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 10.00am on 11 November 2015

	Agenda item	Report	Action	Indicative Timings	Lead
1	Apologies	Verbal	To receive and note	10.00	J Crombleholme
2	Declarations of Interest	Verbal	To receive and note		
3	Approval of the draft Minutes of the meeting held on 9 September 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	Video		10.15	J Crombleholme
7	Strategic Performance Updates • Proactive Care Update	Written Reports	To review and approve financial request.	10.25	V Mehta
8.	Corporate Performance Reports • Strategic Impact Report • Performance Report • Finance Report (including Finance Environment Control Assessment) • Quality Report	Written Reports	To receive, assure and note.	10.45	T Ryley G Mullins G Jones M Chidgey
9	Locality Chairs' Update	Verbal Update	To receive and note	11.25	Locality Chairs

10	Report of the Chair	Verbal	To receive and note	11.35	J Crombleholme
11	Report of the Chief Operating Officer to include the following: • Level 3 Co-Commissioning of Primary Care • Re-validation of CCG Nurses • Financial Turnaround • Vanguard update	Written Report	To debate and approve	11.45	G Mullins
12	Report of the Chief Clinical Officer • Joint Greater Manchester Health and Social Care Governance	Written Report	To approve the arrangements	12:00	R Gill
13	Safeguarding - Focus • Safeguarding and Accountability Assurance Framework • Annual report • CQC action plan update • Domestic Homicide	Written Report	To receive and note	12:10	C Briggs.
14	Risk Strategy	Written Report	To approve	12:30	T Ryley
15	Reports from Committees • Clinical Policy Committee • Audit Committee (including Annual Report)	Written reports	To note	12:40	V Owen Smith J Greenough
16	Any Other Business	**Verbal**		12:50	J Crombleholme
	Date, Time and Venue of Next meeting The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 9 December 2015 at 10:00 at Regent House, Heaton Lane, Stockport, SK4 1BS. Potential agenda items should be notified to stoccg.gb@nhs.net by 16 November 2015				

NHS
Stockport
Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT TOWN HALL, STOCKPORT
ON WEDNESDAY 9 SEPTEMBER 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 Own Smith	Clinical Director for Public Health
Dr L Hardern	Locality Chair: Stepping Hill and Victoria

IN ATTENDANCE

Mr M Chidgey	Director of Quality and Provider Management
Mr R Roberts	Director for General Practice Development
Dr D Jones	Director of Service Reform
Laura Latham	Board Secretary and Head of Governance
Terry Dafter	Stockport Council
Sue Carroll	Healthwatch

APOLOGIES

Mr T Ryley	Director of Strategic Planning and Performance

104/15 APOLOGIES

Apologies were received from T Ryley.

105/15 DECLARATIONS OF INTEREST

Dr Higgins confirmed that from Monday 14 September 2015 he would commence in the role as Lead GP for Safeguarding in Stockport. This would need to be added to his Register of Interest.

It was acknowledged the Item 6 – Future of General Practice 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.

106/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 8 July 2015

The minutes of the meeting held on 8 July 2015 were approved as a correct record.

107/15 ACTIONS ARISING

The following updates on actions were provided:

05/06/15 – Action to be removed as the response would be provided as part of the Chair's update.
08/07/15 - 91/15 – Some further work was being undertaken on the Strategic Impact Report and it would be brought to a further meeting for consideration. The information to be shared with Locality Chairs would be disseminated when some data inconsistencies had been resolved.
08/07/15 – 94/15 – The report from SRG would be provided to the Governing Body at its next meeting. The information from NWAS had been included in the Chief Operating Officers Report and the action could removed.
08/07/15 95/15 – This action had been carried out and could therefore be removed.
08/07/15 99/15 – This action could be removed.

108/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were no items on this occasion.

109/15 PATIENT STORY

The Governing Body watched a patient story from a gentleman who had been diagnosed with Chronic obstructive pulmonary disease (COPD) which had also resulted in depression. He explained the impact of the symptoms on his life and the urgent admission to hospital which had resulted in his diagnosis. He noted that the physical symptoms had also resulted in feelings of loneliness and isolation and had put considerable strain on those supporting him. He noted that in response to his feelings, his son had sought help from the COPD Team who put in place a range of medical treatments and wider and support programmes to help him take control of his symptoms and mental health. He acknowledged the importance of the PARIS exercise support scheme and being taught how to breath properly. He concluded by explaining he now felt in control and empowered to manage his condition, none of which would have been possible without the support he had received.

In responding to the patient story, the Governing Body acknowledged the deep emotion which had been portrayed and the importance of ensuring both medical and personal / social needs were diagnosed and supported through treatment. It was noted that support for carers in such circumstances was crucial and in addition to the Council's Carers' Strategy and new requirements from the Care Act 2014, a range of initiatives were in place across Stockport to support carers.

Linked to COPD was smoking cessation and the importance of ensuring proactive and prevention programmes were effectively resourced and embedded was acknowledged by the Governing Body. In discussing the story it was noted that the trigger for diagnosis was a hospital admission which could have been avoided had the patient been accessing services in primary care at an earlier stage.

Members of the Governing Body considered what cultural changes would be required to encourage patients to seek help earlier and engage with their GP on such matters.

It was noted that conditions such as COPD were preventable and often those with mild symptoms did not heed clinical advice provided to assist them. The importance of behaviour change was acknowledged to help more individuals to proactively manage their own health and empower them to self-manage their conditions through prevention and proactive care.

110/15 GENERAL PRACTICE 2020

R Roberts provided an overview of the report and explained that it had been discussed in detail at the July Locality Meetings. He noted that it provided the starting point for the implementation of the strategic view of the future of general practice and captured the range of feelings which had been expressed by General Practitioners. In highlighting the key areas of feedback he noted that whilst there was interest in the proposals and the need for change had been recognised, there were a range of practical and strategic concerns relating to implementation and workforce capacity raised. V Mehta noted that the national conversations relating to 7 Day Access to primary care had been acknowledged as part of the report and needed to be balanced with an understanding of what was right for the patients of Stockport.

R Gill highlighted the workforce issues relating to the proposals and the need to focus on a needs basis on the requirements of the population and manage public expectations. Greater Manchester Devolution was noted to provide a catalyst for change along with the learning and new model of care being developed through Stockport Together's Vanguard Status. In responding to questions, R Gill noted that the link to Healthier Together focussed on the need to ensure appropriate services existed within primary care to enable patient discharge to take place at weekends. Resulting from that would be an opportunity to build a 7 day model of general practice based on managing complex patients and focussing on prevention to avoid hospital admissions.

C Briggs expressed the mixed feelings of general practitioners regarding the changes and in particular, the feeling that 7 day working was being implemented without appropriate resource being applied particularly in light of on-going workforce development and availability issues. A Johnson agreed with this statement and noted that there were feelings of uncertainty about the nature of neighbourhood working within Stockport and a lack of understanding about what the proposed changes would mean for patients.

G Mullins explained that financial resource would be made available to support implementation but acknowledged that it would not resolve issues relating to recruitment across a number of health care areas. It was noted that the Locality Chairs played a key role in supporting and facilitating a change of culture within their localities and in engaging GP colleagues in the discussions as they continued. Members discussed the phased approach which had been taken to facilitating neighbourhood working and the importance in ensuring that the emerging models were consistent in key areas but designed to meet the needs of the locality populations.

R Gill noted that those working in general practice had to drive forward the new model of care focussed within the community and away from acute hospitals and highlighted the opportunities provided to further the vision through Greater Manchester Devolution. S Carroll highlighted the importance of educating the public in self-care and how to access health care services responsibly to maximise the use of all available resources.

J Crombleholme explained that the structure of the Annual General Meeting on 30 September 2015 would allow for significant time to engage with the CCG membership on the future of general practice and access to 7 day services.

Resolved: That the Governing Body:

1. Notes the content of report and the significant implications and challenges arising for General Practice.
2. Supports the continued development of the plans and continued engagement with CCG members, through the Annual General Meeting and other avenues to consider the implications and next steps in detail.

111/15 PLANNED CARE UPDATE

The Governing Body considered an update on the planned care programme specifically focused on the areas of maximising adherence with the EUR Policy, reducing GP referral variation and changes to a number of care pathways. C Briggs expressed concern about lack of progress in delivery and in particular from NHS Stockport Foundation Trust in certain aspects which had been agreed through the Planned Care Board.

V Owen Smith explained that further clinical evidence had come to light relating to facet joint injections which may result in changes to approval processes and allow for thresholds to be monitored more easily.

J Crombleholme expressed concern that the information provided as part of the report was not sufficient for the Governing Body to take the decisions as requested. She sought further information about the risks associated with a number of the elements and highlighted concerns about the pace of the sign off of optimised care pathways. D Jones noted that staffing resource was limited from the Foundation Trust to assist with the work and Commissioner capacity was also limited.

The Governing Body discussed concerns about the lack of monitoring information available from Stockport Together and the importance of ensuring robust governance processes existed to escalate matters and ensure delivery against the programme aims and priority areas. Similar concerns were raised about the lack of availability of data relating to GP referral variation. It was noted that Planned Care Board played a vital role in ensuring delivery but in some instances issues had not been followed up and progressed as anticipated.

G Mullins noted that these matters had been raised at the Leaders Group and in Board to Board meetings with the Foundation Trust.

Resolved: That Governing Body:

1. Notes the progress to date across the initiatives included within the report.
2. Defers the decision regarding whether the CCG continues to pursue the projects described within this paper within current format and timescales until further information could be provided in particular relating to the risks of continuing or discontinuing with the work.

112/15 FINANCE REPORT

The Governing Body considered the current financial and forecast positions of the CCG as at month 4 of the 2015/16 financial year. G Jones drew Governing Body's attention to the table which outlined the

year to date surplus against the projected financial plans. He noted that continuing financial pressures existed in the areas of prescribing and acute admissions.

He noted that the QIPP Committee would be looking in detail at the CCG's Financial Recovery plan and in particular the significant risks which existed in the forecast plan of £2,691k relating to the delivery of proposed additional CIP (£1,082k) and additional yet to be identified CIP (£1,609k) required to ensure delivery of the planned £1.75m surplus. The Governing Body was informed that the risks within the forecast position assumed approximately £1m of CHC legacy monies would be returned.

J Greenough sought clarification about the overspend on all acute providers and the associated reasons. M Chidgey confirmed that all providers were being equality monitored and reasons for overspend related to contractual interpretation, increased referrals into the system and overall rising costs.

The Governing Body considered how demand could best be managed and the importance of the optimisation of care pathways to reduce demand. It was noted that the implementation of NICE Technology Appraisals within the 14/15 year amounted to approximately £600k of additional spend.

Resolved: That the Governing Body:

1.Notes the month 4 financial position of £1k YTD surplus, which represents a £584k deterioration against plan as at 31st July 2015, with a forecast delivery of the £1.75m surplus target at year end.
2. Acknowledges the significant risk (£2.691k) reflected in the forecast position being:

- delivery of proposed additional CIP / Draft Recovery Plan (£1,082k) and
- additional yet to be identified CIP (£1,609k) needed to ensure delivery of the planned £1.75m surplus.

3. Notes that without the inclusion and the assumption of full delivery of the £2,691k additional recovery measures the CCG would be forecasting c£1m deficit.
4. Acknowledges additional net risk totalling £1.5m not within the forecast position
5. Acknowledges that the CCG position reflects the retention of £0.9m performance Fund held in BCF to offset over performance
6. Acknowledges that the forecast position assumes that the National CHC Risk Pool will underspend in line with 2014/15 and that the CCG will receive back £1.0m as a result.

113/15 PERFORMANCE REPORT

G Mullins explained that the period covered by the report included NHS Constitution Targets for June and July for compliance areas. She noted that performance relating to emergency department activity had deteriorated and highlighted performance against targets in other areas of diagnostic waiting times and cases of clostridium difficile. The Systems Resilience Group preparatory work for winter was highlighted along with the related monitoring by NHS England.

It was noted that whilst the referral to treatment target had been met on aggregate, further work to look at speciality level compliance needed to be undertaken. Members acknowledged the continued challenge of managing the delivery of urgent care within the current financial climate.

V Owen Smith sought clarification about the cases of clostridium difficile and those which had arisen as a result of a lapse of care. M Chidgey noted that contract penalties applied in those circumstances and

that the reported figures which largely related to an outbreak at the start of the year had been closely monitored and discussed in detail.

Resolved: That Governing Body note the report and agree that where relevant cases of clostridium difficile which had arisen as a result of a lapse of care would be highlighted in the report narrative.

114/15 QUALITY REPORT

M Chidgey provided a brief summary of the recent work of the Quality and Provider Management Committee and highlighted in particular issues arising for Commissioners as a result of the updated Safeguarding and Accountability and Assurance Framework and the number of serious case reviews underway.

In discussing the 3 never events at NHS Stockport Foundation Trust and the serious case reviews underway, the Governing Body received information from K Richardson as the Chair of the Quality and Provider Management Committee about the proactive use of an issues log to monitor and track issues and the way of the Committee carried out its work including escalating issues to the Governing Body with requests for action.

Members agreed that they felt assured by the work of the Committee in managing the issues within its remit and highlighting matters for Governing Body's attention and / or action.

Resolved: That the Governing Body note the report.

115/15 LOCALITY CHAIRS UPDATE

It was noted that the issues discussed at the July round of Locality Meetings had been captured and discussed in detail by Item 6 – GP 2020 Vision.

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

116/15 REPORT OF THE CHAIR

J Crombleholme highlighted the response which had been provided in relation to a question at a previous meeting of the Governing Body by the Chief Executive Officer of Action for Sick Children.

Governing Body Members were informed of the arrangements which had been agreed for the Annual General Meeting on 30 September 2015 which included a reduced amount of time for procedural business to allow for engagement with members on 7 Day Access to Primary Care.

To conclude she noted that a meeting had recently taken place to review the Board Development Programme for the previous year and plan for the future year. All Members would be contacted to ascertain feedback on the activities which had taken place to date and seek suggestions for future areas of work.

Resolved: That the update of the Chair be noted.

117/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted the key elements included within the report and in particular the decisions required relating to two procurement matters and the application for the CCG to move to Level 3 Delegated Commissioning which had to be submitted to NHS England by 6 November 2015. She explained that it would be considered by the Primary Care Joint Committee and linked to wider proposals as part of Greater Manchester Devolution. Information about the benefits and any challenges of moving to Level 3 would be circulated to the Governing Body.

The Governing Body was also informed that the Local Authority had recently published a consultation relating to children's and adult's services budget matters. It was agreed that some detailed consideration of the proposals could to be undertaken by the QIPP Committee following consideration by the CCG's Executive Team and reported back to the Governing Body as required.

With regard to the procurement for the Specialist Weight Management Contract, Mark Chidgey explained that the number of potential bidders had reduced as the procurement process progressed and the successful organisation had been deemed able to meet the required specification and deliver the requirements at an affordable level.

In response to questioning, G Mullins noted that moving to Level 3 Delegated Commissioning would not change the CCG's safeguarding responsibilities.

Resolved: That the Governing Body:

1. Note items 2 – 5 contained within the Chief Operating Officer's Report.
2. Approve the move to Level 3 Co-Commissioning and to circulate information to Governing Body Members about the benefits of moving to this level.
3. Request that the QIPP Committee review and respond to the Local Authority consultation relating to children's and adult services budget proposals.

118/15 REPORT OF THE CHIEF CLINCIAL OFFICER

R Gill provided an update on the decisions arising from the Healthier Together Programme which included unanimous approval of the designation of Stepping Hill Hospital as the fourth specialist hospital site. He noted that the implementation plans had been temporarily paused whilst discussions were on-going in relation to the view on Wythenshawe Hospital expressed by the University Hospital of South Manchester. He noted that it was hoped that implementation would commence towards the end of 2015 and a standardised methodology would be applied along with the requirement to create an Association of Teaching Hospitals for all single services including Stepping Hill Hospital.

The financing of the governance for the programme was considered and Members also considered the continued challenge of specialist commissioning across Greater Manchester. G Mullins noted that specialised commissioning was currently being discussed at regional level and a workshop would take place imminently on the matter.

It was noted that it was important that governance processes and methods of influence linked to Greater Manchester Devolution were communicated clearly when available.

Resolved: That the Governing Body note the update provided.

119/15 INVESTING IN STOCKPORT – DRAFT PLAN

Governing Body considered Investing in Stockport Draft Plan. G Mullins informed Members that the plan had been discussed in detail with the Local Authority by herself and T Ryley.

Resolved: That the Governing Body endorses the draft Investing in Stockport Plan.

120/15 GOVERNANCE REVIEW

L Latham provided an overview of the findings and recommendations of a review of the CCG's formal governance processes which had been undertaken between May – August 2015. She highlighted the importance of maximising the value added by the CCG's formal governance structures and the issues of clarity around reporting and delegation which had emerged. The recommendations included a number for internal management action and others relating to structural and operational changes to the governance model.

It was noted that the governance review had been carried out as an initial stage in ensuring the continued development of the CCG's structures particularly in light of changes across the Stockport economy and more widely through Greater Manchester Devolution. In particular recommendations relating to the operation of Locality Committees were highlighted alongside proposals to refocus the work of the QIPP committee and merge the work of Clinical Policy and Quality and Provider Management Committees.

R Gill noted the CCG was moving towards Commissioning for Outcomes and that the recommendations relating to Committee work in this area would support the move. V Owen Smith commented in support of the matters of clinical quality being looked at as part of overall quality work but noted that other elements of the Committee's work would need to be managed continually either at local or linking to Greater Manchester Level. Primary Care Quality would continue to be reviewed by a Sub-Group of the Primary Care Joint Committee.

The views of Locality Chairs regarding the proposals were discussed. It was noted that reducing the formal requirements around the operation of Locality Council Meetings would provide for greater flexibility of conversation with GP Members at the local level and should support more proactive engagement.

C Briggs requested that consideration be given to how the Systems Resilience Group feeds into the overall CCG Governance Model with a view to maximising its effectiveness and reducing duplication. It was further clarified that the model would increase the opportunities for the Governing Body to hold Committees to account for their work through the Chairs. J Crombleholme sought assurance that the This detail was noted to be available to be worked through at an appropriate point.

Resolved: That Governing Body:

1. Notes the contents of the Governance review.
2. Approve the recommendations (a) – (hh) covering both strategic / external and operational internal governance matters.
3. Endorses the elements arising from the approval of recommendations (a) – (hh) covering the strategic / external elements of the governance of the CCG which require Constitutional amendments and recommend their consideration and approval by the Council of Members at the CCG Annual General Meeting on 30 September 2015.

121/15 STATEMENT OF INVOLVEMENT

L Hayes provided an overview of the 2014/15 Statement of Involvement and in particular highlighted that the CCG had engaged with over 5000 individuals using a variety of communication channels. She noted that the 3 projects of focus for the engagement team had included hypertension, Healthier Together and a winter campaign linked to the Stockport Health and Care Finder App. Governing Body was informed of the priority areas for engagement in the year ahead in particular the focus on engaging with the population on the design of an integrated health and social care system through the Stockport Together Work.

Governing Body commended the work of the Engagement Officer and the wider Communications and Engagement Team. S Carroll explained that Healthwatch felt very engaged in the work of the CCG and commented on the high quality of work produced.

A discussion took place regarding the number of Freedom of Information Requests received by the organisation and the management of the required information.

R Gill commented on the engagement in Stockport as part of the Healthier Together consultation and the potential to continue work on digital empowerment and increase patient access to electronic records. L Hayes noted that campaign proposal was currently being developed to cover this area. S Carroll on behalf of Healthwatch expressed interest in working collaboratively with the CCG on this work.

V Mehta commented on the excellent collaborative communications work between the CCG and Stockport partners including the Local Authority and Foundation Trust and opportunities to look more regionally at communications activity.

Resolved: That the Governing Body:

1. Expresses thanks to the Communications and Engagement Team for their excellent and high quality work.
2. Notes the activity and methods used for public engagement in 2014-2015.

122/15 REPORTS FROM COMMITTEES

V Owen Smith provided an update on the recent work of the Clinical Policy Committee as outlined in the report. She updated Governing Body on the potential cost for the new hypercholesterolaemi drug for the CCG depending on thresholds applied. R Gill noted that it was important for the CCG to respond to the draft Technology Appraisal and raise the financial impact and applied thresholds at Greater Manchester Level. He agreed to progress this action.

It was noted that the Committee had recommended to the Governing Body that opportunities be investigated to take learning from the Local Authority linked to workplace policies and practices to improve health and wellbeing of employees.

The issue raised relating to systems for managing medication errors would also be raised at Greater Manchester Level.

Resolved: That the Governing Body:

1. Notes that CPC have endorsed the GMMMG NTS recommendations in section 3.1.

2. Notes that CPC have endorsed the amendments to the black and grey lists in section 3.2
3. Notes the anticipated cost impact of a new high drug for hypercholesterolaemia.
4. Note the impact of NG13 Workplace policy and management practices to improve health and wellbeing of employees.
5. Notes the update on NG5 Medicines optimisation the safe and effective use of medicines to enable best outcomes.
6. Notes the update on QS93 Atrial fibrillation treatment and management.
7. Notes the updated costing summary for NICE TA's.
8. Receives the minutes of the July meeting.
9. Agrees that the two issues outlined in the body of the minute be raised at Greater Manchester Level.

(The meeting ended at 12.51pm)

Public Questions

The following question was raised by in writing by a member of the public in advance of the meeting:

Are there any plans to work jointly with the pharmaceutical industry on the Stockport together vanguard project? What would they like to jointly achieve?

'A written response would be provided.'

NHS Stockport Clinical Commissioning Group
9 September 2015.

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
08/07/15	Strategic Impact Report Future developments to the report to be enacted including: 1. Monthly provision of information to practices. 2. Stockport Level Cumulative Charts with detailed commentary highlighting any particular locality or practice issues to be provided to future governing body meetings. 3. Locality Chairs to be provided with information for use as part of conversations in Localities.	**91/15**	11 November 2015	Tim Ryley
08/07/15	Performance Report The Governing Body to receive a report from	**94/15**	11 November 2015	C Briggs This report will be presented to the September

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
	the Systems Resilience Group at the September Meeting (to be also considered by the Foundation Trust Board) relating to readiness for winter.			meeting of the Systems Resilience Group and subsequently reported to Governing Body as part of a report in October 2015.
09/09/15	Planned Care Update Further information to be provided to the Governing Body in particular relating to the risks of continuing or discontinuing with the work relating to the projects outlined in the report before any further decisions be taken.	**111/15**	11 November 2015	C Briggs
09/09/15	Performance Update Where relevant cases of clostridium difficile which had arisen as a result of a lapse of care these should be highlighted in the report narrative.	**113/15**	11 November 2015	G Mullins
09/09/15	Chief Operating Officers Report Request that the QIPP Committee review and respond to the Local Authority consultation relating to children's and adult services budget proposals.	**117/15**	11 November 2015	G Jones

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
	Information to be shared with Governing Body Members about the benefits of moving to Level 3 Co Commissioning		30 September 2015	G Mullins
09/09/15	<u>Governance Review</u> Detailed work on merging Clinical Policy and Quality and Provider Committee to be fully undertaken before proceeding with the enacting the recommendations.	**120/15**	30 September 2015	Tim Ryley

NHS
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Clinical Commissioning Group

Proactive Care Update

Paper describes the work and progress of proactive care

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

NHS Stockport Clinical Commissioning Group

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Executive Summary

What *decisions* do you require of the Governing Body?
This is a discussion paper but does request the release of money as described
Please detail the key points of this report
Proactive is organised in four parts – Care Homes, Neighbourhoods, Intermediate Care, Borough wide services. It links with all the other three programmes and is a key part of the new MCP as it develops. There are risks in engagement, recruitment, indemnity, estates.
What are the likely impacts and/or implications?
This will be a key building block of future plans. There is also a request for the release of £400,000 that is currently within general practice budgets but currently uncommitted. The current financial climate would suggest that this should be a saving to improve the financial balance of the CCG however GP engagement and participation within Stockport Together would be reduced and implementation would become more difficult.
How does this link to the Annual Business Plan?
This is a key part of Stockport Together
What are the potential conflicts of interest?
There are no conflicts of interest at the discussion stage although all GP members have a conflict at the point of agreeing finance.
Where has this report been previously discussed?
Clinical Executive Sponsor: Dr Mehta
Presented by: Roger Roberts
Meeting Date: 11th November 2015
Agenda item: 5
Reason for being in Part 2 (if applicable)

Proactive Care Up-Date

1. Introduction

1.1. This paper provides an outline of what is happening in the proactive care programme. It shows how it links to the development of the Multi-specialty Community Provider (MCP) and the Vanguard bid. Finally it identifies the difficulties of delivering a new model of care and moving additional activity into the community into a system that is already under pressure.

2. Progress and plans

2.1. The programme is currently managed in four work streams and an update will be presented on each of these with identification of the next steps.

2.2. Care Homes

2.2.1. Members will be aware of the care home work that was initiated under the GP development scheme. This sought to allocate responsibility across the practices according to their size the care home beds in Stockport. This has largely take place now although some patients have exercised their right not to move and this has been respected.

Education for the care home staff is now an important next step. Money has been obtained from Health Education North west to undertake this work so that the cost to the homes is likely to be only the cost of releasing the staff. This element has slowed due to the person leading this leaving the organisation.

2.2.2. The first Advanced Nurse Practitioner has commenced in the Cheadle, Heald Green Gatley area and she will be working closely with the homes. She will be able to manage some of the more routine acute need reducing the GP burden and will support the embedding of the training provided in the homes. The expectation is that she will be linked to the training programme and as the home staff complete an element she will be with them in the home assisting them to implement what they have been taught.

2.2.3. A first version of a contract between the homes, practice and local authority has been drafted but this can and will be developed further. Through this mechanism it is expected that agreements will be made about a range of issues that require clarity between home and practice e.g. what dressings are homes expected to have and what are supplied, what are the arrangements to take people to the GP if they are able to do so. There is also work in place to allow the CCG to comment upon planning applications for new homes as there is a large concentration of homes in the Marple side of the borough.

2.3. Neighbourhood development

2.3.1. Neighbourhood services will be configured around 8 geographical areas within Stockport based on the 4 localities currently recognised by both Health and Social Care in the configuration of services.

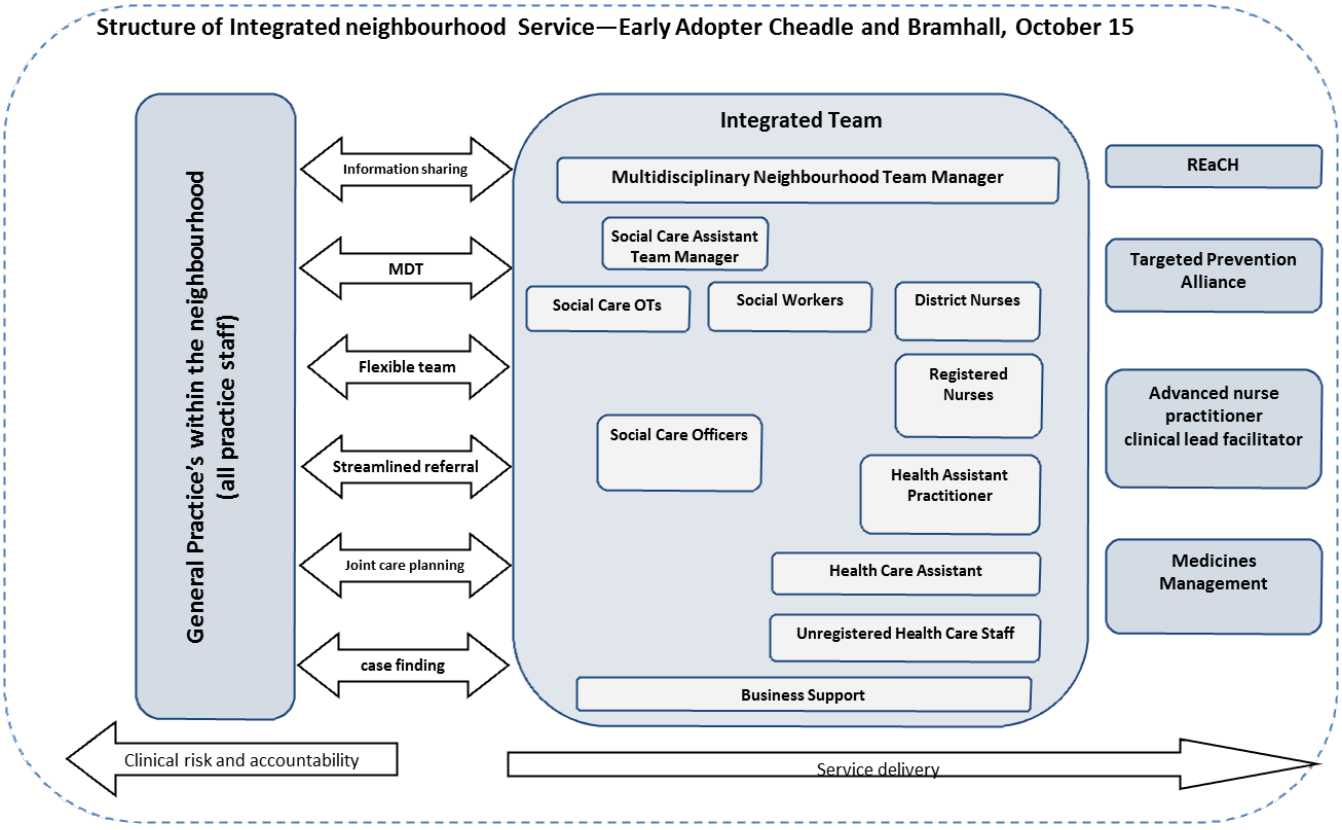
These neighbourhoods are:

- Cheadle
- Bramhall
- Marple
- Werneth
- Stepping Hill
- Victoria
- Heatons
- Tame Valley

2.3.2. Within each of the neighbourhoods there will be a Neighbourhood Service comprising of a broad range of Health and Social Care Services. The principle being that services should be delivered as close as possible to an individual's usual place of residence.

2.3.3. Within the first live neighbourhood in Cheadle, the Proactive Care Programme is testing out the model outlined in the diagram below with a view to expanding the range of staff roles/services included within the Integrated Team and within the Neighbourhood Service.

Diagram 1 Integrated neighbourhood service



2.3.4. Whilst the full Neighbourhood Service Model will be tested out in Cheadle from 21st October an Integrated Team model was established across the whole of Stockport (all eight neighbourhoods). The eight teams are multidisciplinary and contain as a minimum current community health and social care staff within current locality based services with single line management by one of the current locality team leaders/managers. The neighbourhoods will "go live" at the point that the GPs start to work with the teams formally through the multidisciplinary team meetings.

Enabler requirements

2.3.5. A number of enablers are required to offer a full model of neighbourhood working:

2.3.5.1. Co-location of the Integrated Team (community nursing and social care) in order to facilitate joint working and communication and eliminate the need for referrals. Co-located bases in the 8 neighbourhoods should be available for the Integrated Teams by the end of 2015, this requires some small capital schemes to provide appropriate accommodation. The medium to long term plan is to relocate these neighbourhood teams in more purpose- built facilities embedded within their communities in a way that enables them to share a number of common facilities with other public sector organisations. As well as meeting needs, local communities will be able to access a range of services provided to them by the full range of public sector organisations appropriate to that locality's needs; with specific reference to a range of Council- based services which could include (but is not limited to) education, health, local community civic facilities, children's and adult day centres, community police, CAB, library facilities, elderly care facilities, information centres and community cafés.

2.3.5.2. From October GPs, Community Health and Social Care staff are able to access core information from each of the case management/clinical systems through the Stockport Health and Care Record. It is planned to move to a more strategic solution which is dependent on the FT commissioning their community system and interfaces being developed between existing systems in the local authority and the hospital. There is also a need to enable staff to work with mobile technology to make best use of their time and interaction with service users.

2.3.5.3. Investment in some transitional capacity to allow teams to test out new models of care alongside delivering business as usual. This approach will help to measure the impact on the wider system of specific investments in order to be able make future investment and disinvestment decisions.

2.3.5.4. Finance and activity modelling is required in order to be able to demonstrate the impact of neighbourhood working in other parts of the system and be able to describe return on investment for any additional recurrent resources committed.

Multi-disciplinary team (MDT) working

2.3.6. In the Cheadle neighbourhood there will be a weekly neighbourhood multi-disciplinary meeting to discuss individual cases where it would be beneficial to have multi-professional input whilst developing a proactive management plan. Learning from Marple and Werneth the MDT will meet on a weekly basis and seek consent from individual service users to discuss their care with a range of professionals. Each service user will be allocated a Care Co-ordinator who will be a single point of contact for the service user.

Preventative Services and the third sector

2.3.7. Preventative services have been redesigned and re-commissioned with a focus on delivering a tangible contribution to the local care and health economy (prevent, reduce, delay). Optimising what can be provided to a wide range of vulnerable people, ensuring people who need support get it and that people are able to make informed choices and look after themselves. The new range of services will work collaboratively to identify, target and go on to support, in a holistic way Stockport residents who most need help to stay living safely, independently and well in their own homes and communities; with volunteers and peers playing a key role alongside and within the community and voluntary sector helping 'people to help people'.

2.3.8. A key component of the new neighbourhood model is the Targeted Prevention Alliance. This service will work alongside the Integrated Team to provide bespoke person-centred support to promote self-reliance and independence and build upon individual's strengths. The aim of the service is to support people to move towards more independence and self-reliance. This will include a light touch approach where people require low level service information through to intensive one to one work with people with complex needs. The staff team includes Key Workers who deliver one to one support, Complex Key Workers who work with people with the most complex needs, and Community Connectors who help make links with community resources based around the four developing integrated health and social care Locality Hubs

2.3.9. Another key aspect of the new preventative service offer is the Wellbeing and Independence Network (WIN). This is a new network of three main services which will provide very practical help to adults who would otherwise find it very difficult to organise the support they need to remain independent and well. The WIN is aimed specifically at older people, people with a wide range of disabilities or poor mobility and their carers. Users of the service may be either overcoming a sudden event or illness or may need some short-term help to live a normal and independent life or to stop a crisis from happening. The WIN services will also be able to plan tailored support for people whose needs are very specific.

Seven day working

2.3.10. The national requirement to move to seven day working has become interlinked with the requirement for a more proactive service. In the next few weeks the

Integrated Teams (DN and SW) will provide an 8am to 8pm Monday to Friday service. In order to be able to provide seven day working at a neighbourhood level in primary care there is a requirement for practices to be able to view each others records which should be possible from February 2016. The CCG and Viaduct are currently working with practices to work up a proposal for the full seven day working model. The aim of this work in primary care is not to open general practice as it is during the week but to establish a service that provides more screening for high risk people who may not appear during the week or working day and to provide more capacity to optimise the care of those people with long term conditions who may be working or need the support of a working relative to attend a review.

Risks

2.3.11. Engagement of primary care; a programme of 6 workshops per neighbourhood have been designed to bring together GP practices, community nursing and social care to agree ways of working. The sessions seek to agree consensus of new ways of working to test out in each neighbourhood. Unfortunately Bramhall neighbourhood did not feel that this process was sufficiently robust in seeking consensus in the practices so have asked for a pause to resolve some identified issues so are no longer part of the early adopter in October. The issue of general practice indemnity is also difficult as the models of care change.

2.3.12. Information governance and data sharing; the processes required for information governance and data sharing across multiple organisations and different sectors is complex. The Integrated Care Board has agreed to the sharing of caseload information in order to be able to identify the service user cohort who will then be contacted.

2.4. Intermediate Tier

2.4.1. A review of the current services has been completed and the work to redesign the new services is stating. It is anticipated that there are savings to be made in this area although the magnitude of these is not yet clear. Whilst we don't yet know the magnitude of the savings we do know that there are currently 20 services delivering in the Intermediate Tier at an annual cost of £18,053,977; Of which £6,002,733 is spent on 152 beds (not including spot purchases and A10 rehab beds).

2.4.2. There are opportunities to reduce costs through reduced management costs reducing acute length of stay by placing more focus on step-up and mental health capacity. Most services focus on the 'step-down' from hospital and rehabilitation treatment. There is limited 'step-up' with a focus on preventing unnecessary hospitalisation (10% step-up v 90% step down in bed-based services and 20% step-up v 80% step down in home-based services)

2.4.3. Of the 152 intermediate care beds, only 20 are allocated to transitional mental health needs with many care homes not able to take patients with more advanced dementia, delirium, challenging behaviour and other functional mental health needs

2.4.4. The services identified as intermediate were those that fit with the definition below

> *short term, multi-disciplinary* intervention - for people in *transition* - to either support *early discharge from hospital* for people who are recovering from an illness or fall - or to *prevent a hospital admission* for people in the community whose situation has deteriorated.

2.4.5. Looking at the needs of patients within intermediate tier services, three types of need were identified:

- **Time to recover / time to assess**: Some people need more time to recover from an illness or fall before decisions about future care plans can be made or need extra time to build up strength and skills to regain independence before rehabilitation can start. Support can be organised either at home or in a community bed. Crucial is that people receive health, social care and wellbeing support on this recovery journey to achieve optimal independence as soon as possible or are able to start further rehabilitation / reablement treatment timely.
- **Rehabilitation & enablement**: People may require a person-centred therapy, social, psychological and and/or medical intervention to regain independence after an operation, a fall or exacerbation of illness. The care is ideally provided in the person's place of residence. In case this place of residence is not safe, suitable or available, a short term placement in an intermediate tier bed will be needed to support the rehabilitation provision.
- **Clinically enhanced care**: Some people have a sub-acute need and don't need a hospital admission but require short-term treatment that cannot be delivered by the generic neighbourhood team (e.g. IV therapy, more intensive clinical treatment). This care is ideally delivered in the place of residence but can when needed be provided in an intermediate tier community bed.

2.4.6. A number of design principles were identified and are listed

- Single commissioning outcomes framework
- One point of access, one full holistic assessment
- One service, one single management structure, one pooled budget, one performance management system, one governance structure
- Holistic provision 7 days a week, 24hrs as and when needed
- Responsive assessment and flexible support allocation
- Integrated within pro-active care and supporting continuity of care in the neighbourhood
- Offer follows the person's need
- Short-term offer; as short or long as needed to meet agreed outcomes
- Third sector integrated partner in delivering intermediate tier provision
- Opportunities created to ensure healthy ageing and connection with community for patient and carer.

2.4.7. A person-centred care package will be organised for patients with any of the needs above, based on a holistic needs assessment. A co-produced care plan will include outcomes at a 24hrs & 72hrs followed by outcomes on a daily / weekly basis depending on the type of intervention. At the start an estimated conclusion date when the short-term intermediate tier intervention should be completed will be included in the care plan. One of the key professionals delivering the care plan will be responsible for the monitoring of the care plan (care-coordinator) and will ensure links with neighbourhood team. The care plan will be delivered by staff with the right skills meeting the needs of the patient at that moment and may include therapy, nursing, social work, reablement, practical support, equipment & adaptations, prevention, emotional / psychological support.

2.4.8. The review identified several gaps, duplication and fragmentation in the current intermediate tier delivery. Through improvement it is envisaged that the following benefits (financial and quality improvement) can be achieved:

- Increased provision of support at home at night to support early hospital discharge, to prevent hospital admission and to increase intermediate tier provision at home instead of in a community bed
- Increased uptake of IV-therapy in the community to support the delivery of enhanced sub-acute care
- Increased input from mental health specialists to improve an holistic provision at the right time and right place that is inclusive for people with cognitive and mental health problems
- Supportive facilities to meet sub-acute needs in the community, e.g. access to diagnostics, right skill mix
- Increased step up offer instead of intermediate tier being predominantly step down
- Avoiding duplication by providing an integrated service through the framework of one service specification, one clinical governance & management system and one monitoring system
- Cost-savings through efficiencies by making better use of skill mix of staff, continuity of care within one team and avoiding duplication
- Reduced length of stay in hospital through a more streamlined discharge pathway into intermediate tier provision with right input at the right time – if needed outcomes are planned on a 24hrs basis
- Shorter stay in intermediate tier with better outcomes for the person, including a central bed-management system to manage the use of the intermediate tier beds more efficiently
- Increased and improved use of technology for reporting and multi-disciplinary meetings

2.5. Borough Wide Services

2.5.1. In the neighbourhood team there are in the first phase only District Nurses and Social Workers. All other services are borough wide. This work is looking at these services to identify if they can go into the neighbourhood teams or if they sit outside of this how do they connect with an support the neighbourhood team. It is easy to see why a service of three people can not be shared across the 8 neighbourhood teams and this is often why it is not possible to move them into the teams as might

be preferred. In the appendix is a map that shows the complexity of the services in the health part of the community. This does show some services being delivered at a locality level which has since been decided not to be practical as layers of management are to be avoided.

2.5.2. The work has been split into four sections with services grouped as shown. In cohort one the specialist nurses and consultants in psychiatry and care of the elderly are the main focus. The specialist nurses are being given a more comminute facing focus and proposals have been received from both care of the elderly and psychiatry consultants about how they could provide better community support. The mental health work also includes a proposal about the development of mental health liaison posts in the neighbourhood teams.

2.5.3. The review of cohort one is almost complete and work has now commenced on cohort 2. From the first group there are no services joining the neighbourhood teams but this is envisaged to change and the review progresses through the stages above.

Table 1

Borough Wide			
Cohort 1	Cohort 2	Cohort 3	Other
• **Pulmonary Rehab** • **COPD** • **Home O2 Service** • **Specialist Palliative Care** • **Palliative Respite** • **EOL Enhanced Care** • **Continence Service** • **TVN** • **Heart Failure** • **Diabetes** • **Parkinson's** • **Community Geriatrician** • **Community Advanced Nurse Practitioners** **Pennine:** • **IAPTs** • **Substance Misuse** • **Psychological Mindfulness**	• Out Patient Rehab • Wheelchair Services • SALT • Orthotics • Dietetics • Podiatry • CNRT • MSK • Falls • Physio • OT	• Day Services • Local Assistance Team • LD • GP OOHs • CFS • Sexual Health • Healthy Stockport • Discharge Team: • MRI • Salford • Trafford • Hospital SW Team • Voluntary/3rd Sector • Carer Services Pennine Care: • Young Adults • SAMCAS	• Sensory Loss and Impairment Offer • Equipment and Adaptations Handyperson • SMBC Business Support (centralised) • Safeguarding Adult and Quality Service Manager • Safeguarding Adult and Quality Service Social Worker

3. Links with Other programmes

Prevention and Empowerment

3.1.1. The empowerment work being led in Prevention and Empowerment is a key part of the proactive work where patient education and support for self-care is vital if we are to release capacity to manage the ever growing demand for primary care

services. This work includes the activation of communities to support people in their self-management and the empowerment of staff to support and allow this method of care

3.1.2. The additional capacity being built into general practice extended opening is partially being used to support some additional support prevention activity. It is important that vaccination programmes are maintained and rates improve, screening is also important however for some conditions is better that additional activity is delivered in other sites and may include other services. Examples are the town centre programmes ('Know your numbers' for hypertension) and offers at Stockport county prior to a match. These options are being used and explored further. Core to all general practice and work of the neighbourhood teams must be health promotion advice and support with the delivery of brief interventions as appropriate for smoking, alcohol, weight management and exercise.

Planned Care

3.1.3. The key delivery vehicle for the new model of care is the neighbourhood. It is clear therefore that as the planned care review of outpatient activity is completed there will be implications for the work of the neighbourhoods within this. It is not yet clear what this is likely to be at this stage but a strong core team will be important for other elements to be built into their responsibilities.

Urgent Care

3.1.4. The interface with urgent care is particularly in admission avoidance and rapid discharge and need to link with the work being undertaken in this programme. As it becomes clear what the form of the single point of access is for urgent care this too will need to link with the community service provision.

4. Wider Links

4.1. The work in this area is outside proactive care however in developing the models of care proactive care is supporting some of this activity. There is a process to move commissioning functions across the CCG and the council closer together and in parallel there is a move to join up the provider functions. To do this and include General Practice, a core requirement of Vanguard, some form of federation is required. Viaduct Health is trying to achieve this at the moment. To this end there is a Viaduct Health representative on the proactive care board alongside the FT and LA provider representatives.

5. Risks

5.1. Some of the risks have been identified as the programme has been discussed above. Key to this is that raised in the introduction in that there is a new model of care to be delivered by community services. We know that General Practice is under pressure to an extent that has not been seen before; community nursing is struggling, although vacancies are less now that they have been for some time, and social care has the care act increasing the level of

responsibility that it has. Into this we want to introduce new ways of working and a change in culture when people can barely see the way to the end of their current day. We also want them to do more for the people they have now (increasing education, self-care and developing plans) and then take on more again (those people previously in outpatients). A simple solution if there were no financial constraints would be the recruitment of additional staff but there is a shortage of both GPs and nurses and recent recruitment for care of the elderly consultants has not been successful. Changes in traditional skill mix are therefore also required. There may be opportunity later to transfer some staff from the hospital to the community as the hospital reduces in size.

5.2. Doing this at a time of financial reductions is very difficult as at least there is a need for transitional resource to allow changes in the model of delivery to be worked through. Given however the increasing demand on all elements of the community service it is unlikely that altering the models of care alone will achieve the capacity required. The reduction in hospital capacity will not be achieved until community arrangements have been in place for some months and savings will then take time to be released thus meaning that there is little opportunity for transfer of funds from one sector to the other in the near future. This is further the case as the first call on savings will be to stabilise the economy. Whilst partners can decide to live with this risk and thus move their staff as required General Practice units are small and are less able to carry this sort of risk. This is identified by them now and is a barrier to engagement even though in most cases they are supportive of the concept being developed.

5.3. General practice engagement is crucial to the development of the new services and this has been complicated by the introduction at this time of the seven day opening proposal. This has challenged willingness to participate in some areas. The role of the federation in this is important and initially slow to develop this is now working more directly to support the development of the MCP. This is then compounded by other issues such as IT solutions, information governance, professional indemnity etc.

5.4. To achieve true integration there are many issues that need to be addressed pulling together the organisations providing care to deliver for example a single line management arrangement, governance process and support functions. Until this is on place there will be multiple workarounds as savings in the reduction of duplication across the services will not be achieved.

6. Finance

6.1. There is some money identified in the Vanguard bid to support the transition and will allow people to become engaged in the development of the solutions required. None of this money however is recurrent and therefore not something with which we can engage additional staff at the front line. There is money coming from NHS England to support seven day working and it is hoped to use this to support the general practice element of the model to deliver the extended hours. There is also about £400,000 that was spent with general practice in 14/15 the majority for care plans and other things that is not committed

this year that could be used to support this development. Given the difficult financial situation members are asked if they can support the continued use of this money within general practice.

6.2. The money would be used to enable Viaduct Health to employ up to eight GPs. £400,000 is not enough to employ eight but would fund four giving ½ a GP to each neighbourhood. These GPs would be used to provide the capacity to support the MDT working and acute on the day management of people discharged from hospital or who may potentially be admitted. It is important that these GPs are well connected to the practices with which they work. The aim therefore of trying to recruit eight is that there would then be ½ a GP each day that could be sold back to the practices as a rate better than a locum rate and who knows the local situation. The deployment of this resource could vary across neighbourhoods as the additional post may be used to free existing time to provide the MDT and acute support in that area. There is a risk that the additional ½ GP time might not be taken up by the practices and this resource would then be used to support the seven day working at the weekends for which additional GP resource would be required funded through the money identified above. There is a further risk that eight GPs cannot be found and in this instance nurse practitioners and advanced practitioner pharmacists would be explored as alternatives.

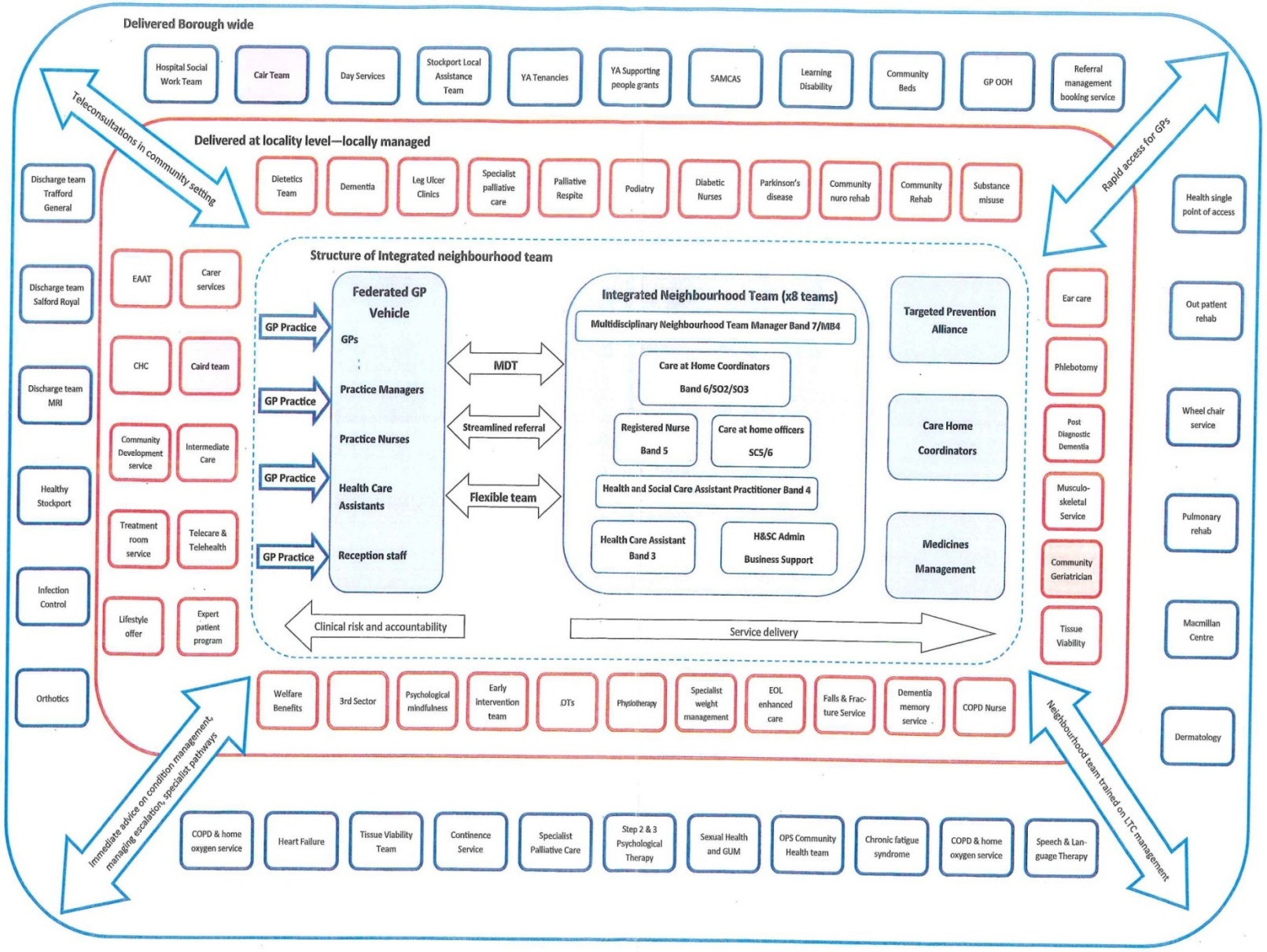
7. Conclusion

7.1. Proactive Care is working hard on a number of fronts to make some substantial changes to the way in which the out of hospital system works. Members as asked to note these and comments are welcome.

7.2. There are areas where savings may be made but there are others where investment is required and it is uncertain at this time if this is transitional or not. This paper asks for the release of £400,000, currently within GP budgets but uncommitted, to support this work. The financial climate would suggest that this is used to offset overspends elsewhere however without the release of this money GP engagement would be more difficult and delivery of Stockport Together would be slower.

Roger Roberts November 2015

Appendix – Community services



NHS
Stockport
Clinical Commissioning Group

Strategic Impact Report

Impact of strategy on shifting activity

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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SK4 1BS

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Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
The Governing Body are asked to note the contents of the report in light of our strategic and operational plans to reduce hospitalisation and contain costs.
Please detail the key points of this report
1. We are above plan in GP 1st outpatient attendances and prescribing. **2.** A&E attendances, long-term condition admissions and elective spells are better than plan **3.** There are some data quality issues the Governing body need to be aware of **4.** There is a lag between changes in strategic data and activity on the ground.
What are the likely impacts and/or implications?
The CCG is now in formal financial turnaround as a result of higher than planned activity and prescribing spend. We will need to review our approach to reducing referrals and understand further why the improvements in management of long-term conditions.
How does this link to the Annual Business Plan?
This report highlights effectiveness or otherwise of the implementation of our business plan.
What are the potential conflicts of interest?
No specific recommendations or decisions impacting on member interest are being made in this paper.
Where has this report been previously discussed?
CCG directors meeting
Clinical Executive Sponsor: Dr Gill
Presented by: Gaynor Mullins
Meeting Date: 11 November 2015
Agenda item: 6
Reason for being in Part 2 (if applicable)
Not applicable

Strategic Impact Report

1.0 Purpose

1.1 The paper presents the CCG's performance against some of the key activity and prescribing metrics used to measure implementation of our strategic and operational plans.

1.2 Where applicable the data is for all providers not just NHS Stockport Foundation Trust.

2.0 Planned Care Performance to date against plan and issues

2.1 The greatest area of growth is in GP referred 1st outpatient activity. We are 3.9% above plan and above the forecast underlying growth in a do nothing scenario. The plan is already phased to reflect that most of the changes being made will take a number of moths to deliver; this means performance will appear *better* than if assumed a flat profile across the year. Financial modelling is based on this flat profile.

2.2 Other referrals resulting in a first outpatient appointment (i.e. hospital doctor-to-doctor) are down -2.4% against plan and elective admissions are down -1% against plan.

2.4 At locality level traditionally higher referrers such as Cheadle and Bramhall have seen the sharpest increase above plan (9.7%)in GP referred 1st Outpatients whilst Marple and Werneth (-0.6%)have seen a modest if statistically insignificant decline. However, the plan required the greatest change in Cheadle and Bramhall and little in Marple and Werneth so this is more likely a reflection of the planning approach.

2.3 It should be noted that referred 1st outpatient activity is a proxy measure of actual referrals. The lag of up to 18 weeks between a referral and a first outpatient appointment means there is a considerable lag between changes in referring patterns and measurement. Further, hospitals for a variety of operational issues will draw different numbers of people off waiting lists into first outpatient appointments each month. The greater the number of months being considered the stronger the proxy measure becomes.

2.4 There is a data quality issue for neurology which is being investigated with Salford Royal and for the time being this is separated out of the underlying GP referred 1st outpatients.

2.5 It is too early in the year to see whether work done with general practice is having an impact but all the underlying growth in elective pressure is in GP Referred 1st Outpatients.

3.0 Non-Elective and Urgent Care

3.1 The number of A&E attendances and the number of GP direct admissions is below plan (-4.2% and -2.1% respectively). This is specifically evident in long-term conditions and care home admissions. Admissions from Care homes are 11.8% below plan, and Long-Term conditions -16.9%, Each reported long-term condition has admission levels below plan (-3.5% to - 41.8%).

3.2 At a locality level there is considerable variation still, however the numbers are often low and thus statistically insignificant at this level of reporting.

3.3 A number of actions were undertaken last year and during the early part of this year to support member practices to address variation in long term condition management and in managing of care homes. At the same-time there have been changes in admission practice at SFT. It is still early in the year and it will be hard to attribute a direct correlation action and benefit.

3.4 Despite the reduction in A&E attendances and reductions in admissions related to long-term conditions there has been an overall 1% increase in non-elective admissions. Further work is being undertaken to understand this.

4.0 Prescribing

4.1 Prescribing spend is above plan and we are moving above England average. The increase in spend is reflected in an increase of 4.7% in items prescribed. All localities have seen an increase in items prescribed though there is variation with Heaton & Tame Valley seeing the biggest increase (5.7%) and Stepping Hill and Victoria the least (2%).

5.0 Summary

5.1 Further work needs to be undertaken to understand the underlying referral patterns and the impact of the latest work being undertaken with practices and also how our main providers are utilising their waiting lists. As part of Turnaround the Governing Body may need to look at a different approach.

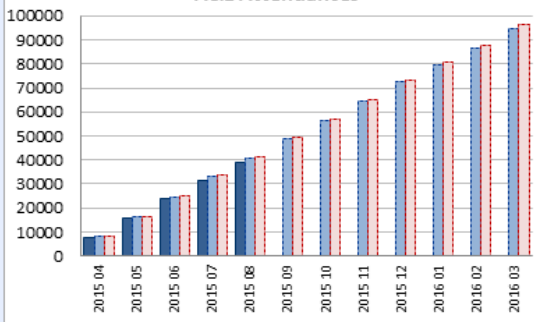
5.2 We need to understand why non-elective admissions are going up and performance remains difficult when A&E attendances, GP direct admissions, long-term condition admissions and care home admissions are all falling.

Stockport Level Strategic Impact Report

NHS Stockport Clinical Commissioning Group

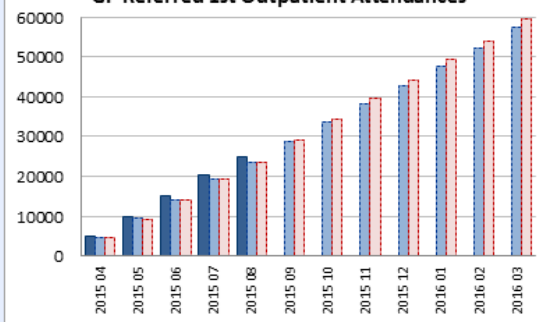
Stockport Level Cumulative Charts 2015/16

A&E Attendances



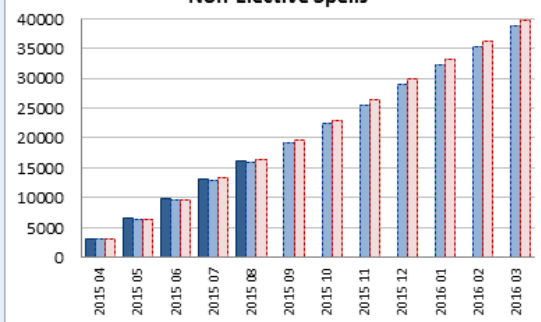
August YTD Total: Actual 39140 Plan 40852 Underlying Growth 41111

GP Referred 1st Outpatient Attendances



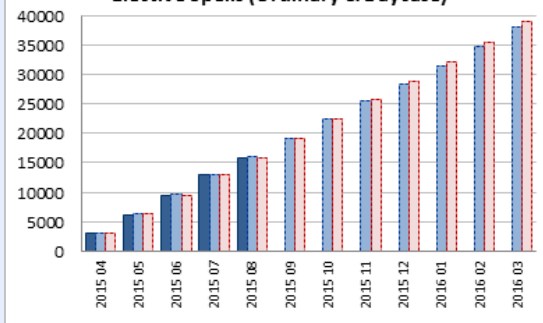
August YTD Total: Actual 25052 Plan 23516 Underlying Growth 23639

Non-Elective Spells



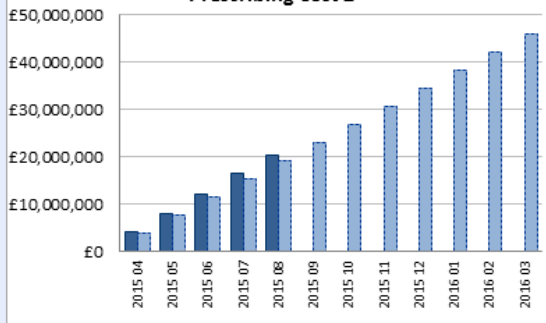
August YTD Total: Actual 16038 Plan 15882 Underlying Growth 16263

Elective Spells (Ordinary & Daycase)



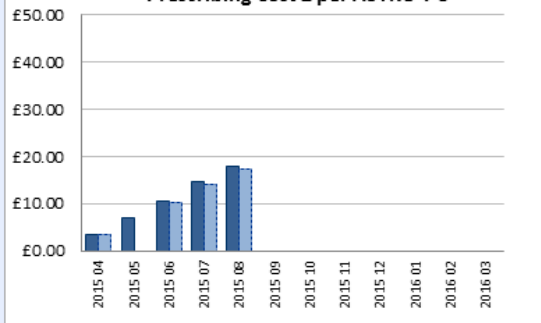
August YTD Total: Actual 15055 Plan 15956 Underlying Growth 15755

Prescribing Cost £



August YTD Total Actual £20,150,812 Budget £19,118,546

Prescribing Cost £ per ASTRO-PU



August YTD Total Actual £17.88 England £17.29

Stockport Wide Data

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-Aug	2015-16 YTD Apr-Aug	Variance	<---------- Practice	%Variance Locality	----------> Stkport
Urgent							
A&E Attendances		40851	39140	-1711	-4.2%	**-4.2%**	**-4.2%**
Ambulance Conveyance Rate		82.0%	80.5%				
Non-Elective Admissions							
All Non-Elective Admissions		15882	16038	156	1.0%	**1.0%**	**1.0%**
GP Direct Admissions		2719	2662	-57	-2.1%	**-2.1%**	**-2.1%**
LTC	**Register**						
CHD Admissions	11666	401	350	-51	-12.7%	**-12.7%**	**-12.7%**
HF Admissions	2627	206	199	-7	-3.5%	**-3.5%**	**-3.5%**
COPD Admissions	6494	212	123	-89	-41.8%	**-41.8%**	**-41.8%**
Asthma Admissions	19327	78	68	-10	-13.1%	**-13.1%**	**-13.1%**
Diabetes Admissions	13981	61	56	-5	-7.7%	**-7.7%**	**-7.7%**
LTC Admissions	54095	958	796	-162	-16.9%	**-16.9%**	**-16.9%**
AF Admissions	5416	256	176	-80	-31.1%	**-31.1%**	**-31.1%**
Care Home Admissions		864	762	-102	-11.8%	**-11.8%**	**-11.8%**
Referrals							
GP Referred 1st OPA		22928	23825	897	3.9%	**3.9%**	**3.9%**
Dermatology		2421	2666	245	10.1%	**10.1%**	**10.1%**
ENT		2483	2729	246	9.9%	**9.9%**	**9.9%**
General Medicine		3771	3933	162	4.3%	**4.3%**	**4.3%**
General Surgery		4289	4446	157	3.7%	**3.7%**	**3.7%**
Obstetrics & Gynaecology		1614	1532	-82	-5.1%	**-5.1%**	**-5.1%**
Opthalmology		1714	1580	-134	-7.8%	**-7.8%**	**-7.8%**
Paediatrics		1044	1094	50	4.8%	**4.8%**	**4.8%**
Rheumatology		530	475	-55	-10.3%	**-10.3%**	**-10.3%**
Trauma & Orthopaedics		2980	3311	331	11.1%	**11.1%**	**11.1%**
Urology		1254	1241	-13	-1.0%	**-1.0%**	**-1.0%**
Other Specialties		827	818	-9	-1.1%	**-1.1%**	**-1.1%**
Other Referred 1st OPA		15128	14767	-361	-2.4%	**-2.4%**	**-2.4%**
GP Referred 1st OPA							
*Other Specialist Medicine		589	1227	638	108.3%	**108.3%**	**108.3%**
Planned							
Elective Admissions		15958	15793	-165	-1.0%	**-1.0%**	**-1.0%**
Prescribing (Apr-Jul)		2114625	2214657	100032	4.7%	**4.7%**	**4.7%**

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

Locality: Cheadle & Bramhall

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-Aug	2015-16 YTD Apr-Aug	Variance	<---------- %Variance ----------> Practice		Locality	Stkport
Urgent								
A&E Attendances		10662	10166	-496.0656	-4.7%		-4.7%	-4.2%
Non-Elective Admissions								
All Non-Elective Admissions		4014	4156	142.406726	3.5%		3.5%	1.0%
Occ Bed Days per 100,000		9703	8872	-831	-8.6%		-6.0%	-13.9%
GP Direct Admissions		641	670	28.8752362	4.5%		4.5%	-2.1%
LTC	**Register**							
CHD Admissions	3221	117	82	-34.719233	-29.7%		-29.7%	-12.7%
HF Admissions	668	60	63	2.64810204	4.4%		4.4%	-3.5%
COPD Admissions	1214	43	26	-17.04708	-39.6%		-39.6%	-41.8%
Asthma Admissions	5184	12	16	4.18608319	35.4%		35.4%	-13.1%
Diabetes Admissions	4080	15	9	-5.9589362	-39.8%		-39.8%	-7.7%
LTC Admissions	14367	247	196	-50.891064	-20.6%		-20.6%	-16.9%
AF Admissions	1753	76	52	-23.805723	-31.4%		-31.4%	-31.1%
Care Home Admissions		182	180	-1.6275614	-0.9%		-0.9%	-11.8%
Referrals								
GP Referred 1st OPA		6921	7590	668.5983	9.7%		9.7%	3.9%
Dermatology		809	903	94.0572157	11.6%		11.6%	10.1%
ENT		770	859	88.9184047	11.5%		11.5%	9.9%
General Medicine		1221	1408	186.523273	15.3%		15.3%	4.3%
General Surgery		1267	1337	70.1891936	5.5%		5.5%	3.7%
Obstetrics & Gynaecology		416	459	43.2057321	10.4%		10.4%	-5.1%
Opthalmology		506	469	-36.951251	-7.3%		-7.3%	-7.8%
Paediatrics		296	355	58.6904399	19.8%		19.8%	4.8%
Rheumatology		142	159	16.6476573	11.7%		11.7%	-10.3%
Trauma & Orthopaedics		869	980	111.119783	12.8%		12.8%	11.1%
Urology		368	401	33.333696	9.1%		9.1%	-1.0%
Other Specialties		257	260	2.86415676	1.1%		1.1%	-1.1%
Other Referred 1st OPA		4101	3930	-170.58347	-4.2%		-4.2%	-2.4%
GP Referred 1st OPA								
*Other Specialist Medicine		204	410	205.986183	101.0%		101.0%	108.3%
Planned								
Elective Admissions		4558	4536	-22.109709	-0.5%		-0.5%	-1.0%
Prescribing (Apr-Jul)		529476	550313	20837	3.9%		3.9%	4.7%

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

Locality: Heatons & Tame Valley

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code: H&TV (H&TV)
Practice Name: Locality: Heatons and Tame Valley
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-Aug	2015-16 YTD Apr-Aug	Variance	<---------- %Variance ----------> Practice		Locality	Stkport
Urgent								
A&E Attendances		10900	10426	-474.18729	-4.4%		-4.4%	-4.2%
Non-Elective Admissions								
All Non-Elective Admissions		4143	4311	168.230745	4.1%		4.1%	1.0%
Occ Bed Days per 100,000		11983	9749	-2234	-18.6%		-12.8%	-13.9%
GP Direct Admissions		724	704	-19.556613	-2.7%		-2.7%	-2.1%
LTC	**Register**							
CHD Admissions	2853	85	81	-4.0969872	-4.8%		-4.8%	-12.7%
HF Admissions	653	49	50	1.23745514	2.5%		2.5%	-3.5%
COPD Admissions	1965	58	41	-17.334905	-29.7%		-29.7%	-41.8%
Asthma Admissions	5112	24	18	-5.9740709	-24.9%		-24.9%	-13.1%
Diabetes Admissions	3495	15	15	0.4843428	3.3%		3.3%	-7.7%
LTC Admissions	14078	231	205	-25.684165	-11.1%		-11.1%	-16.9%
AF Admissions	1181	57	47	-9.8622501	-17.3%		-17.3%	-31.1%
Care Home Admissions		269	243	-25.890305	-9.6%		-9.6%	-11.8%
Referrals								
GP Referred 1st OPA		5600	5731	130.99669	2.3%		2.3%	3.9%
Dermatology		573	606	33.4162382	5.8%		5.8%	10.1%
ENT		633	698	64.6461421	10.2%		10.2%	9.9%
General Medicine		844	864	20.4024929	2.4%		2.4%	4.3%
General Surgery		1069	1124	54.712717	5.1%		5.1%	3.7%
Obstetrics & Gynaecology		443	377	-66.349622	-15.0%		-15.0%	-5.1%
Opthalmology		425	435	10.0156577	2.4%		2.4%	-7.8%
Paediatrics		274	250	-24.089538	-8.8%		-8.8%	4.8%
Rheumatology		145	106	-38.543818	-26.7%		-26.7%	-10.3%
Trauma & Orthopaedics		700	777	76.8561593	11.0%		11.0%	11.1%
Urology		298	276	-21.552889	-7.2%		-7.2%	-1.0%
Other Specialties		197	218	21.4831491	10.9%		10.9%	-1.1%
Other Referred 1st OPA		3909	3883	-25.606998	-0.7%		-0.7%	-2.4%
GP Referred 1st OPA								
*Other Specialist Medicine		139	276	136.72565	98.2%		98.2%	108.3%
Planned								
Elective Admissions		3955	3892	-62.670033	-1.6%		-1.6%	-1.0%
Prescribing (Apr-Jul)		565573	597793	32220	5.7%		5.7%	4.7%

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

Locality: Marple & Werneth

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-Aug	2015-16 YTD Apr-Aug	Variance	<---------- %Variance ----------> Practice		Locality	Stkport
Urgent								
A&E Attendances		7169	6610	-558.5756	-7.8%		-7.8%	-4.2%
Non-Elective Admissions								
All Non-Elective Admissions		2965	2857	-108.23258	-3.7%		-3.7%	1.0%
Occ Bed Days per 100,000		13332	9425	-3907	-29.3%		-28.5%	-13.9%
GP Direct Admissions		524	419	-104.52956	-20.0%		-20.0%	-2.1%
LTC	**Register**							
CHD Admissions	2587	89	83	-5.6730774	-6.4%		-6.4%	-12.7%
HF Admissions	500	40	37	-3.0423416	-7.6%		-7.6%	-3.5%
COPD Admissions	1295	40	22	-18.032512	-45.0%		-45.0%	-41.8%
Asthma Admissions	3779	14	9	-5.0190974	-35.8%		-35.8%	-13.1%
Diabetes Admissions	2537	8	18	9.6712259	116.1%		116.1%	-7.7%
LTC Admissions	10698	191	169	-22.095802	-11.6%		-11.6%	-16.9%
AF Admissions	1211	52	30	-22.446803	-42.8%		-42.8%	-31.1%
Care Home Admissions		189	165	-23.81289	-12.6%		-12.6%	-11.8%
Referrals								
GP Referred 1st OPA		4228	4202	-26.196974	-0.6%		-0.6%	3.9%
Dermatology		414	497	83.0161492	20.1%		20.1%	10.1%
ENT		403	425	22.0128278	5.5%		5.5%	9.9%
General Medicine		708	669	-39.373956	-5.6%		-5.6%	4.3%
General Surgery		821	799	-21.809525	-2.7%		-2.7%	3.7%
Obstetrics & Gynaecology		269	277	7.7803251	2.9%		2.9%	-5.1%
Opthalmology		367	267	-99.856976	-27.2%		-27.2%	-7.8%
Paediatrics		164	183	18.6867492	11.4%		11.4%	4.8%
Rheumatology		100	86	-13.504186	-13.6%		-13.6%	-10.3%
Trauma & Orthopaedics		584	623	38.7250422	6.6%		6.6%	11.1%
Urology		234	247	12.8201147	5.5%		5.5%	-1.0%
Other Specialties		164	129	-34.693539	-21.2%		-21.2%	-1.1%
Other Referred 1st OPA		2933	2749	-184.46825	-6.3%		-6.3%	-2.4%
GP Referred 1st OPA								
*Other Specialist Medicine		90	212	122.461942	136.8%		136.8%	108.3%
Planned								
Elective Admissions		3112	3062	-50.456243	-1.6%		-1.6%	-1.0%
Prescribing (Apr-Jul)		409134	430780	21646	5.3%		5.3%	4.7%

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

Locality: Stepping Hill and Victoria

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-Aug	2015-16 YTD Apr-Aug	Variance	<---------- Practice	%Variance Locality	----------> Stkport
Urgent							
A&E Attendances		12120	11156	-964.1715	-8.0%	-8.0%	-4.2%
Non-Elective Admissions							
All Non-Elective Admissions		4760	4609	-151.4049	-3.2%	-3.2%	1.0%
Occ Bed Days per 100,000		12694	10755	-1939	-15.3%	-12.6%	-13.9%
GP Direct Admissions		831	865	34.3940179	4.1%	4.1%	-2.1%
LTC	**Register**						
CHD Admissions	3005	111	101	-9.5170202	-8.6%	-8.6%	-12.7%
HF Admissions	806	57	47	-10.124042	-17.7%	-17.7%	-3.5%
COPD Admissions	2020	70	30	-40.088644	-57.2%	-57.2%	-41.8%
Asthma Admissions	5252	28	25	-3.4455688	-12.1%	-12.1%	-13.1%
Diabetes Admissions	3869	23	12	-10.869367	-47.5%	-47.5%	-7.7%
LTC Admissions	14952	289	215	-74.044642	-25.6%	-25.6%	-16.9%
AF Admissions	1271	71	46	-24.505743	-34.8%	-34.8%	-31.1%
Care Home Admissions		224	173	-51.389087	-22.9%	-22.9%	-11.8%
Referrals							
GP Referred 1st OPA		6178	6241	62.7117424	1.0%	1.0%	3.9%
Dermatology		626	638	12.0533307	1.9%	1.9%	10.1%
ENT		677	744	67.0903047	9.9%	9.9%	9.9%
General Medicine		997	986	-11.275431	-1.1%	-1.1%	4.3%
General Surgery		1132	1176	43.506515	3.8%	3.8%	3.7%
Obstetrics & Gynaecology		486	419	-67.019218	-13.8%	-13.8%	-5.1%
Opthalmology		416	409	-7.016204	-1.7%	-1.7%	-7.8%
Paediatrics		310	305	-4.5151945	-1.5%	-1.5%	4.8%
Rheumatology		143	123	-20.235705	-14.1%	-14.1%	-10.3%
Trauma & Orthopaedics		826	920	93.6779418	11.3%	11.3%	11.1%
Urology		354	315	-39.465118	-11.1%	-11.1%	-1.0%
Other Specialties		210	206	-4.0894797	-1.9%	-1.9%	-1.1%
Other Referred 1st OPA		4185	4090	-95.341289	-2.3%	-2.3%	-2.4%
GP Referred 1st OPA							
*Other Specialist Medicine		156	304	147.716466	94.5%	94.5%	108.3%
Planned							
Elective Admissions		4333	4248	-84.764016	-2.0%	-2.0%	-1.0%
Prescribing (Apr-Jul)		597492	609239	11747	2.0%	2.0%	4.7%

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

NHS
Stockport
Clinical Commissioning Group

Resilience and Compliance Report - November 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

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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 (1)

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

The main issues are:

- Emergency Department 4 Hour waiting times standard
- Diagnostic waiting times
- Cases of Clostridium Difficile

In terms of ED waiting times, performance continues to be below the 4 hour waiting time target. The SRG Chair has written to both the CCG and Stockport NHS Foundation Trust (SFT) Boards with an assurance assessment of readiness for Winter and the risks and issues associated with delivery of this performance standard. This highlights that there is only limited assurance.

Diagnostic waiting times continue to be met at SFT but not at University Hospitals of South Manchester NHS Foundation Trust (UHSMT) or Central Manchester NHS Foundation Trust (CMFT) both Trusts had plans for recovery in place by October 2015. UHSM are on track to recover, however, CMFT have not made planned progress and this has been escalated to NHSE.

The number of Clostridium Difficile cases remains above trajectory with the majority in August attributed to SFT. However, to date there have only been 2 cases in SFT that have been attributed as lapses in care. A joint CDIFF summit between SFT and Public Health England continues to sit in order to establish and embed lessons learned from the investigation of incidents across the health economy.

There has been a 52 week wait at UHSM within Oral surgery. UHSM have investigated and apportioned the wait to pause periods caused by both patient and hospital cancellations. This wait was identified following the retrospective revalidation of all long waiters at UHSM of which there are clear plans in place to address between the lead CCG and NHS England.

The 18 week incomplete referral to treatment target has been achieved; however there continues to be an increase in the backlog of admitted patients waiting to be treated. This is predominately an issue at SFT in surgical specialities. The CCG has received a trajectory setting out a planned reduction by December 2015 and have received full assurance that the backlog is being clinically validated and risk stratified. Progress will be monitored weekly.

The Care Programme Approach target was not met for August due to 1 patient out of 15 not being seen for follow up within 7 days. As previously reported, low numbers of patients in the service means that if one patient is not seen within the 7 day standard it will be an automatic fail for the month. However, Quarter 2 is on track to achieve the 95% target overall.

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.

Chief Operating Officer's Report

Chief Operating Officer's Report (2)

Complaints

- The Governing Body asked for a more detailed report on complaints. This is set out below and will be included in the Performance Report every 6 months.
- There were 21 complaints received during this period, 2 of which were referred by MPs
- There were 4 Patient enquiries requiring investigation
- There were 7 MP enquiries
- There were also 26 sign-posting enquiries which were handled on the spot or transferred to the relevant service, for example Stockport Foundation Trust, NHS England etc.
- Four compliments were received during the period. All related to the care provided and support given during the Continuing Health Care process
- In addition, we provided supporting information for the HSO to aid in reviewing a complaint about another organisation
- 100% of all complaints and enquiries were acknowledged within the target of three working days
- Stockport CCG responded to 85% of all complaints within the 25 day target.
- Of the four complaints that exceeded target, three were multi-agency complaints necessitating a joint investigation and one required further information internally which was delayed due to annual leave.

The following table sets out complains received by category:

Multiagency complaint - NWAS & SFT	1
CHC - Assessment Tool	1
CHC - Reduction in respite hours, poor communication	1
CHC - Decision not to carry out retrospective Review	3
CHC - Delay in assessment	2
CHC - Assessment outcome and attitude of staff	1
Commissioning of Interpreter Services	1
Commissioning Policy - Earwax removal	1
Care UK - Delays in appointments & answering telephones	2
District Nursing	1
Treatment at BMI Alexander	2
Treatment at SFT and the referral pathway in general - ongoing	1
Outcome of Medicines Optimisation Review Panel	1
Outcome of an IFR decision	1
NWAS - later redirected to SFT	1
Pennine Care complaint - Pennine lead	1

Chief Operating Officer's Report

Chief Operating Officer's Report (3)

We have taken the following action in response to complaints received:

- We have revised our outcome letters following CHC panel decisions to make them clearer and provide a fuller explanation of how the decision has been reached.
- We have reminded our GP practices of how to access Interpreter Services through The Big Word and have also taken on a new face-to-face interpreter.
- We have used the patient feedback to make improvements to the Continence Service.

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters					Last Three Months			Details		
NHS Constitutional Compliance Indicator	Q2	Q3	Q4	Q1	Jun 2015	Jul 2015	Aug 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	93.1	93.3	93.2	93.2	93.8	93.3	92%	Monthly	Target has been achieved but concern remains over the increase in number of patients waiting more than 18 weeks. This is being monitored by specialty and a trajectory agreed to reduce to 350 by Dec (currently approx 540). This is monitored weekly. 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	1	0	1	1	1	0	1	0	Monthly	The 52 week wait originated from UHSM and attended for a maxillofacial surgery apportionment. Total wait time was 58 weeks due to 6 pause periods on the inpatient waiting list and several patient and hospital cancellations over a 10 week period.
Urgent operations cancelled for a second time		0	0	0	0	0	0	0	Daily during Winter (Nov-Mar)	There is no significant risk identified to threaten future performance.
Number of patients not treated within 28 days of last minute elective cancellation	3	7	5	2				0	Quarterly	There is no significant risk identified to threaten future performance.

Diagnostics - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator			Q4	Q1	Jun 2015	Jul 2015	Aug 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99.0	97.9	97.2	98.6	98.6	98.5	98.0	99%	Monthly	This failure to meet target is not originating from SFT the failure is due to Stockport patients being treated at both UHSM and CMFT. Both providers had plans to recover, UHSM are on track, CMFT have made little progress and this has been escalated to NHSE.

A&E waits - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q2	Q3	Q4	Q1	Jun 2015	Jul 2015	Aug 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients should be admitted, transferred or discharged within 4 hours	95.2 ★	90.2 ▲	86.0 ▲	93.4 ▲	94.2 ▲	91.6 ▲	92.9 ▲	95%	Weekly	performance continues to be below the 4 hour waiting time target. The SRG Chair has written to both the CCG and Stockport NHS Foundation Trust (SFT) Boards with an assurance assessment of readiness for Winter and the risks and issues associated with delivery of this performance standard. This highlights that there is only limited assurance.
12 Hour waits from decision to admit until being admitted	0.0 ★	0.0 ★	0.0 ★	0.0 ★	0 ★	0 ★	0 ★	0	Quarterly	There is no significant risk identified to threaten future performance.

Cancer waits - 2 week wait - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q2	Q3	Q4	Q1	Jun 2015	Jul 2015	Aug 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	94.4 ★	95.5 ★	95.7 ★	96.0 ★	94.6 ★	96.7 ★	95.8 ★	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)	93.7 ★	98.4 ★	98.0 ★	95.5 ★	93.4 ★	97.7 ★	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	Q2		Q3		Q4		Q1		Jun 2015		Jul 2015		Aug 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96.9	★	98.6	★	97.6	★	98.3	★	97.7	★	98.5	★	100.0	★	96%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is surgery	95.0	★	98.8	★	97.2	★	98.2	★	97.4	★	97.3	★	100.0	★	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	★	100.0	★	90.0	▲	87.5	▲	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	Q2		Q3		Q4		Q1		Jun 2015		Jul 2015		Aug 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	83.7	▲	75.5	▲	85.5	★	88.3	★	82.7	▲	83.3	▲	98.2	★	85%	Monthly	Performance continues to be monitored on a weekly basis.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	76.9	▲	97.2	★	91.9	★	96.9	★	94.4	★	90.9	★	100.0	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	72.7	▲	80.4	★	72.7	▲	79.5	▲	73.3	▲	60.0	▲	83.3	★	80%	Monthly	There is no significant risk identified to threaten future performance.

Category A ambulance calls - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q2	Q3	Q4	Q1	Jun 2015	Jul 2015	Aug 2015	Operational Standard	Collection Frequency	Status / Commentary
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	70.9 ▲	65.3 ▲	67.0 ▲	77.5 ★	79.8 ★	79.3 ★	77.7 ★	75%	Monthly	The SRG is tracking performance and is awaiting assurance on the risk position across winter.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	71.5 ▲	66.7 ▲	65.8 ▲	76.6 ★	78.2 ★	76.0 ★	75.4 ★	75%	Monthly	The SRG is tracking performance and is awaiting assurance on the risk position across winter.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	94.9 ▲	91.2 ▲	91.1 ▲	95.2 ★	95.9 ★	94.6 ▲	95.1 ★	95%	Monthly	The SRG is tracking performance and is awaiting assurance on the risk position across winter.

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

Mental Health - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q2	Q3	Q4	Q1	Jun 2015	Jul 2015	Aug 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	98.4 ★	98.3 ★	100.0 ★	100.0 ★	100.0 ★	94.7 ▲	93.3 ▲	95%	Monthly	August data relates to one failure of follow up within 7 days, 14 out of 15 patients were seen within the 7 day period for follow up. It is to note that September achieved 100% and Q2 is on track to achieve the 95% target overall.

Healthcare associated infection (HCAI) - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q2		Q3		Q4		Q1		Jun 2015		Jul 2015		Aug 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	▲	22	★	34	▲	6	★	13	▲	11	▲	7.4	Monthly	CDIFF rates are under scrutiny at SFT, there are still low number associated with LIC but extra scrutiny has been given to the investigation methodology. The Trust have held a CDIFF summit in order to streamline review processes and implement lessons learned from cases, as reported to date we have had 2 LIC associated with all acute cases.

Key

Indicator RAG rating

★ Green - Performance at or above the standard

▲ Red - Performance below the standard

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 for September is N/A because the numerator and denominator are both zero.
Percentage of days lost to sickness in the last 12 months	2.25	★	2.23	★	2.01	★	1.89	★	1.84	★	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 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.
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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30 September 2015

Dear Gillian and Jane,

RE: Winter Resilience in Stockport, 2015/16

I am writing to you following the request at the Board to Board meeting on the 2nd July, to provide a letter describing the Stockport system position for Winter 2015/16, along with a level of assurance in the system's ability to meet the 95% ED 4 hour target consistently.

Attachments to this letter include:-

1. the SRG agreed Root Cause Analysis
2. the Utilisation Management review
3. the 90 day Action Plan put in place both to address (1) and (2) and following the challenges of last Winter. This is owned and understood by the SRG
4. the SRG self-assurance document, returned to NHSE on 2nd September.
5. Benchmarked data on the Stockport DTOC rate (at the end of this letter)

The self-assurance document provides the broader perspectives of the system and is in line with the 8 high impact interventions for urgent care that have been reviewed through the SRG meetings.

The SRG self-assurance process has resulted in an assessment of only limited assurance and highlighted 4 key risks to delivery:

1. Significant vacancies and use of locum, bank and agency at SFT.
2. Delays within processes, most significantly access to diagnostics.
3. Escalation beds remaining open throughout Summer with no expansion capacity as Winter pressures rise.
4. Whole system ownership and escalation with action. In particular, there is a concern, shared across the SRG about front-line buy-in and commitment to changes being made through the action plan and indeed to the challenge of the 4-hour target itself. There is the impression within the SRG+ in particular that staff continue to work in silos within the Foundation Trust, not recognising the impact of their work on the rest of the hospital and broader system. This can only be addressed through effective senior leadership and regular communication with frontline staff. This issue will be returned to at the end of this letter.

Vacancies and Recruitment

Failure to fill medical and nursing posts with locum cover are a frequent reason for high levels of evening and overnight breaches. As a result there have been too many patients in ED and thus a higher admission rate. The significant reliance on agency and locum staff also comes at a cost premium. The absence of full staffing levels therefore simultaneously adversely impacts performance, capacity and cost.

In addition to impacting current performance, recruitment is the highest risk to delivery of the 90 day plan.

Delays within Processes

The Action Plan has been compared against the Root Cause Analysis and Utilisation Management review to identify gaps in the system, which have been discussed and are recognised by the SRG. It focuses predominantly on the hospital system and the parts of the system that directly impact on flow.

The action plan has been agreed by SRG as the right thing to do and is absolutely consistent with the commissioned reviews. The plan is owned by the SRG. It has become apparent that there are a number of hurdles and barriers to full implementation of the plan. Some of these have been highlighted to NHSE and Monitor at the recent Tripartite meeting. Others have only recently become clear and have been discussed within the SRG. Those which have been highlighted at the Tripartite include:

- Staffing capacity issues across both nursing and medical within the Trust,
- Consistent social care support and management of DTOCs at an agreed level,
- Buy in within the Trust to the new ways of working to ensure full and consistent implementation as the system is challenged through Winter. This will rely upon a significant culture change within the Foundation Trust and will require sustained high quality leadership when the system is under stress.

The further concern is around areas of the Action plan which are now at risk of being implemented by SFT due to their financial restraints. These constraints have put at risk sustained delivery of the 4 hour target and has resulted in this being rated at 20 on SFT risk register.

The SRG self-assurance process shows that the Action Plan covers the majority of required process improvements, with a smaller number of notable issues that still need to be addressed:

- Managing fluctuations in ambulance demand, in particular around batching of admissions - this should hopefully be improved by the action plan in better streaming of patients out of ED but the SRG is also awaiting an update from NWAS on out of hospital improvements which have apparently addressed this issue in Tameside.
- Pharmacy ward cover for take home prescriptions - this enables earlier discharge of patients and improves flow. This was improved in 14/15 but has now been removed as part of the SFT cost improvement plan.
- Documentation standardisation - this would reduce the need for repeat history taking and would be achieved through an electronic record.
- The potential to identify patients' needs earlier, ideally in the community to reduced attendance - this cannot be addressed through the action plan but will be addressed in the longer term through the proactive stream of Stockport Together.

- Improving the management of patients who are medically fit for discharge and exploring discharge to assess models. This work is ongoing through the SRG and needs to ensure a consistent approach across the system to identification of patients in need of ongoing care and support outside of the acute hospital.

System escalation

One of the learning points from winter 14/15 was the speed and seniority of escalation. Whilst this is now significantly improved with the establishment of the weekly SRG+ group (SRG chair, SFT Director of operations and SMBC Director of Adult Services), performance will also rely heavily on successful implementation of system wide escalation plans and a coordinated timely response to Urgent Care pressures. Significant work is under way to improve and align escalation plans and these will be fully tested and signed off as an economy by the end of October. Further monitoring of escalation will be led through the SRG and weekly SRG+ meetings.

Impact of CIP plans

In addition to the items raised through the SRG self-evaluation process, the CCG has been consistently raising the risks to quality and performance of CIP plans. At present the CCG has not been able to identify a clear process for assessing the impact of CIP plans within SFT. The SRG requested confirmation of schemes and interventions funded in winter 14/15 which are no longer in place. This has now been received and the concern remains that the model of ward based pharmacists to ensure timely completion of TTO's and early discharge of patients has been removed. The SRG is working through the implications of this and has fed back concerns to SFT.

Over and above this SMBC are also consulting on plans for savings to be implemented in 2016/17. Whilst the impact of these schemes will occur after the coming winter, the issue of underlying financial positions and subsequent actions is one which the SRG will continue to highlight as a significant additional risk.

Summary

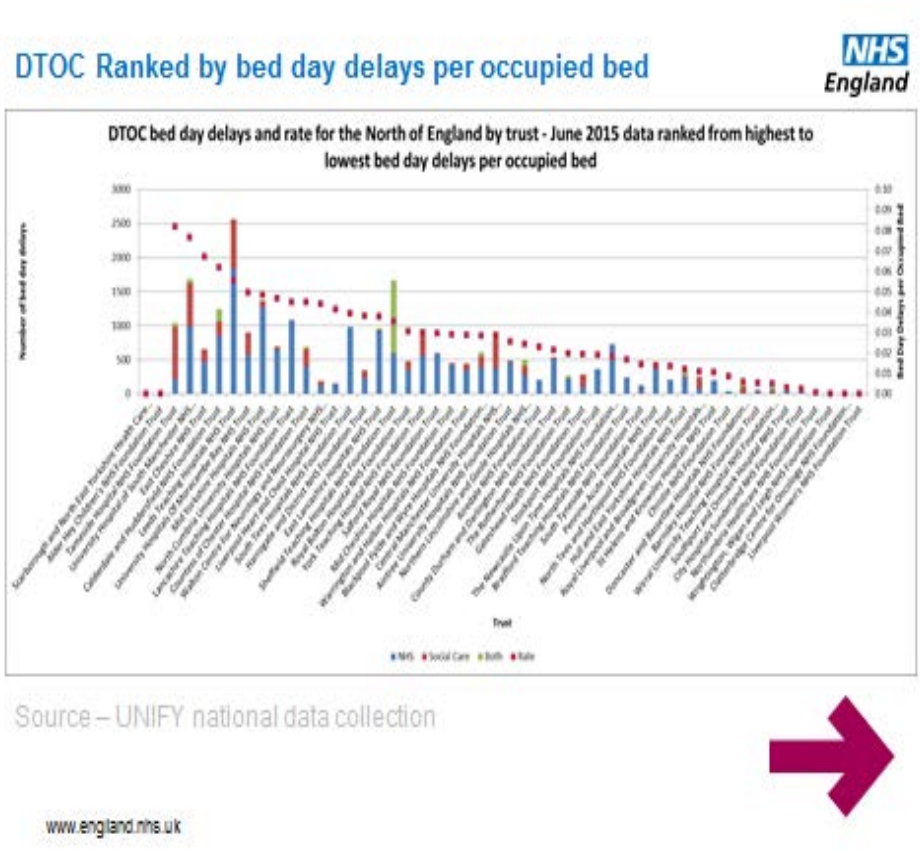
The external feedback from the Tripartite and SRG show that Stockport is an economy which is willing and able to work together to improve. Significant progress has been made as we move towards the coming Winter. However, as an SRG and in my role as SRG Chair, it is felt that we should not move beyond limited assurance of sustained achievement of the 95% 4 hour standard until there is more demonstrable evidence that agreed improvements are significantly impacting. This absolutely includes substantive recruitment but for example, there also remain concerns that the Winter escalation beds have remained open throughout the Summer months, leaving limited capacity for escalation of the Urgent Care system in winter 15/16.

As SRG chair I am very concerned about the areas highlighted in this letter and this needs to be understood by both Boards. I would request an early meeting to discuss the contents of this letter with the Chief Executive, Medical and Nursing Directors of the Acute Trust in order to further expand on the issues raised through SRG regarding leadership and front-line commitment to delivery of the 4-hour ED target.

I hope that this letter provides a clear SRG perspective on our urgent care system, the improvements achieved and the remaining challenges.

Yours sincerely,

Dr Catherine Briggs
Clinical Director of Quality & Provider Management



Source – UNIFY national data collection

www.england.nhs.uk

Mrs. Jane Crombleholme – Chair
Dr. Ranjit Gill – Chief Clinical Officer
Mrs. Gaynor Mullins – Chief Operating Officer

NHS
Stockport
Clinical Commissioning Group

Finance Report September 2015 – Month 6

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

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Executive Summary

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

1. **Note** the 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. **Acknowledge** that this forecast position assumes the delivery of £1,582k CIP achievement in returning a £672k surplus position.

3. **Acknowledge** the significant risk inherent in the delivery of the additional £1,078k savings requirement being taken forward by the QiPP Committee.

4. **Note** the additional net risk totalling £1.75m not reflected within the forecast position (Ref – Table 8).

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

6. **Note** 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. **Note** 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.

Please detail the key points of this report

- Actual surplus reported as at Mth 6 (YTD) of £423k which is £452k below plan
- Actions being taken forward by QiPP Committee to address the £1,078k savings requirement needed to return a £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 £1.75m 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: 11th November 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Report of the Chief Finance Officer as at 30th September 2015

1. Introduction

The format of this report has been revised to provide a more succinct summary of the financial position and any key issues that face Stockport CCG. This report should be read in conjunction with the revised format of the appendices which are now presented in a 'Dashboard' style format so that financial position of the organisation is summarised on 'one page'. These changes have been introduced so as to highlight the key factors that are impacting on the CCG's financial position and ability to deliver against our statutory financial duties.

This report provides an update on:-

1. The financial position both (i) year to date as at 30th September 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

The CCG is required to deliver its statutory duties and financial performance targets as approved by the Governing Body at the start of the financial year. The CCG is held to account by NHSE for delivering these targets and is monitored monthly on the areas contained in Table 1 below:

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty	Performance YTD (Mth 6)	Performance Forecast
Revenue	Not to exceed revenue resource allocation		
Running Costs	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)	Deliver a 0.5% in-year surplus		
Cash	Operate within the maximum drawdown limit		
Business Conduct (Appendix 2 Table 3)	Comply with Better Payment Practices Code		
QIPP (Appendix 2 Table 2)	Fully deliver planned QIPP saving		

Finance Report Headline – Month 6

For the period ending 30th September 2015 Stockport CCG reported a Year-to-Date (YTD) surplus of c£423k which is c£452k below plan. The latest forecast position is to deliver a surplus of £672k against a planned surplus of £1.75m i.e. £1,078k below plan.

Due to forecasting a planned surplus below plan and carrying forward a recurrent deficit of £10.6m into 2016-17 , NHSE are reviewing this position in accordance with national Assurance Framework guidelines and it is expected that the CCG's financial rating will be reassessed.

3. Year to Date (Mth 6) & Forecast Financial Position (Ref – Table 1)

3.1 YTD surplus of £423k which is £452k below plan i.e. planned for £875k surplus at Month 6. In year overspends are being impacted by increases in Elective activity (Trauma & Orthopaedics), Outpatients (£932k forecast o/spd), Non elective (£888k forecast o/spd), AQP/IS (Cataracts & WET AMD) and increased prescribing spend as set out in Table 7.

3.2 The CCG is currently forecasting an outturn position of £672k surplus against a planned surplus of £1.75m, the forecast variances are set out by Provider [table 2] and by Point of Delivery [table 3].

Acute:

3.3 Key risk areas within Acute are AQP/IS contracts which are forecast to overspend by

£2.35m. The main increase is around an AQP contract for Ophthalmology which has been subject to discussion by the QiPP Committee (21st October meeting) in that this reflects increased demand for cataract removals with patients experiencing minimal waiting time given the extra capacity.

3.4 The latest activity data received from the SLAM monitoring data (to August) shows Elective (+2.1%) and Non Elective (+1%) activity above plan. GP written referrals to August 2015 are also up 3.9% compared to 2015-16 planned levels with our contracted providers (NHS & Non-NHS).

3.5 Over performance by specialty:

- Elective –Trauma & Orthopaedics, Urology, ENT
- Non Elective – Gynaecology, Accident & Emergency
- Outpatient – Cardiology-General Medicine, Trauma & Orthopaedics, Chest-General Medicine

Mental Health

3.6 As at month 6 there is an underspend of £204k with a forecast underspend of £339k. This is largely due to cessation of the contract with Calderstones which is now due to be terminated with effect from 31/10/2015 where charges will then 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 area consists of spend against the Stockport NHS Foundation Trust Community contract as well as spend in relation to the Better Care Fund. As at month 6 we are no expecting spend to deviate from plan.

Continuing Care

3.8 As at month 6 the forecast outturn for Continuing Care is a breakeven position. However, Funded Nursing Care is expected to underspend by £200k and this is offset by an expected overspend of £200k against Children's and Complex Care budgets.

Primary Care

3.9 Primary Care budgets are expected to underspend by £270k as result delayed implementation of initiatives detailed within the bids submitted by GP Practices as part of the GP Development scheme and the release of a 2014-15 provision in relation to an employment Tribunal case.

Prescribing (Ref – Table 7):

3.10 There has been an increase of c8% in prescribing for the period April to August (the latest data available) compared to same period 14/15, of which c3.5% is volume related (number of items prescribed). As a result the CCG is reporting a YTD overspend of £784k and a forecast overspend of £1.5m. The main areas of increasing prescribing spend are:

- 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.

Table 3 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 3: 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	530	530	0	1,060	1,042	(18)
CCG Admin	2,506	2,486	(20)	5,364	5,382	18
Total CCG Running Costs	**3,036**	**3,016**	**(20)**	**6,424**	**6,424**	**0**

Reserves (Ref – Table 4)

3.12 Investments – include national "must do's and those agreed collaboratively at a local GM level i.e. GM Risk share. The £0.9m under spend reflects the deployment of the £0.9m performance fund held as part of the Better Care Fund to support NEL over performance

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 Mitigation	**£3.214m**

In addition to the above CIP, the forecast assumes that the proposed recovery plan measures of £1,582k are agreed and 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 30th September 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 – Table 8)

5.1 There are potential risks to the value of £1.75m which have not been brought into the financial position at month 6. These are risks identified on a 'worst case' basis and as such at this time these are identified but not brought into the financial position. Members are aware that should any of these risks materialize then this will deteriorate the CCGs financial position.

5.2 The main element of risk surrounds the CHC legacy Risk Pool which the CCG contributed c£2.1m in 15/16 into the national pot. The CCG's forecast position

assumes a return of c£1m given our understanding that the national pool is significantly underspent and that the funds will be redistributed pro-rata to CCGs. Officers are in the process of seeking clarification about the likelihood that this funding is returned.

6. Recurrent Position (Ref – Table 5)

6.1 Recurrent cost pressures are due to a combination of:

- Increased activity demand above planned levels
- Stockport NHS Foundation Trusts opting for the Enhance Tariff Option (ETO)
- Unachieved recurrent CIP requirements

These recurrent pressures are being funded non-recurrently in 15/16 and GP Development being met from BCF in 15/16 as a one off measure.

6.2 The CCG will be required to deliver a recurrent CIP of **£20.0m** 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%). The impact of recurrent pressures in 2015-16 will add to our recurrent pressure carried forward in 2016-17.

7. Risk Implications / Mitigation

Risks:

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

- The forecast outturn position assumes that the CCG will receive a £1.0m refund from the National CHC risk pool as detailed in the CCG's 2015/16 financial plan. NHS England has informed the CCG that any assumed refund from the CHC Legacy Risk Pool is at risk.

- Proposals to address the deviation from the planned surplus of £1.75m and to deliver a recurrent balance do not deliver the required savings in the short to medium term.

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 the medium to long term objective of delivering a quality, financial sustainable health and social care economy.

8. Recommendations

The Governing Body is asked to:-

I. **Note** the year-to-date underachievement of £452k YTD and forecast gap of £1,078k against the planned surplus of £1.75m.

II. **Comment and Acknowledge** the significant risk reflected in forecast position which relies upon the delivery of £1,582 CIP schemes.

III. **Agree** an approach to prevent further overperformance within our AQP/IS contracts

IV. **Acknowledge** additional net risk totalling £1.75m not within the forecast position

V. **Acknowledge** that the CCG position reflects the retention of £0.9m performance Fund held in BCF to offset over performance

VI. **Acknowledge** that the forecast position assumes that the National CHC Risk Pool will underspend in line with 2014/15 and that £1m is returned to the CCG as a result.

Gary Jones
Chief Finance Officer
28th October 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 6 FINANCIAL DASHBOARD

Appendix 1

TABLE 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

Month 6 Financial Position - as at 30th September 2015

	YTD (Mth 6)				Forecast 15/16							
	Plan £000s	Actual £000s	Var £000s	Var %	Plan £000s	Actual £000s	Var £000s	Var %	RAG RATING	Recurrent Budget £000s	Recurrent Commitment £000s	Recurrent Variance (Favourable) / Adverse £000s
Revenue Resource Limit (RRL)												
Confirmed	(191,309)	(191,309)	0	0.0%	(378,328)	(378,328)	0	0.0%	G	(374,047)	(374,047)	0
In Year	0	0	0	0.0%	(2,032)	(2,032)	0	0.0%	G	(356)	(356)	0
Total RRL	**(191,309)**	**(191,309)**	**0**	**0.0%**	**(380,360)**	**(380,360)**	**0**	**0.0%**	G	**(374,403)**	**(374,403)**	**0**
Net Expenditure												
Acute	110,361	111,608	1,247	1.1%	222,603	226,580	3,977	1.8%	R	220,761	227,949	7,188
Mental Health	15,841	15,637	(204)	(1.3%)	31,683	31,344	(339)	(1.1%)	G	31,103	30,764	(339)
Community Health	17,798	17,975	177	1.0%	35,596	35,596	0	0.0%	G	35,596	35,596	0
Continuing Care	9,590	9,554	(36)	(0.4%)	17,074	17,071	(3)	(0.0%)	G	14,957	15,157	200
Primary Care	6,177	5,968	(209)	(3.4%)	12,483	12,213	(270)	(2.2%)	G	10,073	11,473	1,400
Other	1,973	2,011	38	1.9%	3,882	2,828	(1,054)	(27.2%)	G	2,636	2,590	(46)
Sub Total Healthcare Contracts	**161,740**	**162,753**	**1,013**	**0.6%**	**323,321**	**325,632**	**2,311**	**0.7%**	R	**315,126**	**323,529**	**8,403**
Prescribing	24,332	25,116	784	3.2%	48,664	50,164	1,500	3.1%	R	48,664	50,164	1,500
Running Costs (Corporate)	3,037	3,017	(20)	(0.7%)	6,424	6,424	0	0.0%	G	6,424	6,424	0
Reserves (Ref: Reserves Summary)	1,325	0	(1,325)	(100.0%)	201	(950)	(1,151)	(572.6%)	A	2,966	4,850	1,884
Total Net Expenditure and Reserves	**190,434**	**190,886**	**452**	**0.2%**	**378,610**	**381,270**	**2,660**	**0.7%**	R	**58,054**	**61,438**	**3,384**
Additional Proposed CIP	**0**	**0**	**0**	**0.0%**	**0**	**(1,582)**	**(1,582)**	**0.0%**	A	**0**	**0**	**0**
TOTAL (SURPLUS) / DEFICIT	**(875)**	**(423)**	**452**	**(51.7%)**	**(1,750)**	**(672)**	**1,078**	**0.7%**	R	**(1,223)**	**10,564**	**11,787**

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	144,485	72,243	72,271	28	145,461	976
University Hospitals of South Manchester FT	25,443	12,721	12,690	(31)	26,108	665
Central Manchester University Hospitals FT	18,577	9,288	9,191	(97)	18,308	(269)
Salford Royal FT	4,680	2,340	2,438	98	4,975	295
East Cheshire NHS Trust	2,278	1,139	1,127	(12)	2,338	60
Tameside Hospital FT	1,043	522	542	20	1,089	46
AQPs/IS	11,328	5,664	6,797	1,133	13,678	2,350
Other	14,769	6,444	6,552	108	14,623	(146)
Total Acute	**222,603**	**110,361**	**111,608**	**1,247**	**226,580**	**3,977**

ACUTE

TABLE 3

Forecast variance to plan based on Mth 5 SLAM (£000)	Top 6 Acute Commissioning Contracts & AQP/IS								
PoD	SFT	UHSM	CMFT	Salford Royal	East Cheshire	Tameside	AQP / IS	Other Providers	Total
Elective	610	(91)	(147)	(32)	87	18	2,350		2,795
Drugs & Devices	532		264	(123)	16				689
Outpatients	458	(43)	53	491	(15)	(12)			932
Non Elective	935	493	(533)	(31)	8	16			888
Non Elective (Excess bed days)	(1,031)	72	64	15	0	(17)			(897)
Macular			240						240
Fertility			149						149
Maternity	(200)	51	224		15				90
A&E	(72)	63	18	10	(6)	5			18
Critical Care	0	0	0	0	0				0
Other PoDs	(256)	120	(601)	(35)	(45)	36		(146)	(927)
Total Mth 6 Forecast Variance	976	665	-269	295	**60**	46	2,350	**(146)**	**3,977**

PoD

PRESCRIBING

TABLE 4

Forecast Reserves Summary

	Reserves Held Mth 6	Commits Mth 6 onwards	Forecast Bals Year End
Amounts Held in CCG Reserves	**£000s**	**£000s**	**£000s**
Investments - National	1,457	540	(917)
Investments - Greater Manchester	1,593	1,309	(284)
Contingency	365	0	(365)
In-Year Allocations	0	0	0
CIP - Not embedded in budgets	(3,214)	(2,799)	415
Total Reserves	**201**	**(950)**	**(1,151)**

TABLE 5

Recurrent CIP Requirement 2016-17	£000s
Additional CIP c/fwd from 2015-16	(10,564)
CIP required to deliver 2% in year surplus	(9,435)
Revised 2016-17 CIP Requirement	(19,999)

TABLE 6

Forecast spend against in year allocation (NHS Eng Requirement)	£000s
2015-16 Allocation	(380,360)
Less: Brought forward 2014-15 Surplus	4,281
Forecast 2015-16 Expenditure	379,688
Forecast (under)/over-spend against in year allocation	3,609

TABLE 7

Top Five Increases in Prescribing Spend by Drug Type	Sept 13 - Aug 14 (£000s)	Sept 14 - Aug 15 (£000s)	Change (£000s)	Change in Spend (%)	Change in No. Items (%)
Endocrine System	6,011	6,645	634	10.5%	6.3%
Central Nervous System	10,085	10,685	600	5.9%	6.1%
Cardiovascular System	5,833	6,321	488	8.4%	3.3%
Nutrition And Blood	2,461	2,865	404	16.4%	7.4%
Respiratory System	6,050	6,312	262	4.3%	5.3%

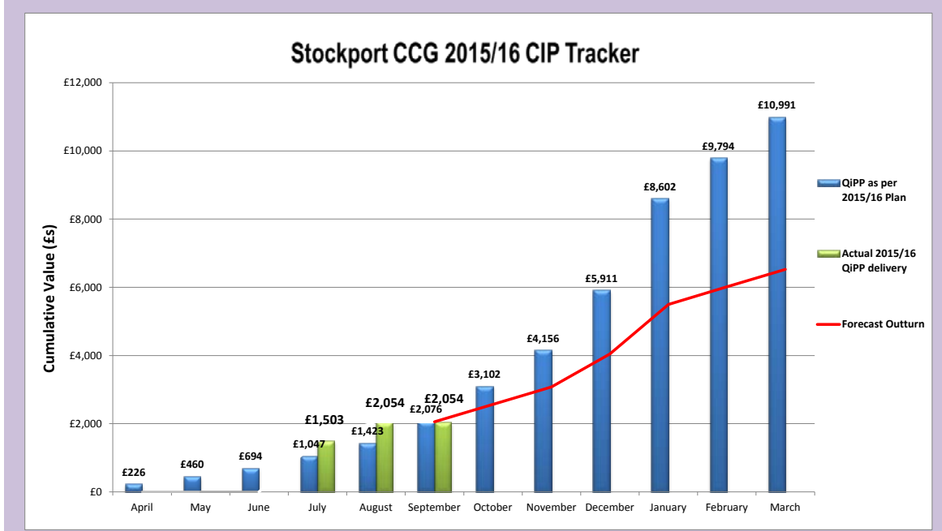

TABLE 8

Risks not in the financial position

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	1.00	Assumed refund from CHC Legacy Risk Pool
Total	1.75	

TABLE 9

Public Sector Payment Policy (PSPP) - Measure of Compliance

The Public Sector Payment Policy target requires CCG's to aim to pay **95%** of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.	September YTD Number	September YTD £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	4,989	33,962
Total Non-NHS Trade Invoices Paid Within Target	4,888	33,259
Percentage of Non-NHS Trade Invoices Paid Within Target	97.98	97.93
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,245	128,639
Total NHS Trade Invoices Paid Within Target	1,191	128,573
Percentage of NHS Trade Invoices Paid Within Target	95.66	99.95
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	6,234	162,601
Total NHS Trade Invoices Paid Within Target	6,079	161,832
Percentage of NHS Trade Invoices Paid Within Target	97.51	99.53

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.

TABLE 10

Cashflow Summary - Month 6	£000s
Cash Limit for the Year	377,902
Cash drawn down YTD	193,174
Remaining cash	184,728
Actual cash drawn down (%)	51.1%
Expected cash drawn down (%)	50.0%

Financial Control Environment Assessment

Introduction

In July 2015 the NHSE Chief Financial Officer wrote out to all CCGs advising of a new initiative being launched around a national toolkit designed to help deliver and achieve financial resilience and sustainability. This toolkit focuses on 4 areas being (i) prevention (ii) early warning (iii) financial recovery and (iv) menu of supporting tools.

One of the key elements of this is the 'prevention module' which is an assessment of the financial governance and control environment of each CCG. Attached is the self-assessment checklist that CCGs were required to complete. The checklist was to be submitted to NHSE end of August (in draft form if not reviewed by CCG Audit Committee by that date).

Review Process for Self Assessment

It was a requirement that this self- assessment had to be agreed by Audit Committee Chair and Chief Clinical Officer and overseen by the CCG's internal auditors. The CCG had fully met this requirement in submitting the draft form by end of August.

The self assessment has to also be reviewed by Audit Committee and Governing Body for final approval. The Audit Committee reviewed the self assessment at its meeting on 21st October and proposed this be presented to the November meeting of the Governing Body for final approval.

Recommendation

That Governing Body approves the attached draft self-assessment checklist as submitted in August as the final submission.

Gary Jones
Chief Finance Officer
Stockport CCG

Financial Control Environment Assessment

CCG name	NHS Stockport CCG
Prepared by	David Dolman
Approved by	Gary Jones
Date approved	20/08/2015

Choose from drop down

		Area of consideration	Sub-area	Excellent	Good	Moderate	Improvement needed	Self-assessment	Key reasons for categorisation of assessment	Actions to address issues identified	Timing for completion of actions
Financial performance	1	Longer term planning		Medium term financial strategy, well developed, consistent with and with sufficient funding to deliver commissioning strategy. Meets business rules and sustainable. Adequate contingencies and reserves to respond to unforeseen events. Key risks identified with clear mitigation plans. Finance actively involved in service developments, procurements and wider commissioning agenda.	Medium term financial strategy, well developed, largely consistent with sufficient funding to deliver the commissioning strategy. Meets business rules and sustainable. Contingencies and reserves identified to respond to unforeseen events. Key risks identified with some mitigation plans. Finance consulted on service developments, procurements and other changes.	Medium term financial strategy largely consistent with commissioning strategy but needs further development and has potential funding gaps. Meets majority of business rules including surplus but some issues re sustainability. Some contingencies and reserves identified but may not be sufficient to respond to unforeseen events. Some key risks identified with mitigation plans but further work required. Limited finance input to service improvements, procurements and improvements except for immediate finance impact.	Medium term financial strategy not consistent with commissioning strategy, needs further development and shows significant funding gaps. Does not meet majority of business rules including surplus; issues re sustainability. Some contingencies and reserves identified but not deemed sufficient to respond to unforeseen events. Key risks to be identified and mitigations developed. Service developments, procurements and improvements initiated with limited or no finance input.	Moderate	Medium term financial strategy is well developed and consistent with Strategic plan held up as best practise by NHSE. Plans include contingency of 0.5% to respond to unforeseen events with key risks identified with clear mitigation plans. Finance actively involved in service developments, procurements and wider commissioning agenda. However the CCG only planning to deliver a 0.5% surplus which is a factor of being a challenged health economy and having a funding gap "Distance from Target" of c£9.5m.	"Stockport Together" a partnership including: NHS Stockport CCG, Stockport MBC, NHS Stockport FT and NHS Pennine Care FT is the formal arrangement under which the leaders from these organisations have committed to the development an overall strategic plan for the borough to integrate and transform health and social care services to address the ever increasing health needs and demands of Stockport. Stockport has also been chosen as a MCP vanguard site.	Services to be redesigned over the next 6 to 36 months
	2	Detailed financial planning	Credibility and degree of stretch	Planning assumptions within the guidelines set by NHS England. Plans stretching with challenging, fully identified QIPP. Comprehensive plans with responsibilities and timescales identified. Very high confidence that plan achievable with well worked contingency plans and/or reserves. Plans including QIPP are appropriately phased and reflected in budgets.	Planning assumptions within the guidelines set by NHS England. Plans stretching with challenging QIPP. Comprehensive plans with key responsibilities and timescales identified. Moderate to high confidence that plan achievable with contingency plans and/or reserves identified. Key elements of plans including QIPP are phased appropriately and reflected in budgets.	Planning assumptions largely within the guidelines set by NHS England with justified exceptions. Achievable QIPP that could be stretched further, or significant amount of unidentified QIPP. Plans with some key responsibilities and timescales identified but further work required. Moderate confidence that plan achievable with some contingency plans and/or reserves identified. Majority of plans including QIPP have phasing that reflects delivery and are reflected in budgets but some work required.	Planning assumptions significantly outside the guidelines set by NHS England. QIPP lacks ambition compared to others, and/or has significant elements under developed or unidentified. Plans require responsibilities and timescales to be identified. Low to moderate confidence that plan achievable with limited contingency plans and/or reserves identified. Major issues with phasing of plans including QIPP with phasing out of line with delivery.	Moderate	Planning assumptions within guidelines set by NHSE however the plan includes £1.8m of unidentified QIPP. QIPP plans have been phased to reflect delivery and are embedded in budgets. Due to the wholescale health and social care reform that is required to deliver the QIPP there can only be moderate confidence that it can be achieved in the timescales required. Some contingency and other mitigations have been identified as well as a recovery plan in the event that QIPP measures are not delivered as planned.	Recovery Plan has been developed to mitigate against QiPP non delivery	ongoing from Aug 15
	3		Alignment with activity and provider contracts	Plans well aligned with planned and contracted activity Contracts signed with all main providers. Very high confidence that plans have sufficient financial resource to deliver CCG & national targets	Plans largely aligned with planned and contracted activity but some limited gaps being resolved. Contracts signed with providers making up over 80% of expenditure. Moderate to high confidence that plans have sufficient financial resource to deliver CCG & national targets.	Plans reasonably aligned with planned and contracted activity but some significant gaps being resolved. Contracts signed with providers making up over 70% of expenditure. Moderate confidence that plans have sufficient financial resource to deliver CCG & national targets.	Plans only partially or not aligned with planned and contracted activity. Major gaps to be resolved. Contracts with main providers remain unsigned. Low/moderate confidence that plans have sufficient financial resource to deliver CCG & national targets.	Good	Plans well aligned with planned and contracted activity. Contracts signed with all main providers. A&E 4 hour wait target always an issue therefore moderate to high confidence that plans have sufficient financial resource to deliver CCG & national targets.	4 - Hour Recovery Plan detailing action over required during July - Sept to deliver against the A&E 4 hour wait target has been developed and being implemented	Sep-15
	4	In year financial performance		All business rules forecast to be delivered for full year with contingency plans and reserves available as required. QIPP plan forecast to be achieved. Year to date expenditure to be in line with plan or below with minimal offsetting across categories. Expenditure run rate forecast to be in line with plan with no signs of deterioration.	All business rules forecast to be delivered for full year with contingency plans and reserves available as required with only minor exceptions. QIPP plan forecast to be achieved. Year to date expenditure to be in line with plan or below. Expenditure run rate forecast to be in line with plan any signs of deterioration being addressed.	Business rules largely forecast to be delivered for full year with some contingency plans and reserves available - more work required to secure plan outturn. QIPP plan forecast to be over 75% achieved. Year to date expenditure to be align with plan overall but with some significant areas of overspend. Expenditure run rate forecast to be broadly in line with plan but with significant signs of deterioration that need to be addressed.	Majority of business rules forecast not to be delivered for full year. Limited or no contingency and reserves available. Low confidence that will secure plan outturn. QIPP plan forecast to be less than 75% achieved. Year to date expenditure above plan or some key areas of overspend. Expenditure run rate forecast to be higher than plan.	Moderate	All business rules largely forecast to be delivered except delivery of 1% surplus. Contingency available however more work required to secure planned outturn. QIPP plan forecast to be over 75% achieved at mth 4 as EL and NEL activity are above levels that would deliver QIPP in full. Year to date expenditure aligned with plan overall but with some significant areas of overspend.	Recovery Plan has been developed to mitigate against QiPP non delivery	ongoing from Aug 15
	5	Financial reporting	Consistency of reporting with ledgers and NHSE submissions	Reports reconcile to ledger with reconciling items fully documented and signed off by Chief Financial Officer. Non-ISFE submissions agree to board reports and are in compliance with NHS England guidelines including AoB.	Reports reconcile to ledger with reconciling items documented and major items signed off by Chief Financial Officer. Non-ISFE submissions agree to board reports and are substantially in compliance with NHS England guidelines.	Reports don't fully reconcile to ledger with only some items documented. Evidence of sign off by Chief Financial Officer. Non-ISFE submissions normally agree to board reports and are mostly in compliance with NHS England guidelines.	Reports don't reconcile to ledger with no evidence of sign off by Chief Financial Officer. Non-ISFE submissions don't routinely agree to board reports and are not in compliance with NHS England guidelines.	Excellent	Finance reports to Governing Body reconcile to ISFE. Reported position is agreed with CFO who is copied into Non ISFE submission to NHS England. ISFE reports are completed in compliance with NHSE guidance.	No further actions needed	
	6		Comprehensiveness and use as control mechanism	Financial reports provide detailed information of actual and budgeted spend on all areas of expenditure. Standard and customised ISFE reports used. Variances from budget and forecast outturn actively reviewed monthly with budget holders identifying actions to achieve agreed outturn. QIPP performance monitored at least monthly at individual initiative level with figures reconciling to I&E performance. Non-financial indicators used extensively to inform QIPP and overall financial performance.	Financial reports provide detailed information of actual and budgeted spend on key areas of expenditure. Standard and customised ISFE reports used. Variances from budget and forecast outturn reviewed with budget holders identifying actions to achieve agreed outturn with major areas of concern reviewed monthly. High confidence that agreed actions will resolve variances. QIPP performance monitored monthly at individual initiative level with figures reconciling to I&E performance. Non-financial indicators used to inform QIPP and overall financial performance.	Financial reports provide detailed information of actual and budgeted spend on key areas of expenditure but with some issues on timeliness or quality. Standard and customised ISFE reports used but significant use of off-ledger reporting. Variances from budget and forecast outturn reviewed with budget holders identifying actions to achieve agreed outturn with major areas of concern reviewed monthly with moderate confidence that the actions will resolve variances. QIPP performance monitored monthly for key individual initiatives with figures reconciling to I&E performance. All initiatives reviewed at least quarterly. Non- financial indicators used in some cases to inform QIPP and overall financial performance but with further scope.	Financial reports don't provide timely and accurate information of actual and budgeted spend on key areas of expenditure. Standard and customised ISFE reports used but extensive use of off-ledger reporting that isn't reconciled to the ledger. Variances from budget and forecast outturn not routinely and systematically reviewed with budget holders. Limited actions identified and agreed to achieve outturn. Low confidence that variances will be resolved or offset. QIPP performance not monitored monthly at individual initiative level. Figures don't reconcile to I&E performance. Non-financial indicators used infrequently to inform QIPP and overall financial performance.	Moderate	Financial reports provide detailed information of actual and budgeted spend on all areas of expenditure. Standard and customised ISFE reports used. Variances from budget and forecast outturn actively reviewed monthly with budget holders identifying actions to achieve agreed outturn. There is moderate confidence that actions will resolve variances however if recent trends continue the level of confidence will reduce. QIPP performance monitored at least monthly at individual initiative level with figures reconciling to I&E performance. Non-financial indicators used to inform QIPP and overall financial performance.	QIPP reporting and monitoring continually in development. Future QIPP reporting and monitoring will be at individual scheme level as appropriate.	Oct-15
	7		Sufficiency of board reporting to manage overall financial position	Reporting provides very clear explanation of current and forecast position and underlying run rate, including corrective actions and full risk analysis. I&E, cash and balance sheet all covered with integration with key non-financial measures including activity. Format formally & regularly reviewed by appropriate committee.	Reporting provides good explanation of current and forecast position including corrective actions and risk analysis for key risks. I&E, cash and balance sheet all covered with integration with key non-financial measures including activity. Format reviewed by appropriate committee as need identified.	Reporting provides some explanation of current and forecast position including some corrective actions and risk analysis for key risks but reports could be better. Cash and balance sheet partially covered with limited integration with key non-financial measures including activity. Format reviewed from time to time but not approved by appropriate committee .	Reporting provides limited explanation of current and forecast position. Corrective actions and risk analysis difficult to understand and not comprehensive. Cash and balance sheet only partially covered. Very limited integration with key non-financial measures. Format not reviewed in last year.	Good	Reporting provides very clear explanation of current and forecast position and underlying run rate, including corrective actions and full risk analysis. I&E, cash and balance sheet all covered integrated with key non-financial measures however improvement is needed to align the information better.	Current finance reports format and content under review. New format to include the improved integration and alignment of non-financial measures including activity.	Oct-15
	8		Standing orders, SFIs and delegated authorities	Standing Orders, standing financial instructions and delegated authorities regularly reviewed and approved. Clear guidance documents in place for relevant aspects such as procurement and recruitment. All staff trained on financial governance and training documented. Delegated authorities built into ISFE with complete hierarchies.	Standing Orders, standing financial instructions and delegated authorities regularly reviewed and approved. Guidance documents in place for relevant aspects such as procurement and recruitment. Key staff trained on financial governance. Delegated authorities built into ISFE with substantially complete hierarchies or well documented and approved working arrangements for exceptions.	Standing Orders, standing financial instructions and delegated authorities reviewed and approved in the past 12 months but no timetable for future reviews. Guidance documents in place for relevant aspects such as procurement and recruitment. Some evidence of staff training on financial governance but more needed. Delegated authorities built into ISFE but with incomplete or out of date hierarchies. Adequate working arrangements in place but not fully documented.	Standing Orders, standing financial instructions and delegated authorities not reviewed and approved in the past 12 months. No timetable for future reviews. Limited or no guidance documents for relevant aspects such as procurement and recruitment. Limited or no staff training provided and if delivered it is on an ad hoc basis. Delegated authorities built into ISFE but with incomplete or out of date hierarchies. Working arrangements to operate ISFE inadequate and not documented.	Good	Standing Orders, standing financial instructions and delegated authority levels regularly reviewed and approved. Procedures/Guidance in place for relevant aspects such as procurement and recruitment. Key staff trained on financial governance. Delegated authority built into ISFE with substantially complete hierarchies or well documented and approved working arrangements for exceptions.	Refresher financial governance training to be provided to all staff	Dec-15

Financial controls & processes	9	Systems of financial control	**Budget setting, monitoring and forecasting and key area cost control**	Draft budgets prepared by fully trained budget holders with guidance on assumptions including growth, efficiencies and inflation provided by CFO. Budget holders take budget management responsibilities seriously. Budgets include the impact of QIPP and are phased in line with activity or other primary cost driver. Reserves and contingencies transparent and phased appropriately. Budgets formally accepted by budget holders by start of financial year and any budget adjustments clearly documented and agreed. Budget virement process clear with high level sign off of major changes. All areas of expenditure budgeted at sufficiently detailed level to facilitate understanding of actual performance and enable control.	Budgets prepared by budget holders with guidance on assumptions including growth, efficiencies and inflation provided by CFO. Majority of budget holders take responsibilities seriously. Budgets including QIPP phased in line with activity or primary cost driver. Reserves and contingencies transparent and phased appropriately. Budgets formally accepted by budget holders by end of April and any budget adjustments clearly documented and agreed. Budget virement process documented with clear system of sign off of major changes. Key areas of expenditure budgeted at sufficiently detailed level to facilitate understanding of actual performance and enable control.	Budgets largely prepared by budget holders with some guidance on assumptions including growth, efficiencies and inflation provided by CFO. Some budgets imposed to achieve overall surplus. Some budget holders not taking responsibilities seriously. Most expenditure and QIPP budgets phased in line with activity or primary cost driver but some key lines phased in straight line. Reserves and contingencies not as transparent as they should be to the governing body. Budgets not formally accepted by budget holders and adjustments not always clearly documented and agreed. Budget virement process working but without documented or appropriate sign off of changes. Key areas of expenditure budgeted at reasonably detailed level to facilitate understanding of actual performance and enable control but some evidence of off ledger record keeping.	Budgets largely prepared by finance with limited consultation with budget holders. Limited evidence of budget holders taking their responsibilities seriously. Poor or no guidance on assumptions including growth, efficiencies and inflation. Expenditure budgets not phased in line with activity or primary cost driver. Reserves and contingencies not transparent and if exist are hidden in budget lines or phasing. Budgets not formally accepted by budget holders and adjustments not documented and agreed. Budget virement process ad hoc without documented or appropriate sign off. Key areas of expenditure not budgeted at a detailed level so understanding of actual performance difficult. Substantial off-ledger record keeping.	Good	**Budgets prepared in accordance with Gov Body strategic steer and agreement on assumptions applied to all budgets re: growth, efficiencies and inflation as advised by CFO and approved by Gov Body. CFO overview of approved financial plan presented to Senior Managers and to all staff at start of year conference. Majority of budget holders take responsibilities seriously and meet with finance . Budgets including QIPP phased in line with activity or primary cost driver. Use of Reserves and contingency transparent and phased appropriately. Budgets formally accepted by budget holders by end of August and any budget adjustments clearly documented and agreed. Budget virement process documented with clear system of sign off of major changes. Key areas of expenditure budgeted at sufficiently detailed level to facilitate understanding of actual performance and enable control.**	**Finance training to also cover budget holder roles and responsibilities**	**Dec-15**
	10		**Balance sheet including intercompany balances (AoB) & cash**	Balance sheet reviewed and signed off every month with full reconciliations especially for accruals, provisions and prepayments. Agreement of balance returns reconcile to ledger and completed on time - differences with providers and other NHS bodies actively resolved. Supplier statements for all non-NHS providers routinely reconciled with no unresolved issues. Ledger and other systems with financial impact subject to active access and posting control in line with delegated authorities. Cash forecast and drawdown requirements signed off. Cash at bank minimised without overdrafts and no supplementary cash drawdowns.	Balance sheet reviewed every month with full reconciliations for key accounts and minimum quarterly reconciliations for remaining accounts. Agreement of balance returns reconcile to ledger and completed on time - major differences with providers and other NHS bodies actively resolved. Supplier statements for key non-NHS providers routinely reconciled and no major issues. Ledger and other systems with financial impact subject to active access and posting control in line with delegated authorities. Cash forecast and drawdown requirements signed off. Cash at bank minimised with only occasional overdraft or supplementary drawdown requests.	Balance sheet reviewed most months with full reconciliations for key accounts and minimum quarterly reconciliations for remaining accounts. Some reconciliations incomplete. Agreement of balance returns reconcile to ledger and completed on time - major differences with providers and other NHS bodies being resolved but some historical and unresolved issues. Supplier statements for non-NHS providers routinely reconciled when issues arise with supplier. Ledger and other systems with financial impact subject to active access and posting control in line with delegated authorities. Some outstanding issues. Cash forecast and drawdown requirements signed off. Overall low cash balances at bank with occasional overdraft or high cash balances.	Balance sheet reviewed irregularly by CFO. Incomplete reconciliations for key accounts with items on control accounts unresolved for long periods. Agreement of balance returns don't reconcile to ledger and not completed on time. Major differences with providers and other NHS bodies not being resolved. Supplier statements for non-NHS providers not reconciled with frequent issues with suppliers. Ledger and other systems with financial impact not subject to active access and posting control in line with delegated authorities. Cash forecast and drawdown requirements not signed off. Poor cash forecasting and high variability in month end cash balance.	Excellent	**Balance sheet fully reviewed and signed off every month covering all control accounts. Agreement of balances return reconcile to ledger and completed on time - differences with providers and other NHS bodies actively resolved. Supplier statements for all non-NHS providers which are received are routinely reconciled with no unresolved issues. Ledger and other systems with financial impact subject to active access and posting control in line with delegated authorities. Cash forecast and drawdown requirements signed off. Cash at bank minimised without overdrafts and no supplementary cash drawdowns.**	**No further actions needed**	
	11		**Systems & processes (including internal audit response)**	Robust system of controls exists including segregation of duties & control account and other balance sheet reconciliations. Journals fully documented and approved by appropriate level supervisor. Accounts payable and receivable regularly reviewed with minimal overdue debts or delayed payments to creditors . All processes documented with clear responsibilities for delivery and review. No internal audit category 1 findings and recommendations and all lower level recommendations implemented on time and in full. Unqualified external audit report.	Robust system of controls exists. Segregation of duties, control account and other balance sheet reconciliations almost 100% in place with only minor exceptions. Journals fully documented and approved by appropriate level supervisor. Accounts payable and receivable regularly reviewed with minimal overdue debts or delayed payments to creditors. Key processes documented with clear responsibilities for delivery and review. No more than one internal audit category 1 finding and recommendation in last year. Remaining lower level recommendations implemented on time and in full. Unqualified external audit report.	Robust system of controls exists with some minor issues. Segregation of duties, control account and other balance sheet reconciliations substantially in place with only minor exceptions. Journals well documented and approved by appropriate level supervisor with minor exceptions. Accounts payable and receivable regularly reviewed but with some overdue debts and/or delayed payments to creditors. Key processes documented with clear responsibilities for delivery and review. No more than two internal audit category 1 findings and recommendations in last year. Remaining lower level recommendations implemented on time and in full. Unqualified external audit report.	System of control poorly documented with some major issues. Issues with segregation of duties, control accounts and other balance sheet reconciliations. Journals poorly documented and not generally approved by appropriate level supervisor. Accounts payable and receivable not regularly reviewed and show significant overdue debts and/or delayed payments to creditors. Key processes not documented, clear responsibilities for delivery and review not clear. More than two internal audit category 1 findings and recommendations in last year and majority of lower level recommendations not implemented on time and in full. Qualified external audit.	Excellent	**Core financial controls are reviewed annually and an overall significant assurance opinion provided. Robust system of controls exists including segregation of duties & control account and other balance sheet reconciliations. Journals fully documented and appropriately authorised. Accounts payable and receivable reviewed monthly with minimal overdue debts or delayed payments to creditors . All processes documented with clear responsibilities allocated. Audit review of control environment identified 2 recommendations : - (i) to implement a flash reporting system to highlight significant issues for Gov Body attention , this has now been introduced and (ii) reporting QiPP scheme measures and benefits realisation which is currently being addressed via**	**No further actions needed**	
	12		**Risk sharing & income recognition**	Where applicable, risk sharing arrangements with other CCGs and trusts fully documented and associated financial risks evaluated monthly. Total risk evaluated and CCG share agreed with other parties. All anticipated recharges have agreement. Where CCG receives income for the provision of services commissioned by other organisations financial controls are in place to ensure the CCG is not placed at any risk, and that all transactions and balances are separately identified. No income, expenditure or cash transactions that could be constituted to be brokerage or similar arrangement.	Where applicable, risk sharing arrangements with other CCGs and trusts documented and associated financial risks routinely evaluated. Sufficient information for CCG to assess and account for its own risk. Risk included in risk register and in risk adjusted position. All anticipated recharges have outline agreement or a process for getting agreement. Where CCG receives income for the provision of services commissioned by other organisations financial controls are in place to ensure the CCG has minimal risk, and that all transactions and balances can be identified. No income, expenditure or cash transactions that could be constituted to be brokerage or similar arrangement.	Where applicable, risk sharing arrangements with other CCGs and trusts documented sufficiently to evaluate associated financial risks. Risk assessed at least quarterly and included in risk register and in risk adjusted position. Majority of anticipated recharges have outline agreement or a process for getting agreement. Where CCG receives income for the provision of services commissioned by other organisations - financial controls need strengthening. CCG has moderate exposure to risk that it can't directly mitigate. Any income, expenditure or cash transactions that could be constituted as brokerage or similar are minimal, transparent arrangements and don't have a major impact on surplus.	Where applicable, risk sharing arrangements with other CCGs and trusts not documented sufficiently to evaluate associated financial risks. Majority of anticipated recharges don't have outline agreement or a process for getting agreement. CCG receives income for the provision of services commissioned by other organisations - poor financial controls. CCG has significant exposure to risk that it can't directly mitigate. Significant income has been received non-recurrently or invoices reduced in value on the basis that this will be reversed in future periods. Lack of transparency.	Good	**Risk sharing arrangements with GM CCGs agreed via GM governance and local governance arrangements with ongoing updates to CFO. Total risk evaluated and CCG share agreed with other parties. All anticipated recharges have agreement. The CCG does not receive any 'miscellaneous income' from other NHS bodies which could be construed as brokerage. All income from NHS bodies is agreed as part of year end 'Agreement of balances'.**	**GM Risk Share signed off at a GM level by all CCGs with regular update reports to CFOs. All commitments against the risk pool analysed by CCG so position reflected in CCG forecast.**	
	13	Risk management	**Identification and monitoring process**	Pro-active horizon scanning process with risks assessed in terms of likelihood and financial impact. Clear responsibility of governing body or appointed committee. Clear documented process for identifying mitigations. Mitigations evaluated financially with early and effective stakeholder engagement. Tracking and reporting system in place with regular reporting to the appropriate committee. All risks on risk register financially assessed monthly.	Process for assessing risk well established with risks assessed in terms of likelihood and financial impact. Clear responsibility of governing body or appointed committee. Mitigations evaluated financially with stakeholder engagement. Tracking and reporting system in place with regular reporting to the appropriate committee. All risks on risk register financially assessed with major risks reviewed regularly.	Process for assessing risk reasonably well established with risks assessed in terms of likelihood and financial impact - some improvements needed. Responsibility of governing body or appointed committee clear. Risks sometimes overlooked. Mitigations evaluated financially with some stakeholder engagement. Tracking and reporting system in place with regular reporting to the appropriate committee. Key risks on risk register financially assessed but more in depth review required to fully evaluate.	Process for assessing risk ill defined - major improvements needed. Unclear responsibilities for assessing and reporting. Only some mitigations evaluated financially with limited stakeholder engagement. Tracking and reporting system poor with irregular reporting to the appropriate committee. Key risks on risk register financially assessed but more in depth review required.	Good	**Process for assessing risk well established with risks assessed in terms of likelihood and financial impact. Clear responsibility of governing body or appointed committee. Mitigations evaluated financially with stakeholder engagement. Tracking and reporting system in place with regular reporting to the appropriate committee. All risks on risk register financially assessed with major risks reviewed regularly.**	**Current process for identifying and reporting risks and mitigations is well documented. However, as part of the CCG's continued development of the CCG's approach to risk the CCG's risk strategy is being reviewed. The work will include working with Directors to develop a new themed approach to risk management and oversight to accommodate the increasing complexity of the CCG's priority work areas.**	**Oct-15**
	14		**Level of net risk**	Fully quantified risk. All risks matched by fully worked and credible mitigations capable of deployment in-year, leaving a net opportunity.	Key risks fully quantified risk. Risks matched by mitigations leaving no net risk.	Majority of risks quantified but with some key risks under evaluation. Risks matched by mitigations leaving overall net risk within business rules.	Risks only partially quantified & only partially matched by under-developed mitigations leaving material net risk outside business rules.	Improvement needed	**Fully quantified risk however mitigations still leaving material risk outside business rules as CCCG has only planned to deliver 0.5% surplus.**	**Stockport Together initiative as described above**	**Services to be redesigned over the next 6 to 36 months**
	15	Finance team capability and capacity including support services	**Core team**	Fully staffed team with clear roles and responsibilities. All permanent roles filled, low staff turnover. Staff well trained and appropriately qualified, training & development taken seriously, CPD up to date for all applicable staff members. Where relevant, shared management team recognises the organisational boundaries and allows sufficient time to focus on the separate issues of each CCG.	Fully staffed team with clear roles and responsibilities with minimal use of interims. Low staff turnover. Staff well trained and appropriately qualified. Training and development taken seriously but some areas to address. Where relevant, shared management team recognises the organisational boundaries and allows time to focus on the separate issues of each CCG.	Clear roles and responsibilities with some use of interims but with firm plans to recruit substantively. Moderate staff turnover. Training & development seen as important but limited progress. Where relevant, shared management team usually recognises the organisational boundaries and allows some time to focus on the separate issues of each CCG.	Roles and responsibilities unclear with extensive use of interims - high staff turnover with ***CFO interim for more than 3 months*** . No firm plans to reduce reliance on interims. Staff not all qualified to perform roles. No training and development plan. Where relevant, shared management team does not always recognise the organisational boundaries and sometimes allows insufficient time to focus on the separate issues of each CCG.	Good	**trained and appropriately qualified, training & development taken seriously, CPD up to date for all staff members. However, going forward there is potential capacity issues resulting from additional workload from GM Devolution, Primary Care Co-Commissioning and Specialist Commissioning transferring back s to CCG's especially if running cost allowance is not increased.**	**Finance structure to be reviewed in line with 2015/16 planning**	**Mar-16**
	16		**Commissioning support services (mark as N/a if no CSU support)**	Signed contract with commissioning support service provider detailing all services to be delivered and related standards of performance. Excellent working partnership with roles and working arrangements clearly defined. Commissioning support service provider rated highly by the CCG, reports etc. delivered on time to a high standard, no unresolved formal disputes.	Signed contract with commissioning support service provider detailing all services to be delivered and related standards of performance. Good working partnership with roles and working arrangements defined. Commissioning support service provider rated highly by the CCG with majority of reports and other deliverables delivered on time to reasonable standard, no major unresolved formal disputes.	Signed contract with commissioning support service provider outlining all services, but detailed service specifications an/or standards of performance missing for some services. Good working partnership with roles and routine feedback reasonably defined but some clarification required. Commissioning support service provider rated moderate by the CCG with some key reports and other deliverables delivered late or incomplete. No major unresolved formal disputes but number of minor disputes or long running service issues.	Commissioning support service contract is missing detail of service provision in a significant number of areas. Poor working arrangements with roles and routine feedback not clearly defined. Commissioning support service provider rated moderate to poor by the CCG with some key reports and other deliverables often delivered late or incomplete. Major unresolved formal disputes.	Not applicable	**Do not use CSU for financial services. All financial services provided in-house**		

	17	Audit and other finance committees	Governing body ensures effective financial management	Committee structure well designed with clear roles and reporting for all finance related committees. Reviewed in last 12 months and fit for purpose. All committees chaired by a different suitably qualified non-executive or member of the governing body. Audit chair is a qualified accountant. Separate audit and financial committees. Training on responsibilities and processes provided to members to a high standard and documented. Committees meet as regularly as stipulated in terms of reference with agendas and decisions within the committee's remit. Constructive, focussed and relevant challenges with timely and robust monitoring and follow up of actions. Committee chairs report to the governing body following each meeting and have an annual review of the committee's performance reported to the governing body.	Committee structure well designed with clear roles and reporting for finance related committees. Reviewed in last 12 months, fit for purpose and future review scheduled. Chaired by suitably qualified non-executive or member of the governing body. Audit chair is a qualified accountant or is supported by a suitably qualified lay member. Separate audit and financial committees. Training on responsibilities and processes provided to members where requested by Chair. Committees meet as regularly as stipulated in terms of reference with agendas and decisions within the remit . Some constructive, focussed and relevant challenges, and actions followed up regularly. Committee chairs report to the governing body following each meeting and review the committee's performance at least once per year.	Committee structure established but some areas of overlap and gaps to be addressed. Not reviewed in last 12 months with no process for committee structure to respond to financial and operational challenges. Chaired by non-executive or member of the governing body with reasonable qualifications and/or experience. Audit and financial committees not separate. Training on responsibilities and processes provided to members on an ad hoc basis and needs strengthening. Committees plan to meet as regularly as stipulated in terms of reference but sometimes meeting cancelled. Agendas and decisions largely within the remit but some gaps and overlaps in work with other committees. Members provide some financial challenge but needs improvement. Committee chairs report to the governing body on an irregular basis and performance reviewed informally at least once per year.	Committee structure in need of redesign and not reviewed in last 12 months. No process for committee structure to be reviewed in response to financial and operational challenges. Audit chair not a qualified accountant and/or other chairs not suitably qualified or experienced. Audit and financial committees not separate. Training on responsibilities and processes not provided to members. Committees fail to meet as regularly as stipulated in terms of reference. Agendas and decisions not within the remit with major gaps and overlaps in work with other committees. Members as a group provide limited financial challenge with poor follow up of actions. Committee chairs report to the governing body on irregular basis and performance not reviewed formally or informally.	**Good**	**Committee structure well designed with clear roles and reporting arrangements. Reviewed in last 12 mths and planned for internal audit review of Committee effectiveness scheduled in Q4. Chaired by non-exec member of the Gov Body who is a qualified accountant. There are separate audit and financial committees however Audit Committee chair also chairs the QiPP and Remuneration Committee's. Separate audit and financial committees. Training on responsibilities and processes provided to members where requested by Chair. Committees meet as regularly as stipulated in terms of reference with agendas and decisions within the remit. Constructive, focussed, relevant challenges and follow up of actions. Processes to evaluate and monitor of QiPP still need to mature. Committee chairs report to the governing body following each meeting and review the committee's performance at least once per year.**	**The CCG Governing Body currently comprises of 2 lay members and it is difficult therefore to have separate separate chairs for each committee. The CCG is currently undertaking a governance review part of which is to determine whether Governing Body memnership should be increased.**	**Oct-15**
	18		**Audit Committee performance**	Audit Committee ensures responsibilities for implementing recommendations are appropriately assigned and implemented within timescales agreed. Audit recommendations followed up as a standard item on agenda. Audit Committee receives and follows up all internal audit reports and approves internal audit plan. Chair meets with internal and external auditors without management present. Chair ensures that lay members are appropriately skilled and experienced. Audit Committee receives service auditor reports from commissioning support service providers and ensures overall control environment is of excellent quality with only minor issues. Audit Committee obtains direct evidence where appropriate and is not reliant on representations from senior management.	Audit Committee ensures responsibilities for implementing recommendations are appropriately assigned with timescales agreed with major items delivered on time. Audit recommendations followed up as a standard item. Audit Committee receives all internal audit reports and approves internal audit plan. Chair meets with internal and external auditors. Chair works actively to improve the skills and experience of lay members. Audit Committee receives service auditor reports from commissioning support service providers and ensures overall control environment is of a good quality. Audit Committee obtains direct evidence in key areas of concern to reduce reliance on representations from senior management.	Audit Committee ensures responsibilities for implementing recommendations are appropriately assigned with timescales agreed with majority of items delivered on time but with some exceptions to be addressed. Audit recommendations followed up as a standard item. Audit Committee receives all internal audit reports and approves internal audit plan. Chair may be considering working more actively to improve the skills and experience of lay members. Control environment is of a good quality but with some areas of concern which Audit Committee needs to address. Audit Committee may often rely on representations from senior management.	Audit Committee does not ensure responsibilities for implementing recommendations are appropriately assigned with timescales agreed. Audit recommendations not followed up as a standard item. Audit Committee does not receive all internal audit reports and/or approve internal audit plan. Skills and experience of lay members not sufficient to fulfil role. Control environment is considered to be poor quality with significant areas of concern. Audit Committee usually relies on representations from senior management and rarely seeks direct evidence.	**Good**	**Audit Committee ensures responsibilities for implementing recommendations are appropriately assigned and implemented within timescales agreed. Audit recommendations followed up as a standard item on agenda. Audit Committee receives and follows up all internal audit reports and approves internal audit plan. Chair meets with internal and external auditors without management present. Chair ensures that lay members are appropriately skilled and experienced. Service auditor reports received as appropriate. Audit Committee obtains direct evidence where appropriate and is not reliant on representations from senior management. However, there is an acknowledgement that the committee should receive more performance related information**	**Financial performance information to be taken to Audit committee as determined by the Audit Committee Chair**	**Oct-15**

Financial Control Environment Assessment

		Area of consideration	Sub-area	Self-assessment
Financial performance	1	Longer term planning		Moderate
	2	Detailed financial planning	Credibility and degree of stretch	Moderate
	3		Alignment with activity and provider contracts	Good
	4	In year financial performance		Moderate
	5	Financial reporting	Consistency of reporting with ledgers and NHSE submissions	Excellent
	6		Comprehensiveness and use as control mechanism	Moderate
	7		Sufficiency of board reporting to manage overall financial position	Good
Financial controls & processes	8	Systems of financial control	Standing orders, SFIs and delegated authorities	Good
	9		Budget setting, monitoring and forecasting and key area cost control	Good
	10		Balance sheet including intercompany balances (AoB) & cash	Excellent
	11		Systems & processes (including internal audit response)	Excellent
	12		Risk sharing & income recognition	Good
	13	Risk management	Identification and monitoring process	Good
	14		Level of net risk	Improvement needed
	15	Finance team capability and capacity including support services	Core team	Good
	16		Commissioning support services (mark as N/a if no CSU support)	Not applicable
	17	Audit and other finance committees	Governing body ensures effective financial management	Good
	18		Audit Committee performance	Good

NHS
Stockport
Clinical Commissioning Group

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 October 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?
Not applicable
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Mark Chidgey
Meeting Date: 11 November 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 is assurance of SFT CIP plans.
- The issue of glaucoma follow-up waits at CMFT has been reduced to amber. A response has been received from CMFT and the issue has been quantified.

2.0 Issues highlighted to the Governing Body

2.1 Safeguarding Reports

2.1.1 This is a separate agenda item. The Committee reviewed the Safeguarding Reports and:-

- Acknowledged the challenges on CCG executive attendance at Safeguarding Boards and that this would be addressed through the appointment of a CCG Executive Nurse.
- Highlighted the risks that reduced capacity within the team has had in respect of assuring Provider compliance with safeguarding standards.
- Raised concerns over the pace of implementation of the CQC action plan.
- Noted the progress of the Domestic Homicide Reviews and the importance of ensuring lessons are learnt and improvement embedded.

2.1.2 In addition, the Committee was updated on safeguarding compliance at SFT Maternity, acknowledging that positive progress is being made.

3.0 Decisions for the Governing Body

- None

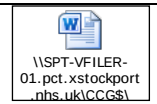
Compliance Checklist:

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 16 September 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	~~01/11/2015~~ Jan 2016		Aug-15	H:\Misc\Mark C\ Q&PM\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 fro November.	SG	Nov-15		Aug-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 November once compliance has remained consistent through Q1 - September.	MC	~~01/10/2015~~ Nov- 2015		Aug-15	
4	18/02/2015	There is an issue with timely follow-up of glaucoma patients at CMFT.	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. To seek further information RE: risk stratification through the contract lead and to enquire if there are any issues with follow ups across GM.	CB	Nov-15		Aug-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.	CB	~~01/09/2015~~ Dec-2015		Aug-15	Trajectory & SFT Risk rating G:\Committees\ 2015 16\Q&PM\ 17June15\Agenda
6	18/06/2014	There is an issue that out-patient letters are not consistently being received by GPs in sufficient time across all specialties. This may present a patient safety risk if GPs are not aware of medicaiton changes.	Progress is monitored through the bi-monthly performance meeting. Performance met the target of 95% with 97%- in July and met in August with 96%, to remove once compliant for 3 months.	CB	~~01/09/2015~~ Nov-2015		Aug-15	

Quality Provider Management Committee Issues Log
(Following Q and PM Committee of 16 September 2015)

7	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. Expected date of removal be agreed at the next meeting.	MC	~~01/09/2015~~ Nov-2015		Jul-15	
8	20/11/2013	There is an issue with patients receiving timely follow-up in cardiology/gastroenterology - the level of risk to patient care is not understood nor is the plan to resolve.	The Trust supplied a revised trajectory for cardiology and the CCG is awaiting data regarding detailed gastro plans- will be discussed in the October contract meeting - to stay amber.	MC	Sep-15		Aug-15	

Actions removed following last meeting									
	17/06/2015	There is an issue that 76% of Stockport patients with a LD have not had an annual health check. This may result in an unmet health need in these patients.	June Q&PM recommended removal since data on compliance will not be received until next annual self assessment.	GE	Jun-15			**Closed JUNE 15**	
	18/03/2015	SFT report - 70 wte nursing vacancies across medicine & surgical business groups.		GMi	May-15	**Safe staffing levels are reported to be maintained. Concern over resilience and impact on staff morale - note staff survey. Has been on issues log previously - removed in October 2014.**	Will be tacked through Safe Staffing & Papers to SFT Board	**Closed MAY 15**	
	20/11/2013	There is an issue with patients receiving timely follow-ups in ophthalmology.	CCG has written to SFT with a contract query to establish the position in terms of numbers and assessed risk. A response has been received and considered at the September meeting.	MC	May-15	**See SFT Integrated Performance Report.**	SP advised Q&PM of confidence in SFT Opthalmology management to monitor follow-ups.	**Closed MAY 15**	SFT Performance Report
	18/09/2013	There is an issue with the current under performance of the high risk TIA pathway which is resulting in some patients not been seen in the 24 hour target window (60% target). This could increase a patients risk of subsequent stroke if clinic appointments are delayed over 7 days and may result in a poor patient experience	Formal escalation from CCG Clinical Director of PM to SFT Director of Nursing.	CB	May-15	**Contract query 3 December. Action Plan received. Clinical audit completed - audit reviewed by March committee and agreed assurance that patients delayed on the TIA pathway are not at greater risk of a stroke. SFT hyper acute stroke centre from 1 April - will improve access at weekends. Performance should continue to be monitored.**	Track as a performance issue - no known quality risk.	**Closed MAY 15**	SFT Performance Report
	18/09/2013	There is an issue with the timely appointments for IAPT Counselling which may result in a compromise to patient safety, outcomes and experience.	**1.** An improvement action plan will be implemented. **2.** The CCG will commission additional capacity during 14/15.	GE	May-15	**Ongoing improvement in the counselling waiting list has been achieved. The service provider monitors waiting list on a regular basis and offers people alternative psychological treatements.**	GE advised this is not a significant issue in the wider context of mental health provision.	**Closed MAY 15**	\\SPT-VFILER-01.pct.xstockport.nhs.uk\CCG$\
	18/09/2013	There is an issue with the timely referrals within Speech and Language therapy for School Aged children which may put some children at risk of delayed development.	An improvement action plan, supported by non-recurrent funding has been implemented by SFT.	MC	May-15	**An options paper for a joint commissioning approach with schools/SMBC was presented to Q&PM in February & March. Proposal agreed and agreed to monitor through implementation.**	AC to progress and escalate any concerns to Q&PM	**Closed MAY 15**	\\SPT-VFILER-01.pct.xstockport.nhs.uk\CCG$\

NHS
Stockport
Clinical Commissioning Group

Chief Operating Officer's update

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

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?
This report provides an update on a number of issues and seeks endorsement of the Co-Commissioning Programme.
Please detail the key points of this report
Provides an update on: 1. Level 3 Co-Commissioning of Primary Care 2. Re-validation of CCG Nurses 3. Financial Turnaround 4. Vanguard update
What are the likely impacts and/or implications?
These have been outlined in the report.
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: 11th November 2015
Agenda item: 9

Chief Operating Officer Update

1.0 Purpose

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

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2.0 Level 3 Co-Commissioning of Primary Care

The CCG will submit a proposal to operate at Level 3 by the 6th November deadline, which will be circulated to members.

3.0 Revalidation of CCG Nurses

NMC Revalidation will be the way in which nurses and midwives demonstrate to the NMC that they continue to practice safely and effectively, and can remain on the register. In order to revalidate, every nurse and midwife will have to declare to the NMC that they are meeting the standards of the revised NMC code, received confirmation from an appropriate confirmer that this is true, and be able to offer evidence which shows how this has been achieved.

It will be implemented from next April and wil
l need to be repeated every three years.

The NMC has piloted its proposed model for revalidation in different settings across the UK. The model piloted requires evidence that nurses and midwives have:

- completed the required minimum hours of practice and continuing professional development (CPD) over the 3 year period
- obtained a minimum of five pieces of feedback over the 3 year period from a range of sources
- recorded at least five reflections on this feedback, the Code and/or learning activities undertaken, and had a professional development discussion with another NMC registrant, covering these reflections
- obtained confirmation from an appropriate confirmer that they have met the requirements for revalidation.

Within the CCG there are 18 nurses, primarily within the safeguarding and CCHC teams, of these none are required to revalidate in April 2016. The CCG has submitted an action plan to NHSE which has been accepted and is in the process of being implemented. The action plan is currently on track. As a system then revalidation applies to all providers, the CCG does not have any formal role in assuring the status of our providers but:-

- Stockport NHS Foundation Trust – the process is being led by the Director of Nursing.
- Primary Care – the CCG is assisting in awareness raising but responsibility lies with nurses and their employers (ie GP Practices)

• Care Homes – again responsibility is with the employers. No assessment has been undertaken of the state of readiness

4.0 Financial Turnaround

4.1 The CCG's financial Assurance rating has been reassessed by NHSE (GM & Lancs Area Team) following submission of our month 5 financial position showing (i) forecast position 15/16 c£1m off track and (ii) raising concern on our ability to deliver 1% surplus given our c£20m savings challenge in 16/17.

4.2 In applying their assurance framework guidance, NHSE AT have increased the CCG's financial rating to level 3 placing the CCG into Turnaround.

4.3 CCG officers have met with NHSE AT to understand the immediate impact of this on the CCG. A Turnaround Director will be brought in to conduct an 'in-house' review of the CCG and it is expected that this will be supplemented by additional monitoring and reporting over the coming months.

5.0 Vanguard

5.1 The Value Proposition for the Vanguard Programme has been approved. This has provided an additional £3.98M to support the Vanguard Programme which is excellent news and will support the CCG and partners to move forward with the Stockport Together progamme.

6.0 Action requested of the Governing Body

1. To endorse the Co-Commissioning Programme
2. To note the other items

1. Introduction

1.1 In Greater Manchester health and social care partners across the economy are working together to reform health and social care services to support GM to achieve its ambition of improving health outcomes for residents as quickly as possible. In order to support this vision and enable system wide change to take place transparently and clearly, robust and inclusive governance structures need to be developed and agreed.

1.2 This paper sets out the proposals for governance from October 2015 in shadow form and April 2016 in final form for the first phase of health devolution, recognising that this may change as the system becomes more self assured and is able to demonstrate sustainability and maturity.

1.3 The proposals are set within the framework of the MOU which was agreed by all parties in February 2015 and in particular with reference to the governance principles of:

- GM NHS will remain within the NHS and subject to the NHS Constitution and Mandate;
- Clinical Commissioning Groups and local authorities will retain their statutory functions and their existing accountabilities for current funding flows;
- Clear agreements will be in place between CCGs and local authorities to underpin the governance arrangements;
- GM commissioners, providers, patients and public will shape the future of GM health and social care together;
- All decisions about GM health and social care to be taken with GM as soon as possible;
- Accountability for resources currently directly held by NHS England during 2015/16 will be as now, but with joint decision making with NHSE in relevant areas to reflect the principle of "all decisions about GM will be taken with GM";
- There will be a new partnership reflecting the contributions and competencies of all parties.

1.4 Since the Devolution Agreement was signed earlier this year there has been considerable work undertaken both with localities and at GM level. In the light of this work, progress is being made in the development of the GM Strategic Plan which will become the essential platform for delivering the transformation which all stakeholders aspire. Over the coming months we need to progress all the process based activities which will be required to deliver a truly effective governance system, and these will be brought forward for agreement within the structure described below.

2. Shadow form from October 2015

2.1 This will mean that from October 2015 the governance structures set out in this paper will be operational and all GM wide health and social care decisions will be taken with the involvement of and in consultation with the local NHS and social care team, NHSE (NHS England), GMCA, AGMCCG (Association of GM CCGs) and GM NHS trusts and providers.

2.2 This will include decisions on funding, commissioning and (subject to ongoing detailed discussions with Monitor and CQC) the application of regulatory regimes. Providers will not take part in commissioning decisions.

2.3 It is recognised that Shadow Form is a developmental stage to devolution in April 2016 and that the arrangements set out in this report will be kept under review during that period and amended as appropriate with the agreement of the GM partners.

3. Devolution from April 2016

3.1 From April 2016 all decisions about health and social care will be taken by organisations within GM (i.e. GMCA, LAs, CCGs and NHS England) subject to the existing legal framework which includes the amendments in the Cities and Devolution Bill which will enable GMCA to have health and social care functions.

Funding

3.2 From April 2016 current NHS and Department of Health funding streams will remain in place but internal allocation and spend will be agreed by the parties through the governance structures set out in this note, and in the context of the existing statutory and accountability framework/s. Any new funding streams will be dealt with in the same way as the Transformation Fund set out in paragraph 17 below.

4. Proposed Structure

4.1 The proposed structure is set out in more detail below. In brief the high level strategy will be set out in a Strategic Plan by the Strategic Partnership Board which will have an Executive group. The Strategic Plan will set out what is to be led and agreed locally (underpinned by 10 locality plans) and what will be led and agreed at GM level. At GM level the strategy will be implemented by the GM Joint Commissioning Board. Existing funding will flow through existing routes. At this stage, the criteria for how Transformation Funding can be accessed for the benefit of GM will be formulated at the Strategic Partnership Board and recommended for adoption by the existing bodies who are responsible for allocation.

4.2 Procedures will be put in place to deal with any conflict of interest issues. The decision making structures will be supported by an officer team, GM Health and Social Care.

5. Strategic Partnership Board – functions

5.1 The Strategic Partnership Board will be responsible for setting the overarching strategic vision for the Greater Manchester Health and Social Care economy. As it is not a legal body, its decisions are not binding decisions of its members, but recommendations for its members to formally adopt following their own governance procedures which may include delegation to a group of its members where possible.

Its principal responsibilities will be:

- To set the framework within which the Strategic Partnership Executive will operate.

- To agree the GM Health and Social Care Strategic priorities in accordance with the NHS five year forward view. The priorities and vision as defined by the Strategic Partnership Board will be delivered by the GM Joint Commissioning Board and the localities.

- To approve the content of the GM Strategic Plan (for financial and clinical sustainability), and note the content of the 10 locality plans to deliver the Strategic Plan locally and the matters remaining for the GM Joint Commissioning Board's remit.

- To agree the criteria that determine access to the Transformation fund and ask the fund allocators (NHS England and GMCA) and fund recipients (Local Authorities and CCGs) to adopt them.

- To ensure that there remains ongoing and significant organisational commitment across the GM health economy to both the devolution agenda and a devolved health system.

- To be responsible to the people of Greater Manchester and to each other for the financial and clinical sustainability of the Greater Manchester health economy, through the agreement and the delivery of the Strategic Plan. The Board will receive regular update reports from the Executive on the ongoing progress of the delivery of the Strategic Plan.

- To provide a mutual assurance function over the outcomes linked to the commissioning decisions taken by members to deliver the Strategic Plan.. The Board will receive regular reports from the Executive about the commissioning decisions of the GM Commissioning Board, and the performance (via agreed outcomes) linked to those decisions.

- To provide the system wide assurance that ensures the Transformation Fund is fiscally neutral over its lifetime. By fiscal neutrality it is meant that:
  - The investment is paid back over a period of time by improved financial performance. It is not a cash repayment.
  - The benefit capture is measured against the counter factual. The benefits achieved must be greater than the sum of the investment during the CSR period.

- The Board will receive regular reports from the Executive with respect to progression towards fiscal neutrality and will be responsible for providing assurance on delivery of this objective to NHSE. The Board will also provide assurance on any relevant wider commitments in the context of the spending review process.

- To agree an assurance framework, developed jointly with regulators where required, that reflects the outcomes required by Greater Manchester, because the formal assurance that each individual party is delivering on their commitments to the Strategic Plan will be provided in the usual way by the relevant statutory body. The Board will receive regular reporting of GM's performance against agreed assurance metrics.

- To provide leadership across the GM health economy to ensure that the key strategic priorities for a GM health system are achieved.

- To receive quarterly reports from the (Public Health) Prevention and Early Implementation Board

- To receive quarterly reports from the GM Quality Surveillance Group

6. Strategic Partnership Board – membership

6.1 The Strategic Partnership Board is not a legal entity. Its decisions are not binding decisions of its members, but recommendations to the Board so that the respective Board members formally adopt them following their own governance procedures. It will be a widely based membership body supported by a smaller Executive (the Executive). The wider Strategic Partnership Board has previously been referred to as the Standing Conference.

6.2 The membership of the Strategic Partnership Board is not a closed membership at this point but will include:

- GMCA (The Chair of the GMCA)
- 10 AGMA authorities (Leaders or Lead Members)
- 12 Clinical Commissioning Groups (Chairs or Chief Officers)
- 15 providers - all acute NHS Trusts and Foundation Trusts, mental health and community providers and NWAS (Chairs or Chief Officers)
- NHS England (as they determine).

6.3 Monitor/TDA (NHS Improvement), CQC, Public Health England, Health Education England, Greater Manchester Fire and Rescue Service (Chair), and Greater Manchester Police and Crime Commissioner will be invited to attend as non voting members of the Board.

6.4 From October 2015 Primary care partners will be represented at the Board through the GMLMC. Further work will be undertaken from October to April 2016 the outcome of which will inform and determine the representation of primary care in the governance framework. This work will ensure that primary care is appropriately represented by accountable and representative bodies on an ongoing basis.

6.5 GMCVO will attend to represent the voluntary sector pending further discussion on third sector representation as set out below.

7. Strategic Partnership Board Executive – functions

7.1 The principal functions of the Strategic Partnership Board Executive will be:

- To develop the GM Health and Social Care Strategic priorities, particularly in the context of the NHS five year forward view. The priorities and vision as defined by the Board will be formal recommendations to each of the members to adopt within their respective organisations or joint committees (where relevant).

- To operate within the framework set by the Board.

- To provide the leadership and challenge required to ensure that the Strategic Plan is delivered.

- To receive regular reports on the delivery of the locality plans, and refer any concerns that are identified back to the relevant locality.

- To provide a forum for the membership to raise any issues relating to the delivery of locality plans that cannot be addressed at a locality level.

- To be responsible individually and collectively for the financial and clinical sustainability of the Greater Manchester health economy, and the delivery of the Strategic Plan. The Strategic Partnership Board Executive will receive regular reporting from the GM Health and Social Care Team with respect to this and challenge each other on delivery and progress.

- To propose to the fund holders of the Transformation Fund the allocation in accordance with the agreed criteria, and to seek reports from the recipients to enable reporting to the Strategic Partnership Board in relation to each of the investments.

- To collate information to ensure that the Transformation Fund is fiscally neutral over its lifetime. Regular updates will be taken to the Board with respect to this.

- To develop the detailed assurance framework, jointly with regulators where required, that reflects the outcomes required by and of GM.

8. Strategic Partnership Board Executive – membership

8.1 The Strategic Partnership Board Executive will comprise 13 members with four representatives each from AGMA (post April 2016 the representatives will be from GMCA), AGMCGG, and providers plus 1 representative from NHS England. Initially this will be officers of AGMA/GMCA, Chairs of CCGs and CEOs of Providers.

8.2 The Executive will focus on the broader GM plan and any locality issues that may affect the delivery of the plan. Representatives at the Executive will be expected to represent (and report back to) their larger stakeholder group to ensure that decisions are taken in the best interests of GM. However, it is proposed that the Executive is reflective but not representative of the conurbation and the parties need to agree how there is representation from across GM.

8.3 The membership of both the Board and the Executive will have the ability to change over time as the GM health and social care economy evolves and develops into an increasingly place based economy. Both bodies will have the ability to engage a broader membership where there is a benefit to do so, for example, where there are strategic decisions to be taken about Primary Care at a GM level Primary Care Providers will be engaged in that discussion.

9. Provider Representation

9.1 Provider representation will be through nomination by the Provider Federation Board.

9.2 The Greater Manchester provider NHS trust chief executives group has made significant progress in agreeing to move to a new governance model recognising the need to change how provider organisations work together. The proposed model is closely linked to, the development of the broader governance structures for GM Devolution, namely the Strategic Partnership Board and the Partnership executive. A 'federation board' of GM NHS trust providers is to be the vehicle to facilitate greater collaboration, particularly on strategic issues and to provide the mechanisms that will enable the providers to play a full role within the GM Devolution governance arrangements.

9.3 The Provider Federation Board will be independently chaired and its aims and objectives are threefold:

- To improve patient outcomes and the quality of patient care (e.g. through sharing best practice and the reconfiguration of services);
- To achieve financial stability (e.g. through reduced duplication and better use of existing resources across the sector);
- To create a sustainable service (e.g. by improving resilience and responding in a better fashion to constraints such as the scarcity of specialist staff).

9.4 A system of 'locked gateway decision-making' has been developed which it is proposed should be used (where appropriate) to achieve agreements that will be binding across relevant members. Subject to the final approval of trust boards, it is proposed that the current trust Chief Executive's Group becomes

10. Meetings and Representation of the Strategic Partnership Board and Executive

Frequency

10.1 The Strategic Partnership Board will meet quarterly, and the Executive will meet monthly. The meetings will be held in public and papers will be made

available and published to an agreed timeframe. There may be a need for some papers to be confidential and therefore not available for the public.

Deputisation

10.2 Terms of reference will be developed for each that allows nomination of deputies.

Chair

10.3 Both the Board and the Executive will be independently chaired. The Chair will be the same person for both bodies, and will be appointed and remunerated through the NHS independent commission process, following Treasury guidelines.

10.4 The appointment of the Chair will be a joint appointment of AGMA, AGMCCG, Providers, and NHS England.

11. Primary Care, Patient , Third Sector, and Private Sector representation at the Strategic Partnership Board

Primary Care

11.1 As decisions around Primary Care will largely be taken at a locality level, Primary Care Engagement will be at a locality level. The Terms of Reference for both the Strategic Partnership Board and the Executive will make clear provision for appropriate Primary Care engagement, particularly when decisions are required on a GM footprint, for example around any further iterations of the Prime Minister's Challenge Fund, or any strategic decision around the GM health and social care estate.

Patient representation

11.2 As there is no single person who can represent the patient voice on a GM level, the patient voice will continue to be engaged at local Health and Wellbeing Board level by Health Watch. However, it is vital that the residents of Greater Manchester are engaged with the both the strategic vision and decision making process. Therefore GM will consider supplementary local engagement by the adoption of the 'NHS Citizen' model, which seeks to engage residents in the NHS England decision making process. Further work will take place to develop this proposal.

Third Sector

11.3 Whilst it is recognised that the third sector is an important provider of services, there is no single umbrella organisation (or individual) that can adequately and appropriately represent the views of the sector at a GM level. As such, third sector engagement will take place at a local level. It is likely that a number of larger third sector organisations, who operate on a GM platform will be engaged in the overarching provider forum.

Private Sector

11.4 The Board will bring together those commissioners and providers with the largest representation of patients and residents in the GM area. However, it is mindful of the wider groups who also interface with patients, and of patients' interests in their own right. It will not be possible to conduct business with all

providers and so involvement of those wider interests will be considered in a proportionate way.

11.5 Discussions will also take place with Primary Care, the Third Sector, patient representatives and Trade Unions to explore how they can be effectively engaged in the GM wide activity including the option for consultative fora which will be created to encompass their memberships.

12. Decision making capability of the Strategic Partnership Board

12.1 Both the Board and the Executive represent four principal stakeholder groups: GMCA/AGMA; AGMCCG; Providers; and NHS England.

Strategic Partnership Board

12.2 For any vote to carry, 75% of the four membership groups eligible to vote must vote in favour of the proposal. Each of the four membership groups will hold one vote apiece, with the person taking that vote being accountable to their constituent stakeholder group. It is assumed that discussion around key decisions will take place in the existing constituent bodies – AGMA/GMCA, AGMCCG, NHSE and the Provider Federation Board.

Strategic Partnership Board Executive

12.3 For any vote to carry 75% of those eligible to vote must vote in favour of the proposal. Each of the principal stakeholders will hold one vote each, with the person taking that vote being accountable to their constituent stakeholder group.

12.4 In order to support the decision making process a clear framework is being developed to clarify those decisions that will be taken by the Board and those that can be taken by the Executive. Discussions are also taking place to ascertain how the providers could be bound by a majority voting mechanisms at the Provider Federation and within this governance structure.

13. Joint Commissioning through the GM Joint Commissioning Board

13.1 The Joint Commissioning Board (GMJCB) is not a separate legal body but a Board where each participant makes joint decisions which are binding on each other. It is a Joint Committee. However, a formal joint committee cannot be created until some legal issues are resolved. The remainder of these sections therefore will apply to the formally established GMJCB from April 2016 and in shadow form from October 2015.

13.2 The GMJCB will have significant commissioning decision making responsibility as the largest single commissioning vehicle in GM. As such it will need a clear decision making framework in place.

13.3 In order to comply with regulatory requirements the GMJCB will need to function independently of providers.

13.4 The key functions of the GMJCB are as follows:

- Be responsible for the commissioning of health and social care services on GM footprint
- Have strategic responsibility for commissioning across GM
- Be responsible for the delivery of the pan GM strategy via its commissioning decisions (local commissioning will remain a local responsibility).

13.5 The GMJCB will only take GM wide commissioning decisions; local decisions will be made in the localities. A mechanism will be developed to make clear the decisions that are within the remit of the GMJCB and the locality. A starting principle is that those commissioning decisions which are currently made in localities will continue to be so unless all the members of the GMJCB are agreed that it is more efficient and effective for the decisions to be made on a GM wide basis. Some matters will remain within the remit of NHSE where they are of national significance (e.g. highly specialised services with small patient numbers).

13.6 All commissioning decisions will be evidence based and pay due regard to clinical opinion and expertise.

13.7 The exact range of legal functions which can be exercised in the Board by each party in this joint way remains to be fully identified but it will include the production of a GM Commissioning Strategy and GM wide services commissioning in areas such as Specialised Commissioning, Primary Care, Learning disabilities, Dementia Services, and Mental Health.

14. Meetings and Representation of the Joint Commissioning Board

14.1 The form of the GMJCB will differ between the Shadow and the post April 2016 phases, due to the need to progress certain legal matters. The remainder of this section describes the post April 2016 phase.

14.2 The JCB will meet monthly and Healthwatch will be invited to attend.

14.3 Initially, each participant requires its own representative to attend; this will be representatives from:

- CA x 1
- NHSE x 1
- The CCGs x 12
- The LAs x 10

Total 24 representatives

14.4 The GMJCB will be jointly chaired by local authorities and CCGs. The GMCA, NHSE, CCGs and LAs will each have one vote (i.e. four votes in total). Decisions will require a 75% majority of the participant organisations.

14.5 There may be circumstances where NHSE has no present interest in a particular matter e.g. where the matter relates to a function that NHSE has delegated to GMCA and/or CCGs. In circumstances where NHSE does not

vote it is proposed CCGs have two votes on behalf of the NHS, and LAs and GMCA one vote apiece.

14.6 Due to the fact that NHSE commissions many services on a national basis, notably specialised services, there will be a proportionate ability for NHSE to notify the GMJCB where an item due for consideration could have significant ramifications for NHSE, eg proposed spending beyond existing budget(s); or potential and significant adverse implications for communities beyond GM. The exact circumstances, in which these arrangements apply, have yet to be determined and further is required to develop such criteria. In these instances, any decision will need to be taken with the consent of NHSE.

14.7 Due to the large membership, heavy reliance will be placed on high quality preparation and socialisation of papers: consultation and engagement outcomes; market analysis; clinical advice, data and analysis; impact assessments on cohorts/geographies; legal advice where required. For this reason, an Executive arm of the GMJCB will be required to commission and prepare sufficient and timely distribution of materials and interface with GMJCB members ahead of any meetings. This Executive will have the same Chairs as the GMJCB.

14.8 During the Shadow phase all decisions on any GM commissioning matter will be taken in accordance with existing legal structures but will wherever possible be made following full engagement between the parties and in accordance with the principles of the post April 2016 procedures set out above.

15. Advisory Groups

15.1 Detailed work is currently being undertaken on GM wide commissioning issues through specific Boards for Cancer, Specialised Services, Co-Commissioning and Learning Disabilities. It is proposed that this arrangement continues and is developed when required. The Groups will not make commissioning decisions and will make recommendations to the Joint Commissioning Board for final decisions.

16. GMJCB Funds

16.1 The GMJCB does not hold GM funds because it is not a legal body. If and where GM level funds can be pooled, they will be pooled and hosted by one member for and on behalf of the matters in the GM pool in the normal way.

16.2 Where GM funds are not pooled, the original fund holder will keep its own funds, provide transparent information on them, and only spend them on the basis of GMJCB decisions; a virtual pooled fund.

17. The Transformation Fund

17.1 The criteria for accessing the Transformation Fund will be developed by the Strategic Partnership Board Executive and agreed by the Strategic Partnership Board and central government. One of the key functions of the Strategic Partnership Executive will be to oversee access to the

Transformation Fund. Funding flows will be through existing legal structures and pathways.

17.2 The access to the Transformation Fund will be underpinned by a contractual relationship between the recipient of funding within the locality and the allocator of those funds (NHSE/GMCA).

17.3 An assurance framework that underpins the contractual arrangement set out above will be developed to ensure that the Strategic Partnership Executive is able to maintain an oversight of work that is progressing with regards to investments made. The Strategic Partnership Board will have responsibility for ensuring that the Transformation Fund is fiscally neutral over its lifetime, and will monitor progress against this key objective via a robust monitoring framework. The Board will receive regular performance reports from the Executive on Transformation Fund spend and outcomes.

18. Assurance and performance

18.1 GM will operate within the existing national assurance framework. However, it will be necessary to develop a robust GM assurance/performance management framework, that focuses on system wide performance rather than compartmentalise each of the component parts. Any such framework will need to include a suite of metrics that are suitable for GM, the challenge that exists, and that focuses energy on achieving the outcomes that are wanted by GM. This will ensure that GM has a health and social care system that does not work against each other, and works for the benefit of those who use services.

18.2 We will need to develop a system whereby GM (including local NHS England leadership) is assured once by NHS England's regional/national teams as a place, and GM then assures its component parts internally. However, as part of any developing assurance and performance framework it is likely that in extreme circumstances 'step in rights' will be retained by NHS England's regional/national leadership and the Secretary of State. These will only be exercised in cases of extreme failure.

19. Regulatory framework

19.1 Discussions are taking place with Monitor to agree an Addendum to the Licence setting out how the GM Health system can progress mutual assurance and regulation within the existing legal framework.

20. (Public Health) Prevention and Early Intervention Board.

20.1 The Prevention and Early Intervention Board (PEIB), created to ensure GM operated a unified public health leadership system, will be expected to develop a strategic plan that is aligned to the GM overarching Strategic Plan. As such any plan produced by the PEIB would be approved by the Strategic Partnership Board. The SPB will receive regular reports with respect to progress made against the plan, and the SPB (or Executive) will provide an assurance function over it.

20.2 The PEIB will also form one of the advisory groups (set out in 14.1) to the GMJCB. As the PEIB cannot hold fund (it is not a legal body), any GM wide commissioning requirements, including the development of agreed standards for procurement executed at a local level, will be delivered through the GMJCB. However, the PEIB will make recommendations to the GMJCB in respect of this.

21. Greater Manchester Health and Social Care Team

21.1 The Greater Manchester health economy will be serviced by a Greater Manchester Health and Social Care team. This team will be led by an Accountable Chief Officer post, appointed jointly by AGMA/GMCA and NHS England and reporting to the GMCA Head of Paid Service and NHSE (the precise details of which are to be determined).

21.2 The role of the Chief Officer will include assurance of GM CCGs (including financial viability), conduct of GM commissioning on behalf of NHSE and having oversight of the Strategic Clinical and Financial Plan.

22. Further Actions required

- Progress the development of engagement mechanisms for Primary Care, Patients, and the Third Sector
- Complete discussions with Monitor/TDA.
- Open discussions with CQC
- Determine arrangements for the GMJCB Executive and principles for GM wide commissioning of services.
- Progress the development of a decision making framework for the proposed governance structures, setting out the type and nature of decision to be taken, and who will take those decisions
- Produce an accountability report to identify where the consequences of decisions ultimately vest i.e financially, statutorily.
- Progress the development of an assurance framework (to be the subject of a separate paper).
- Clarification of legal issues concerning vehicles for decision making within the JCB and issues arising from amendments to the Devolution Bill during its progress through the Commons.
- Sign off the role and accountabilities of the Chief Officer.

23. Next steps

23.1 This paper and the governance proposals set out within will be presented at the GM Health and Social Care Devolution Programme Board on 18th September.

23.2 Thereafter arrangements will be made where required for each organisation to formally agree the arrangements to establish the governance structures and recruit the Independent Chair.

24. Review

24.1 Within individual localities Health and Well Being Boards will continue to have oversight of activities within their areas. It will be a matter for individual local authorities, CCG's and their local providers etc to determine what

arrangements work best for them to ensure the effective delivery of their Locality Plans. Within localities there are also Health Scrutiny Committees which will continue unchanged. It is clear that at GM level scrutiny will become even more important particularly in overseeing the implementation of the Strategic Plan. A report will be brought forward to AGMA/ CA in due course.

24.2 The governance arrangements of GM Health and Social Care Devolution will be reviewed in April 2016 on the move from shadow form to devolution and in April 2017 to ensure that they remain fit for purpose. Consideration will be given to the inclusion of independent scrutiny in the review.

25. Recommendations

24.2 The CCG Governing Body are recommended to

- support the in principle shadow governance arrangements set out in the report.

- note 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 that they are fit for purpose for devolution in April 2016.

- note that the in principle shadow governance arrangements are also agreed by the GMCA/ AGMA

NHS
Stockport
Clinical Commissioning Group

Safeguarding Report

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015

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

Executive Summary

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Executive Summary

What *decisions* do you require of the Governing Body?
To acknowledge that the updated framework has placed additional requirements on the CCG in respect to safeguarding To note the actions that will need to be put in place to ensure that SCCG is compliant with these requirements
Please detail the key points of this report
The report is presented as a table which lists the requirements, the CCG's current position and the action required to meet those that are not currently being met. The updated framework identifies: Seven requirements unchanged from the 2013 guidance Six were the wording is more explicit and the current position will require strengthening Five new requirements that will require specific action.
What are the likely impacts and/or implications?
There is a risk that the actions cannot be delivered by the current CCG safeguarding resource. The CCG will not be compliant with the required authorisation safeguarding duties.
How does this link to the Annual Business Plan?
Safeguarding is integral to all aspects of the CCG business plan.
What are the potential conflicts of interest?
Nil
Where has this report been previously discussed?
Quality and Provider Management Committee
Clinical Executive Sponsor: Dr C Briggs
Presented by: Dr C Briggs
Meeting Date: 11.11.15
Agenda item:
Reason for being in Part 2 (if applicable)

In June 2015 NHS England published an updated Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework to reflect statutory, political and structural changes in the NHS. The document sets out the safeguarding role, duties and responsibilities for all organisations commissioning NHS care.

The attached table lists the CCG responsibilies outlined in the document, the organisations current position and what actions will be required in 2015 -16 to ensure the CCG are fulfilling them. The table identifies were the requirement is new, the wording in the updated version is more explicit or if it is unchanged. Any compliance issues will be raised with the Quality and Provider Management committee and will be escalated to Governing Body, if necessary, by the executive lead. The Governing Body will receive the 2015-16 assurance as part of the Safeguarding Annual Report.

CCG RESPONSIBILITIES	CCG CURRENT POSITION	ACTION REQUIRED
To be assured that the organisations who they commissions from have effective safeguarding arrangements Unchanged	Safeguarding standards included in all contracts. Annual assurance audit completed by some providers	A more systematic process for ensuring annual assurances are received and assessed from all commissioned services
Securing the expertise of Designated Professionals on behalf of the local health system. This is a whole economy role not just a CCG role Unchanged	The CCG has all the appropriate professionals in post	None required
To include Designated Professionals in all parts of the commissioning cycle Wording more explicit	The Designated Professionals are not routinely included or consulted with in respect to service development, redesign or procurement. The professionals are involved in the performance, quality and incident management processes	For safeguarding to be considered at all stages in the commissioning cyle and service redesign as part of Stockport Together Risk • The capacity of the team to undertake this
To agree with providers how the safeguarding standards are monitored Unchanged	There are regular meetings throughout the year with Stockport and pennine FT. Bi annual meetings with the other organisations we commission from	Review the current process to explore if this is the most effective way of monitoring
To gain assurance from ALL commissioned services throughout the year to ensure continuous improvement New requirement	Only the main contracts are assured more than once a year and some of the smaller contracts bi annually	To be compliant with this responsibility the following would be required: • To review the current process for requesting and receiving assurance • To review the current process for monitoring • To apply the above to ALL contracts Risk: • The team does not have the

		administrative support to manage this process • The team doesn't have the capacity to review all the evidence and make contact with ALL providers throughout the year
To have a clear line of accountability and governance arrangements. A named executive lead should take overall leadership responsibility for the organisations safeguarding arrangements Wording more explicit	The current executive does not have the capacity to undertake the role in line with the previous requirements (2013)	To ensure that the new executive nurse JD reflects the requirements of the role in the updated statutory guidance
The organisation has clear safeguarding policies Unchanged	There are policies in place, due updating December 15	To ensure when the policy is updated it addresses any relevant legislative changes
The organisation has appropriate safeguarding training and supervision processes in place Unchanged	The training strategy is an appendix to the policy and will be updated December 15 The CCG has purchased a new suite of e learning which includes safeguarding material which is compliant with the updated 2014 requirements for children and the Care Act and has assigned all staff to complete as part of their mandatory training. The Designated Professionals access supervision. Ad hoc supervision is provided to members of CHC when they have safeguarding concerns	To ensure when the training strategy is updated it reflects the new guidance.
The organisation must work effectively with other agencies and includes appropriate arrangements to cooperate	The Designated Professionals appropriately represent the CCG at the relevant Boards and sub groups.	The JD of the executive nurse included attendance at the Adult Safeguarding Board therefore once this person is in

with local authorities in the operation of Safeguarding Children and Adult boards and Health and Well Being Boards Wording more explicit	The CCG only has executive presence at the Children's Safeguarding Board. The CCG contributes financially to both Boards	post the organisation will fulfill this requirement.
The organisation has effective information sharing arrangements Unchanged	The CCG has a Caldicott Guardian The CCG has signed up to the Stockport Children Safeguardiing Board Information Sharing agreement	As part of Stockport Together and Devolution Manchester there needs to be a clear information sharing agreement in place to safeguard vulnerable groups
The organisation s required to have Designated professionals for Safeguarding Children and Looked After Children and a Designated Paediatrician for unexpected deaths in childhood Unchanged	The CCG employs the relevant safeguarding and LAC professionals. The CCG contributes to the GM Rapid Response team that fulfills the Designated Professional for unexpected deaths requirement.	The SLA for the Designated Dr LAC is in place but this needs to be replicated for the Designated Dr Safeguarding Children
The organisation is required to have a Designated Adult Safeguarding Manager which should include the Adult Safeguarding lead role and a lead for the MCA, supported by the relevant policies and training. New requirement	The CCG currently has a Designated Nurse for Adults whose JD incorporates the MCA lead function but not the Designated Adult Safeguarding Manager function	The job description for the current Designated Nurse post will require benchmarking against the additional requirements, any amendments made and to ascertain if additional capacity will be required.
The CCG needs to demonstrate that it is supporting the development of a positive learning culture across partnerships for safeguarding adults to ensure organisations are not unduly risk averse New requirement	The Designated Nurse for Vulnerable adults has been key in driving forward an a multi agency threshold document to ensure consistency in agency reporting and investigating safeguarding incidents relating to adults The Designated Nurse along with the Care Home Officer will attend the newly formed Thresholds Panel to assist in moderating incidents and to identify if there are any themes and trends relating	To ensure the Threshold document is embedded across the health economy including primary care. To ensure that any themes and trends are communicated and appropriately actioned across the health economy. Potential capacity risk as this is a new process and unclear yet what will be generated from this process.

	to health organisations	
The CCG needs to demonstrate that it is working with the Local Authority to enable access to community resources that can reduce social and physical isolation for adults New requirement		Will require evidencing that this is part of Stockport Together
The CCG is required to work with others to ensure critical services are in place to respond to children and adults who are at risk or who have been harmed Wording more explicit	The CCG funds specific sevices for Looked After Children Pennine is commissioned to provide front door services for children, young people and adults who may be in crisis due to being vulnerable or abused Pennine is commissioned to provide psychological therapy and councilling services	Further consideration of this requirement should be undertaken and should be linked with Stockport Together for adults and Stockport Family for children
The CCG should demonstrate that it is delivering improved outcomes and life chances for the most vulnerable Wording more explicit	CCG is moving towards outcome based contracting	As above
That the Designated Clinical Experts (children and adults) are embedded in the clinical decision making of the organisation with the authority to work within local health economies to influence local thinking and practice Wording more explicit	The Designated Professionals are not currently embedded in the clinical decision making of the organisation.	How this will be addressed will be discussed with the Executive Nurse when in post
Co commissioning New requirement	As a joint commissioner NHS England retains safeguarding responsibilities for Primary Care	The CCG will need to assess the impact on the safeguarding team before it becomes a delegated commissioner for Primary Care

Compliance Checklist:

Documentation		Statutory and Local Policy Requirement	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	To follow
Page numbers	Y	Service Changes: Public Consultation Completed and Reported in Document	
Paragraph numbers in place	N	Service Changes: Approved Equality Impact Assessment Included as Appendix	
2 Page Executive summary in place (Docs 6 pages or more in length)	y	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	N
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

NHS
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Safeguarding Annual Report 2014 - 2015

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Executive Summary

What *decisions* do you require of the Governing Body?
1. To confirm that the report provides assurance that the CCG is meeting its safeguarding responsibilities. **2. To acknowledge the gaps/risks in the system and the actions in place to address them.**
Please detail the key points of this report
1. Identifies how the CCG is meeting the statutory safeguarding requirements. **2. It reports on our providers' compliance with the CCG safeguarding standards.** **3. It incorporates the statutory requirement for the CCG to produce a :** **- Safeguarding Children Annual Report** **- Looked After Children Annual Report**
What are the likely impacts and/or implications?
The statutory safeguarding requirements for the CCG will be enhanced following the publication of the Revised Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework later this year
How does this link to the Annual Business Plan?
Safeguarding is integral to all aspects of the SCCG business plan
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Quality and Provider Management Committee
Clinical Executive Sponsor: Dr C Briggs
Presented by: Dr C Briggs
Meeting Date:11.11.15
Agenda item:
Reason for being in Part 2 (if applicable)

Safeguarding Annual Report 2014

1.0 Purpose

The purpose of this report is to review the safeguarding activity that has taken place over the past 12 months and benchmark it against the statutory requirements that Stockport Clinical Commissioning Group (SCCG) is required to meet.

Safeguarding forms part of the CCG compliance framework. NHS England assures compliance through interactions such as check point meetings and the CCG's participation in the safeguarding nursing collaborative.

Safeguarding for the purpose of this paper includes; Children, Vulnerable Adults and Looked After Children.

2.0 Safeguarding Requirements of Stockport CCG

2.1 *Statutory Requirements*

The following are the statutory requirements as identified in *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework March 2013,* and a summary describing how the organisation is meeting these requirements.

2.1.1 *Responsible for ensuring that commissioned services provide a safe system that safeguards children and adults at risk of abuse and neglect. [Fully Met]*

The CCG safeguarding standards are included in a schedule contained within all clinical contracts for which SCCG is the lead commissioner. Within this schedule there is a requirement for each provider to complete an annual audit based on the safeguarding standards specified in the contract. The audit is reviewed by the safeguarding team and RAG rated. All action plans resulting from the audit findings are monitored by the safeguarding team. Quarterly meetings are held with our main providers and less frequently with others. Although the CCG is not the lead for Pennine Care NHS FT, quarterly reviews are undertaken jointly with the other CCG Safeguarding Leads who commission from this organisation. Failure to progress action plans in a timely manner results in escalation to the Quality and Provider Management Committee (Q&PM) who then agree on the next steps.

It should be noted that this year the above process has extended to seeking assurance not only from our main providers but also from

- Care homes with nursing,
- Specialist placements providers,

The CCG should be informed by a lead commissioner if a provider in its area has been identified as not meeting its safeguarding standards and the CCG commissions services from there. This process is robust around Care Homes with Nursing who are commissioned using the North West framework.

The Q&PM committee has received a monthly exception report and additional reports in respect to specific areas which are highlighted later in the main body of this report. The committee has brought to the Governing Body's attention, via the

quality report, any issues that it has deemed that the Governing Body require to be sighted on prior to this Annual Report.

2.1.2. *To be a member of Stockport Safeguarding Children Board (SSCB), engaged with Stockport Safeguarding Adults Board (SSAB) and work in partnership with local authorities to fulfil their safeguarding responsibilities. [Partially Met]*
These requirements are fulfilled as follows:
SSCB – "Working Together to Safeguard Children - 2014" clarifies that the Board representative should be at executive level and the Designated Doctor and Nurse attend as specialist advisors. The Stockport Safeguarding Children Board (SSCB) expects 80% attendance by members. Dr Catherine Briggs is the SCCG executive representative, however the required level of attendance has been a real challenge and the deputising arrangements that were put in place to address this have not been successful. Dr Briggs advised the Chief Operating Officer and Accountable Officer of this challenge and the Chief Operating Officer has been attending the SSCB as an interim measure. The designated professionals have met the required attendance levels.

[Note – this issue will be addressed in 15/16 through the appointment of an Executive Nurse but this falls outside of the time period covered by this report].

The Designated Nurse to fulfil the partnership requirements also chairs one of the SSCB sub groups and attends a further 6 sub-groups, all bi-monthly.

The Designated Doctor attends one sub group bi-monthly and another as required.

The Designated Nurse is also the CCG strategic lead for Domestic Abuse and attends the Supporting Families Executive Steering Group which includes Domestic Abuse as one of its terms of reference.

Vulnerable Adults – currently the Stockport Safeguarding Adult Board (SSAB) representative is the Designated Nurse for Vulnerable Adults, however the Care Act 2014 has made this board statutory and CCG Executive attendance, as with the children's board, was required from April 2014. This is currently not achieved due to executive director capacity. There is also now a requirement to make a contribution to the funding of the board which has been agreed and paid for 2014-15. The Designated Nurse also attends three board sub groups to fulfil partnership requirements.

Looked After Children – Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2014 and underpinned by Children Act 2004 requires the CCG to work in partnership with the Local Authority to meet the needs of Looked After Children. The Designated Nurse attends the Integrated Looked After Children Board (ILAC) quarterly and the Health Steering group monthly. Attendance at the Health Partnership Board and CAMHS Partnership Board also ensure that the health needs of Looked After Children are considered in all the relevant strategic forums.

2.1.3. *To have in place robust processes to learn lessons from cases where children and adults die or are seriously harmed and abuse or neglect is suspected. [Fully Met]*

The designated professionals are required to be involved in any review that the Safeguarding Boards commission or Stockport Safer Partnership, who commission Domestic Violence Homicide Reviews (DVHR). There have been no Serious Case Reviews (SCRs) this year but the SSCB have commissioned a number of learning reviews which have resulted in action plans. Action plans are monitored as part of the Integrated Heath Safeguarding groups chaired by the respective Designated Nurses and the learning disseminated via these groups and the GP Safeguarding Leads briefings. There have been two DVHRs in 2014/15; neither are completed due to parallel statutory processes and criminal proceedings. The recommendations pertaining to the CCG from one of these reviews have all been actioned, but until the report is published a briefing cannot be provided to the Governing Body.

2.2 *CCG Authorisation Requirements*

The Q&PM committee is made aware if there are any issues that impact on the authorisation requirements but it is a key component of this report to provide the Governing Body with the evidence that demonstrates the CCG's compliance.

2.2.1. *Training [Fully Met]*. The SCCG has a safeguarding training strategy which is incorporated within the Safeguarding Policy. In 2014-15 safeguarding was part of the mandatory training requirements for all SCCG staff and uptake for both children and adults safeguarding training was 91% New statutory guidance published at the end of March 2014 for children has increased the competencies required and also at level 1 introduces a requirement to update staff every 3 years. Some face to face sessions were provided this year to ensure ongoing compliance of which 60 staff attended. Specific training for Board members also became a requirement and this was delivered in February 2015. Going forward the CCG has purchased a suite of e-learning which is compliant with the 2014 guidance and the Care Act 2014 relating to Safeguarding Adults and staff have been assigned in their mandatory training to complete this. The CCG closely monitors mandatory training uptake so there is no risk anticipated in maintaining the organisations compliance.

Additional training for safeguarding vulnerable adults and mental capacity has been delivered to the continuing health care team. The additional level is required for these staff due to their direct contact with the public.

PREVENT training was introduced this year as a statutory requirement. Face to Face sessions were delivered by the PREVENT lead in the safeguarding team 70 staff attended.

2.2.2 *Accountability [Fully Met].* There is a clear line of accountability reflected in the SCCG governance arrangements (Appendix 1)

2.2.3 *Co-operation with Partners [Fully Met].* The SCCG co-operates with the Stockport Metropolitan Borough Council (SMBC) in the operation of the SSCB and SSAB, outlined previously, and the Health and Well-being Board.

2.2.4 *Information Sharing [Fully Met]*. The SCCG has a Caldicott Guardian, Dr Vicci Owen-Smith, to ensure there are effective arrangements for information sharing. This is also addressed in the safeguarding policy.

2.2.5. *Designated Posts [Fully Met].* The SCCG has all the appropriate Designated Professionals in place and the Designated Nurse for Vulnerable Adults is the Mental Capacity Act Lead and the Designated Nurse LAC is the PREVENT lead.

3.0 Specific Provider Issues

The following issues were escalated to the Q&PM committee in 2014 - 15 and where deemed appropriate were included in the monthly Quality Report to the Governing Body.

3.1 *Stockport NHS FT*

Maternity – there has been a focus on safeguarding supervision in midwifery following the receipt of data that indicated very few staff were accessing supervision, despite a 2012 action plan stating this was now in place. The CQC also identified this as a concern and an action around this is now being progressed however it still remains incomplete.

Safeguarding Children Training – this issue continued to be a focus but by March 15 compliance with the 2010 guidance was achieved. The additional requirements identified in the March 2014 updated guidance will not be implemented until April 2015.

Safeguarding Adult Training – the data provided at the end of Q4 2013 -14 showed that the organisation, despite being incentivised with CQUIN monies, remained non-compliant, so a KPI was agreed. By November 14 significant progress had been made and by March 15 the organisation had nearly achieved compliance.

Mental Capacity Act and Deprivation of Liberty training along with PREVENT became a focus due to national requirements. The organisation has worked closely with the Designated Nurse around MCA/DoLs and, with funding from NHS England, plans were put in place to achieve compliance. The completion of these plans however falls beyond the scope of this report so organisational compliance remains outstanding.

PREVENT continues to be a significant challenge with compliance data remaining in single figures. A considerable number of factors have contributed to this issue; however the focus in 2015-16 will be to address this.

The integration of Stockport community staff in a division with Tameside required escalating via the community contract as assurance data just for Stockport was not available. This has now been resolved.

3.2 *Pennine Care NHS FT*

The organisation appointed a Head of Safeguarding in October 2014; this gave the 6 CCGs who commission from the organisation an opportunity to co-ordinate assurance via a central lead. The clearer insight into safeguarding systems and processes has identified some gaps, particularly around training. Close working between the CCG Safeguarding Team, the CCG lead commissioner for mental health services and our partner CCGs is ensuring that this provider is being managed on a consistent and equal basis as our other providers.

3.3 *Care Homes with Nursing*

In May 2014 a new assurance tool was issued to the homes which had been drawn up in conjunction with SMBC to combine the requirements of both organisations. Joint visits were then commenced with the quality team. Unfortunately, due to a long period of absence by the adult lead and re-organisation within the local authority, which resulted in key people involved in this work retiring, the process did not continue. This work needs to be revisited in 2015-16.

Several of the reports presented to the committee have highlighted homes which have been subject action plans following inspections by the Care Quality Commission and / or closed to admissions by the SMBC Quality team. Some of these concerns have been due to safeguarding issues. The committee has been assured that the Continuing Health Care Team (CHC) review any patients placed by the CCG whenever concerns are raised. CHC also communicate any concerns to the SCCG safeguarding team and receive support and guidance on appropriate responses and escalation of potential safeguarding incidents.

3.4 *Out of Area Providers*

This primarily covers Mental Health and Learning Disability providers where individual packages of care are commissioned for Stockport patients. The safeguarding team contacts these providers directly and each completes our self-assessment tool. The commissioners use the information provided in the safeguarding standards audit when deciding the suitability of individual out of area placements.

The committee was alerted to a significant safeguarding concern at one of the providers but was given assurance that the individual placed by Stockport was not affected. The placement was subsequently reviewed and an alternative placement identified.

3.5 *Third Sector Providers*

There has been limited focus on this sector this year. One of the providers was involved in providing a service to an adult involved in one of the domestic homicide reviews. The review identified no issues in respect to the providers safeguarding arrangements.

3.6 *Independent providers*

Including:-

- BMI Alexander
- Priory Cheadle Royal
- St Ann's Hospice
- Beechwood Cancer Care Centre
- Mastercall

Each of these providers is visited and their compliance with safeguarding standards monitored. Of these providers:-

St Ann's Hospice has been brought to the attention of the committee due to the organisation failing to progress an action in respect to training. This was escalated to a formal contract meeting and progress is now being made.

Priory Cheadle Royal has been involved in a serious case review due to the death of a young person placed at the hospital from another area. None of the statutory processes that were conducted following the death identified any short comings in safeguarding processes.

4.0 Other Areas

4.1 *Looked After Children 2014/15 Issues*

An update paper was presented in August 2014 in respect of the two service gaps that had been identified in last year's annual report:-

- inconsistency in Tier 2 mental health provision
- lack of commissioned health services for care leavers.

The mental health provision was raised and included for consideration as part of the CAMHS redesign. There was no change to the provision in 2014-15 however with the increased national focus on mental health provision for all young people and access to some additional funding, this is now being revisited as part of the future commissioning intentions.

The health needs of care leavers were assessed in a pilot study and presented through a short form business case with a number of options. The preferred option is now being implemented as an expansion of capacity within an existing community service.

In respect to the Looked After Children cohort all other requirements are being met by the CCG.

4.2 *General Practitioners*

Although SCCG does not hold the contracts for GPs, *Safeguarding Vulnerable people in the Reformed NHS: Accountability and Assurance Framework, 2013,* requires the designated professionals to work closely with the safeguarding leads in each practice. To fulfil this requirement there are three children's leads briefings and three adult briefings organised each year. The purpose of the briefings is to ensure practices are aware of local safeguarding arrangements and developments, to review and share learning from reviews and provide appropriate education to develop the leads safeguarding competencies. Attendance is variable, the children's briefings attendance averages 30 practices (out of 47), and the adults' is not as well attended but has seen an increase in numbers this year with the profile of vulnerable adults and mental capacity being raised. The designated professionals have prepared and provided training packages and pathways for GP practices and there has also been input into the Master Classes provided by the SCCG.

4.3 *CQC Thematic Review of Safeguarding Children and Looked After Children*

The CQC thematic review was undertaken in December 2014, initial verbal feedback was generally positive and the inspectors did not identify any areas that required an immediate response.

The draft report arrived in March 2015 with the final version not being published on the web site until June. A formal action plan could not be formulated until the finalised report was received. This considerable delay has impacted on the momentum of the providers to progress the actions identified.

The vast majority of the recommendations were linked to processes not being embedded and ensuring consistency in quality of practice rather than gaps in systems and processes. The inspection has provided a lens into the providers over and above that which the CCG capacity and processes are able to provide. Through the monitoring of the action plan, the CCG will receive additional assurance, particularly in respect to quality of services.

4.4 *NHS England Safeguarding Collaborative*
There is a requirement in "*Safeguarding Vulnerable People in the Reformed NHS",* for the designated professionals to work with NHS England to drive improvements in safeguarding practice across the health economy. The Area Team has coordinated the production of the GM wide safeguarding standards and assurance tool that has been included in all of the 2014-15 contracts. The area team have also tried to produce a heat map identifying providers across GM who are not compliant with safeguarding standards. This is still being modified but should be in place during 2015-16. All the CCG Designated Nurses attend the collaborative meetings and assist in progressing pieces of work by being members of Task and Finish groups.

4.5 *Saville Enquiry / Lampard Recommendations*
A briefing was provided to the Q&PM committee on these recommendations and Stockport NHS FT and Pennine Care NHS FT were both asked to provide assurance that they had reviewed their systems and processes and put in place an action plan if required. Assurance was received that both organisations had reviewed their processes and were implementing the necessary changes.

5.0 Current Challenges/Risks

5.1 *Adult safeguarding* – the CCG capacity to meet this agenda remains a risk to the organisation. This is partly due to absence of the post holder but the Care Act 2014, in putting this agenda on a stronger statutory footing, has raised both profile and demands. Stockport Together and Vanguard will provide new opportunities to reinvigorate the joint assurance work with the local authority that has not progressed this year.

5.2 *Training* – ensuring that all providers have amended their training strategies and are implementing the revised guidance for children published in March 2014, and for adults the Care Act 2014 changes. This is a significant challenge for our providers as it involves thousands of staff and the national e-learning only been updated in mid-2015 to support them.

5.3 *PREVENT* – the requirement for monitoring compliance with this agenda was transferred to CCG's in April 2014 and included in the standard NHS contract. Holding the providers to account has been extremely challenging as the requirements have been changed nationally several times creating uncertainty about what level of information/training has to be provided. With the ever increasing profile of radicalisation, achieving compliance in this area has to be a priority for 2015-16.

5.4 *Mental Capacity Act and Deprivation of Liberty* - Although the MCA has been in place since 2005, it was recognised by a House of Lords Select Committee in December 2013, that the application of the act was very poor. A recent ruling by the Supreme Court has also highlighted this issue. In February 2014 monies

were made available by NHS England to CCGs via the safeguarding leads to improve this issue in their areas but had to be spent before the 31st March 2014 which limited what could be implemented. Further funding was provided in 2014/15 specifically to support providers achieving compliance, but again late notification of this funding restricted the level of training that could be provided. Unlike in 2013/14 the funding could be carried over and by November 2015 a comprehensive programme will have been delivered and the numbers of staff trained will have increased.

Provider compliance with the MCA is included in the safeguarding standards and at assurance meetings they are being asked if they have reviewed the implications for the organisation following the Supreme Court judgment. The CCG MCA lead is working with the Local Authority and across the wider GM footprint to ensure that there is a common understanding, response and application of this judgment. There is also a KPI in place for 2015-16 to monitor this area.

This section of the report has addressed the SCCG's statutory and authorisation requirements.

6.0 Quality & Provider Management Committee

The Q&PM committee in October 2015 agreed that:

1. The information provided demonstrated that the SCCG is meeting its statutory safeguarding requirements
2. The information provided demonstrated that the SCCG is meeting its authorisation requirements
3. It also agreed the information and format that the annual safeguarding report would take. This annual report is a statutory requirement and will be presented to the Governing Body, both the Stockport Safeguarding Children and Stockport Safeguarding Adult Boards and the Integrated Looked After Children Board.

The committee asks that the Governing Body endorse point 1&2 above and in addition:

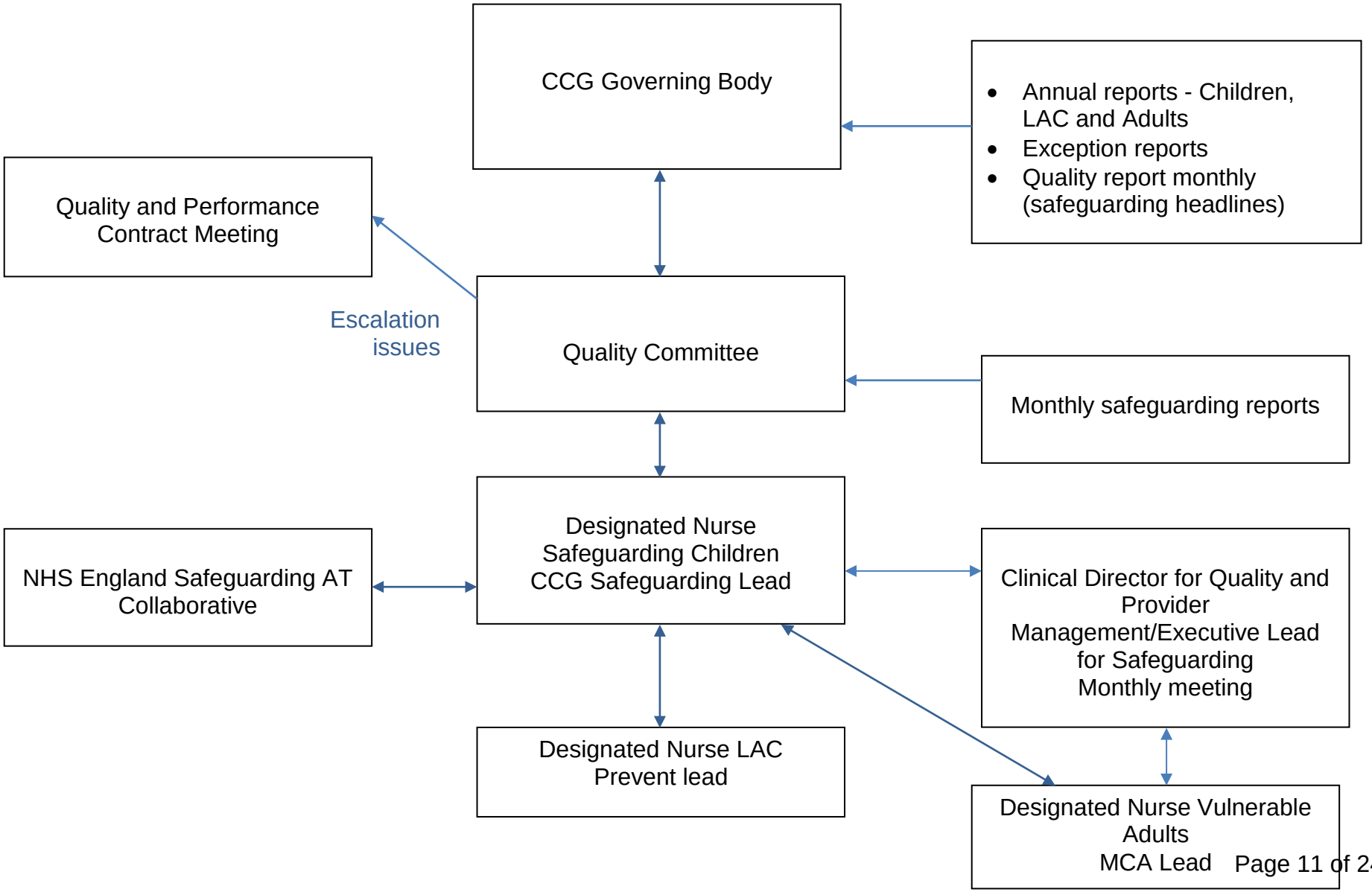
The Governing Body confirms that the Designated Professionals will continue to coordinate the safeguarding children, safeguarding adults and looked after children agendas on behalf of the CCG by providing strategic and clinical leadership both to members of the CCG and to partner agencies across the Stockport economy.

The following sections will address specifically the work undertaken by the designated professionals in their specific areas of work and identify any risks and future plans.

Section 1: Safeguarding Children
Section 2: Looked After Children

It must be noted that this report is primarily a position statement at March 2015 for 2014 – 2015 and that work across all three areas has subsequently progressed beyond this.

Governance Arrangements



Section 1: The 2014 – 15 Safeguarding Children Annual Report

1.0 Purpose

1.1 To advise the Governing Body in respect to the level of assurance provided from services commissioned by the CCG in respect to their safeguarding arrangements for children.

1.2 To update the Governing Body on its safeguarding activity during 2014-15.

2.0 Context

2.1 All health organisations have a statutory responsibility to safeguard children - *Children Act 1989, 2004.*

2.2 The statutory responsibilities are outlined in *Working Together to Safeguard Children 2013, updated March 2015,* and are expanded on in *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework, 2013, updated July 2015.*

2.3 As part of the CCG's statutory responsibilities it must

- Ensure that the providers from which services are commissioned, deliver a safe system that safeguards children
- Ensure robust systems are in place to learn lessons from cases where children die or are seriously harmed and abuse or neglect is suspected
- Be a member of the Stockport Safeguarding Children Board (SSCB)
- It should be noted that the CCG no longer commissions Health Visitors and School Nurses, both key in providing services to children.

3.0 Background

3.1 The multi-agency safeguarding and support hub (MASSH) the new front door service into children's social care received 7,416 referrals in 2014-15 compared to 6,315 the previous year. Of these 2856 required social work assessment and the remaining 4560 were diverted to the supporting families pathway to be assessed as potential families in need.

3.2 In 2014 – 15 346 initial children protection conferences were held (a decrease of 63 on the previous year) and at the end of March 2015, 243 children were subject to a child protection plan, a 32% decrease over 2013 – 14. Emotional abuse and neglect continue to account for the majority of child protection plans. Numbers in Stockport are now in line with the national picture.

3.2 The number of children present in households where police were called to incidents of domestic abuse has seen a slight fall this year from 2,033 in 13/14 to 1959 in 14/15. What needs to be noted is that victims of domestic abuse often suffer a number of attacks before calling the police; therefore these figures do not reflect the true numbers of children who witness domestic abuse. The impact on both children's and adult's health is seen across a wide range of health services, including general practice, mental health services and accident and emergency. Domestic abuse therefore remains a key issue for the safeguarding team.

3.3 Early Help and Prevention is one of the key drivers to reduce the number of children requiring intervention from expensive statutory services and will play an

ever increasing role going forward with further local authority budget cuts. This has seen a shift in provision, with more children who have high levels of need, being managed by universal services. In 14/15 over 1,500 common assessments were completed by universal services including Health Visitors, School Nurses and GPs (the tool used to assess identified need). At the end of March 2014 1,684 children were deemed as being in need and receiving support by universal services.

3.4 The number of multi-agency statutory case reviews in Stockport remains low. A domestic violence homicide review was completed in 2014 but still remains unpublished due to delays within the Home Office; however learning identified has been actioned. A further domestic homicide review was undertaken following an incident in August 2014. This report cannot be finalised until criminal proceedings have been completed but again the learning has been actioned. Both cases involved children and the Stockport Safeguarding Children Board undertook an additional review focusing on the multi-agency package that was being provided to the children. There have been no serious case reviews commissioned as defined by Chapter 7 of Working Together to Safeguard Children. However, an independent review into the case of two young people who suffered significant sexual harm was undertaken after agreement by the National SCR scrutiny panel that a full SCR was not required. The report posed a number of challenges to the Safeguarding Children Board which are being addressed by the Child Sexual Exploitation Strategic group which is attended by the Designated Nurse. There were no specific challenges for health.

3.5 There have been three multi-agency learning reviews commissioned this year. The Designated Nurse has been a member of all the review panels and had the opportunity to review front line practice by staff in our health providers. As in all practice reviews improvements were identified, but no significant failings were identified. Our health providers fully engage in these reviews and are noted for the thoroughness of their reviews into their own practice and their commitment to learning and improvement.

4.0 Resources

The resources for safeguarding children are:-

- Designated Nurse/CCG Safeguarding Lead 1wte
- Designated Doctor 2 pa's/week, there has been a change in post holder this year.
- Shared 0.5 administrative support with Safeguarding Adult and Looked After Children Nurses

There is also a Clinical Director who has safeguarding in her portfolio. The CCG Chief Clinical Officer is ultimately responsible for safeguarding.

5.0 Equalities

The safeguarding team strives to ensure that all service users, whatever their disability, sexual orientation, age, race, culture, religion or gender receive the same level of protection from abuse from all our commissioned services.

6.0 Report Context

6.1 NHS Stockport FT (acute and community).

6.1.1 At the March 2015 assurance meeting 5 out of the 22 safeguarding contractual standards remained on amber. There is an action plan in place to address these issues:

- Whilst training figures are now compliant with the 2010 guidance SFT is required to amend its strategy and implement the 2014 guidance. This is a huge undertaking involving approximately 5,000 staff.
- The sharing of 'did not attend' letters with Health Visitors and School Nurses – the Trust were not able to address this fully but the steps put in place to mitigate risk had been accepted by the Q&PM committee. The CQC however did not feel this was sufficient and the FT is now addressing this as part of the CQC action plan.
- The identification in records of carers – audit evidence has shown a significant increase in the number of records documenting this and it is now a standard in the organisations regular record keeping audits. The CQC identified that this information is not included on the documentation completed in ED and there is now an action for this to be addressed.
  Safeguarding supervision for the children's workforce – the trust has still not provided data to demonstrate that the supervision framework introduced for midwives has been implemented. This links to findings by the CQC and is now in the CQC action plan.
  Liaison between HVs and midwives and GPs with both these services – despite pathways being reportedly in place the CQC did not find the evidence to support this hence it being included in the CQC action plan.

6.1.2 The FT has increased the resource in the specialist vulnerable children's team to cope with the ever increasing pressures in this area of work. The FT Named safeguarding professionals engage well with the Designated Nurse and Doctor and attend the Integrated Health Safeguarding Group. The Named Nurse accesses supervision from the Designated Nurse and the Named Doctor from the Designated Doctor.

6.1.3 Child Protection – Information Sharing Project (CSIP) – SFT has committed to this national project which will ensure ED, Maternity and Paediatric services are aware of children on child protection plans or who are Looked After at the point of contact with the service and the information would be automatically shared about their attendance with their lead professional. Progress has been made during 2014-15 to implement this but there have been delays at the national level as well as with the local IT solution which have delayed its implementation.

6.2 Pennine Care NHS FT – Assurance for this organization is now as robust as that of Stockport FT. It is led by Heywood, Middleton and Rochdale CCG but scrutinised jointly by all the Designated Nurses from the CCGs who commission from them. 21 contractual safeguarding standards apply to safeguarding children of which 14 were green, 5 amber and 2 red when assessed November 2014. The two reds were actioned immediately and plans put in place to address the ambers. Quarterly monitoring is now in place to review progress against the actions and to ensure any new guidance is acted upon. The organisation reorganised into boroughs in 2014 -15 and there has been some changes to resource and responsibility for safeguarding. Stockport now shares a Named Nurse for Safeguarding with Tameside, who is supported by an adult lead. Though this is more capacity than previously allocated Pennine Care still struggles to evidence compliance with the safeguarding standards which apply

specifically to each borough rather than the whole organisation. Issues that particularly relate to Stockport are:

- Unable to provide specific training data for Stockport
- The named professional is not regularly engaging with safeguarding board work and providing updates to multi agency action plans in a timely manner.
- The named nurse does not access supervision from either Stockport or Tameside Designated Nurse as required in statutory guidance
- Safeguarding supervision was identified by the CQC as not being sufficiently robust. This forms part of the CQC action plan.
- The Named Doctor for Safeguarding Children only fulfils this role in respect to the CAMHS service rather than the whole borough. This is contrary to what the organisations governance structure indicates and is a gap in support to Stockport medical staff employed by Pennine.

All these will be addressed as part of the ongoing monitoring of the organisation.

6.3 Mastercall – From a child safeguarding perspective the organisation is fully compliant with the required safeguarding standards.

6.4 Independent Providers

6.4.1 BMI – Alexander –Whilst SCCG does not commission services for children from this provider, we do commission adult care. Adult facing staff are required to be appropriately trained in respect to children's safeguarding and the organisation appropriate policies in place. Other Greater Manchester CCGs do commission care for children from BMI therefore as lead commissioner we have a responsibility to inform them if the organisation's safeguarding standards as per contract are not being met. The organisation is fully compliant with all the required safeguarding standards applicable to children and following the appointment of a new children's service lead safeguarding pathways have been further strengthened. A number of good practice examples relating to safeguarding children have been identified this year.

6.4.2 Priory Cheadle Royal – SCCG has no children or young people placed at this hospital but as a provider our footprint which provides NHS services the Designated Nurse has a responsibility to audit their safeguarding standards. The organisation has completed the annual self-assessment and provided supporting evidence that demonstrates it is fully compliant with the required safeguarding standards. Following the death of a young person at the hospital in 2014 a number of statutory investigations and reviews were undertaken. None of the reviews identified any failings in their safeguarding systems and processes.

6.4.3 A number of adult only providers, St Ann's Hospice, Beechwood Cancer Care Centre and a range of third sector providers have all been visited and details of their assurance are included in the adult safeguarding report. Adult facing health staff are required to have a level of safeguarding children training. Beechwood are compliant however St Ann's failed to progress their action plan in a timely manner and in January this was escalated initially to Q&PM then managed through the contracting process. Progress is being made but compliance will not be achieved until late 2015.

7.0 Risks

7.1 Primary Care remains an ongoing risk with NHS England and SCCG still having no clear agreement in respect of who is responsible for safeguarding in primary care, specifically around the provisions of training and the appointment of a Named GP for safeguarding . As a result there is no safeguarding assurance audit data available as neither organisation has undertaken this process. As a CCG being responsible for the quality and safety of the member practices, this is a significant gap in the organisation's intelligence. A proposal was presented to chief operating officers by NHS England outlining two models which addressed the provision of a Named GP. Stockport opted for a model which required the CCG to fund one session of a named GP and to be responsible to recruiting to this post and NHS England would recruit a nursing team which would support this role. Stockport would receive 2 days support from this team. Neither of these posts had been recruited to at the end of March 2015. The designated professionals are required to engage with the GP safeguarding leads. The current arrangement is that three briefings a year are held, where the average attendance is 30, to date there is no system in place to follow up the practices that do not attend, though they do receive all the material from the briefing, including presentations, electronically. The Designated has also provided bespoke training to GP practice staff as part of the Masterclass program which was well attended.

7.2 The changing commissioning arrangements for key services that safeguard children, notably health visiting and school nursing, have challenged the previous provider focused assurance process and the health economy wide responsibilities of the designated professionals. To address this, joint assurance has been undertaken with Public Health, which has ensured that the Designated Nurse continues to have oversight of the school nurse provision and this arrangement will be extended to health visiting when commissioning responsibilities pass to the local authority from NHS England in October 2015.

7.3 There has been significant progress this year by our providers to achieve full compliance for safeguarding training, the new requirements as outlined in *'Roles and Competencies for Health Care Professionals', March 2014* increase this challenge. The Designated Nurse will continue to work with the providers to progress this implementation.

7.4 Increased expectation on GPs to be more actively involved in safeguarding processes and increased awareness of GPs as they access training has seen a rise in the numbers of call to the safeguarding team for advice. Though NHS England continue to have overall responsibility for safeguarding in primary care it falls to the Designated professionals to access information for local learning reviews and homicide reviews and to ensure any learning for primary care is disseminated. The CQC in their recommendations identified the CCG in conjunction with NHS England as being responsible for ensuring the appropriate actions were put in place.

8.0 Progress to Date

8.1 Assurance of Pennine Care NHS FT is more robust and there is now a framework in place which will ensure it receives the same scrutiny and challenge as our acute trust.

8.2 Assurance from a wider number of providers has been scrutinised this year, partly by direct auditing and partly by the Designated Nurse being a member of the Q&PM committee and questioning/challenging safeguarding arrangements in providers where the CCG is not the lead commissioner for example Arriva and NWAS.

8.2 Safeguarding standards have been embedded all the contracts.

8.4 Ongoing work with NHS England to understand the CCG's responsibilities in respect to the Named Doctor role and Primary Care.

8.5 Compliance with the safeguarding training has improved significantly in our providers

8.7 The Designated nurse plays an active role in all aspects of safeguarding board activity.

9.0 Next Steps

9.1 To recruit a Named GP and ensure that Stockport receives the nurse resource from the centralised safeguarding nursing team when appointed.

9.2 To continue to monitor safeguarding compliance across all commissioned services.

9.3 To ensure that all service developments take into account safeguarding.

9.4 To work with commissioners/CSU/ NHSE to streamline the assurance process.

9.5 To identify emerging safeguarding issues and any associated risks or commissioning requirements to the CCG.

9.6 To engage with the GP safeguarding leads who do not attend the briefings

9.7 To be a critical friend to the proposed Stockport Family model

9.8 To benchmark, when published the revised accountability framework and advise the Governing Body of any gaps/risks

9.9 To ensure that the CQC action plan is fully implemented and evidence is available to support this.

Sue Gaskell **Designated Nurse** **Safeguarding Children**	Dr Cath Briggs **Clinical Lead for** **Safeguarding**	Dr Ian Mecrow **Designated Doctor** **Safeguarding Children**

09 October 2015

Section 2: The 2014-15 – The Looked After Children Annual Report

1.0 Purpose

This is the third annual report for Stockport Clinical Commissioning Group (SCCG) in respect to Looked After Children (LAC). The purpose of this report is to:

1.1 Advise the Governing Body on the delivery of services for LAC during 2014-2015.

1.2 Assure the Governing Body of the extent to which the services commissioned by the organisation are meeting their statutory functions and delivering best practice.

1.3 Outline the Governing Body's statutory responsibilities for LAC and SCCG's compliance.

2.0 Context

2.1 All health organisations have a statutory responsibility to promote the Health and well-being of Looked After Children.

2.2.1 Framework

- The statutory responsibilities are outlined in: *Statutory Guidance Promoting the Health and Well-Being of Looked After Children' DH 2015*.
- The specific duties for health are explained in *'Delivering the health reforms for looked after children: How the new NHS will work from April 2013'.*
- *The Intercollegiate Framework for Professionals working with Looked after Children (2015)* provides clear recommendations and expectations for all staff working with LAC.

2.3 The SCCG's statutory responsibilities are:

- To cooperate with the local authority in fulfilling its duties towards looked after children, including the commissioning of statutory health assessments and reviews.
- To have a Designated Doctor and Nurse for Looked After Children.
- To commission most secondary health care, including for those originally from the CCG area but now placed outside, even where the child registers with a GP practice in the new CCG area in which they have been placed.

3.0 Background

3.1 At the time of reporting Stockport has 297 Looked After Children of which 73 are placed outside Stockport. As a CCG we are responsible for commissioning services including health assessments for Stockport children. In addition, Stockport needs to provide services for Out of area children living in Stockport. As part of the responsible commissioner guidance, the placing authority can be asked to pay however this system is not fully implemented in Stockport.

3.2 In addition to Stockport's own LAC, an additional 300-400 LAC from other local authorities reside here. The estimate of this number is due to the notification process when a child moves. Although there is a statutory requirement for notification there is still not an accurate reflection of numbers placed in Stockport

from other local authorities. It should be recognised that the online reporting system in place with the local authority has significantly improved this.

3.3 The availability of placements for children from other areas is mainly due to the 43 plus residential units that have been granted planning permission in Stockport. These homes are operated by a number of independent providers and are regulated by Ofsted. The young people residing in these units are some of the most vulnerable and challenging and often access multiple services across organisations including health.

3.4 In December 2014, CQC undertook an inspection of Safeguarding and Looked after Children services in Stockport. This resulted in Stockport services with 46 recommendations, 9 specifically relating to LAC.

3.5 A comprehensive action plan was put in place which now provides a framework to address service improvement. The Designated Nurse LAC has benched marked current provision in light of these recommendations alongside the new statutory guidance and intercollegiate framework for professionals published 2015.The Designated Nurse LAC will continue to monitor the improvements to ensure they are implemented and then embedded in light of the pressures on the system. Once embedded, Stockport will be providing a good service for LAC when measured against statutory guidance.

4.0 Resources

4.1 The SCCG has a statutory responsibility to have designated health professionals for LAC. We continue to be compliant with authorisation requirements by having the following in post-

- A 0.5wte Designated Nurse LAC.
- A medical resource for Looked after Children - a Designated Doctor who is a paediatrician with 2PAs / week to fulfil this role.
- Administrative support of 0.5 wte is shared with safeguarding children and vulnerable adults' leads.

4.3 The provider organisation is commissioned to provide a dedicated resource for Looked after Children which sit alongside universal services. Together these fulfil the aim of reducing inequalities and ensuring Looked after Children's health needs are met, in accordance with statutory guidance – SCCG statutory responsibility 1.

5.0 Equalities

5.1 Looked After Children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers, in part due to the impact of poverty, abuse and neglect.

5.2 The vision across Stockport is that Looked after Children will access

universal health services in the same way as other children and young people. Additional needs will be met through targeted interventions and specialist services. Furthermore, children and young people who are cared for by any Local Authority, but living in Stockport, will receive the same opportunities to access health services within the borough irrespective of their originating CCG.

6.0 Report Context

Services should be developed in response to the need to improve outcomes for LAC and take into account the requirements of national guidance.

6.1 Assurance

6.1.1 Stockport NHS Foundation Trust

- Provide a dedicated resource for LAC which works alongside universal services.
- There is an on-going quality assurance process in place to ensure all health assessments meet the required standard. Following CQC inspection the audit tool has been reviewed and Stockport is looking to adopt a GM model as identified in Payment By Results (PBR).
- The specialist LAC health team have been proactive in managing the KPI requirement alongside some difficulties encountered with service redesign within the Local Authority and long term sickness within the service. Although the timeliness was not always achieved, the exception reports provided were appropriate and all children received the statutory assessments required.
- There is a planned programme to seek opinions of young people with regard to their experience of health assessments; however this has not yet been achieved due to capacity within the service.

6.1.2 Pennine NHS Foundation Trust

- There remains an identified gap in the provision of CAMHS services for LAC, particularly around transition and tier 2 services.
- There is currently no dedicated resource for care leavers.

Both these points remain a challenge but are being considered as part of the CAMHS transformation programme and a separate business case for a Care leaver's resource. A business case was agreed for an additional Care-leaver resource to extend the provision within the existing service. The provider team are planning to implement this in 2015 -16, which will support the needs of Care-leavers identified within the service specification and fulfil a CQC recommendation.

6.2 *SCCG statutory responsibilities*

6.2.1 CCGs and NHS England have a duty when fulfilling their Commissioning roles to have regard to the need to:

a) reduce inequalities between patients with respect to their ability to access health services, for the CCG this is access to secondary care and NHS England, primary care, dental care, pharmacy, optometry and specialist services such as tier 4 CAMHS.

b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

6.2.2 Currently there are access issues to some services for LAC, most notably around emotional health and wellbeing and this impacts on their outcomes.

7.0 Risks

7.1 *Funding*

There continues to be uncertainty around the implementation of the national tariff and how this will impact on future income.

There is no GM strategic lead or direction resulting in CCG's locally and nationally choosing to implement the tariff arrangements as they see fit. We are currently in a position in which we are being charged for children placed out of area but there is no charging arrangement for children placed in Stockport. Stockport Foundation Trust has made some initial enquiries into how this could be implemented locally.–This is an opportunity for the economy to bring in resources from other CCG areas which must be used to improve the LAC service and address some inequalities in access for out of area LAC placed in Stockport.

7.2 *Access to Services*

There are two areas where there are difficulties

- Mental health services
- No dedicated health team for care leavers

Both of these pose a moderate risk to the CCG. There are services available but access is inconsistent and/or there is insufficient capacity. There is now a strong emphasise on the need to provide health support to Care-leavers and the implementation of the resource, identified in the business case, in Stockport would provide a service for this vulnerable group and also strengthen the likelihood of a good judgement using the new Ofsted inspection criteria framework.

7.3 *Access to data and information*

This is predominantly a risk for Stockport NHS Foundation Trust; however, there is an impact on the SCCG which creates a moderate risk when planning services. The Provider services are looking at improvements in IT, including Child Health, in improving this area.

7.4 *Service Delivery*

7.4.1 Following the CQC inspection (Dec 2014) the Local Authority, Stockport NHS FT, CCG and Pennine Care NHS FT have worked in partnership to support the action plan and implement the agreed improvements. This service development may prove a challenge due in part to on-going service redesign and cuts to services across the economy. Improvements to processes are developed through the Multiagency Health Steering Group which, in turn, reports to the Integrated LAC board.

7.4.2 The specialist LAC team appears under resourced when benchmarked against the intercollegiate framework (2015). Consideration needs to be given to the implementation of PBR to provide a funding stream for investment into staffing to be able to manage the large numbers of children placed here from other authorities. This is an opportunity for the economy to bring in resources from other CCG areas which can then be used to improve the LAC service and address LAC access.

7.4.2 SCCG has the duty to commission statutory health assessments, but does not commission health visitors or school nurses that carry out the majority of review health assessments. The Designated Nurse works closely with the LA and NHS England to ensure there is on-going scrutiny of the service specifications to ensure this role is included in both service specifications.

8.0 Progress to date

8.1 The new Designated Doctor LAC is in post however the role needs embedding within her job plan. Consideration needs to be given to the Named Doctor and Named Nurse roles identified within the intercollegiate framework.

8.2 There is a specialist looked after children health team service specification in place. The team strive to deliver best practice and review this as new guidance is published. However additional requirements and developments in practice would be difficult within the existing resource. There are processes in place to ensure that the Designated Professional's roles and provider services work together to meet the health needs of LAC in accordance with statutory guidelines.

8.3 Service user involvement continues to help shape service delivery. As a CCG we continue to source a range of views to influence future service provision. The Designated Nurse LAC continues to work with Care-leavers as part of New Belongings. New Belongings is a national pilot aiming to create a 'gold standard' to support care leavers which can be replicated in other areas. Views and experiences from the young people have been used to influence training for professionals. The views of care leavers have also been taken into account in the design of services to support care-leavers.

8.4 The Designated Nurse represents the SCCG at a number of multiagency forums which monitor and drive service improvements, the focus being improving outcomes for all Looked after Children – SCCG statutory responsibility 1.

8.5 There remains an inconsistency about how the national tariff will be implemented. Models of implementation have been considered and there has been some initial consultation with the provider organisation on its implementation. The SCCG has started to consider the potential impact of this.

8.6 Work needs to be continued in conjunction with public health in creating a health profile for LAC in Stockport. There needs to be consideration to the best way of collecting this data in light of IT systems and change in service structuring.

8.7 Following the CQC thematic review, an action plan has been agreed to drive forward improvements in the IHA documentation and recording. Further audit and training will be needed to evidence that the desired improvements are embedded.

8.8 The Designated Nurse LAC has continued to provide a 'Drop in' session for support and advice for young people at Café Zest as part of the New Belongings project. This has enabled the capturing of views and experiences from young people on their access to services across health and listening to what matters to them. This has been evaluated positively and has successfully influenced a care leaver's business case. Information received from the young people has been utilised into training for professionals linked to their experiences.

9.0 Next Steps

9.1 *Funding*

To continue to engage with the commissioners and provider organisations who are leading on the implementation of the national tariff at a GM and local level and advise the SCCG on its impact.

9.2 *Access to services*

To work with mental health commissioners and Public Health to support the CAMHS transformation project, specifically in relation to improved access for 16+ age group.

9.3 *Access to data*

9.3.1 There is still a need to develop the data set available to enable the construction of a health profile of LAC living in Stockport. The profile can then be used to feed into the JSNA, benchmark service provision and inform future commissioning.

9.3.2 To provide input on the monitoring and reporting required from a LAC perspective during the development and implementation of the new Child Health IT system across the economy.

9.4 *Service delivery*

9.4.1 To ensure that the health needs of Stockport Looked After Children placed outside of the area are having their health needs identified and met – SCCG statutory responsibility 3. To benchmark Stockport's progress against the quality standard for the Health and Well-Being of Looked After Children and Young People (NICE quality standard 31 April 2013) and identify any gaps that the SCCG may need to consider.

9.4.2 To identify if a formal agreement is required with health visitor and school nurse commissioners in respect to the completion of review health assessments.

Jane Hancock	Dr Erika Houston	Dr Catherine Briggs
Designated Nurse LAC	**Designated Doctor LAC**	**Clinical Lead**

13 October 2015

Compliance Checklist:

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

NHS
Stockport
Clinical Commissioning Group

Safeguarding Report

CQC Action Plan Progress report October 2015

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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Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
To acknowledge the progress that has been made **To note the actions that are in place to complete the plan**
Please detail the key points of this report
The report provides a high level summary of progress against the required actions following the CQC visit December 2014 which identifies: • **10 actions have been completed** • **31 actions are working progress** **The apppendices contains the whole action plan and the progress made against each individual reccomendation.**
What are the likely impacts and/or implications?
There will continue to be safeguarding systems and processes that are not robustly embedded into the respective services.
How does this link to the Annual Business Plan?
Safeguarding is integral to all aspects of the business plan
What are the potential conflicts of interest?
Nil
Where has this report been previously discussed?
Quality and Provider Management Committee
Clinical Executive Sponsor: Dr C Briggs
Presented by: Dr C Briggs
Meeting Date: 11.11.15
Agenda item:
Reason for being in Part 2 (if applicable)

CQC Action Plan Progress Report October 2015

The CQC undertook their thematic inspection in respect to children looked after and safeguarding in December 2014. The feedback at the end of the week was generally positive and no immediate actions were identified by the inspectors.

The draft report was received for factual accuracy comments in March 2015, and only one recommendation was challenged. Due to purdah the final report could not be published prior to the general election and eventually was published on the CQC web site in June 15.

The vast majority of recommendations were linked to processes not being embedded and lack of consistency in the quality of practice rather than gaps in systems and processes.

The action plan was submitted to the CQC within the required time frame; to date the CQC have made no comment on the action plan and have not requested a progress report.

There were 41 separate recommendations, many requiring a number of actions to ensure that the recommendation was addressed and evidence that it has been embedded in practice.

To date:

- 10 recommendations have been completed in full
- 31 recommendations are working progress
- There are no recommendations that have not been progressed
- Of the 31 in working progress:
  9 have been actioned but repeat audit to demonstrate embedding is not due to be completed
  5 are awaiting a particular staff group to be briefed as the final action, all are scheduled for October/November
  3 have the new process agreed, awaiting implementation
  3 involved staged actions, short, medium and longer term, the completion time has not been reached yet
  1 will be complete once it has been uploaded onto a micro site
  2 have been reportedly completed but the evidence has not been received
  5 are beyond their original time scale

As the final report was not received until May 15 and the action plan was not submitted until June15, the post inspection momentum was lost. The progress in this report has been achieved over the past 5months as the providers didn't progress any actions until they saw the final recommendations.

There has been some significant progress around areas that the CCG had been unable to progress prior to the CQC visit most notable:

- The agreement to trial HVs and SNs access to advantis so they will be aware of DNA’s
- Midwives to have reliable IT access off site to enable them to access historical data and upload live data ensuring up to date information is available at all times

Frustratingly some of the recommendations which should have been actioned quickly have been made over complicated notably:

- Liaison between midwives and HVs
- Liaison between GPs, midwives, HVs and School Nurses
- Liaison between school nurses and community mental health teams
- More robust supervision in substance misuse services

The Designated Nurse will continue to monitor the progress of this action plan and to review the supporting evidence.

Recommendation	Action	Lead	Timescale	Progress	RAG
1. Stockport CCG & Stockport FT					
1.1 That a robust quality assurance process is established for initial and review health assessments.	1. Reviews – update the audit tool using NICE guidance and review the audit process and content. 2. Clarify audit process with the business group for LAC. 3. Initials; formalise audit process for initial health assessments, consider how this audit could have a multiagency peer review dimension	**Reviews:** Rebecca Tate/Angela Meldrum **Initials:** Louise O'Connor/Jane Hancock	Nov 2015	Initial and review audit tool updated completed July 2015 Training session for all HV's June 2015 staff want to do peer and self-audit to be done in Sept and review pilot findings. School nurse training Oct 2015. Jane H audit 20 1A's August 2015. Audit completed results to be discussed with Designated Dr and action plan formulated Initial health assessment training for Drs planned Nov 2015. Repeat audit of IHA's to evidence change March 2016.	
1.2 That the observation, engagement and use of voice of the child is developed in initial health assessments.	1. Training for paediatricians around the record keeping aspect of the IHA in recording the voice of the child. 2. Review of the frequency of clinics and admin support to facilitate better record keeping.	Erika Houston/Jane Hancock Kelly Curtis (Business Manager)	Nov 2015	Voice of the child questionnaire developed and trialled in clinic Aug 2015. Questionnaire to get views from CICC Oct	

				2015 Draft guidance for completing IHAs Aug 2015 Training planned Nov 2015 Repeat audit planned to evidence change March 2016.	
1.3 That record keeping policies are clarified within health visitor and school nursing teams to ensure appropriate use of case notes, chronologies and ROPE methodology.	1. Review and update of current guideline. 2. Using new guideline refresh training to all qualified, new staff and student (public health nurses) in the use of Rope, management of records and record keeping including demography and chronologies.	Angela Meldrum/Julie Parker/CPT/Team Managers	Oct 2015	Training needs to be delivered on a continuous rolling programme in order to capture new starters and reflect audit outcomes. Guidelines updated launch Sept 2015 following training sessions with staff and feedback from them completed June/July 2015.	
1.4 That actions from initial health assessments are reviewed routinely as part of next health assessment, with a process for monitoring follow up actions from health plans to ensure children and young people's needs are being met.	1. Training to practitioners to use the assessment as an ongoing review of a child's health needs – training package to be reviewed and used for induction, trainees, mentorship and ongoing awareness in workforce.	Rebecca Tate/ Specialist Safeguarding Nurses/Angela Meldrum/ICS Managers	Oct 2015	Included in the training package to practitioners delivered Jun 2015 to HV and Oct 2015 to SN. Work still needs to include in induction and mentorship for all new starters. Follow up of actions will be reviewed as part of the safeguarding clinical supervision re recording in the child's records.	
1.5 That service user involvement for children who are looked after is further developed, established and monitored.	1. Practitioners to be proactive in managing review health assessments in advance and recognising/respond to the	Claire Woodford/Elizabeth Donegan	Oct 2015	KPIs for completion of reviews is best for 2 years – evidence of	

	need for choice of location. 2. Provide administrative support to assist practitioners in planning assessments proactively. 3. Use information already available around where children wish to be seen .			staff engaging with YP Plan that children will be seen over Summer. All staff have received training reminding them to take into account where YP wish to be seen. June and Oct 2015.	
1.6 That paperwork used or adult attendances at emergency departments is modified to include prompt questions regarding any children at home.	1. **Interim solution.** Request prompt added to "high risk" adult attendances (mental health, self harm, overdose) to document clear social history regarding children/contact with children and C4C completed. 2. Audit high risk attendances for compliance. 3. Identify which EDs are routinely asking all audit attendances about children. **Medium term** 1. Develop field in PAS to add data at registration about children in the household. 2. Develop link with AdvantisED so data pulled into clinician record.	**Interim Action** 1&2 Paula Bennett No. 3 Judith Morris. **Medium term action** No. 1 Clare Phillips No. 2 Paula Bennett & IT	July 2015	July 15 – IT changes specified awaiting development time tbc. Initial agreement is that triage nurses will ask the questions re dependents. Sept 15- medium term solution has not been technically possible therefore triage arrangement will be ongoing solution	
1.7 That receptionist staff in ED are trained in safeguarding in line with Trust policy.	1. Allocate those staff with no evidence of Level 1 training onto the next available training session. 2. As reception staff will require Level 2 training according to revised training strategy arrange bespoke session for this cohort of staff.	Paula Bennett with Specialist Safeguarding Nurses	July 2015	All reception staff trained. Level 2 work book with an assessment, working through it will be assessed by VCT and additional input will be required if	

				there are still knowledge gaps.	
1.8 That staff training and development is undertaken to drive up the quality of child protection reports in midwifery services.	1. Named Midwife to produce a model case conference/court report/CAF and cascade to wider midwifery workforce. 2. Named Midwife to attend midwifery team meetings to update staff on report writing and review all reports prior to submission. 3. Named Midwife to complete a baseline audit on the current quality of child protection reports before training and repeat after 6 months.	Rebecca Oatway (Named Midwife)	By July 2015	Model case conference report - this is on shared drive and a launch. Case conference reports seen by named midwife before sending Model CAF. Base line audit completed 21.9.15 Re audit planned March 16	
1.9 That individual birth plans are established using a consistent format in midwifery notes.	1. Postnatal safeguarding management plan as agreed with the allocated social worker to be incorporated into the safeguarding documentation held in the clinical file. 2. Review process in safeguarding position.	Rebecca Oatway (Named Midwife)	By Sept 2015	New post natal management plan for babies who are on CP or level 3 TAC Safeguarding management plan which will be in both mothers and babies records has been formulated due ratification 10.7.15 Neonatal until will receive copies in Anticipation that these babies might require admission. All on orange paper to ensure they are visible. Now ratified and uploaded onto micro site Some spot checks will take place during Oct/Nov to check process working	

1.10 That adherence to the DNA policy is monitored across midwifery practitioners to ensure there is not drift in cases due to lack of follow up.	1. To develop the Euroking system to generate a weekly reporting of community and hospital DNA/No Access contracts; this will be reviewed by the team leaders. 2. Complete a review of existing processes re recording DNA/NA both in hospital and community settings. 3. Work towards finding an IT solution for all community midwives to access their systems in the Children's Centres (some firewalls preventing this).	Janet Cotton (Clinical Midwifery Manager) Julie Estcourt (Head of Midwifery)	Nos 1&2 by Sept 2015. No. 3 by Dec 2015	Drafted a DNA guideline following comments this requires additional work before being ratified Trying to obtain an off line solution. IT business case for tablets has been approved these have been ordered and will be introduced in a phased approach An algorithm has been developed for use in midwives diaries	
1.11 That robust processes for liaison between maternity services and the adult substance misuse team is formally established.	1. Review and launch the formalised referral pathway form between maternity and adult substance misuse. 2. Launch at the public health study days and at team meetings.	Rebecca Oatway (Named Midwife)	By July 2015	Pathway produced and ratified with lead in drug and alcohol service. Requires uploading onto micro site	
1.12 That a definitive policy to include timescales is implemented for notification of vulnerabilities and completion of appropriate paperwork to named midwife.	1. Write an SOP to define the timescales and standards around all first and antenatal contacts; the SOP to include the timescales and identification of risks and vulnerabilities which will include notification of high risk cases to the Named Midwife. 2. Mandatory sessions to all midwives around the SOP. 3. Ensure that the SOP is linked to the overall Safeguarding Children Trust SOP. 4. Audit of compliance to the SOP once systems in processes in place.	No. 1, 2 & 4 (Julie Estcourt/Janet Cotton/Rebecca Oatway. No. 3 Julie Parker	By Sept 2015	Referral criteria for escalating to Named Midwife with timescales is now on shared drive. New safeguarding form with requirement to identify what actions will be taken to act as a prompt to take to supervision. Substance misuse pathway to be referenced in SOP HOM to launch SOP at all team meetings and all community midwives to be provided with a	

				personal copy	
1.13 That formal face to face mechanisms are established between health visiting and maternity services.	1. To identify the most effective mechanism of liaison within the integrated teams either through joint meetings and using the ante natal pathways. 2. Health Visiting and Midwifery leads to establish communication pathway for alerting high risk antenatal cases to Health Visitors. 3. Audit current practice of communication between health visiting with a focus around the process of referral to health visitors from midwifery (suggestion that a month snapshot of all referrals to HV's from midwives completed by HV managers). 4. Further review of action plan based on outcome of audit.	Julie Estcourt (Head of Midwifery) Janet Cotton (Clinical Midwifery manager) ICS Service Managers/Claire Woodford	By July 2015	Midwifery teams have been revised to improve integrated working into CCG localities with defined Health Visiting Leads. A letter is being developed to improve MW/HV liaison re social risk. Sept 15 – discussion re use of a duplicate form to HV teams All community midwives asked to arrange as a minimum monthly contacts with their HVs 70% have completed this Midwifery team leaders have attended locality managers' meetings	
1.14 That information and outcomes of specialist planned care appointments is communicated to health visiting and school nursing services.	1. Explore access to Advantis system for school nurses and health visitors. 2. Work with Head of Performance & Quality to produce weekly reports of all children's attendances to central admin to share with HV and SN teams.	Claire Woodford/Kelly Curtis	Sept 2015	Process agreed around access to Advantis for HV/SN in the community. Weekly report format and sharing agreed. Trial commencing Oct 15 to match up this report with Advantis access	
1.15 That health visitors and school nurses attendance at GP safeguarding liaison meetings is prioritised.	1. Benchmark against existing practice. Clarify with all GP practices that they have safeguarding lead and meet to discuss safeguarding concerns. 2. Team managers in 4 localities to coordinate attendance and prioritise within workload.	GP Lead/Sue Gaskell/Janet Hanley	Ongoing	May 2015 – audit started, awaiting responses. Results received GP safeguarding Leads were provided with the findings.	

1.16 That domestic violence enquiries are made routinely by midwives throughout pregnancy and recording of this is monitored.	1. Explore the possibility of a Euroking prompt which would allow evidence that the question has been asked by delivery of the baby at the latest. 2. Continue to raise the profile of routine domestic abuse enquiry in all appropriate midwifery safeguarding training/supervision. 3. SOP (as per rec. 1.10) to include the process of providing an opportunity to see all women on their own at least once ante natally to enquire re domestic abuse. 4. Baseline audit of current practice re domestic abuse enquiry and then follow up 6 months later. 5. This and all these actions will be presented by the midwifery leadership team to all staff in a mandatory briefing session.	Julie Estcourt (Head of Midwifery) Marie Dooley (Governance Lead)	Nos. 1, 2, 3 & 5 by Sept 2015 By Dec 2015	DA guideline has been produced and flow chart. First 15 mins of booking appt woman to be seen alone and documented if not on Euro King. Asked more than once and again documented on Euroking Managers can review Euro King and monitor if this is being undertaken and can drill down on individual practitioners.	
1.17 That CAF forms completed in midwifery clearly articulate goals, outcomes and expected timescales.	1. See action for 1.8.2 Produce a model example of a good CAF and use in all the training opportunities. 2. Audit of CAFs which are requesting social care involvement in June-August 2015. 3. Named Midwife to review CAFs prior to submission.	Rebecca Oatway (Named Midwife)	By Sept 2015	Model CAF Audit tool in place and commenced. Training planned specifically for midwives. Named midwife is quality assuring all CAFs completed	
1.18 That a policy on FGM is developed.	1. Develop local policy based on GM policy – local policy detailing the operationalisation of the GM policy.	Julie Parker/Louise O'Connor/Tessa Malone	July 2015	19/052015 – Initial meeting with Judith Morris to consider that all reporting of FGM is completed through the daitix incident system.	

				Now on national platform and cases have been registered. Lead in midwifery Policy in draft Tameside NN taking lead..	
1.19 That parental health history and child birth history is routinely collected by health professionals undertaking initial health assessments.	1. Work with social care in accessing the parental health history on child's entry into care. 2. Adapting existing procedure with GPs around the known parental relevant history.	Jeanette Warburton/Erika Houston/Jane Hancock/Rebecca Tate	Nov 2015	There is already an established process for collecting this information for IHA. The request letter has been strengthened to reflect importance. Designated Dr LAC has met with GP safeguarding leads and advised what information is required and why. New parent health form has been developed. New Parental health form now being trialled at time children come into care. To review if there provides an increase in information received Nov 2015 and then as part of IHA audit March 2016.	
1.20 That a formal process for midwifery liaison with GPs is established.	1. Explore and understand the current process of communication between midwifery and GPs and review the pathways to improve communication opportunities. 2. Ensure midwifery have the latest list safeguarding GP leads .	Julie Estcourt	By Sept 2015	Community midwives are linked to practices and a list circulated to midwives identifying the GP safeguarding lead in each practice. All midwives to liaise with HV and were safeguarding	

				meetings are arranged with GPs to link into process. As a minimum to arrange to go into practice and meet GP monthly	
1.21 That the use of SDQs is developed to fully contribute to the provision of healthcare for children and young people who are looked after.	1. Review current process with CAMHS and social care leaders to address issues and improve process and actions. 2. Improve pathway to ensure good feedback loop from CAMHS to inform review health assessment.	Jeanette Warburton/Jane Hancock/KITE/CAMHS Lead (TBC)	Oct 2015	Pathway has been agreed. Need to identify the best way of implementing. SDQs are now sent out from social care as the request is sent out to health. Further work needs to happen to ensure the process gets the information required to the Lead health professional prior to the health assessment.	
1.22 That the LAC health team routinely request contributions from GPs for IHAs and RHAs.	1. Address through training of HV and SN to include GP information in reviews. 2. Admin support to practitioners to proactively plan reviews. 3. Admin access to child health database so SN and HV has imm's data to inform review.	Rebecca Tate/Angela Meldrum	Nov 2015	Designated Doctor (LAC) is presenting to the Safeguarding Leads in June 2015/Revised flow chart re the IHA and RHA developed by Rebecca Tate to inc. GP information. Plan to audit this change to practise as part of the record keeping audit Nov 2015	
1.23 That learning and action points from serious incidents is audited to ensure improvements in practice are embedded.	1. All recommendations need to be cascaded to all practitioners through development days, PDR's team meetings and training. 2. All recommendations and action plans	Julie Parker/service managers and team managers. All children's workforce.	Ongoing	2 repeat audits (Jan and March 2015) from historical learning reviews have shown consistent improvement in	

	are reported and monitored through the Trust Quality & Governance Committee plus business group Quality Board, Integrated Children's Senior Managers group and the Directorate meetings. 3. Regular audit to demonstrate improvement and sustainability.			practice. Plan to include action plans as an appendix to overall Trust and Governance Committee Adult and Children's safeguarding report NN to discuss at 1:1 with Director of Nursing. Oct 15-agreement that Risk and Governance meeting will monitor all safeguarding action plans. TOR amended	
1.24 that case record management audits are established in community health teams to ensure the ROPE model of record keeping is further developed and monitored to ensure continual evaluation and thorough analysis in case notes.	1. Revamp current audit tool. 2. Repeat baseline audit Spring 2015 and repeat 6 months on 100 sets of records across the service and split by locality. 3. Follow Trust policy and flowchart in dealing with poor record keeping linked to poor performance.	Angela Meldrum/Service managers/Team managers.	Ongoing	2 previous audits following introduction of ROPE in 2012 and 2014. New audit completed July 2015 now requires analysis and dissemination	
1.25 That a rolling programme of training for health professionals undertaking RHAs is established.	1. Cross reference to 1.4 – training and update guidance include in the Trust overall safeguarding children strategy.	Angela Meldrum/Practice Teachers, Safeguarding Nurses & ICS Team managers	Oct 2015	See 1.4 HV's are linking with Specialist LAC nurse to enhance their practice. There is an open door policy providing support. Specific training has been delivered. There needs to be some consideration as to how this is embedded in the overall training strategy.	
1.26 That arrangements are established to	1. ED to address recruitment and	Paula Bennett	Ongoing	When the Maternity	

ensure sufficient numbers of paediatric trained nurses are available to cover periods of absence within the emergency department in line with intercollegiate standards.	retention. There is a risk assessment in place to ensure the safe management of children in ED when there is no children's nurse on duty. The gaps in 2014/15 have been due to not being able to cover Maternity Leaves with suitably experienced children's nurses. We have over established in 2015 to mitigate against this.			Leave staff return (May/June 2015) there will be no gaps in cover and the establishment can cover adhoc sickness and one Maternity Leave at any one time. 28.7.15 Failed to recruit to FT vacancy. LTS covered in short term Commenced 5th October	
1.27 That the CASH team risk assessment proforma is modified to include FGM vulnerability.	1. Member of the service to visit a site where routine enquiry is in place and discuss in team meetings. 2. All sexual health staff to complete the online FGM training. 3. Whole team training for Stockport and Tameside Sexual health Service to cover FGM in detail – booked for 06/10/2015. 4. FGM is considered as a routine enquiry by CASH team when YP may be from a higher risk cohort	Stella Marsden, Linda Leach and Tessa Malone	No. 1 No. 2 July 2015 Nos. 3 & 4 Oct 2015	Meeting April 2015 with CASH team to discuss how the question would be phrased in the template as routine enquiry. Oct 15 all staff have completed e learning and further training Oct 15 Enquiry question has been included in proforma to ask if deemed appropriate Patient pathway to be put in place	

4. Stockport CCG & Pennine Care NHS FT					
2.1 That practitioners in CAMHs are proactive in their approach to ensuring attendance at child protection meetings and subsequent receipt of written plans.	1. Individual practitioners should prioritise attendance at safeguarding and child protection meetings in line with 'Working Together 2015'. Adult mental health team leaders/duty workers and admin Lead (D&A) to monitor any child protection or TAC meeting requirements and escalate accordingly within teams in order to allocate and ensure attendance. 2. Ensure staff are aware of their responsibilities in seeking written plans and escalate to the appropriate managers where there is no response to this request. 3. Escalation protocol to be developed within PCFT – links to 2.6 4. Reaffirm safeguarding as a standing item in supervision and team meetings and that minutes have been received	PC/MC/MC/JD (AMH service managers) NN (MH) & Ops service managers Ops service managers	June 2015 Sept 2015 May 2015	Briefing to Business units for cascade to service areas (1&2) Revised supervision framework and documentation agreed and circulated to all Adult MH teams	
2.2 That staff availability is monitored to facilitate ongoing joint working between the Adult substance misuse team and MOSAIC team as part of the hidden harm Think family parenting programme.	1. Following recent review of service provision the resource now available to the D&A service, delivery of the course would not be viable in its existing format. 2. Going forward MP (D&A) to meet with MOSAIC and review the current programme and consider if the joint working is deliverable in a modified format.	MP/MOSAIC	Oct 2015	Substance Misuse team manager has met with MOSAIC on 4/9/15 to discuss Pathfinder input into Think Family programme. The format of the programme being delivered has changed and service redesign has led to reduction in resources in the	

				Pathfinder service. However agreement has been reached to input into one session per programme and will highlight the findings from the Hidden Harm research	
2.3 That formal safeguarding supervision arrangements are put in place for the adult substance misuse team.	1. Cases discussed in supervision will be routinely recorded in the chronology of the service user records and will document whether there are any safeguarding issues, and brief notes of agreed safeguarding actions plans. These can be cross referenced with the supervision records of the clinician. 2. The Named Nurse (MH) to trial providing safeguarding specific supervision to clinical leads on a quarterly basis, and facilitate additional safeguarding knowledge and skills training.	MP/Named Nurse (AS)	July 2015	Revised supervision framework and documentation agreed and circulated to all AMH teams. Date booked with team manager in Drug and Alcohol service	
2.4 That liaison processes between the Adult mental health team and school nursing is developed.	1. Develop an protocol jointly with School Nurse Service.	CSM, TMs & School Nurse Rep	Sept 2015	A meeting took place between 2 services 9.7.15 and AMH lead will attend their team managers meeting in Sept to provide a briefing and to develop a working together protocol around liaison and sharing information	
2.5 That the CAMHs team routinely contribute to RHAs.	1. Ensure CAMHS documentation identifies the responsible health professional undertaking the review health assessments and that those health staff receive regular updates relating to assessments, reviews and	ML (LAC Psychologist)	Oct 2015	DN LAC liaising with staff identified to progress actions. A joint pathway has been drafted between	

	care plans in time to inform the statutory LAC health assessment. 2. CAMHS including KITE team to work with the Local Authority and Stockport NHS Foundation Trust LAC team to develop a plan which will ensure the SDQs are administered scored and, if appropriate, reviewed by a mental health practitioner in time to inform the lead professional undertaking the review health assessment. (see 2.8).			Pennine, SFT and CSC. Now need to identify best way of implementing.	
2.6 That a formal professional disagreement and escalation policy is established for CAMHs and Adult mental health teams.	1. Develop an escalation protocol for PCFT – links with supervision process – see 2.1	AS/SM's	Sept 2015	In development revised date Nov 15	
2.7 That Level 3 safeguarding children training in Adult mental health and CAMHs teams is robustly monitored for compliance.	1. Continue to drive up compliance with mandatory training requirements. 2. Development of a training passport to meet compliance requirements in line with the Intercollegiate document 2014 and the Core Skills Framework.	OL&D Service line Ops Managers	Quarterly reports to CCG via contract monitoring	Reports being provided by PCFT Performance & Information Dept. LSCB providing bespoke L3 training	
2.8 That the KITE team provide progress reports for review health assessments.	1. KITE team are an integrated service with CAMHS and has links with D&A (see actions in Item 2.5). 2. KITE teams to provide regular updates to inform the review health assessments.	ML	Oct 2015	DN LAC liaising with staff identified to progress actions. Process has been agreed. Now need to identify best way of implementing.	
5. Stockport CCG & NHS England					
3.1 That Level 3 safeguarding children training for GPs is developed in line with national guidance.	1. To provide all GP's with a copy of the required safeguarding competencies 2. To provide all GP's with a directory of level 3 training currently available 3. To work with the CCG GP development team to include in their programme level 3 topics throughout the year	Designated Nurse Designated Nurse	Completed Feb 2015 Completed April 15	Document sent via CCG comms team to all GP's Feb 2015 Information included in CCG Directory of training available for GP practices updated	

		GP development team / Designated Professionals/ Named GP	June 15	and re circulated by primary care training coordinator April 15 22.4.15 At GP leads briefing ideas requested re delivery methods 1.7.15 Pod cast planning 3.9.15 Safeguarding masterclass. If well evaluated as meeting needs will repeat 2-3 times / year	
3.2 That ways to develop GP participation and consistency in style of contribution to child protection conferences is explored and trialled across Stockport.	1. Benchmark audit to ascertain engagement of GP's in case conferences 2. Ascertain GP's views re case conferences, barriers to engagement, ideas which would support/increase participation 3. Formulate an action plan taking into account the results of actions 1&2 4. Re audit participation and contribution 3 months after action 3 completed	Named GP / Designated Nurse	Completed May 15 July 15	Request to Head of Safeguarding for information to be extracted from minutes of two month's initial case conferences April 15 Data received 14.5.15 3.9.15 GP training organised CC template launched and rational for engagement/provision of reports reiterated. In light of feedback Named GP will discuss an alternative pro forma with safeguarding leads Nov 15 briefing	
3.3 That named GP arrangements for Stockport as part of the Greater Manchester strategy are finalised imminently.	1. To recruit a Named GP:	Executive Lead / Designated Professionals	July 2015	Job Description completed – April 15 Role promoted at GP leads briefing –	

	To sign the memorandum of understanding with NHS England to be part of the GM arrangements for Safeguarding in Primary Care Services	Chief Operating Officer		22.4.15 JD and request for expression of interest sent out to all CCG GP's 30.4.15 closing date 15.5.15 Interview 23.6.15 Commence Sept 15 22.6.15 meeting at NHS E to discuss GM model 7.10.15 recruitment has still not been undertaken to the GM team that the CCG has committed to. Des Nurse has raised this again with NHS E Sept 15	
6. Stockport CCG, Stockport NHS FT & Pennine Care NHS FT					
4.1 That referrals to the MASH and CAF documentation clearly sets out the safeguarding risk to children and is quality assured with management oversight.	1. The current Stockport economy CAF documentation, quality assurance tool and practitioners self-assessment tool will be reviewed within the multi-agency CAF/TAC steering group to; • .Review the current use of CAF as a referral tool for child protection • Amend the current tool ensure that safeguarding risks can be clearly identified.	SFT rep/Pennine rep/in conjunction with chair of multi-agency CAF / TAC steering group	September 15	Recommendation has been shared with CAF/TAC steering group. April 15 as completion of this action will require close working with this group As an interim measure practitioners to identify risks in the conclusion section of the current CAF form. Both Named Nurses will ensure that this is communicated to Team managers/ team	

				leaders to cascade to front line staff 2.7.15 meeting with Chair CAF/TAC steering group. There has been agreement with the Head of Children's Social Care that there will now be a separate Child protection referral form. This will ensure that practitioners will have to identify risk for those cases that they believe require assessment by CSC. Sept 15 Separate CAF and CP referral forms have been implemented therefore referrals to the MASSH for safeguarding risks will be clear Pennine Named Nurse will join the group As part of the multi-agency group CAF auditing is already embedded however an additional audit will be undertaken by health for 3 months. As this was to check identification of risk when there was only one process it is now	
	2. Pennine to identify a representative on the CAF/TAC steering group 3. Using the Stockport economy QA tool team leaders/team health managers will quality assure all CAF's for 3 month, June-August, were social work involvement is being requested. The action will Then be reviewed dependent on findings	Named Nurse Pennine Team leaders/Team managers in SFT and Pennine FT	Completed May 15 September 15		

				no longer required with the introduction of the two documents	
4.2 That all teams ensure team around the child plans are developed for each child within a family rather than one plan for a family, to ensure individual needs are effectively addressed.	1. The current TAC plan is adapted to ensure that the actions required and desired outcomes are clear for each child by clearly marking in the action section the child's name and list below which actions relate specifically to the child. 2. This will be communicated to front line practitioners via a briefing 3. Supervisors audit a sample of cases in TAC to check individual plans are in place	Named Nurses SFT and Pennine FT Safeguarding supervisors SFT and Pennine FT	September 15 September 15 onwards	VCT specialist nurse SFT has undertaken a TAC audit as part of supervision and repeated it following briefing. The audit results have been put on a poster. Process being monitored during supervision Pennine need to provide evidence	
4.3 That audit arrangements are established for CAF assessment, impact of intervention and case recording across all teams and that audit findings and actions are regularly monitored to continually improve practice.	1. To ensure that the Stockport economy QA tool is embedded in practice. 2. To evidence that any findings that are identified in the quarterly CAF/TAC audit reports are acted upon	SFT and Pennine FT reps on CAF/TAC steering group	June 15 Dec 15	The QA tool is currently been used by health managers in addition to the multi agency quarterly audits that are being undertaken by the CAF/TAC steering group. The findings and actions are reported to the safeguarding board quality and performance sub group	

Compliance Checklist:

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y	Change in Financial Spend: Finance Section below completed	
Page numbers	Y	Service Changes: Public Consultation Completed and Reported in Document	
Paragraph numbers in place	Y	Service Changes: Approved Equality Impact Assessment Included as Appendix	
2 Page Executive summary in place (Docs 6 pages or more in length)	y	Patient Level Data Impacted: Privacy Impact Assessment included as Appendix	/ N
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	n/a

NHS
Stockport
Clinical Commissioning Group

Safeguarding Report

Domestic Homicide Review Briefing

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?
To note the content which provides assurance that the CCG is fulfilling one of its statutory requirements, participating in multi agency reviews.
Please detail the key points of this report
The homicide was deemed to be neither predicatable or preventable. Two of our providers and one of the member practices were involved in the review. The review noted good practice by the GP and the emergency department at Stockport NHS FT The review also noted two areas of practice that could be improved within Pennine Care mental health services. All identified actions have been completed.
What are the likely impacts and/or implications?
Learning from a significant event has been implemented in practice
How does this link to the Annual Business Plan?
Safeguarding, of which domestic abuse is included, is integral to all aspects of the SCCG business plan.
What are the potential conflicts of interest?
Nil
Where has this report been previously discussed?
Quality and provider Management committee.
Clinical Executive Sponsor:
Presented by:
Meeting Date:
Agenda item:
Reason for being in Part 2 (if applicable)

Domestic Homicide Review Briefing

Incident Date: 20.11.12
Publication Date: 17.07.15

Summary of Incident

A male victim suffered a fatal stab wound inflicted by his partner. The perpetrator was convicted of manslaughter and is serving a custodial sentence. Four children have lost their father, of which three have complex and enduring health conditions.

It was the view of the Panel that the events that took place on 20th November 2012 that led to the victim's death could not have been predicted or prevented. The Panel however, did feel that agencies could learn from this case and identified areas of practice which could be improved.

Health Services Involvement

Stockport NHS FT Acute and Community Services, Pennine Care NHS FT Mental Health Services, NWAS, Family GP and University Hospital of South Manchester all provided care to this family.

The Providers all produced reports for the review and Stockport NHS FT, Pennine Care NHS FT, NWAS and the GP submitted single agency action plans in response to the findings from their investigations. Pennine Care also identified this to be a STEIS reportable incident. The actions have all been completed.

Areas of Good Practice noted in this report

1. The Family GP demonstrated considerable good practice, pro-actively following up both parents.

2. The Emergency Department at SHH identified the male victim as a carer of young children and via the cause for concern pathway ensured relevant health and social care professionals were aware of his attendance.

Areas of practice noted in the report that could be strengthened

1. Mental health services did not link the victim and perpetrator so were unaware they were living together. As a consequence, neither received a full assessment of the impact of their individual mental health problems on their parenting capacity.

2. Adults with alcohol misuse issues are advised to self-refer to the Stockport Treatment – Access to Recovery Team. The appropriateness of this practice was questioned when the client is vulnerable and they have consented to treatment.

It is not within the remit of a Domestic Homicide Review to consider the care that was being delivered to the children; however the Panel did feel that there was learning for the children facing practitioners in this case and recommended that the safeguarding children board undertake a learning review. This has been completed.

NHS
Stockport
Clinical Commissioning Group

Risk Management Strategy

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 Risk Management Strategy has been presented to Governing Body for approval.

The views and endorsement of the Audit Committee were sought on the draft Strategy at its meeting on 21 October 2015.

Please detail the key points of this report

The Risk Management Strategy sets out NHS Stockport Clinical Commissioning Group's (The Group) overarching approach to the management of risk in the organisation.

The Group recognises and acknowledges the importance of embedding a culture of risk management at all levels of the organisation and risk leadership from those senior officers. It recognises in particular the need to ensure that the Governing Body, its Committees and Executive Decision Makers are aware of all significant risks and opportunities and have sufficient information to enable decision-making to be carried out on the basis of the implementation of appropriate controls and the allocation of appropriate resources.

An essential element in the corporate management of any complex organisation is accepting that risk cannot be entirely avoided. The Strategy seeks to provide the framework in which the organisation works proactively to minimise exposure to unnecessary risks, provide mitigation against those risks which cannot be avoided and maximise opportunities presented to most benefit.

The Strategy has been written to take into account the complex environment in which the CCG is operating and the significant amount and pace of change which the organisation is currently experiencing.

In particular it further develops:

- Partnership risk
- Management of opportunity
- Consistency and moderation of risk management.

What are the likely impacts and/or implications?

It is anticipated that the revised Risk Management Strategy, focussing on a theme based approach will better meet the organisation's need to manage risk proactively within an increasingly complex cross sector partnership working environment.

There will need to be continued work to embed the approach across the CCG to maximise the Strategy's effectiveness.

How does this link to the Annual Business Plan?

Risk management is an integral part of the CCG's business operations and underpins all aspects of the work against the Annual Business Plan.

What are the potential conflicts of interest?
None
Where has this report been previously discussed?
A risk workshop was undertaken by the CCG's Directors to review the approach and the revised Strategy in early September 2015. The draft strategy was considered by the CCG's Audit Committee on 21 October 2015.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 11 November 2015
Agenda item: 12

Laura Latham (22 October 2015)

NHS
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Risk Management Strategy

1. Introduction

The Risk Management Strategy sets out NHS Stockport Clinical Commissioning Group's (The Group) overarching approach to the management of risk in the organisation.

The Group recognises and acknowledges the importance of embedding a culture of risk management at all levels of the organisation. It recognises in particular the need to ensure that the Governing Body, its Committees and Executive Decision Makers are aware of all significant risks and opportunities and have sufficient information to enable decision-making to be carried out on the basis of the implementation of appropriate controls and the allocation of appropriate resources.

An essential element in the corporate management of any complex organisation is accepting that risk cannot be entirely avoided. The Strategy seeks to provide the framework in which the organisation works proactively to minimise exposure to unnecessary risks, provide mitigation against those risks which cannot be avoided and maximise opportunities presented to most benefit.

Risk management seeks through systematic and iterative processes to minimise the overall burden of risk. Key to this are the formal structures in place which enable the CCG to identify, assess, control and minimise risks attached to all areas of activity. This includes a renewed focus on the risks and opportunities incurred by the CCG in working in a complex series of partnerships involved in the transformation of the health and social care economy in Stockport.

It is as a result of embedded operational processes that awareness of risk management is raised and behaviour change occurs. This requires strong risk leadership from the Governing Body and the organisation's managers and the active participation of all employees.

2. Scope

The CCG is committed to commissioning the highest quality healthcare services to improve the health and wellbeing of the population in Stockport. In order to carry out its commissioning responsibilities, lead service redesign across the local health economy and achieve its strategic objects, risk management must be accepted as a key part of the organisation's business processes. Through agreeing the risk appetite of the organisation and assessing and quantifying risks, the CCG can be a flexible and dynamic organisation whilst retaining oversight of its risks and mitigations through clear standards of internal control.

This Strategy covers the management of strategic and operational risks within the NHS Stockport Clinical Commissioning Group. Due to the nature of the collaborative work across the Stockport economy, the actions of partner organisations involve risk and can significantly impact on whether the CCG achieves its objectives.

Therefore, those activities and actions do come within the scope of the Strategy.

3. Aims and Objectives

The aim of this strategy is to provide guidance to all staff on the management of strategic and operational risks within the organisation. It also plays a vital role for the CCG's Governing Body in acting as the organisation's strategic leaders and in taking the vision of the organisation forward through its decision making.

It aims to:

- Set out the responsibilities for the management of strategic and operational risks for the Governing Body and staff throughout the organisation.

- Outline the procedures to be used in identifying, analysing, evaluating and controlling risks and opportunities to the delivery of key organisational strategic objectives.
- Set the context of the management of the strategic and operational risks and opportunities of the organisation within the complexity of cross sector partnership arrangements.

The objectives of the strategy are to:

- Through effective risk identification, prioritisation, treatment and management minimise the impact of adverse incidents, risks and complaints.
- Maintain a risk management framework which provides assurance to the Governing Body and its Committees that strategic and operational risks are being managed effectively.
- Effectively manage risk management resources through maintaining a cohesive approach to corporate governance.
- Maintain robust systems for addressing issues external to the organisation.
- Embed risk management as an integral part of the CCG's culture.
- Minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy
- Ensure the organisation as far as possible maximises opportunities available to it and assesses and quantifies through the framework the benefit achieved and / or negative impact resulting from lost opportunities.

The organisation's risk profile is detailed in the two key documents:

- Board Assurance Framework – this is the register of the CCG's key strategic risks which have been approved by the Governing Body. It provides the tool by which the organisation's strategic leaders are assured about the management of strategic risks.
- Operational Risk Register – this is the document which contains cross cutting thematic risks known to the organisation and details how they are monitored proactively.

4. Responsibilities and Duties

The organisation's Governing Body retains overall responsibility for the management of the organisation's strategic risks.

The Chief Operating Officer has overall accountability and responsibility for risk management across the Clinical Commissioning Group.

It is important that those with whom the responsibility lies are supported by all CCG members, managers and staff in the management of strategic and operational risks.

As part of the embedding of the strategy, managers at all levels ensure that staff are suitably aware of the organisation's approach to risk and carry out their roles in light of the framework and look to highlight, manage and mitigate risks proactively.

The specific duties of those with responsibility for the management of risk are outlined below:

Component	Responsibility
Governing Body	Agreeing the organisation's strategic risk profile and Board Assurance Framework.
Chief Operating Officer	Holds overall accountability and responsibility for risk management within the Clinical Commissioning Group. Designated as the accountable and responsible officer for implementing the systems of internal control, including this Strategy

Chief Finance Officer	Designated as the organisation's Senior Information Risk Owner (SIRO) This responsibility extends to coordinating finance-based reviews conducted by internal audit and external agencies and for the implementation of action plans arising from these inspections.
Director of Strategic Planning and Performance	Holds accountability for risk management within the Clinical Commissioning Group maintains an overview of the impact of the CCG's partners and stakeholders on the level of risk exposure by the CCG. This responsibility extends to linking the strategy of the organisation to areas where opportunities can be maximised.
Board Secretary and Head of Governance	Provides support to the Chief Finance Officer and Director of Strategic Planning and Performance in: Ensuring that the processes and procedures described in this Strategy are in place across the organisation. Maintaining the Board Assurance Framework and Operational Risk Registers and ensuring the detail is reported through the organisation's decision making structures. Providing access to appropriate risk management training for relevant staff. Liaising with partners and stakeholders in maintaining an oversight of risks impacting on the CCG.
Managers	Ensure that risks are identified and managed and mitigating actions implemented in functions for which they are accountable. Demonstrate personal involvement and support for the promotion of risk management. Ensure that staff reporting to them understand and pursue risk management as part of carrying out their duties. Ensure registers relating to the organisation's risks and maintained and updated in line with agreed schedules and ownership of risks is promoted. Escalating newly identified risks to the appropriate level within the organisation and for inclusion on the relevant register. Attending risk management training as required by the organisation.
Staff	Identifying and reporting risks to their line manager using the CCG's risk processes and documentation; Co-operating with others in the management of risks Taking action to protect themselves and others from risks. Attending risk management training as required by the organisation.

Other Responsibilities

In addition to the Governing Body, the organisation's **Audit Committee** has delegated authority in the area of risk management. Its functions include providing the Governing Body with assurance that the risk management systems are working and that adequate controls are in place for all significant risks. To assist it in its role it takes advice from the CCG's internal and external auditors.

Where gaps in the organisation's system of internal control or assurance processes are identified, it will seek assurance from the Executive Team that action plans are being put in place, are prioritised and implemented with progress reviewed regularly.

The CCG's Clinical and Executive Teams will also play an active role in the management and oversight of risk across the organisation and in particular the impact of the risks of partners on the delivery of the CCG's strategic objectives.

The focus will be on how the active management of risk adds value to the organisation.

The Strategic Leadership Team will receive the Operational Risk Register and Board Assurance Framework twice annually.

The Management Team will review the Operational Risk Register on a bi-monthly basis.

5. How Risk is Defined

NHS Stockport Clinical Commissioning Group defines risk as follows:

'Anything that can cause harm to stakeholders to whom we owe a duty of care or which threatens the achievement of our strategic objectives. This includes damage to the reputation of the CCG that could undermine public confidence.'

In addition to risk management, it is important that the CCG manages its opportunities alongside its risks.

Improving the commissioning and delivery of health care requires innovation and for new opportunities to be seized and the associated risks managed. As with risks, the CCG will manage opportunities proactively. It will assess delivery and benefit against the opportunities highlighted within its registers, acknowledging where not fulfilling an opportunity impacts on the organisation within the overall themed approach.

The CCG defines the overall management of risk and opportunity as:

'The identification, assessment and prioritisation of risks and associated measures to minimise, control and monitor the probability or impact of adverse risk events or to maximise benefits from opportunities. ' (ISO 31000 standard)

6. Risk Management Process

The CCG adopts a proactive approach to the risk management process, including that of managing positive benefits arising from opportunities and seeking to maximise them.

There is also reactive risk management in the form of incident reporting.

The process and tools for managing risks are outlined in Appendix 2.

7. Risk Evaluation

The CCG applies a risk evaluation process based on the Australian / New Zealand Risk Management Standards AS / NZS 4360:1999. This process is universally accepted as good practice and has been adopted by the NHS.

In applying this process the Clinical Commissioning Group is able to apply a systematic and quantifiable assessment of risks alongside their recording and treatment. The process whilst applied to the management of strategic and operational risks can also be applied at all levels of the CCG, including programmes and projects. It is important that records are kept at all stages of the process which can be made available for internal audit.

The main elements of the process are outlined as follows:

- **Establish context** – Establish the strategic, organisational and risk management context in which the rest of the process will take place. Criteria against which the risk will be evaluated are established and the structure of the analysis defined.
- **Identify risks** – Identify, using an organisational themed approach what, why and how things can arise as the basis for further analysis
- **Analyse risks** – Determine the existing controls and analyse risks in terms of consequence and likelihood in the context of these controls. The analysis should consider the range of potential consequences and how they are likely to occur. Consequence and likelihood would be combined to produce a level of estimated risk.
- **Evaluate and rank risks** – Compare estimated levels of risk against pre-established criteria. This enables risks and themes to be ranked so as to identify management priorities. If the levels of risk are low then the risks may fall into an acceptable category and treatment of these risks may therefore not be required.
- **Treat risks** – Accept and monitor low priority risks. For other risks, action plans will need to be implemented, including any relevant cost considerations.
- **Monitor and review** – Monitor and review the performance of the risk management system and changes which may affect it.
- **Communicate and consult** – Communicate and consult with internal and external stakeholders as appropriate at each stage of the risk management and overall process. Following assessment, all risks and themes deemed to be highly significant will be escalated for inclusion on the Operational Risk Register or the Board Assurance Framework.

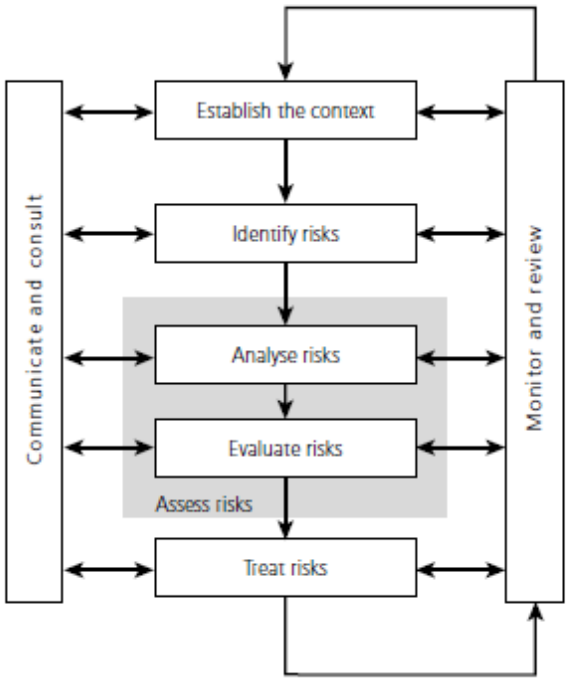

Figure 3.1 Risk management overview

8. Assurance Framework Information and Review

The CCG Governing Body receives its assurance about the organisation's most strategic risks through the Board Assurance Framework. This is related to the NHS England assurance process for CCGs and represents the strategic risks facing the CCG in relation to its overall aims and objectives. This is supported on an operational level by the Operational Risk Register. This register is NOT a log of issues or reported adverse incidents. It will only include identified risks within broader themed areas which present a continuing threat to the achieving the CCG's objectives and operations.

For each risk registered the following information must be captured:

- Risk theme
- Risk description
- Named risk owner
- Risk scores
- Events and mitigating actions
- Update comments
- Where it is an opportunity (all of the above) along with comments on the risks associated with not maximising the opportunity fully.

Both the Board Assurance Framework and the Operational Risk Register are dynamic 'live' documents which are regularly updated to reflect changes in risk levels and controls which can be exercised.

Monitoring of the documents will take place as follows:

Board Assurance Framework	•Updated quarterly •Bi-annual review by Management Team •Bi annual review and monitoring by Governing Body •Bi annual review and monitoring by Audit Committee
Operational Risk Register	•Updated bi monthly •Bi annual review and monitoring by Audit Committee •Bi monthly review by Management Team •Bi-annual review by Strategic Leadership Team •Annual review and refresh by Management Team

*Risks where the score is greater than 15 will be supplemented by a more detailed risk analysis and explanation of mitigations and monitoring which will accompany any documents presented for review.

9. Defining and Scoring Risk and Opportunity

The CCG utilises a risk rating system which, through a matrix classifies risks and opportunities into four categories of severity:

- Extreme
- High

- Moderate
- Low

Whilst the distinction between extreme and low can be more clearly identified, the categorisation process will inevitably contain a subjective element.

It is important therefore that the CCG's Executive Management Team supported by the Board Secretary and Head of Governance ensure that moderation and consistency in scoring takes place as part of regular monitoring and reporting.

Through use of a structured framework (attached at Appendix 1), those managing risk on behalf of the CCG will assess the severity of a risk on the basis of the likelihood of the risk occurring and the consequences of the risk should it occur.

The risk matrix enables the severity of the risk to be determined from the assessments of likelihood and impact assessed as a colour.

The use of colour enables risks from different themes to be compared and used to guide the CCG in identifying priority areas of focus, requirements for additional resource or areas where management action is required. As the CCG is operating in a complex environment where the risks associated with partnership working are key to the successful delivery of the organisation's strategic objectives, the Board Assurance Framework and Operational Risk Register will also enable those risks to be tracked.

10. Themes

To provide for a holistic and cross cutting approach to the management of risk and opportunity within the CCG, specific risks will be grouped by theme. This will at an operational level deliver connectivity across the risk management of the organisation beyond its Directorate based organisation form and should allow for more strategic management of risk and opportunity.

The themes will be as follows:

Theme	Risk Appetite	Rationale
Quality	Moderate	We will ensure the provision of high quality services to our patients and will only rarely accept risks which threaten that goal.
Safety	Low	We hold patient and staff safety in the highest regard and will seek to minimise any risks that threatens either
Financial Resilience	Moderate	We will stay within set financial limits and will accept risks that may cause financial loss only in certain circumstances and where the benefits merit the risk
Compliance	Low	We will comply with all legislation relevant to NHS

		Stockport CCG and will not accept any risk which, if realised, would result in non-compliance
Reputational	Moderate	We will maintain high standards of conduct and will accept risks that may cause reputational damage only in certain circumstances and where the benefits merit the risk
Innovation	High	We encourage a culture of innovation within NHS Stockport CCG and are willing to accept risks associated with this approach.
Partnerships	High	We will work with other organisations to ensure the best outcome for patients and are willing to accept the risks associated with a collaborative approach
Organisational Development	Moderate	We will work to ensure that the CCG continues to develop in terms of its workforce, culture, governance and structure to meet the requirement to be an agile organisation able to work at pace and will accept the risks associated with this approach.

11. Implementation, Communication and Training

The effective communication of the Risk Strategy will ensure it is embedded and effectively implemented across the organisation. The CCG will:

- Publish internally and externally a copy of the Strategy following approval.
- Produce risk registers at the frequency outlined which will be subject to routine review.
- Share with and communicate as required action to be taken by employees and partners arising from the management of risks

The CCG will ensure that risk management training is available for all employees. This will take the form of:

- Regular training to all employees, on the management of risks using blended learning including online training and face to face sessions.
- Provide tailored training for the CCG's Senior Managers and risk owners.
- Inclusion as part of its induction and mandatory training, elements as required linking to risk and opportunity management.
- Ensuring regularly that all staff have the required understanding, skills and can access support to implement the requirements of the Risk Strategy.

12. Monitoring and Compliance

The CCG will monitor and review its performance in relation to the management of risk and to the continuing suitability and effectiveness of the systems and processes in place to manage risk. The will be achieved through a programme of internal and external audit work and through the oversight of the Audit Committee which will provide assurance to the Governing Body.

Appendix 1

Risk Matrix Tools

1. Impact Assessment Table

These elements will need to be reviewed alongside the themes when confirmed.

This is the value which represents the consequence of severity of the harm that might be caused assuming that the event happens (the risk or opportunity is realised.) The value should represent the severity of the consequences or harm that will happen most of the time that the event occurs, rather than the maximum consequence that could possibly happen. This will result in a reasonable risk rating which will then allow the risk to managed and mitigations to be put in place.

Grade Category	1 Very Low	2 Minor	3 Moderate	4 High	5 Severe
Service Quality - Patient Safety	No medical attention required. No impact beyond 1 day.	Single person requiring medical attention but not hospital admission, multiple minor incidents.	Single hospital admission, multiple minor injuries requiring medical attention.	Single fatality or permanent disability; or multiple injuries requiring hospital admission.	Multiple fatalities or permanent disabilities.
Service Quality – Clinical Effectiveness	Minor breach of guidance – no impact on patient outcomes.	Significant breach leading to harm for a small number of patients.	Significant breach of guidance leading to harm for a number of patients.	Breach leading to reduced life expectancy for multiple people.	Multiple fatalities or permanent disabilities.
Service Quality – Patient Experience	Minor inconvenience to single individual.	Minor inconvenience to many individuals, significant inconvenience to single individual.	Significant inconvenience to many individuals, patient experience impact on health outcomes for a few.	Patient experience impact on health outcomes for a significant number.	Multiple fatalities or permanent disabilities.
Health Inequalities	Possible increase to inequalities.	Probable small increase to inequalities.	Probable significant increase to inequalities.	Actual small increase to inequalities.	Actual substantial increase to inequalities.
Health Improvement	Possible slowing of decline of prevalence.	Probable slight slowing in rate of improvement in death rates, No decline or significant slowing in prevalence.	Probable significant slowing in improvement of death rates. Slight increase in prevalence.	Slight increase in death rates. Substantial increase in prevalence.	Substantial increase in death rates.
Health Protection	Minor injury or illness requiring no medical attention.	Injury or illness requiring medical attention for a few.	Injury or illness requiring a few hospital admissions, or multiple numbers requiring medical attention.	Single fatality or permanent disability; or multiple injuries requiring hospital admission.	Multiple Fatalities.
Regulatory Compliance	Minor breach of standards with no impact on organisation.	Breach of broader health standards or minor targets.	Breach leading to discussion with NCB.	Breach leading to DH improvement team intervention. Breach leading to	Breach leading to court action against executive.

				threat of court action.	
Financial Balance	<£1,000 loss.	£1,000 - £25,000 loss.	£25,001 - £250,000 loss.	£250,001 - £2,000,000 loss.	>£2million loss.
Financial Governance	Isolated technical breach with minimal impact.	Numerous minor technical breaches. Technical breach leading to financial loss.	Limited assurance on single key financial systems.	Failure to get Statement on Internal Control agreed. Fraud leading to imprisonment of staff member. No assurance on single key financial system. Limited assurance on multiple systems.	Fraud >£2million. Investigation by the Audit Commission. No assurance on multiple financial systems.
Information Governance	Minor technical breaches of standards not directly impacting on members of the public.	Single loss of data or other breach affecting a single individual.	Multiple losses of data or other breaches of governance standards impacting on small numbers of people. Single loss of data impacting on many people.	Multiple losses of data or other breaches of governance standards each impacting on hundreds of individuals.	Breach leading to court action against executive.
Staff Safety and Wellbeing	Minor cuts and bruises. Isolated incidence of low morale	Medical treatment required. Less than three days' absence. Low morale among a number of staff groups.	Single admittance to hospital for less than 24 hours. Absence of three days or longer. Sickness rates increasing.	Single fatality or permanent disability. Rapid increase in sickness rates threatening service delivery	Multiple fatalities or cases of permanent disability.
Reputation	Complaint only.	Minor out of court settlement. Two days or less coverage in local press.	Civil action. Local press coverage longer than two days. Two days or less of national media coverage	Class action, Criminal prosecution. National media coverage longer than two days. Questions in the House.	Imprisonment of executive officer. Full public enquiry.

2. Likelihood Grading

Choose a value which represents the likelihood of the incident occurring i.e. how often will it or does it happen?

Grade Descriptor	1	2	3	4	5
Percentage	<15%	15-39%	40-59%	60-79%	>80%
Probability	Only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	More likely to occur than not	Almost certain or happening now
Frequency	Not expected to occur for years	Expected to occur annually	Expected to occur monthly	Expected to occur weekly	Expected to occur daily

3. Overall Grading

Use the scores from the rating of impact and likelihood to calculate the risk grading.

Risk grading = Likelihood x impact

	IMPACT					
LIKELIHOOD		1	2	3	4	5
	1	Low	Low	Low	Moderate	Moderate
	2	Low	Low	Moderate	Moderate	High
	3	Low	Moderate	High	High	Extreme
	4	Moderate	Moderate	High	Extreme	Extreme
	5	Moderate	High	Extreme	Extreme	Extreme

The scoring of opportunity should be carried out using the same matrices as outlined above to ensure consistency.

4. Checking the effectiveness of controls

To understand the effectiveness of their controls managers should ask:

- Is there a policy/process/procedure in place?
- Are all those who need to understand the policy/process/procedure trained?
- Do senior managers follow the policy/process/procedure and promote their use?
- Has an external body or Internal Audit assessed this recently?
- Is there evidence that the policy/process/procedure is being followed in all areas/cases?
- Is there a contingency plan in place?

The more questions which are answered positively (with supporting evidence) the stronger the controls and thus the lower the likelihood of the risk occurring.

Appendix 2

Glossary of Common Risk Management Terms

Complaint: Action taken by a patient or client of a healthcare facility, or his or her agent, to communicate dissatisfaction or concern about any aspect of care, treatment or experience.

Consequence: The outcome of an event, being a loss, injury, disadvantage or gain in respect of the physical, emotional, financial, social or credibility status of the individual or organisation.

External Assurance: A process designed to provide evidence that the NHS in total and its constituent parts is doing its reasonable best to manage, direct and control itself so as to protect itself, its employees', patients and stakeholders' safety and interests against risk of all kinds.

Cost: Activities, both direct and indirect, which result in a negative outcome or impact for an individual or the organisation - cost includes money, time, labour, disruption, and goodwill, political and intangible losses.

Event: An incident or situation occurring in a particular place during a particular interval of time.

Frequency: A measure of the rate of occurrence of an event expressed as the number of occurrences of an event in a given time.

Hazard: A source of potential harm or a situation with the potential to cause loss.

Incident: Any unplanned event or circumstance resulting in, or having a potential for, injury, ill health, complaint, claim, damage or loss.

Incident: A formal structured process and approach to enable the occurrence of incidents.

Reporting to be reported, recorded and the root cause of reported incidents identified, in and Investigation: order to manage risk exposure and identify corrective actions.

Likelihood: A qualitative measure or description of probability or frequency.

Loss: Any negative consequence, financial or otherwise.

Monitor: To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis in order to identify change.

Organisation: A NHS Trust, CCG, company, firm, enterprise or association etc. that has its own function(s) and administration.

Risk Appetite: Is the amount of risk on a broad level that an organisation is willing to take in pursuit of its strategic objectives.

Risk Owner: CCG senior manager / Director responsible for managing and owning a risk.

Risk Theme: Is an area of the CCG’s strategic operations used to group risks.

NHS
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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

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?
• To note the update on the falls/Osteoporosis pathway • To note CPC response to new national NICE guidance: NG17 Type 1 diabetes in adults diagnosis and management. • To note the decision made by CPC regarding its requirements for NICE compliance reporting. • To note CPC have endorsed the GMMMG recommendation listed under section 3.4. • To note CPC have endorsed the GMMMG NOAC guidance. • To approve the change in process for new Greater Manchester EUR policies. • 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: Roger Roberts
Meeting Date: 11.11.15
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 reviewed the draft pathway for CG146 Osteoporosis. The group recommends that the CCG focuses on outcomes and falls prevention; prioritising this co-hort. CPC recommends that falls prevention is worthy of investment.

3.2 CPC noted new national guidance NG17 Type 1 diabetes in adults: diagnosis and management. CPC would like to make Governing Body aware of quality issues, the pathway needs review and diabetes is a risk.

3.3 CPC have written the Medical Director, SFT to advise that the committee has confirmed its requirements regarding NICE Technology Appraisals and the NICE compliance backlog. The committee will continue to request compliance updates on new guidance published on or after January 2015 and it will continue to monitor areas identified as a risk. The committee will no longer request updates on the compliance backlog with the exception of Technology Appraisals.

3.4 CPC have endorsed the following GMMMG recommendations: Tioropium/Olodaterol (spiolto® Respimat®) 2.5/2.5 microgram combination inhaler to relieve symptoms in adult patients with COPD and The sequential use of biological agents in the treatment of chronic or plaque psoriasis, for those patients, fulfilling NICE criteria.

3.5 CPC have endorsed the GMMMG NOAC guidance. The committee recognised that prescribers need guidance on the CCG expectations on the choice of first line treatments with Warfarin as the preferred first line drug.

3.6 Governing Body is asked to approve a change in process for CCG authorisation of new Greater Manchester EUR policies. Once AGG give final approval, this is taken as the point at which Stockport CCG approves these policies.

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.

Roger Roberts

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

NHS
Stockport
Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group
Audit Committee
Unconfirmed Minutes

Date of Meeting:	**21 October 2015**	**Time**	**From**	**To**
			13:00	**14:47**
Venue:	**Room 1, Floor 7, Regent House**			
Present:	(JG) Mr J Greenough, Lay Member (Chair) (BB) Mr B Braiden, Lay Member (DS) Mr D Swift, Lay Member (AJ) Dr A Johnson, GP Locality Chair			
In Attendance:	(GJ) Mr G Jones, Chief Finance Officer (CFO), NHS SCCG (DD) Mr D Dolman, Deputy Chief Finance Officer, NHS SCCG (MT) Mr M Thomas, External Auditor, Grant Thornton (JF) Mr J Farrar, External Auditor, Grant Thornton (LL) Mrs L Latham, Head of Governance & Board Secretary, NHS SCCG (LW) Ms L Warner, Internal Auditor, MIAA (RC) Mr R Causer, Deputy Director, Anti-fraud MIAA (CR) Ms C Robson, Anti-Fraud Manager, MIAA			
Apologies:	Mr T Ryley, Mr T Crowley			
Secretary to Committee:	(EB) Elaine Biglen, Committee Support, NHS SCCG			

MEETING GOVERNANCE		
Item No	**Meeting Item**	**Respo nsible**
37.920	**1. Declaration of Interests** A Johnson declared an interest in Item 11 – Employment Tribunal Settlement. The nature of the interest being that his wife had been a party to the legal proceedings. He would leave the meeting during consideration of that item. D Swift declared that from 1 November 2015 he would take up the position of Lay Member for Governance and Audit at East Lancashire Clinical Commissioning Group. A form to update his Register of Interest would be sent to him.	**LL**
37.921	**2. Apologies** Apologies were noted as above. Introductions were made by everyone at the meeting as both Roger Causer and Cath Robson from MIAA were new to Stockport CCG and would attending these meetings in future.	
37.922	**3. Minutes of the last meeting held on 17 June 2015**	

	The minutes were approved as a correct record.	
37.923	**4. Action Log** The action log was discussed and the following updates provided: • 37.909 (i) – G Jones noted that this action would be progressed through a discussion with Stockport Foundation Trust. • 37.914 – This matter would be discussed under Item 7. • Actions 37.909 (ii), 37.913, 37.917, 37.919 (i), 37.919 (ii) would be removed.	
37.924	**5. Notification of items for any other business** There were no further items to be notified under any other business.	
37.925	**6. Financial Position Update** G Jones provided an overview of the CCG's current financial position and the submission of a financial recovery plan to NHS England in August 2015. He explained that Stockport was moving towards a category 3 rating which meant that the CCG was no longer on track to deliver the minimum forecasted savings as agreed with NHS England. He noted the continued challenge between the CCG's existing financial circumstances and the wider work across the economy to create a financially sustainable system. He noted that a meeting was due to take place with NHS England to discuss the next steps. In considering the financial position, the Committee noted the work of the CCG's QIPP Committee in monitoring and tracking the delivery of CIP plans and the increasing demand across the health system in Stockport. G Jones noted that Greater Manchester Devolution provided opportunities for financial autonomy and control within the region although the exact details had not yet been clarified. **Resolved:** That the Committee note the financial position update.	
37.926	**7. Audit Work Plan** D Dolman presented an updated version of the Audit Committee Work Plan for 2015/16 which included the actions arising from the recent Internal Audit Review of Corporate Governance. The re-tender process for external audit was suggested as an addition for early 2016. He noted that meeting dates would be set for 2016 aligned to the key activities of the Committee. **Resolved:** That the Audit Plan be agreed subject to the addition of an item on the re-tender process for external audit for early 2016 and the Board Assurance Framework being included as an item for December's meeting. .	**DD**
37.927	**8. Audit Committee Annual Report** The Chair presented the Audit Committee Annual Report for 2014/15 which would be forwarded to Governing Body for endorsement. He explained that in future years it would be completed in line with the timetable for approving the	

	CCG's accounts. **Resolved:** That the Audit Committee Annual Report for 2014/15 be agreed and forwarded on to Governing Body for endorsement.	
37.928	**9. Financial Control Environment Assessment** D Dolman provided an overview of the Financial Control Environment self-assessment exercise which the CCG had undertaken during August 2015. He explained that the assessment had been agreed with the Audit Committee Chair and Chief Clinical Officer and overseen by the CCG's internal auditors before submission to NHS England. The Committee's retrospective approval of the document was now being sought. The Committee considered the areas where the CCG had identified areas for improvement or where mitigation against known risks could be strengthened. D Dolman confirmed the assessment would be submitted to Governing Body for final approval at the meeting on 11 November 2015. **Resolved:** That the Committee: 1. Note and approve retrospectively the CCG's self-assessment submission to NHS England. 2. Note that the submission will be submitted to the CCG's Governing Body on 11 November 2015.	
37.929	**10. Greater Manchester Devolution Briefing** The Committee received a briefing on the establishment of the shadow arrangements for Greater Manchester Devolution which commenced on 1 October 2015. G Jones explained the financial modelling work being undertaken across the region alongside the development of Locality Plans. The Greater Manchester strategic vision would include a bid to the Treasury to seek financial support to progress. Members considered the links between the work in Stockport through Stockport Together and the support provided by the Vanguard Programme on developing new models of care. G Jones explained that work towards full implementation from 1 April 2016 would continue whilst in shadow form, with particular focus on governance arrangements and how assurance with regulators would take place under the arrangements. In explaining potential opportunities for Stockport arising from Devolution, G Jones explained that there could be some equalisation of funding across the region which may be positive for the Borough through local revisions to funding formula and pace of change policies. He noted that improvements in health outcomes across Manchester were a key driver of Devolution and there was a risk that this may flow funding into other areas of the region. **Resolved:** That the Committee note the update.	
37.930	**11. Employment Tribunal Settlement** **A Johnson left the meeting for the consideration of this item.*	

	The Chair provided an overview of the outcomes of two employment tribunals which had been brought against the CCG and noted the actions taken by the Remuneration Committee in reaching a settlement in the case of one individual. He explained that the CCG's External Auditors had been informed at relevant stages of the progression of the matter. **Resolved:** That the Committee note the outcome of the employment tribunal settlement.	
37.931	**12. Risk Strategy Review** L Latham presented a revised Risk Management Strategy to the Committee for comment. She explained that the Strategy had been revised in light of previous audit recommendations and would operate on the basis of a themed approach to better reflect the cross cutting nature of the CCG's work. The revised strategy included a clearer focus on partnership risk, the management of opportunity and placed greater emphasis on moderation and consistency. She noted that training would be provided for those responsible for risks and work undertaken to embed a culture of 'risk leadership' amongst senior managers. The operational management of risk for the CCG would link more closely with economy wide strategic risks managed by Stockport Together. The Committee sought an understanding of how within a themed approach, risk ownership would be embedded. It was suggested that prior to approval by Governing Body, the internal and external auditors be given the opportunity to comment on the document. The implementation of the strategy would be monitored by the Committee through the monitoring schedule as outlined in the document. **Resolved:** That subject to any further comments from the CCG's internal and external auditors, the revised Risk Management Strategy be submitted to Governing Body for approval on 11 November 2015.	**'s**
37.392	**13. Draft Governance Statement** The Committee considered the draft governance statement for the 2015/16 year. L Latham explained that it was good practice that the statement remained under continuous review and that the underpinning governance processes were reviewed in year. **Resolved:** That the mid-year review of the draft Governance Statement be noted.	
37.393	**14. Detailed Financial Policies Review** D Dolman informed the Committee that the detailed financial policies had been reviewed and were being presented to the Committee for information and assurance purposes. It was requested that in future changes to such documents should be indicated in red for ease of tracking/identification. **Resolved:** That the Committee note the review of the CCG's detailed financial policies.	

37.934	**15. External Audit Progress Report** The Committee considered a report of the External Auditor as at October 2015 which provided a mid-year view on the audit process. M Thomas explained that the interim accounts audit would start in December 2015 and that there would be an audit review of the accounting of the Better Care Fund. Members were informed that a document on Value for Money had been consulted on by the National Audit Office with revised guidance anticipated to be available mid November 2015. **Resolved:** That the Committee note the external audit progress report.	
37.935	**16. Internal Audit Progress Report** L Warner provided an overview of the internal audit progress report, explaining that one review of corporate governance had concluded in the most recent quarter. She highlighted the recommendations which had been agreed with the CCG and in particular the creation of a policy tracker for suggested monitoring by the Audit Committee and the creation of a specific Gifts and Hospitality Register. She noted that the review of the Information Governance Toolkit would commence on 28 October, a review of Co-Commissioning would commence in Quarter 3 and the key financial systems audit was due to commence in November 2015. The review of Safeguarding had been delayed in light of new guidance and would recommence in Quarter 4. The Committee considered the recommendations which were outstanding from previous reviews including the review of QIPP and noted progress. In response to a question regarding Board succession planning as highlighted in the Corporate Governance Review, L Latham advised that this issue had been discussed with the Chair of the Governing Body and its importance acknowledged. **Resolved:** That the Committee: 1. Note the report of the internal auditor. 2. Agree that as recommended in the Corporate Governance Review the Committee would include as part of its work programme annual review of the policy tracker and the gifts and hospitality register.	
37.936	**17. MIAA Insight Audit Committee update** The Committee considered a regular update from the CCG's internal auditors which included a number of best practice briefing notes, benchmarking and events of interest to Members. G Jones highlighted that cyber security would become increasingly important for the organisation as work continued to develop on integrated care records across health & social care. In response to a question it was noted that the CCG's revised risk management strategy included risk appetites for each of the themed areas. Members suggested that future updates would be of greater use if they were specific to CCG's.	

	Resolved: That the update be noted.	
37.937	**18. CCG Assurance Framework benchmarking report** The Committee considered the benchmarking report and L Warner highlighted particular areas of interest, including the top ten risk themes. G Jones sought clarification about the pie chart on high scoring risk themes and the figures relating to QIPP. Further information would be provided. L Latham noted that work would be undertaken to review the content of the benchmarking report against the operation of the assurance framework. **Resolved:** That the Committee: 1. Note the Benchmarking report. 2. Would receive further information on the underpinning detail of the pie chart detailing high scoring risk themes and in particular, the information relating to QIPP. 3. Agree that L Latham should review the CCG's Board Assurance Framework in light of the benchmarking contained within the report.	
37.938	**19. Internal Audit Charter** D Dolman confirmed to the Committee that the Internal Audit Charter as had been previously agreed remained applicable. **Resolved:** That the Internal Audit Charter be noted.	
37.939	**20. Counter Fraud Progress Report** A report on Counter Fraud was presented by C Robson. She explained that a self-assessment had been completed by MIAA and the CCG in July 2015 with an overall score of amber. She explained that the self-assessment focussed on risk identification, mitigation and evidence of compliance and an action plan would be created to cover those actions assessed as red and amber. The Committee was informed that of 31 CCG's in the North West, approximately two thirds had been self-assessed as amber and that the document limited the assessment for those CCG's which had not been able to provide evidence in relation to action taken as a result of fraud or suspected fraud. It was noted that the Continuing Healthcare Audit had been submitted to the CCG and that responses were awaited from the CCG managers involved **Resolved:** That the Committee: 1. Note the amber self-assessment rating as submitted by the CCG. 2. Agree to receive the full report at the meeting to be held in December 2015. 3. Note that the work against the plan at Appendix A is on track and that a meeting had recently taken place with the Anti-Fraud Specialist. 4. Arising from the meeting some lunchtime briefings for staff would take place along with a session for Governing Body as part of an away day in early 2016.	

	5. That thanks be formally extended to Berwick Dawson, MIAA for his work at the CCG.	
37.940	**21. Anti-Fraud Newsletter** It was noted that the Anti-Fraud Newsletter had been circulated to the Committee for information purposes.	
37.941	**22. Chief Finance Officer Routine Reports** **22.1 Losses and Special Payments** The report contained in the agenda pack was noted. **22.2 Receivables>£5k** None. **22.3 Register of Waivers** None. **22.4 Register of Sealing Update** None.	**DD**
ANY OTHER BUSINESS		
37.942	**23. Any Other Business** There were no items of any other business on this occasion.	
DATE AND TIME OF NEXT MEETING		
The next meeting will take place on 16 December 2015 13.00 – 15.00 in Meeting Room 1, Floor 7, Regent House		

Date of Committee	Minute Number	Action Point	Complete by Date	By Whom
17.06.2015 & 21.10.15	37.909 (i)	**CCG to nominate a Local Security Management Specialist (LSMS)** GJ advised he still had to speak to the FT. Action: GJ to update the Committee at the next Audit meeting.	16.12.15	GJ
21.10.15	37.925	**Audit Work Plan** Action: DD to amend the Audit Work plan as per requests. Look at future meeting dates.	16.12.15	DD
21.10.15	37.928	**Financial Control Environment Assessment** Action: GJ take Assessment to the November Governing Body.	11.11.15	GJ
21.10.15	37.931	**Risk Strategy Review** Action: LL to regularly update members on the Risk Strategy Review.	16.12.15	LL
21.10.15	37.937	**CCG Assurance Framework benchmarking report** Action: LW to report back on the reasoning for the QIPP ratio on the pie chart.	16.12.15	LW

NHS Stockport CCG

Audit Committee

Annual Report

2014-2015

1. Foreword by the Chair of the Audit Committee

I am pleased to present the Annual Report of the Audit Committee which outlines the Committee's work and achievements over the year ending 31st March 2015. Going forward the Committee will look to develop further, helping to address many of the issues in what promises to be a very challenging and difficult environment.

Our priorities for 2015/16 are:

- Continue to deliver our work plan informed by a risk based approach and discussions held with internal audit and management;

- Be responsive to emerging issues including Co-commissioning, Devolution Manchester, the Better Care Fund and the changing policy within the NHS.

I would like to thank Dr Andy Johnson, Bernard Braiden and Dave Swift who, as members of the Committee, have supported me in my role as Chair of the Audit Committee. I would also like to express my thanks to Colleagues from our Internal Audit, Anti-Fraud and External Audit providers for their hard work in support of the Committee, and the Officers of the CCG whose attendance and enthusiastic participation in meetings is crucial to the effective completion of our work programme.

I am happy to commend this report to the Governing Body for adoption in accordance with our Constitution and terms of reference.

John Greenough

Lay Member for Governance and Finance

October 2015

2. Introduction

The role of the Audit Committee is to provide assurance to the Governing Body that the CCG has effective systems of integrated governance, risk management and internal control across the whole of the organisation's activities that support the achievement of the CCG's financial and non-financial objectives. This report sets out how the Committee has discharged its responsibilities and met its terms of reference.

3. Meetings of the Committee

The Committee has met on five occasions during the 2014-15 financial year, and on each occasion has been quorate in line with the Committee's terms of reference.

The members of the Committee were as follows

- J Greenough (Chair)
- B Braiden
- A Johnson
- D Swift

A summary of members' attendance is given at appendix 1.

In addition to the members of the Committee, Officers were in attendance at the invitation of the Chair:

- Chief Finance Officer
- Director of Strategic Planning and Performance
- Internal Auditors
- External Auditors
- Local Anti-Fraud Specialist
- Other Officers as and when required

4. Delivery of Work programme

The Committee devised and implemented a risk based work programme for the full financial year, and this serves to ensure that the full breadth of its responsibilities is addressed in a timely and comprehensive manner. This work programme for 2014-15 can be summarised as covering:

- Governance and Risk
- Internal Audit reporting
- Anti-Fraud reporting
- External Audit Reporting
- Reports from the Chief Finance Officer.

An equivalent work programme has been devised for 2015-16.

Governance and Risk

The Committee was appraised of issues relating to governance and risk, and reports on these topics were received at each meeting. The format and presentation of the risk register was considered by the Committee. The Committee suggested changes to the reports format and presentation to improve the monitoring and reporting of risks. It was accepted that some risks would be present on an on-going rather than a task-and-finish basis as the NHS is in a position of complex transformation and financial vulnerability.

The Committee also sought and received assurance that the Governing Body Assurance Framework was in place, and routinely submitted to both the Director's weekly meetings (on a monthly basis) and the Governing Body. This was underscored by Internal Audit's review which provided significant assurance that an assurance framework has been designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

Internal Audit Reporting

Internal Audit Services for the CCG have been provided by Mersey Internal Audit Agency (MIAA). A proposed Greater Manchester-wide process to retender internal audit services was considered during the financial year, however after careful consideration the Committee decided that the plan was not viable and therefore did not to participate in the process. Internal Audit produced a work-plan for 2014-15 which was reviewed and agreed by the Committee, and which facilitated compliance with the requirements of the Audit Committee handbook in terms of the content of the plan, the resources required, and the linkages with the Assurance Framework.

Progress against plan was reported at each meeting, and assurances provided to the Committee regarding the suitability of the CCGs systems for risk management, assurance framework, financial reporting systems and internal controls. The Committee ensured that recommendations as a result of internal audit reviews were implemented in full, through internal audit follow up and regular reporting to the Committee. There were no significant issues outstanding from this work.

The Director of Audit Opinion Statement at the end of the financial year provided the CCG with significant assurance that there is a "generally sound system of

internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently".

Anti-Fraud Reporting

The nominated Local Anti-Fraud Specialist for the CCG submits a work-plan for the approval of the Committee, and reports periodically on progress with its implementation. The work plan included identified CCG-specific fraud risks which are reflective of the changing commissioning landscape.

The Committee has received assurances that the 'pro-active' programme of establishing an anti-fraud culture within the CCG has progressed during the year, and has been kept informed of national developments of potential fraud. There are no current anti-fraud investigations under way within the CCG, nor have there been any investigated during the financial year in question.

The Anti-Fraud survey results provides evidence that the CCG has established and embedded a strong anti-fraud culture through the development of policies, procedures and corporate governance structures.

External Audit Reporting

Grant Thornton UK LLP are the External Auditors for the CCG, appointed nationally by the Audit Commission, and their work is undertaken in the context of the Statement of Responsibilities of Auditors and Audited Bodies. The external audit plan was received and approved by the Committee, and periodic update reports provided on progress. At the end of the year, the External Auditors confirmed that they issued an unqualified opinion on the financial statements, which gave "a true and fair view of the CCG's financial position and of its net operating costs". The CCG had achieved all of its key 2014/15 financial targets, including achieving a surplus of £4.3 million, containing administration expenses within the prescribed limit and operating within its cash limit. In accordance with Section 5 of the Audit Commission Act 1998, the External Auditors also issued their Value for Money (VfM) conclusion, which stated that "in all significant respects the CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015".

The Committee continued with the "best practice" of receiving regular summaries of emerging issues and developments to which the Chief Finance Officer provided the Committee with written assurance as to how each of the emerging issues and developments were being addresses.

Reports from the Chief Finance Officer

The Committee commissioned and regularly received reports from the Chief Finance Officer relating to Losses and Special payments (including Debtors greater than £5k); entries in the register of waivers; and entries in the register of sealing. The incidence of all of these transactions was minimal, and there were no matters of significance arising.

Other ad hoc reports covered potential issues in relation to cash allocations; annual accounts timetables, and agreement of balances, which were received and noted by the Committee.

Summary of assurances and sources of evidence used

- The financial systems are reliable [Internal Audit reports; External Audit Reports];
- There were no significant issues arising from the review of the financial statements [External Audit Reports];
- No major breakdowns in internal control were evident [Internal Audit Reports; Anti-Fraud Reports; External Audit Reports; Chief Financial Officer Reports];
- No major weaknesses in governance systems were evident [Risk and Governance Reports; Internal Audit Reports; Anti-Fraud Reports; External Audit Reports; Chief Financial Officer Reports];
- No concerns were evident in relation to the performance of the External Auditor;
- No additional payments were made to Internal or External Auditors for non-audit services provided.

5. Committee Effectiveness

The Audit Committee is required to carry out a review of its effectiveness annually however this has been deferred until February 2016 to take into account any recommendation from the governance review being undertaken across the whole of the CCG.

6. Conclusion and Recommendations

During the 2014-15 financial year, the Audit Committee of NHS Stockport CCG has fully discharged its responsibilities to the Governing Body. In accomplishing this, the Committee has demonstrably met the requirements of its terms of reference.

Whilst conducting its business the Audit Committee will remain mindful, vigilant and responsive to emerging issues including co-commissioning, Devolution Manchester, the Better Care Fund and the changing policy context following the election of the new government.

The Governing Body of NHS Stockport CCG is requested to receive and formally accept this document as providing the above assurances for the financial year 2014-2015.

Appendix A - Membership and Meeting Attendance 2014-15

	30th April 2014	18th June 2014	15th October 2014	18th December 2014	18th February 2015
J Greenough (Chair)	A	P	P	P	A
B Braiden	P	P	P	P	P
A Johnson	A	A	P	A	P
D Swift	P	P	P	A	P
Quorate (Minimum Two Members)	YES	YES	YES	YES	YES

Key: P= Present;

A= Apologies for absence received