latest activity data received from the SLAM monitoring data (to September) shows Elective in line with plan, Non Elective (+0.3%) and Outpatient (First +1.7% and Follow Up +2.6%) activity all above plan. GP written referrals to September 2015 are also up compared to 2015-16 planned levels with our contracted providers

(NHS & Non-NHS).

3.5 Over performance by specialty:

- Elective –Trauma & Orthopaedics, Urology
- Non Elective – Gynaecology, Paediatrics and Urology
- Outpatient – Cardiology-General Medicine, Trauma & Orthopaedics, Paediatrics
- Drug & Devices

Mental Health

3.6 Year to date underspend of £165k with a forecast underspend of £248k. This is largely due to cessation of the contract with Calderstones which terminated with effect from 30/09/2015. Charges will now be incurred on a cost per case basis. There is currently a zero occupancy rate at Calderstones and as such no further costs are expected.

Community Health

3.7 This budget reflects spend against the Stockport NHS Foundation Trust Community contract and also the new integration monies pooled under Better Care Fund. It is forecast that spend on this budget will be contained within planned levels.

Continuing Care

3.8 As at month 7 there is a small underspend of £86k which is forecast to increase to a £511k underspend at year end. This underspend is largely due to actual CHC placement numbers being lower than planned levels. Funded Nursing Care is expected to underspend by £200k although this is offset by an expected overspend of £200k against Children's and Complex Care budgets.

Primary Care

3.9 Primary Care budgets are forecast to underspend by £322k which is as result delayed implementation of initiatives detailed within GP Development scheme. These are being worked through the practices.

Prescribing (Ref – Appendix 1 Table 7):

3.10 There has been an increase of c9% in prescribing for the period April to September (the latest data available) compared to same period 14/15, of which c3% is volume related (number of items prescribed). This has resulted in the CCG reporting a YTD

overspend of £915k and trend continuing with a forecast overspend of £1.5m by year end. Table 7 sets out the % the main contributors to this overspending which are summarised below:

- Cardiovascular - Anticoagulants & Protamine (particularly Apixaban) showing increasing spend following NICE TA
- Endocrine - cost increase is being driven by increased prevalence and new drugs being added to current treatment
- Nutrition and Blood - cost increase is being driven by a combination of item growth and cost growth
- Central Nervous System - increase in the number of items prescribed particularly within Analgesics and Antiepileptics

Running Costs

3.11 The CCG is required to operate within its 2015/16 running cost allocation of £6.42m based on £22.5 per head.

The table 2 below provides a breakdown of the running costs directly incurred by the CCG and incurred via the service level agreement with the Greater Manchester Commissioning Support Unit (GMCSU):

Table 2: Running Costs

Running Costs	YTD Budget £000s	YTD Actual £000s	Variance (Favourable) / Adverse £000s	Annual Budget £000s	Forecast Outturn £000s	Variance (Favourable) / Adverse £000s
GMCSU - SLA	618	588	(30)	1,060	1,024	(36)
CCG Admin	2,925	2,781	(144)	5,364	5,174	(190)
Total CCG Running Costs	**3,543**	**3,369**	**(174)**	**6,424**	**6,198**	**(226)**

Reserves (Ref – Appendix 1 Table 4)

3.12 Investments – include national "must do's and those agreed collaboratively at a local GM level i.e. GM Risk share across CCGs. The £0.9m under spend on national investments reflects the retention of the £0.9m BCF performance fund (NEL element) by the CCG given 3.5% reduction in NEL activity is forecast not to be achieved with these costs being met by the CCG.

3.13 Contingency – this reflects the balance of the original £1.9m (0.5%) contingency set aside required for planning purposes. The balance of £365k is being fully utilised to support the CCG's forecast position.

3.14 Savings & Efficiency – £3.214m reserve reflects the remaining value of CIP savings not yet embedded within expenditure budgets. The table below provides

details of these CIP schemes:

CIP schemes not yet embedded

QIPP Scheme	Value
1) Other Funded CIP	£1.815m
2) CHC National Risk Pool	£0.949m
3) Quality Premium	£0.450m
Total	**£3.214m**

In addition to the above CIP, the forecast assumes that the identified recovery plan measures of £756k will be delivered in 15/16 (Ref – Table 1).

4. Balance Sheet

Appendix 2 details the CCG opening balance sheet as at 1st April 2015, closing balance sheet as 31st October 2015 and a forecasted balance sheet as at 31st March 2016.

Members will be assured that the CCGs payment liabilities will be maintained with the cash limit set for the 2015-16 financial year referred to within **Table 10** of Appendix 1.

5. Risks outside the reported financial position (Ref – Appendix 1 Table 8)

5.1 There are potential risks to the value of £1.67m which are acknowledged but have not been brought into the financial position at month 7. These are potential risks that could materialise on a 'worst case' basis and as such are identified and recorded but not brought into the financial position. Members are aware that should any of these risks materialise then this will deteriorate the CCGs financial position.

5.2 Members should note that at month 6 this table captured the risk of £1m around CHC legacy not being returned to CCGs by NHSE. This risk has now materialised and therefore been removed from Table 8 and reflected within our forecast position.

6. Recurrent Position (Ref – Appendix 1 Table 5)

6.1 Recurrent cost pressures are due to a combination of:

- Increased activity demand above planned levels
- Introduction of Enhance Tariff Option (ETO) 15/16 (c£4m)
- Unachieved recurrent CIP requirements

These recurrent pressures are being funded non-recurrently in 15/16.

In 15/16 the CCG secured the funding of part of the GP Development being met from BCF as a one off measure with this cost being mainstreamed in 16/7.

6.2 The impact of recurrent pressures in 2015-16 are carried forward in 2016-17.As a result the CCG will be required to deliver a recurrent CIP of **£19.1m** before any investments are made in 2016-17 in order to deliver the NHS England required 2% (£7.6m) recurrent surplus (assuming the CCG receives funding growth of 2%).

Due to this challenging position and concern raised by NHSE on the CCG's ability to deliver against Business rules in 2016/17, the CCG has now been place in formal turnaround and will be subject to an external review in line with NHSE protocols.

Members should note that the recurrent savings requirement of c£19m for 16/17 is based on planning assumptions made as part of 2 year operational plans approach (15/16 & 16/17) and will therefore be subject to refresh when allocations announcements and planning guidance is issued in mid-December.

7. Risk Implications / Mitigation

Risks:

- The key risks remain continual acute contract over performance and prescribing price and volume growth.

- Proposals to address the delivery of £1.75m planned surplus in 15/16 are non recurrent in nature and therefore do not benefit the recurrent position going forward into 16/17.

Mitigation:

- The QiPP Committee is continuing to scope further savings measures whilst recognising the short term requirement to deliver the 2015-16 planned surplus of £1.75m and support to the Operational Plan in 16/17.

8. Recommendations

The Governing Body is asked to:-

I. **Note** the year-to-date surplus of £598k representing a £423k shortfall compared to plan.

II. **Note** the current forecast of £1,101k surplus representing a £649k shortfall compared to plan.

III. **Acknowledge** the additional net risk totalling £1.67m not within the forecast position

IV. **Acknowledge** that the CCG position reflects the retention of £0.9m BCF performance Fund to offset the additional costs faced by the CCG.

V. **Note** that the CCG has now been placed in 'Turnaround' and will be subject to an external review commissioned by NHSE.

Gary Jones
Chief Finance Officer
26th November 2015

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

MONTH 7 FINANCIAL DASHBOARD

Appendix 1

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 7 Financial Position - as at 31st October 2015

	YTD (Mth 7)				Forecast 15/16					Recurrent Budget	Recurrent Commitment	Recurrent Variance (Favourable) / Adverse
	Plan £000s	Actual £000s	Var £000s	Var %	Plan £000s	Actual £000s	Var £000s	Var %	RAG RATING	£000s	£000s	£000s
Revenue Resource Limit (RRL)												
Confirmed	(222,826)	(222,826)	0	0.0%	(378,328)	(378,328)	0	0.0%	G	(374,047)	(374,047)	0
In Year	0	0	0	0.0%	(4,598)	(4,598)	0	0.0%	G	(1,362)	(1,362)	0
Total RRL	**(222,826)**	**(222,826)**	**0**	**0.0%**	**(382,926)**	**(382,926)**	**0**	**0.0%**	G	**(375,409)**	**(375,409)**	**0**
Net Expenditure												
Acute	128,825	130,052	1,227	1.0%	223,701	226,698	2,997	1.3%	R	221,767	227,193	5,426
Mental Health	18,482	18,317	(165)	(0.9%)	31,683	31,435	(248)	(0.8%)	G	31,103	30,855	(248)
Community Health	20,764	20,995	231	1.1%	35,596	35,636	40	0.1%	A	35,596	35,596	0
Continuing Care	10,838	10,752	(86)	(0.8%)	17,074	16,563	(511)	(3.0%)	G	14,957	15,157	200
Primary Care	7,201	6,962	(239)	(3.3%)	12,483	12,161	(322)	(2.6%)	G	10,073	11,473	1,400
Other	2,440	2,479	39	1.6%	5,375	3,723	(1,652)	(30.7%)	G	2,636	3,317	681
Sub Total Healthcare Contracts	**188,550**	**189,557**	**1,007**	**0.5%**	**325,912**	**326,216**	**304**	**0.1%**	R	**316,132**	**323,591**	**7,459**
Prescribing	28,387	29,302	915	3.2%	48,664	50,164	1,500	3.1%	R	48,664	50,164	1,500
Running Costs (Corporate)	3,543	3,369	(174)	(4.9%)	6,424	6,198	(226)	(3.5%)	G	6,424	6,424	0
Reserves (Ref: Reserves Summary)	1,325	0	(1,325)	(100.0%)	176	3	(173)	(98.3%)	G	2,966	4,850	1,884
Total Net Expenditure and Reserves	**221,805**	**222,228**	**423**	**0.2%**	**381,176**	**382,581**	**1,405**	**0.4%**	R	**58,054**	**61,438**	**3,384**
Additional Identified CIP	**0**	**0**	**0**	**0.0%**	**0**	**(756)**	**(756)**	0.0%	G	**0**	**0**	**0**
TOTAL (SURPLUS) / DEFICIT	**(1,021)**	**(598)**	**423**	**(41.4%)**	**(1,750)**	**(1,101)**	**649**	**0.4%**	R	**(1,223)**	**9,620**	**10,843**

ACUTE

PRESCRIBING

TABLE 2

Acute Contract Performance		Year to Date			Forecast	
Top 6 Acute Commissioning contracts & AQP/IS	**Annual Budget**	**Budget**	**Actual**	**YTD Variance - Overspend / (Underspend)**	**Forecast Outturn**	**Forecast Variance - Overspend / (Underspend)**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Stockport FT	144,431	84,251	84,066	(185)	144,659	228
University Hospitals of South Manchester FT	25,490	14,841	14,761	(80)	25,467	(23)
Central Manchester University Hospitals FT	18,577	10,836	10,754	(82)	18,635	58
Salford Royal FT	5,633	2,730	2,809	79	5,768	135
East Cheshire NHS Trust	2,259	1,318	1,311	(7)	2,249	(10)
Tameside Hospital FT	1,084	649	754	105	1,264	180
AQPs/IS	11,328	6,608	8,010	1,402	13,829	2,501
Other	14,899	7,592	7,587	(5)	14,827	(72)
Total Acute	**223,701**	**128,825**	**130,052**	**1,227**	**226,698**	**2,997**

PoD

TABLE 3

Forecast variance to plan based on Mth 6 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	(240)	(353)	(60)	(68)	12	17	2,501		1,809
Drugs & Devices	443	0	317	(194)	32	0			598
Outpatients	329	(29)	36	484	0	(10)			810
Non Elective	755	519	(481)	(26)	40	68			875
Non Elective (Excess bed days)	(1,003)	53	70	20	(1)	21			(840)
Macular	0	0	241	0	0	0			241
Fertility	0	0	108	0	0	0			108
Maternity	(176)	58	189	0	9	0			80
A&E	(43)	68	(8)	13	(3)	8			35
Critical Care	(440)	(171)	249	(126)	(29)	73			(444)
Other PoDs	(121)	96	(602)	33	(71)	4		386	(275)
Total Mth 7 Forecast Variance	(496)	241	59	136	(11)	181	2,501	**386**	**2,997**

TABLE 4

Forecast Reserves Summary

	Reserves Held Mth 7	Commits Mth 7 onwards	Forecast Bals Year End
Amounts Held in CCG Reserves	**£000s**	**£000s**	**£000s**
Investments - National	1,457	540	(917)
Investments - Greater Manchester	1,502	1,247	(255)
Contingency	365	0	(365)
In-Year Allocations	66	66	0
CIP - Not embedded in budgets	(3,214)	(1,850)	1,364
Total Reserves	**176**	**3**	**(173)**

TABLE 5

Recurrent CIP Requirement 2016-17	£000s
Additional CIP c/fwd from 2015-16	(9,620)
CIP required to deliver 2% in year surplus	(9,487)
Revised 2016-17 CIP Requirement	(19,107)

TABLE 6

Forecast spend against in year allocation (NHS Eng Requirement)	£000s
2015-16 Allocation	(382,926)
Less: Brought forward 2014-15 Surplus	4,281
Forecast 2015-16 Expenditure	381,825
Forecast (under)/over-spend against in year allocation	3,180

TABLE 7

Top Five Increases in Prescribing Spend by Drug Type	Oct 13 - Sep 14 (£000s)	Oct 14 - Sept 15 (£000s)	Change (£000s)	Change in Spend (%)	Change in No. Items (%)
Endocrine System	6,083	6,693	610	10.0%	5.3%
Central Nervous System	10,154	10,715	561	5.5%	5.2%
Cardiovascular System	5,883	6,367	484	8.2%	2.4%
Nutrition And Blood	2,491	2,891	400	16.1%	6.2%
Respiratory System	6,109	6,304	195	3.2%	5.3%

TABLE 11

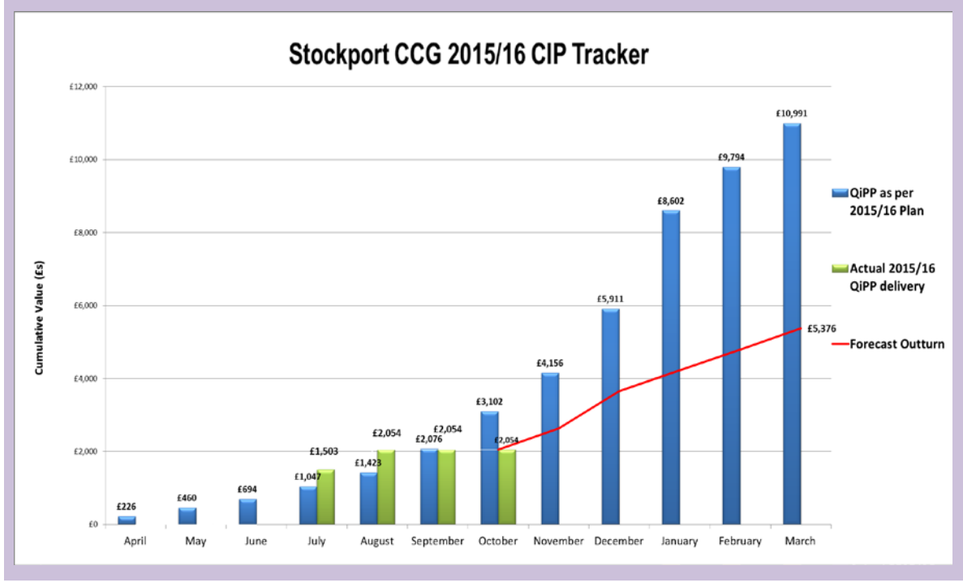

TABLE 8

Risk	Risk Value (£m)	Explanation of risk
Acute SLAs	0.50	Case mix / price pressures
Prescribing	0.25	NICE TAs, volume & price increases
Other risks	0.92	Better Care Fund contingency cannot be used to support the financial position
Total	1.67	

TABLE 10

Cashflow Summary - Month 7	£000s
Cash Limit for the Year	380,468
Cash drawn down YTD	221,122
Remaining cash	159,346
Actual cash drawn down (%)	58.1%
Expected cash drawn down (%)	58.3%

TABLE 9

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.	October YTD	
	Number	**£000s**
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	5,733	37,607
Total Non-NHS Trade Invoices Paid Within Target	5,599	36,854
Percentage of Non-NHS Trade Invoices Paid Within Target	97.66	98.00
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,420	151,021
Total NHS Trade Invoices Paid Within Target	1,366	150,954
Percentage of NHS Trade Invoices Paid Within Target	96.20	99.96
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	7,153	188,628
Total NHS Trade Invoices Paid Within Target	6,965	187,808
Percentage of NHS Trade Invoices Paid Within Target	97.37	99.57

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.

NHS STOCKPORT CCG BALANCE SHEET as at 31st October 2015 (Month 7)

Appendix 2

	Opening Balances 1.4.15 £000s	Closing Balances 31.10.15 £000s	Movement in Balances £000s	Forecast B/S 31.3.16 £000s
Non-current assets:				
Property, plant and equipment	14	11	(3)	10
Intangible assets	0	0	0	0
Trade and other receivables	0	0	0	0
Total non-current assets	**14**	**11**	**(3)**	**10**
Current assets:				
Cash and cash equivalents	43	38	(5)	50
Trade and other receivables	1,363	349	(1,014)	500
Inventories	0	0	0	0
	1,406	**387**	**(1,019)**	**550**
Non-current assets classified "Held for Sale"	0	0	0	0
Total current assets	**1,406**	**387**	**(1,019)**	**550**
Total assets	**1,420**	**398**	**(1,022)**	**560**
Current liabilities				
Trade and other payables	(20,923)	(21,164)	(241)	(21,000)
Provisions	(883)	(727)	156	0
Borrowings	0	0	0	0
Total current liabilities	**(21,806)**	**(21,891)**	**(85)**	**(21,000)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(21,493)**	**(1,107)**	**(20,440)**
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)**	**(21,493)**	**(1,107)**	**(20,440)**
FINANCED BY:				
TAXPAYERS' EQUITY				
General fund	(20,386)	(21,493)	(1,107)	(20,440)
Revaluation reserve	0	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(21,493)**	**(1,107)**	**(20,440)**

NHS
Stockport
Clinical Commissioning Group

Resilience and Compliance Report - December 2015

Report to Governing Body on NHS Stockport CCG's performance, including NHS Constitution indicators and Legal Compliance indicators.

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

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?
Note the report.
Please detail the key points of this report
Performance on NHS Constitutional targets and legal compliance indicators
What are the likely impacts and /or implications?
Continue to monitor measures and compliance. Especially ED, Diagnostic waiting times and cases of Clostridium Difficile.
How does this link to the Annual Business Plan?
Updates Governing Body on performance on the measures laid out in our annual business plan.
What are the potential conflicts of interest?
N/A
Where has this report been previously discussed?
Directors Meeting
Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Gaynor Mullins
Meeting date:
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Chief Operating Officer's Report

Chief Operating Officer's Report

This report covers data to September 2015 for both NHS constitution targets and for statutory duty and compliance indicators.

Additional information is provided below for:-
• Urgent care, including; the 4 Hour ED waiting times standard, 12 hour standard and ambulances.
• Cases of Clostridium Difficile

Urgent Care

The performance levels in this report are to September and future reports will reflect a significant reduction in performance which is mirrored across GM. Escalation plans are being actioned on a daily basis and NHSE have initiated daily reports and weekly conference calls across much of the system.
Linked in with this will be ambulance performance, which is also highlighted as being at significant risk in the coming months. NWAS have now provided to the SRG an escalation plan along with plans to increase capacity. There are significant challenges to these plans, for example an NWAS co-ordinating post which was to be located in SFT ED has not been recruited to. Use of the pathfinder service has increased but by itself is not sufficient.
To date 12 hour breaches (measured as the wait time from admission decision to admission) have been avoided but there have been a number of near misses and therefore the risk of occurrence is assessed as high.
SFT have implemented their action plan, this will be reviewed by SRG in December; early indications are that this is delivering planned improvements, for example a reduction in admission rates.
The NHS111 extension to service was implemented in November, the early indications are positive with planned reductions in out of hours demand being evidenced without any material increase in ED attendances.

Clostridium Difficile

The total number of cases remains above trajectory and the target will not be achieved in 2015/16. The Q&PM committee received a report on c-diff in November that confirmed that lapses in care in the acute Trust remain low (2 cases) and that the key lessons learned / actions from the local C-Diff summit include:-

- 10 community cases are repeat samples, improvements in processes and communication required to avoid these.
- SFT Medical Director championing revisions to the investigation process.
- Improvement opportunities for timeliness of sample taking, antibiotic ward rounds and documentation.
- Communication to GPs re usage of PPI, repeat samples and antibiotic stewardship.

Part of the review confirmed that some of the increase is due to cancer end of life patients who are appropriately treated on antibiotics but consequently vulnerable to C-Diff infection.

Statutory Duty and Resilience

We continue to perform well against the Statutory Duty and Resilience indicators. The numbers of people not on substantive contracts has increased as we have brought in some additional temporary staff to support the Stockport Together programme, and the move to counting GP office holders as part of the employee count.

NHS Stockport Clinical Commissioning Group

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters									Last Three Months			Details		
NHS Constitutional Compliance Indicator	Q3		Q4		Q1		Q2		Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients on incomplete non-emergency pathways (yet to start treatment) should have waited no more than 18 weeks from referral	93.1	★	93.3	★	93.2	★	93.4	★	93.8 ★	93.3 ★	93.1 ★	92%	Monthly	Target continues to be achieved but concern remains over the number of patients waiting more than 18 weeks. Weekly monitoring shows that the backlog is starting to reduce. We have received full assurance from SFT that the backlog is being clinically validated and risk stratified.
Number of patients waiting more than 52 weeks	0	★	0	★	1	▲	1	▲	0 ★	1 ▲	1 ▲	0	Monthly	This breach again relates to UHSM. UHSM are working with Local commissioners, Monitor and NHSE to address these issues.
Urgent operations cancelled for a second time	0	★	0	★	0	★	0	★	0 ★	0 ★	0 ★	0	Daily during Winter (Nov-Mar)	Risks against this indicator are evident as we enter winter.
Number of patients not treated within 28 days of last minute elective cancellation	7	▲	5	▲	2	▲	2	▲				0	Quarterly	Risks against this indicator are evident as we enter winter.

Diagnostics - Last Four Full Quarters									Last Three Months			Details		
Name of NHS Constitutional Indicator					Q1		Q2		Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	97.9	▲	97.2	▲	98.6	▲	98.1	▲	98.5 ▲	98.0 ▲	97.6 ▲	99%	Monthly	SFT remain compliant, this indicator is not being achieved due to performance issues at UHSM and CMFT.

A&E waits - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients should be admitted, transferred or discharged within 4 hours	90.2 ▲	86.0 ▲	93.4 ▲	92.1 ▲	91.6 ▲	92.9 ▲	91.4 ▲	95%	Weekly	See COO report above.
12 Hour waits from decision to admit until being admitted	0.0 ★	0.0 ★	0.0 ★	0.0 ★	0 ★	0 ★	0 ★	0	Quarterly	See COO report above.

Cancer waits - 2 week wait - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	95.5 ★	95.7 ★	96.0 ★	95.8 ★	96.7 ★	95.8 ★	95.1 ★	93%	Monthly	There is no significant risk identified to threaten future performance.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	98.4 ★	98.0 ★	95.5 ★	97.2 ★	97.7 ★	96.8 ★	96.8 ★	93%	Monthly	There is no significant risk identified to threaten future performance.

Cancer waits - 31 days wait - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	98.6 ★	97.6 ★	98.3 ★	98.9 ★	98.5 ★	100.0 ★	98.3 ★	96%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is surgery	98.8 ★	97.2 ★	98.2 ★	98.2 ★	97.3 ★	100.0 ★	97.4 ★	94%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	100.0 ★	100.0 ★	100.0 ★	100.0 ★	100.0 ★	100.0 ★	100.0 ★	98%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	100.0 ★	100.0 ★	90.0 ▲	100.0 ★	100.0 ★	100.0 ★	100.0 ★	94%	Monthly	There is no significant risk identified to threaten future performance.

Cancer waits - 62 days wait - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	75.5 ▲	85.5 ★	88.3 ★	88.2 ★	83.3 ▲	98.2 ★	84.4 ▲	85%	Monthly	This is a quarterly target and Q2 has been achieved.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	97.2 ★	91.9 ★	96.9 ★	85.2 ▲	90.9 ★	100.0 ★	75.0 ▲	90%	Monthly	This target reflects small numbers - cumulatively this year 54 of 59 patients have been treated within the standard (92%)
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	80.4	72.7	79.5	72.1	60.0	83.3	75.0	No National Standard	Monthly	There is no national standard for this measure.

Category A ambulance calls - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	65.3 ▲	67.0 ▲	77.5 ★	78.5 ★	79.3 ★	77.7 ★	78.4 ★	75%	Monthly	See Above COO Report
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	66.7 ▲	65.8 ▲	76.6 ★	75.4 ★	76.0 ★	75.4 ★	74.9 ▲	75%	Monthly	
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	91.2 ▲	91.1 ▲	95.2 ★	94.8 ▲	94.6 ▲	95.1 ★	94.6 ▲	95%	Monthly	

Mixed Sex Accomodation Breaches - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Minimise breaches	0 ★	0 ★	0 ★	0 ★	0 ★	0 ★	0 ★	0	Monthly	There is no significant risk identified to threaten future performance.

Mental Health - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Jul 2015	Aug 2015	Sep 2015	Operational Standard	Collection Frequency	Status / Commentary
Care Programme Approach (CPA) : the proportion of people under adult mental illness specialities on CPA who were followed up within seven days of discharge from psychiatric inpatient care during the period	98.3 ★	100.0 ★	100.0 ★	96.1 ★	94.7 ▲	93.3 ▲	100.0 ★	95%	Monthly	This is a quarterly standard and Q2 has been achieved.

Healthcare associated infection (HCAI) - Last Four Full Quarters								Last Three Months						Details		
Name of NHS Constitutional Indicator	Q2		Q3		Q1		Q2	Jul 2015		Aug 2015		Sep 2015		Operational Standard	Collection Frequency	Status / Commentary
Incidence of healthcare associated infection (HCAI) i) MRSA	2	▲	2	▲	0	★	0	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Incidence of healthcare associated infection (HCAI) ii) C. Difficile	24	▲	24	▲	34	▲	36	13	▲	11	▲	12	▲	7.4	Monthly	See COO Report above.

Key

Indicator RAG rating

★ Green - Performance at or above the standard

▲ Red - Performance below the standard

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Statutory Duty & Resilience Compliance

Statutory Duty and Resilience - Last Four Full Quarters									Last Three Months						Details		
Statutory Duty or Resilience Measure	Q3		Q4		Q1		Q2		Jul 2015		Aug 2015		Sep 2015		Operational Standard	Collection Frequency	Status / Commentary
Percentage of FoIs handled within the legal timeframe	98.0	★	100.0	★	100.0	★	98.3	★	100.0	★	100.0	★	93.8	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Number of limited assurance reports received from auditors	1	▲	1	▲	0	★	0	★	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Number of statutory Governing Body roles vacant	0	★	0	★	0	★	0	★	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Percentage of complaints responded to within 25 working days	93.8	★	77.8	▲	84.6	★	90.9	★	100.0	★	85.7	★	N/A		80%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of days lost to sickness in the last 12 months	2.25	★	2.23	★	2.01	★	1.89	★	1.84	★	1.89	★	1.94	★	2.5%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of staff contracts which are substantive.	83.8	★	85.6	★	80.7	★	78.9	▲	79.3	▲	79.1	▲	78.7	▲	80%	Monthly	The numbers of people not on substantive contracts has increased as we brought in some additional temporary staff to support the Stockport Together programme, and the move to counting GP office holders as part of the employee count.
Percentage of staff working with vulnerable people who have a confirmed up to date DBS check	100.0	★	100.0	★	100.0	★	100.0	★							100%	Quarterly	There is no significant risk identified to threaten future performance.

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Quality Report

Report of the Quality & Provider Management Committee

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

The Governing Body is requested to consider whether any of the issues raised in this report require a higher level of escalation.
Please detail the key points of this report
Summary • This report summarises the key decisions of the Quality & Provider Management October Committee. **Decisions** • None **Attachments** • Quality & Provider Management November Issues Log
How does this link to the Annual Business Plan?
Improving the quality of commissioned services is a key strategic aim within the CCG Annual Operational Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Quality & Provider Management Committee
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Mark Chidgey
Meeting Date: 9th December 2015
Agenda item: 8
Reason for being in Part 2 (if applicable)
Not applicable

1.0 Decisions of the Quality & Provider Management Committee

1.1 Issues Log:

- The only `red' issue remains assurance of SFT CIP plans. Resolution of this long standing issue will is included within commissioning intentions for 2016/17.
- The issue of PREVENT training was added to the issues log as 'amber' - the current trajectory would mean that the training programme is not fully completed until 2018.
- The issue of safeguarding at St Ann's Hospice was revised to 'green' in recognition of the progress that has been made.

2.0 Issues highlighted to the Governing Body

2.1 Future Governance changes – The committee are sighted on the agreed changes to committee structures. The new Quality committee will remain a committee of the Governing Body and STAMP will become a sub group of it. The committee will cover the quality agenda, meet formally bi monthly and will have bi monthly deep dive meetings

3.0 Decisions for the Governing Body

- None

Compliance Checklist:

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	N/A
Page numbers	Y	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

Quality Provider Management Committee Issues Log
(Following Q and PM Committee of 18 November 2015)

Issue	Date added	Description	Action / Progress	Owner	Expected date of removal	Q&PM RAG rating	Last Updated	Context (papers)
1	17/06/2015	There is an issue regarding safeguarding assurance in Maternity at SFT.	SG fed back the limited progress regarding the revised action plan, however, all areas had progressed in some way.The action plan to be tracked by SG and progress to be brought back to Q&PM.Trust board aware of concerns.	SG	Jan-16		Nov-15	H:\Misc\Mark C\ QPM\Q&PM 2015-16\17June15\PDF\
2	20/05/2015	There is an issue with St Ann's Hospice non-compliance with Safeguarding standards which may put patient safety at risk.	Escalated to NHS England. Action Plan received from St Ann's in June. Reviewed and monitored by SG, currently on trajectory, for removal if it remains on track to January 2016.	SG	Jan-16		Nov-15	St Ann's Action Plan.
3	15/04/2015	There is an issue with patients waiting beyond 62 days for cancer treatment. This exceeds the national standard.	Trust achieved this target for Q1 but performance dipped in July due to a complex cohort of patients who required several pathways, in August the target was met at 92.7%. Compliance is tracked through the bi-monthly performance meetings - for removal in January 2016 once compliance has remained consistent through Q2.	MC	Jan-16		Nov-15	
4	18/02/2015	There is an issue with timely follow-up of glaucoma patients at CMFT. There may be an issue with timely follow-up of other high-risk patients e.g. diabetic retinopathy and Wet AMD.	CB has written to the Medical Director at CMFT. GM sought further clarification through the contracting meeting, this data received from CMFT was discussed at the October Q&PM meeting. November Q&PM agreed CCG to write to CMFT asking for further risk assessment of all high risk ophthalmology patients who have delayed follow-up appointments.	CB	Jan-16		Nov-15	
5	19/11/2014	There is an issue that the District Nurse service staffing levels are not at a level to meet patient needs. Stockport GPs are reporting a need to provide additional care to patients. This is not sustainable.	SFT trajectory to achieve compliance with staffing establishment monitored at community contract meeting. The Trust have rasied some concerns that the baseline staffing is incorrect due to no uplift being applied historically, they are currently performing a staffing and acuity audit, results to be reviewed at community meeting and Q&PM updated. A revised trajectory was provided to the November contract meeting, showing existing staffing at 118 against a staffing establishment of 140.	CB	Jan-16		Nov-15	Trajectory & SFT Risk rating G:\Committees\ 2015 16\Q&PM\ 18Nov15\For info\

Quality Provider Management Committee Issues Log
(Following Q and PM Committee of 18 November 2015)

6	18/12/2013	CIP - CCG only has sight of high level CIP Plans and no formal mechanism for reviewing plans or monitoring progress against plans.	High level QIAs received but no assurance RE: the quality impact of cost savings. Escalated to COO.The issue was raised at the contract meeting and has been addressed in the SRG chairs letter which has been circulated to the Executive at the Trust. It was noted that the CCG would not sign off the CIP until further information was received from the Trust. This has been escalated to the Chief Executive. No clear view on next steps.	MC			Nov-15	
7	20/11/2013	There is an issue with patients receiving timely follow-up in gastroenterology.	A breakdown of the gastro patients awaiting follow up have been received by the CCG. Awaiting a Consultant review of this waiting list before the CCG can agree to support a planned discharge of a proportion of the out-patient list.	CB	Jan-16		Nov-15	G:\Committees\ 2015 16\Q&PM\ 18Nov15\For info\
8	18/11/2015	There is an issue that front-line staff at SFT have not received PREVENT training and this may not be rectified until 2018.	Compliance with PREVENT training has been tracked through a KPI since April 2015. This has not been met. Trajectory for compliance is by 2018. Stockport CCG communicated that this is not acceptable.	SG	Mar-16		Nov-15	

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Chief Operating Officer's update

Chief Operating Officer's update to the December 2015 meeting of the Governing Body

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Executive Summary

What *decisions* do you require of the Governing Body?
This report provides an update on a number of issues.
Please detail the key points of this report
Provides an update on: 1. Mid-Year Conference 2. Update re integrated commissioning 3. Update re Stockport Together 4. Governance Review Implementation and Constitutional Changes
What are the likely impacts and/or implications?
How does this link to the Annual Business Plan?
Supports delivery.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 9th December 2015
Agenda item: 10

Chief Operating Officer Update

1.0 Purpose

1.1 This is the report of the Chief Operating Officer to the Governing Body for December 2015.

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2.0 Mid-Year Conference

2.1 The CCG held a Mid-Year Conference for all staff on Wednesday 25th November. The purpose of the event was to review how we are performing against our key objectives, celebrate success and provide a forum to discuss in detail some of the significant programmes that are being taken forward: Stockport Together, Vanguard Programme, Integrated Commissioning and Devolution. These themes and the need to ensure consistent and timely information about them has been highlighted in staff surveys.

The event was positive and there will be a formal review of feedback.

3.0 Update re integrated commissioning

3.1 The CCG and Council have agreed to pool significant resources under a section 75 agreement from 2016/17. Significant work is now taking place to:

1. Develop an integrated commissioning function to support those arrangements
2. Review and update the governance arrangements in support of the pooled fund
3. Review and re-draft the formal legal agreement between the two organisations

A detailed update will be provided at a future meeting.

4.0 Update re Stockport Together

4.1 Stockport Together is entering an important stage as the Business Case for the first phase of developments is finalised. The Business Case will be discussed by the Governing Body early in 2016.

4.2 To strengthen the leadership capacity within Stockport Together to support the next phase of development and implementation, tow changes have been made:

- Gaynor Mullins to act as joint SRO with Andrew Webb (Corporate Director, Stockport MBC)
- Tim Ryley to act as Programme Director for the programme

5.0 Governance Review Implementation and Constitutional Changes

5.1 The CCG Governing Body approved the recommendations of a full review of the organisation's formal governance arrangements at its meeting in September 2015. The changes requiring amendments to the CCG's Constitution were subsequently considered and approved

by the Council of Members at the Annual General Meeting on 30 November after which an application for the changes to be actioned was sent to NHS England. The CCG received confirmation that the changes had been accepted on 23 November 2015 and the Constitution has since been republished on the CCG's website.

5.2 The content of the changes allows the CCG to re-position the focus of its governance arrangements to create a refreshed Finance and Performance Committee to closely monitor and actively oversee the delivery of the organisation's QIPP programme, a new Quality Committee with a remit across all areas of quality and some minor amendments to the wider Committee structure. It also included a number of technical amendments to better aid the smooth running of meetings arrangements and some procedural changes to financial requirements. The changes will be enacted from 1 January 2016

6.0 Action requested of the Governing Body

1. To note the updates provided

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Clinical Policy Committee Update

New policies that have been agreed at Committee (CPC); costing implications for new NICE technology appraisals; best practice gaps

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Executive Summary

What *decisions* do you require of the Governing Body?
• To note the update on the changes to the EUR treatment list. • To note the cost implications of new national NICE guidance: TA358 Tolvaptan for treating autosomal dominant polycystic kidney disease. • To note CPC have endorsed the GMMMG NTS recommendations in section 3.2. • To note the updated costing summary for NICE TA's.

Please detail the key points of this report
This paper informs the Governing Body of new policies that have been agreed at Clinical Polices Committee (CPC), best practice gaps around NICE guidance and costing implications for new NICE technology appraisals.
What are the likely impacts and/or implications?
Impacts on budget identified in NICE costing tool. All other measures are in place to manage clinical cost effectiveness
How does this link to the Annual Business Plan?
Effective use of resources is an essential part of QIPP. This process ensures innovation by systematic and timely dissemination and adaptation to new NICE guidance and the control of new developments in-year.
What are the potential conflicts of interest?
None.
Where has this report been previously discussed?
Clinical Policy Committee (CPC)
Clinical Executive Sponsor: Dr Vicci Owen-Smith
Presented by: Dr Vicci Owen-Smith
Meeting Date: 09.12.15
Agenda item:
Reason for being in Part 2 (if applicable) n/a

1.0 Purpose

1.1 This update ensures that the CCG is able to introduce new policies, innovate and adapt to new NICE guidance in a systematic and timely manner and prioritise investment within our financial envelope.

2.0 Context

2.1 The Governing Body is asked to note the TA costing summary for 2015/16. The total cost impact is currently unchanged at £403,167.00

3.0 General Policies and NICE Guidance

3.1 CPC noted new national guidance TA358 Tolvaptan for treating autosomal dominant polycystic kidney disease. CPC have identified this is a high cost drug with a potential cost impact of £300,000.

3.2 CPC have endorsed the following GMMMG NTS recommendations: Xultophy Insulin Degludec Liraglutide, Topical Gabapentin and Ivermectin cream for acne roseaca.

3.3 CPC have reviewed and updated the EUR treatment list. The list has been updated to remove requests that have only been received once; the status of these items has been moved to precedent decision. GM recommend a policy is set when at least 5 requests have been received these changes therefore bring the CCG policy in line with GM.

4.0 Duty to Involve

4.1 The Governing Body of the CCG has delegated the ultimate decision on changes to policies to the CPC.

4.2 Due to the technical nature of policy discussions around new treatments and medications, the Clinical Policy Committee (CPC) has four members of the Governing Body, including a GP (as chair), the Public Health Doctor, and the lay chair of the Governing Body (as vice chair) as well as expert directors and managers and lay representation from Stockport's Healthwatch.

4.3 Where individual patients or referring clinicians disagree with a decision, their case will be reviewed on an individual case basis by the Individual Funding (IF) panel.

5.0 Equality Analysis

5.1 As a public sector organisation, we have a legal duty to ensure that due regard is given to eliminating discrimination, reducing inequalities and fostering good relations. In taking our decisions, due regard is given to the potential impact of our decisions on protected groups, as defined in the Equality Act 2010.

5.2 We recognise that all decisions with regards to health care have a differential impact on the protected characteristic of disability. However, in all cases, decisions are taken primarily on the grounds of clinical effectiveness and health benefits to patients. As such, the decision is objectively justifiable.

Dr Vicci Owen- Smith

Compliance Checklist:

Documentation		Statutory and Local Policy Requirement	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	n/a
Page numbers	Y	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	na
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	Na
		Any form of change: Risk Assessment Completed and included	n/a
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	na

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Report from QIPP Committee

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Executive Summary

What *decisions* do you require of the Governing Body?
This report provides an overview of the discussions at the QIPP Committee which took place on 24 November 2015. It is important that Governing Body is aware of the progress in delivering the CCG's QIPP Schemes in year and able to identify schemes which are off track and actions to mitigate / support delivery.
Please detail the key points of this report
A key role of the CCG's QIPP Committee is to maintain a strategic overview of the delivery of QIPP schemes and track progress and implementation. To further develop this role, a review of the Committee was undertaken and arising from the wider review of CCG Governance, the Committee will re-focus to become a Finance and Performance Committee from 1 January 2016. The report provides an overview of the discussions which took place at the meeting relating to the following matters: • Maximising Adherence to EUR • GP Referral Management • QIPP Scheme Management and oversight • Reviewing spend on clinical areas
What are the likely impacts and/or implications?
Non delivery of QIPP impacts significantly on the CCG's financial plans and the delivery of required efficiencies (both non-financial and financial.)
How does this link to the Annual Business Plan?
QIPP is an integral part of the CCG's Operational Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
The issues covered by this report were considered at the QIPP Committee on 24 November 2015.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 9 December 2015
Agenda item: 12

QIPP Committee Update for Governing Body

Maximising Adherence to EUR

As part its role in holding to account those responsible for the delivery of QIPP Schemes the Committee received an update from the Project Lead and Senior Responsible Officer on maximising adherence to Effective Use of Resources policy (EUR). The report included progress in achieving the savings projected and highlighted areas where investigatory work had indicated that milestones would not be achieved as had been planned. The Committee considered audit work which had been undertaken in a pain clinic at Stockport Foundation Trust and the assurance which had been provided. It was noted that greater capacity was required to carry out audit work to support QIPP monitoring and delivery.

The Committee discussed the difficulties in deflecting activity without creating capacity which was then backfilled which did not reduce cost pressures for commissioners. Meetings had taken place working with NHS Stockport Foundation Trust and linked to the work of the Planned Care Board to review how EUR prior approvals could be built into existing systems where fitness for surgery had also been assured. Learning from South Manchester Hospital had been reviewed and proposals existed to pilot the approach with orthopaedic triage before considering widening. It was noted that existing GP systems may be able to provide a front end approach to EUR and fitness for surgery approvals.

Key matters for the Committee in discussion included:

- Provider culture and approach to managing finances / costs impacted on the robustness of systems for monitoring adherence to EUR.
- It is important to ensure we implement the right things for patients, whilst achieving financial efficiency across the system.
- Existing pressures and workloads across general practice must be considered in terms of actions pursued.
- Communication is key to ensuring the benefits of any systems implemented are clearly understood by all.
- Trialling processes could be carried out in a sample of practices via existing systems to assess impact / benefits.
- The link to the Referral Management QIPP Scheme is key.
- Additional capacity linked to Planned Care from the CCG could support delivery of adherence to EUR working across care pathways at the point of referral and listing for treatment.
- Stockport Together through the work on planned care and links to the capitated contract is key to working across the broader system to solve the issues identified and provide robust challenge around effective financial investment.
- The CCG needs to ensure continued provision of appropriate Business Intelligence information and support to QIPP leads to access and analyse data to support the delivery of schemes and provide for robust challenge.

A further report would be considered by the Committee in December to include scoping for a front end system for adherence to EUR and fitness for surgery. Any decisions would be escalated as appropriate to Governing Body at a future meeting.

GP Referral Management

As part of its role in holding to account those responsible for the delivery of QIPP Schemes the Committee received an update from the Project Lead for GP referral management. A discussion

took place regarding the issues in proceeding further with proposals regarding the Manchester Triage Gateway and the potential to trial with a small number of practices to get an understanding of any benefits if this could be done with no financial cost.

The Committee expressed support for the development of the Consultant Connect system to enable conversations to take place between GPs and hospital clinicians to advise on the appropriateness of referrals prior to action being taken. The importance of accurate practice level referral data was noted to be essential to support targeted use of systems. The specific areas of medicine for older people and urology were noted as those where agreement to trial with NHS Stockport Foundation Trust had been gained. Other areas would be approached. Consultant buy-in was noted as crucial to ensuring success.

In considering the matter in detail Members of the Committee highlighted the following areas:

1. The Consultant Connect approach was consistent with Zone 3 included as part of the Urgent Care Work of Stockport Together.
2. The Consultant Connect System ensured robust clinical governance was maintained on behalf of primary and secondary care.
3. Pace in trialling the system and buy-in from clinicians were essential.
4. Changes to the way clinicians work to ensure time for the Consultant Connect clinical conversations would need to be managed carefully through ongoing Workforce Development work as part of Stockport Together.
5. The CCG's Commissioning Intentions would be consistent with this approach to include telephone tariffs in place of follow-ups.
6. Communication with general practice was important.
7. The approach was consistent with the proposed establishment and operation of the Multi-Speciality Community Provider.

The importance of ensuring a Senior Responsible Officer was in place for the scheme was acknowledged and a resolution would be sought in addition to the potential for flexible capacity to be made available to support periods of intense work which may arise around system roll-out / embedding. The link to maximising adherence to EUR was identified along with a need for collaborative work around system developments.

The 'You Said – We Did' style communication back to practices about actions implemented arising from referral audits was supported by the Committee. At its December meeting the Committee will consider a project plan to take forward the Consultant Connect work following further conversations with NHS Stockport Foundation Trust and linked to the work of the Systems Resilience Group.

.**QIPP Scheme Management and oversight**

A detailed discussion took place regarding the internal processes for planning for, monitoring and ensuring the on track delivery of QIPP. It was agreed that as a priority, regular and robust reporting mechanisms needed to be fully implemented by a single responsible QIPP Lead who could track and report on QIPP delivery monthly through the Committee and to Governing Body. Available data to support robust reporting was noted to be of key importance. The CCG's Operational Plan was noted to contain the measures for delivery of QIPP schemes, linked to milestones, risk and anticipated financial efficiencies.

The role of the Committee in bringing together clinical guidance reviewed by a revised STAMP Committee and financial analysis of the implementation of guidance was noted as a future way of operation along with a consistent approach to the measuring delivery.

The list of QIPP Schemes would continue to be monitored on a monthly basis by the Committee overseen by the Director of Finance as the lead senior officer responsible for QIPP and managed by the QIPP Lead.

Reviewing spend on clinical areas

At the meeting on the 24th November the Committee considered the CCG's healthcare commissioning approach and the links to the wider Stockport Together Programme. Linked to a number of QIPP Schemes (including Referral Management and Adherence to EUR as outlined above) a number of approaches were discussed to guide the overall system to ensure the quality of patient care was maximised alongside ensuring the money spent across Stockport secured the best value. Discussions took place regarding a number of areas where there was scope for further work to review existing processes and make systematic changes working jointly with Providers. Discussions took place regarding the importance of ensuring fitness for surgery, smoking cessation at the point of referral to ensure suitability and efficient use of resources.

Information about use of patient decision aides and the benefits for patients and the wider system were considered and further scoping detail around use across a range of appropriate pathways would be brought back to the December meeting of the Committee.

The Committee discussed and supported investigation of the use by providers of the Bluetech system to create robust systems around approvals for higher cost medication at the point of prescribing either on individual or group prior approvals. It was noted this kind of system would allow robust monitoring of prescribing costs and could, if successful, be extended to build in prior approvals for all EUR area. The importance of appropriate prescribing expertise both within the CCG and based in provider settings to support system development and implementation was discussed and noted for inclusion in the CCG's Commissioning Intentions .Consideration was also given to how collaborative work could continue to be undertaken with Practices to ensure appropriate prescribing.
A number of areas for further investigation which would be best delivered at a Greater Manchester level were flagged by the Committee to be raised as part of regional commissioning discussions and policy setting.