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 Town Hall, Stockport at 10.00am on 9 September 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 8 July 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 (COPD)	Video		10.15	J Crombleholme
5	Strategic Performance Updates • General Practice 2020 • Planned Care Update	Written Reports	To consider, scrutinise and agree.	10.25	Viren Mehta / Roger Roberts Cath Briggs
6.	Corporate Performance Reports a) Finance Report b) Performance Report c) Quality Report	Written Reports	To receive, assure and note.	10.55	Gary Jones Gaynor Mullins Mark Chidgey
7	Locality Chairs' Update	Verbal Report	To receive and note	11.15	Locality Chairs
8	Report of the Chair	Verbal and written report	To receive and note	11.25	J Crombleholme

9	Report of the Chief Operating Officer to include the following: • Value Proposition • Specialist Weight Management Procurement Outcome • ECG Procurement Process • EPRR assurance of NHS England Core Standards • Co-Commissioning Level 3 update	Written Report	To debate and approve	11.35	G Mullins
10	Report of the Chief Clinical Officer • Healthier Together Update	Written Report	To receive and note	11:50	Ranjit Gill
11	Stockport Borough Plan	Written report	To endorse	12:05	G Mullins
12	Governance Review Final Report and Recommendations	Written Report	To approve	12:15	T Ryley
13	Statement of Involvement	Written Report	To approve	12:30	T Ryley
14	Reports from Committees • Clinical Policy Committee	Written reports	To note.	12:45	V Owen Smith
15	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 11 November 2015 at 10:00 at Regent House, Heaton Lane, Stockport, SK4 1BS. Potential agenda items should be notified to stoccg.gb@nhs.net by 13 October 2015				

NHS
Stockport
Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT BREDBURY HALL, STOCKPORT
ON WEDNESDAY 8 JULY 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

IN ATTENDANCE

Mr M Chidgey	Director of Quality and Provider Management
Mr R Roberts	Director for General Practice Development
Mrs L Hayes	Board Secretary and Head of Governance (taking minutes)
Dr D Jones	Director of Service Reform

APOLOGIES

Dr L Hardern	Locality Chair: Stepping Hill and Victoria
Mr T Ryley	Director of Strategic Planning and Performance
Dr V Owen Smith	Clinical Director for Public Health

85/15 APOLOGIES

Apologies were received from L Hardern, V Owen Smith, T Stokes and T Ryley.

86/15 DECLARATIONS OF INTEREST

There were none on this occasion.

87/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 10 JUNE 2015

The minutes of the meeting held on 10 June 2015 were approved as a correct record. In approving the minutes the Governing Body ratified the recommendations made as decisions at the inquorate meeting.

88/15 ACTIONS ARISING

The following updates on actions were provided:

101114 – Greater Manchester Devolution Governance would be considered as part of the Chief Clinical Officer's Report and the action should be removed.
030215 – Winter Lessons learned had been considered as part of the Chief Clinical Officers report and the action should be removed.
010615 – The briefing for Healthwatch on the work of the End of Life Care Team had been arranged and the action could be removed.
020615 – Both issues had been raised at regional level and could therefore be removed from the action plan.
030615 – Arrangements were in place for Proactive Care to be considered at Locality Committees in July so the action could be removed.
040615 – Both elements had been included in the July Chief Operating Officers Report so could be removed from the action plan.
050615 – M Chidgey confirmed that the meeting had taken place with the Chief Executive Officer of Action for Sick Children and the CCG's Lead Contract Manager. The discussions had focussed on increasing the Chief Executive Officer's knowledge of the CCG's commissioning arrangements. A brief summary would be provided as part of the Chair's report at the next meeting.

89/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were no items on this occasion.

90/15 PATIENT STORY

The Governing Body watched a video on collaborative care planning which had been created by the Royal College of GPs. It highlighted the importance of collaborative care planning to address the holistic needs of an individual within a primary care setting and to enable GP's to focus on meeting an individual's medical needs as part of a wider package of support. The video highlighted the importance of the 4 stages of care planning and the benefits of collaborative working for the patient and also for the GP in maximising the use of limited time resource.

V Mehta commented that embedding care planning across the wider health and social workforce would be challenging but with the right change in culture and support would have significant benefits for patient health and well-being. This linked to the work being undertaken as part of Stockport Together.

C Briggs commented that care planning was already happening in practices across Stockport but was not occurring system wide. There was an opportunity to build the work around the work of the Neighbourhood Teams. Stockport was noted to have approximately 4300 care plans in place against an initial target of 6000.

J Crombleholme sought confirmation about training provided for care planning. P Carne noted that some work had been undertaken locally but needed to be extended to a wider group of clinicians and health and social care professionals. It was acknowledged that the number of care plans currently in place in Stockport was positive but that they could only be uploaded to the Stockport Health Record as

individual documents which was time consuming. V Mehta noted that the aspiration to move to a single system across Stockport would assist with such technical issues

D Jones explained that as part of the Stockport Together design work, there was a focus on re-designing the system around the patient and carer as part of a co-production approach. This would include strong clinical and professional input.

91/15 STRATEGIC IMPACT REPORT

G Mullins introduced the report and explained that its purpose was to provide the Governing Body with an overview of how the CCG was performing against strategic indicators. The report included detailed data which could be analysed in different ways and broken down by locality and practice. She noted that data would be provided to individual practices on a monthly basis and that the content, style and presentation of the report would be developed over the coming months. Feedback was sought from the Governing Body on the report.

The Strategic Impact Report would be considered alongside regular performance reporting to Governing Body to streamline and manage information efficiently. It was noted that the current data included in the report only provided a limited picture at the current time.

J Crombleholme sought assurances about the support available to practices to use the data provided and look to make improvements. It was noted that Area Business Managers would play a key role and that the information provided at practice level would be very useful and this was supported by Locality Chairs. It was suggested that patient level data wold be useful to practices to look at appropriateness of referrals and other similar issues. V Mehta noted that practices would be piloting the dashboard data over the next 3 months to refine it further.

G Mullins clarified that the CCG would look at how that level of data could be developed but could not process the patient level data itself. Providing data on a locality basis was noted to be useful to Locality Chairs to identify trends.

J Greenough commented that in its strategic role, it would be useful for the Governing Body to see the Stockport Level Cumulative Charts with detailed commentary highlighting any particular locality or practice issues. G Jones noted the link between the Strategic Impact Report and the regular finance reporting.

Resolved: That the Governing Body:

1. Notes the content of the Strategic Impact Report and its future development in line with the comments included as part of the minute.
2. Requests that thanks for the development of the work be passed to staff involved.

92/15 PLANNED CARE

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 the spinal pathway of Care. The benefits of making progress across each of the areas were highlighted by C Briggs and updates on recent activity were provided.

A Johnson commented that in reducing the variation in referrals across Practices it would be

important to identify practices with willingness and capacity to develop and where good practice could be shared in addition to focusing on those where data indicated scope for improvement. V Mehta noted that this was the approach being taken and that managing referrals had formed a key part of the CCG's financial planning for the current year along with other key areas where performance levels needed to be maintained.

The benefits of implementing the EUR Policy more effectively across the system were noted and in particular the potential reduction in activity costs. C Briggs explained the work being undertaken as part of the redevelopment of the spinal care pathway and the need to reintegrate the existing patients requiring treatment back into care and support settings locally as appropriate to their level of need.

J Crombleholme sought assurance that the CCG had an appropriate level of resource in place to enable the required outcomes to be achieved in all areas of planned care linked to the challenging financial position of the CCG. G Mullins noted that the pace of delivery had not been established as quickly as anticipated and it was important that practices were able to also apply resources to work collaboratively to achieve the CCG's strategic objectives. It was acknowledged that Locality Chairs played a key role in facilitating conversations at practice level and would require support from the CCG to carry out some of this work. It was also acknowledged that to ensure success there had to be a balance in behavioural change at practice level, particular in the area of variation in referrals and management of public expectations. The Governing Body considered the time taken to communicate and embed change and for demonstrable improvements to be seen. The next steps would be discussed jointly by clinical and executive directors and also at the Locality Meetings to be held in late July.

Resolved: That Governing Body:

1. Notes the progress to date across the initiatives included within the report.
2. Notes the risks to delivery of the operational plan targets as outlined in the report.
3. Notes the importance of maintain pace in the delivery across all areas.
4. Notes the need to provide support to Locality Chairs in discussing variation in referral levels within Localities.
5. Requests that an update be received at the September meeting of Governing Body on progress in implementing the operational plan targets outlined in the report linked to a future Strategic Impact Report.

93/15 BOARD ASSURANCE FRAMEWORK

The Governing Body considered the Board Assurance Framework. G Jones explained that the framework was underpinned by an Operational Risk Register which was monitored internally with oversight maintained by the Audit Committee. He noted the document highlighted the organisation's most strategic risks and should be read in conjunction with other reports relating to financial, performance and quality matters.

In response to questioning it was noted that there was an error in relation to risk 01. 'There are inadequate systems in place for managing the quality and safety of services commissioned.' This risk should have been graded as moderate and the document would be amended accordingly. It was noted that to provide a greater level of assurance to the Governing Body, further detail relating to events and mitigating actions should be included.

Regarding risk 3 – 'The Members are not adequately engaged with the CCG's strategy and priorities' it was noted that the scoring was felt to be an accurate reflection of current circumstances.

Resolved: That Governing Body note the report.

94/15 PERFORMANCE REPORT

G Mullins explained that the period covered by the report included NHS Constitution Targets for April and May for compliance areas. She noted performance relating to emergency department activity in April and noted that the Systems Resilience Group was undertaking some detailed work relating to winter readiness. The same report from the Group would be received by both the Governing Body and the Foundation Trust's Board in September covering this matter.

The main risks to delivery of constitutional compliance in 2015/16 were highlighted and it was noted that an update in response to the performance noted issued to North West Ambulance Service would be reported to a future meeting of the Governing Body.

The good level of performance in relation to cancer was noted and in particular, the need to maintain performance.

Resolved: That Governing Body note the report.

95/15 FINANCE REPORT

The Governing Body considered the current financial position of the CCG as at month 2 of the 2015/16 financial year. G Jones noted that the revenue column on Table 1: Statutory Duty and Performance Targets should be deleted from the report. He explained that the main elements of the QIPP plans had been incorporated into planning for reserves. He noted that emerging month 3 data did show an increase in non-elective admissions and that prescribing figures in April were showing an increase compared to budgeted projections.

G Jones explained that the end of month 3 figures were showing a £250k deterioration in year which would impact on the CCG's ability to meet the required financial surplus as agreed with NHS England if it continued on the same trajectory during the year. This message would be shared with members at the upcoming Locality Meetings and the CCG's Flash Reporting Mechanism used to inform Governing Body Members of financial developments during the summer break period.

In relation to questions regarding prescribing, G Jones noted that further data was required to identify trends and understand the position more fully. R Roberts noted that the introduction of new drugs meant that there was a continued need to manage prescribing resources within budget. R Gill noted that practices needed to focus on this area and receive support from the CCG where there was an ability to make positive change. V Mehta commented that for those practices where NHS England money had been accessed to recruit a practice pharmacist, early indications had been very positive.

Resolved: That the Governing Body:

1. Notes the financial position as at 31 May 2015 and forecast delivery of the £1.75m surplus target.
2. Notes that the majority of the QIPP savings had been embedded within the expenditure budgets.

3. Notes that delivery of the planned £1.75m surplus is dependent on the CCG's ability to deliver c£11m savings and for all other expenditure budgets to remain within planned levels.

96/15 QUALITY REPORT

M Chidgey provided a brief summary of the recent work of the Quality and Provider Management Committee and noted priority areas of focus including Stockport Foundation Trust's CIP Plans, safeguarding at St Ann's Hospice and assurance relating to safeguarding in maternity services. He noted that the revised model of care for community mental health services had not yet been implemented due to on-going consultation with staff. In light of this the Committee had re-stated its support for the proposed model of care as previously agreed by the Governing Body.

Councillor Pantall enquired about the timescales for follow up from the CQC review of Looked After Children and Safeguarding. M Chidgey noted that a summary of the report and actions would be brought to the next meeting of the Governing Body.

The importance of Healthwatch representation at Committees and meeting and input to the work of the CCG was noted. J Crombleholme agreed to contact Healthwatch to discuss this further.

Resolved: That the Governing Body note the report.

97/15 LOCALITY CHAIRS UPDATE

P Carne on behalf of the Locality Chairs reported that the next round of Locality Meetings would take place at the end of July and Cheadle and Bramhall would be the first to adopt the cluster approach. Fortnightly meetings would take place leading up to implementation in October and learning would be shared across localities. Stepping Hill and Victoria Locality would be the second area to commence work.

A discussion took place regarding the sharing of intelligence and working processes across practices relating to referral management and the importance of sharing best practice. It was noted that operating a single IT system would assist with this. P Carne noted that 3 practices in his Locality were moving across to EMIS web in line with this and thanks for expressed to those practices.

It was noted that the CCG membership was positively engaged in the approach to cluster working. V Mehta noted that the CCG was reviewing Executive meetings to ensure clinical leadership was fully involved. J Crombleholme commented that this would be a positive development.

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

98/15 REPORT OF THE CHAIR

J Crombleholme reported that prior to the main meeting of the Governing Body a Part 2 meeting had taken place relating to a contracting issue with NHS Stockport Foundation Trust. She also explained that the CCG Governing Body had recently met with the Foundation Trust's Board to discuss a range of matters including community services, Stockport Together, Healthier Together, winter planning and emergency department issues and the future strategic direction of the Trust. The meeting had been positive with a future meeting scheduled to take place in November 2015.

99/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted the key elements included with the report. She noted that at the recent Quarter 4 Assurance meeting between the CCG and NHS England, the CCG's operational plan had been highlighted as exemplar. This had also been noted by the Vanguard Team. She noted that the Strategic Impact Report enabled delivery against the key indicators to be monitored closely to ensure implementation of the plan remained on track. In discussions with NHS England it had been noted that to enable the CCG to ensure delivery of some of the key objectives in the plan, staff time had been reprioritised and therefore some elements of the CCG's business would not be achieved fully in year. NHS England had agreed with this approach.

A discussion took place regarding the resourcing of Stockport Together and an update on the design phase was provided. G Mullins explained that the CCG's responsibilities to the programme as commissioners focussed on the design and business case and on leading engagement with the community. The Governing Body was informed of the need to secure the services of consultants to deliver on some technical areas where expertise did not exist within the local economy. New NHS England contracting rules meant that if the amount totalled £50,000 or more, a full business case would need to be prepared.

Governing Body considered the risks and mitigating factors in progressing the Stockport Together programme and the work being undertaken to prepare a value proposition for the Vanguard Team to access further funding and technical support. It was noted that to maintain the programme's pace, all partners had contributed additional funding at the early stages. It was clarified that the recent £150,000 which had been received from Vanguard had been allocated against monies already spent.

J Greenough sought confirmation about where Stockport fitted as part of the variation across the North West information provided in the report. G Mullins confirmed that more detail would be circulated to Governing Body on the CCG's position.

Resolved: That the Governing Body:

1. Note items 1 – 3 contained within the Chief Operating Officer's Report.
2. Approve the detailed plan for the use of the CCG resources in support of the Stockport Together Programme and receive quarterly progress reports.

100/15 REPORT OF THE CHIEF CLINCIAL OFFICER

R Gill provided an outline of the existing and emerging governance structures related to Greater Manchester Devolution. He noted that much of the thinking and discussion was on going, particularly relating to the establishment of permanent governance arrangements to operate from April 2016 onwards. He explained the roles of the Partnership Board, the Joint Commissioning Board, Standing Conference and the Provider Forum and noted that the role of the regulators as part of the governance arrangements was currently being considered. He outlined the accountability between the various boards and noted that the Combined Authority remained the statutory body.

G Mullins explained that a Strategic Sustainability Plan was being developed which would aim to address the challenges around the high spend poor health outcomes issues across Greater Manchester and inform the approach to the Government's Comprehensive Spending Review in the Autumn and future discussions with the Treasury in relation to the 2016/17 year.

Councillor Pantall highlighted the importance of public health in improving health outcomes through early preventative work. D Kendall raised a question about the role of clinical leadership in the governance model as outlined and noted that it should remain high priority in on-going discussions. Similarly it was noted that the role of providers covering a whole range of health services should be included.

R Gill acknowledged the pace at which the Devolution was progressing and the lack of an existing comparator region to take any learning from. It was noted that Devolution extended beyond health and social care and the wider place shaping opportunity and increased autonomy which would arise from the change would have significant benefits across the region if successful.

Governing Body considered the importance of collaborative working in Devolution and the need for all partners to be open to working in partnership across a range of different sectors. V Mehta sought an understanding of how Local Authorities would separate existing commissioner and provider functions as Devolution moved forward.

J Crombleholme asked about Stockport's involvement in the developing work on Devolution at a regional level in light of previous Governing Body decisions about ensuring that the work supported the continued improvement of health outcomes for the population of Stockport. G Mullins noted that she was leading on primary care work as part of Devolution and R Gill was the Chair of the Group developing the Strategic Sustainability Plan. Stockport also had G Jones involved in early discussions relating to finance matters and P Fleming on IM&T matters. Other CCG's were noted to be taking the lead in other key areas. V Mehta noted the importance of striking the right balance between influencing the development of Devolution and maintaining focus on delivering local Stockport priorities.

In summary the Governing Body acknowledged the importance of maintaining focus on the opportunities provided by Devolution for improved health outcomes for the population of Stockport, collaborative working and innovation across the region and greater autonomy.

Resolved: That the Governing Body note the update provided.

101/15 INTEGRATION OF HEALTH AND SOCIAL CARE RESOURCES

Governing Body considered a report which outlined the CCG's intentions to pool financial resources with Stockport Metropolitan Borough Council commencing in the 2016/17 financial year and the proposed direction of travel thereafter. G Jones explained that the CCG was proposing a staged approach to pooling linked to a cohort approach. The financial pooling proposal would build on existing pooled budget arrangements with the Council managed by the current Section 75 arrangement through the Health and Wellbeing Integrated Commissioning Board and increase the financial commitment of the CCG by a further £97million to approximately £122million. G Jones noted that any decisions made by the Governing Body would need to be subject to final confirmation of the financial sum to be pooled by the CCG as the £97million proposed did not include efficiency savings. He confirmed that the proposals had been shared with the Council who had indicated support for the approach which would be discussed further at a meeting of the Council's Executive on 18 August 2015. He explained that the initial proposal from the Council included pooling the entirety of the Adult Social Care Budget as part of the arrangements which would decrease in the coming years as a result of reduction in government grant.

A discussion took place regarding the drivers for change and the need across the sector to work collaboratively to develop new models of care and change the current commissioning process and contractual form. This included proposals to commission for outcomes. G Jones drew Governing

Body's attention to the dynamics included in the paper of pooling and managing money as single budget and the importance of appropriately sharing risks across organisations. It was noted that the proposed further pooling would require a review of the governance arrangements in place to manage and oversee the money.

K Richardson sought an understanding of the skills and knowledge of members of the Governing Body to make decisions relating to commissioning for outcomes. This was acknowledged as a development area for the Governing Body which would be considered as part of the current Board Development work. It was acknowledged that the existing Section 75 governance arrangements would need be strengthened to manage a larger pooled budget operating across a large number of demand led areas. The Governing Body would consider revised arrangements across a number of workstream areas (including governance) as the work started to develop in future subject to the Council Executive's decision on 18 August 2015.

V Mehta raised a question about the specialist knowledge and capacity which existed locally to develop a commissioning for outcomes approach and the creation of new contracting forms. G Mullins noted that as part of the Vanguard Programme, money would be made available to develop new forms of provision, service models and contracting and the CCG would be seeking to access monies to engage the support of specialists in these areas.

Governing Body acknowledged the pace at which change needed to occur but in doing so highlighted the risks incurred by both partners. In discussing the future direction of travel, R Gill acknowledged that whilst pooling of budgets provided a mechanism for collaborative spending, the real opportunity for improvement and future development came through the proposals to change the joint approach to commissioning and form of contracting. The impact of Greater Manchester Devolution was also acknowledged in terms of proposals for wider financial pooling on a regional basis.

The Governing Body discussed the Local Authority's views on the proposed pace of change. Councillor Pantall commented that the Chief Executive of the Council had expressed support in writing for the proposed integration of health and social care resources and in doing so, acknowledged the work which would need to be undertaken to ensure progress was made following the Council Executive's consideration of the proposals on 18 August 2015. He noted that cultural change was required on the commissioning and delivery of services by both organisations.

In summarising the Governing Body's discussions, J Crombleholme highlighted the importance of continuing to progress integration on a local level for the benefit of the people of Stockport alongside involvement in strategic work across Greater Manchester to look at proposals for wider pooling as part of work on Devolution covering potential areas such as specialised commissioning.

Resolved: That the Governing Body:

1. Agrees the additional pooling intentions for 2016 -17 subject to final confirmation of the additional figure to be pooled from the Chief Finance Officer.
2. Endorses the direction of travel beyond 2016-17
3. Agrees principles for the next stage.

102/15 REPORTS FROM COMMITTEES

J Greenough provided an overview of the recent work of the Audit Committee including consideration of the annual audit letter, approval of the Internal Audit Plan for 2015/16 and oversight of the operational risk register. He noted that agency and consultancy fees for the 2014/15 financial year had been

reviewed by the Committee and they had been assured that the level of spend had provided value for money and benefit for the CCG.

J Crombleholme outlined the recent work of the Clinical Policy Committee and in particular the areas where endorsement was sought by the Governing Body. V Mehta explained that a GP Masterclass had been arranged for September to consider the Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult policy with details being circulated amongst GPs following the Governing Body Meeting.

Resolved: That Governing Body:

1. Notes the minutes of the Audit Committee held on 17 June 2015.
2. Notes the following areas as highlighted by the Clinical Policy Committee:

- The endorsement of the GMMMG NTS recommendations in Section 2.1 of the report.
- The amendments to the black and grey lists in Section 2.2 of the report.
- The endorsement of the Unified Do Not Attempt Cardiopulmonary Resuscitation Adult Policy.
- The endorsement of the GM EUR policies in section 2.4 of the report.
- The content of the minutes of the meeting held in May.

103/15 ANY OTHER BUSINESS

V Mehta commented that changes to the presentation and formatting of Governing Body agendas had been received positively by those accessing document electronically. He requested that any further suggestions be made to the Board Secretary with a view to moving towards a paperless approach to future meetings.

(The meeting ended at 12.41pm)

Public Questions

The following questions were raised by members of the public present at the meeting and responded to as follows:

1. Can the financial figure to be contributed by the CCG to the pooled budget with the Council be clarified?

   G Jones confirmed that the contribution on top of the existing £25million would be approximately £97million but this would be subject to adjustments for efficiency savings.

2. What would the contribution to the pooled budget from Stockport Metropolitan Borough Council?

   G Jones confirmed it would be in the region of £72million - £78million and this comprised the organisation's adult social care budget. The total pooled budget including existing pooled monies would increase to approximately £200million.

3. How will the spend within the budget be governed to ensure health money is spent on health matters and will elements be ring-fenced?

G Mullins explained that the Section 75 agreement would detail how the money would be spent across all areas commissioned and include provisions to managing overspends in line with other budget areas.

4. How will the Governing Body be accountable for the money pooled by the CCG?

   J Crombleholme explained that she currently chaired the Health and Wellbeing Integrated Commissioning Board which managed the Section 75 agreement with the Leader of the Council as Vice-Chair. All arrangements for the Board would be reviewed as part of future work on the integration of health and social care resources.

5. When is the next decision on the Healthier Together Programme due to be made?

   R Gill confirmed the Committee in Common would make its next decision on 17 July 2015.

NHS Stockport Clinical Commissioning Group
8 July 2015

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
05/06/15	Public Questions Meeting to be arranged with CCG's Lead Contract Manager in response to question submitted in advance by Val Jackson, Chief Executive Officer of Action for Sick Children. Brief notes of the meeting would be published alongside the minutes of the meeting		8 July 2015	Mark Chidgey Further to the meeting taking place some brief notes will be provided as part of the Chair's report at the September meeting.
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	**91/15**	9 September 2015	Tim Ryley

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
	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.			
08/07/15	<u>Planned Care</u> An update be received at the September meeting of Governing Body on progress in implementing the operational plan targets outlined in the report linked to a future Strategic Impact Report. Support to be provided to Locality Chairs to assist with discussions in localities regarding variation in practice referral levels.	**92/15**	9 September 2015	C Briggs
08/07/15	<u>Performance Report</u> The Governing Body to receive a report from the Systems Resilience Group at the September Meeting (to be also considered by the Foundation Trust Board) relating to readiness for winter.	**94/15**	9 September 2015	C Briggs This report will be presented to the September meeting of the Systems Resilience Group and subsequently reported to Governing Body as part of a report in October 2015.

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
	An update in response to the performance noted issued to North West Ambulance Service would be reported to a future meeting of the Governing Body.			
08/07/15	<u>Finance Report</u> A flash report would be issued to Governing Body Members during the summer break to provide information on the CCG's financial position.	**95/15**	August 2015	G Jones
08/07/15	<u>Report of the Chief Operating Officer</u> As part of the variation across the North West information provided in the report further detail would be reported to Governing Body Members on Stockport's position.	**99/15**	August 2015	G Mullins Circulate letters. DB – circulated for info – use as part of planning.

NHS
Stockport
Clinical Commissioning Group

General Practice Update

Paper includes the future of general practice, extended hours and 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.

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Executive Summary

What *decisions* do you require of the Governing Body?	
This is a discussion paper and does not require decisions.	
Please detail the key points of this report	
A future position paper has been discussed in the locality meetings and the results are shown for debate. Part of moving toward the future state is seven day working and proactive care developments and progress is described.	
What are the likely impacts and/or implications?	
This will be a key building block of future plans.	
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 implementation.	
Where has this report been previously discussed?	
Locality meetings discussed the 2020 paper.	
Clinical Executive Sponsor:	**Dr Mehta**
Presented by:	**Roger Roberts**
Meeting Date:	**9 September 2015**
Agenda item:	
Reason for being in Part 2 (if applicable)	

General Practice Development Update

1. Introduction

1.1. This paper is not seeking approval from members but is to inform update and support debate around the proposed direction. A paper entitled General Practice 2020 was developed and circulated to practices prior to the last round of locality meetings and was then discussed at these meetings. The 2020 paper is attached in the appendix and this paper captures the feedback of the discussions.

1.2. Some elements of the future working are coming forward within

- Extended hours. Part of the Greater Manchester Healthier Together work developing primary care to support the reduction in secondary care services.
- Neighbourhood working the development of which is just starting. This paper seeks to update on progress in these areas.

2. Future of General Practice 2020

2.1. The fullest response to the paper is contained in the minutes of the Heatons and Tame Valley locality meeting. The minutes and the paper are attached.

2.2. There is acceptance that the current way of working is not sustainable. There is interest in the approach but understandable caution about the implications on the existing service given current workload and ability to recruit staff. A summary from one of the locality chairs stated that there was a feeling of strong opposition to extensive involvement of current Stockport GPs in the direct delivery of care beyond the current core and the extended hours already on offer.

2.3. There was a feeling that 7 day access to Primary Care is inevitable as it is being driven by political pressure, though that this need not necessarily be through routine GP access. There was a view that involvement of GPs need not be at a locality or neighbourhood level but that provision of an appropriate number of appointments centrally (e.g. via Mastercall) might be more appropriate, in addition to them continuing to provide a separate service for urgent and out of hours care. This might create an economy of scale as if DNA rates are high for the routine appointments, as has proved the case in the pilots for weekend opening so far, then the doctors could see or triage out of hours or urgent patients.

2.4. Provision of preventative measures, e.g. through chronic disease reviews or screening / case finding might be deliverable by other professionals at a neighbourhood level or centrally.

2.5. There was support for the neighbourhood based MDT to facilitate communication, holistic care and delivery of care plans at a neighbourhood level. There was a feeling that this team would be best employed & administered by Viaduct Health or another local provider initially but transitioning towards an evolving provider MCP corporate form, which would ultimately lead delivery in a cohesive manner when operational.

3. Extended Hours

3.1. Additional hours to extend the current 8.00am to 6.30pm contract were a commitment given by the Greater Manchester CCGs at the primary care summit in June 2015. Currently there is some provision delivered by practices as part of the national extended hours Directed Enhanced Service (DES) 30mins per 1,000 patients. This is offered by all practices in Stockport and the provision required by the DES is doubled through the local GP development scheme (total of 1hr per 1,000 patients).

3.2. To support the delivery of the additional hours Greater Manchester Area team have identified a sum of money for which CCGs can bid. A bid was prepared and submitted. The key elements of this bid are

- Offer additional capacity Monday to Friday proposed 8-8 across a neighbourhood
- 6 hours on Saturday and 4 hours on Sunday across a locality
- The service will be for patients with chronic disease and people with complex needs. It will also focus on identification of people with disease or at risk of developing disease, including health checks. The service is not designed to offer increased access to urgent care or offer a walk-in service.
- It will be supported by shared access to patient records with appropriate IM&T / IG infrastructure in place
- Standard diagnostics will be available (including pathology and transport)
- The service will be responsive to local divert schemes, including Out of Hours and 111

3.3. The bid is under review at NHS England and it is anticipated that there will be a sum of £1.2m released to support this service recurrently for four years with an additional £100,000 none recurrent project cost.

3.4. Implementation is anticipated to form part of the neighbourhood working and will form part of the programme of work in this area. It is planned that the Cheadle and Bramhall neighbourhoods will review this and consider its implementation at its meeting on 1st September.

4. Proactive Care

4.1. Neighbourhood Working

- A key part of the Stockport together work is the development of neighbourhood teams to identify and support complex care patients, find and initiate treatment of people with early long term conditions and where possible improve long term condition management moving support from reactive to proactive with a clear emphasis on supporting self-care.

- The first phase of this work is to put together the social work (SW) and district nurse (DN) teams and to link these with the practices in that neighbourhood area. The DN and SW services have identified leaders for the eight neighbourhoods. In each of the four localities there will be a neighbourhood that will be led by a nurse and another led by a social worker and they will provide professional supervision to their professional group across both neighbourhoods. The teams are being identified by neighbourhood and accommodation for the joint team is being sought. The initial location may be temporary until the full requirements of the movement of planned care and additional community services into neighbourhoods is clear.

- GP practices in the Cheadle and Bramhall locality are meeting at the moment with the wider team to start to develop the working practices they will employ. The design is not driven from above but is to be designed by the team on the ground. It is anticipated that there will be differences in the ways in which neighbourhoods will work although there will need to be sufficient commonality in approach to allow the wider services to work with them.

4.2. Other community and social care services

- As can be seen the initial team is quite small and will form the core of the neighbourhood. There are many other services that will sit around the core including mental health, third sector, therapy services and medicines management. Smaller services may not be able to be broken down to neighbourhood level but may be delivered there. This wider work to review these services has started but will take some time.

4.3. Intermediate Tier Services

- There are a range of about 20 services that sit between primary care and the hospital either to avoid admission or to support discharge. There is also substantial investment in this range of services. No current service can support a person with physical mental and social care needs. This range of services is therefore under review. An initial scoping has been undertaken and high level options defined. More work is required to come to the appropriate design for the future.

4.4. Consultant support

- The current team has no additional access to consultant support over the usual out patient access. This is being considered and the care of the elderly and psycho-geriatricians are considering how they might support this way of working. In particular hot consultant telephone support with the FT is being developed. This also contributes towards developing a outpatient process in the community and quicker, more responsive care pathway

4.5. Vanguard

- The submission for support from Vanguard will provide significant help to the proactive care work in a number of ways. It is not possible to bid for support for service provision unless this is to allow time for the service to reform then returning to the original financial envelope. There is however support in many other ways including backfill to allow the frontline staff to attend the development meetings, support for the consultants identified above to review and change their services and some IT support for the move to EMIS web for practices and the community service.

5. Conclusion

5.1. There is interest in the review of general practice services and there is good work taking place in the neighbourhood development meetings. People support the concept but significant threats are seen. The principle areas of concern are the loss of GP practice autonomy and a perceived threat that it is the start of a move to an employed service. There is concern that there is not the workforce to deliver the services and the current workforce is at and beyond capacity so any request for them to do more is not reasonable.

5.2. The seven day working proposal is likely to be accepted by NHS England soon but implementation will not be easy and is the main source of anxiety within neighbourhood working.

5.3. Proactive care is moving forward and the neighbourhood working as a concept is supported although there are still a lot of questions about resource to be resolved. Further work is underway in relation to other services that may become part of the neighbourhood service or link to it and those services that it will need to keep people out of hospital in the intermediate tier.

Appendix

Extract of mins from Heaton and Tame Valley Locality

Advantages/ benefits	• Ability to provide holistic care/joined up care within neighbourhood MDT • More convenient appointments for patients • Improved access/appointment availability • Collaboration within neighbourhoods to manage workload • Sharing expertise within neighbourhood – potential to reduce referrals • Potential to deliver more local care at weekends within a neighbourhood. • Safer discharge of patients at weekend with more MDT support. • Opportunity to allow increased screening/case finding/chronic disease management at weekends
barriers/ risks	• Loss of continuity of care – patients may not want to see a new/different GP. Reduction in patient choice outside core hours. Longer term management plans may not be followed. Patients could be over-investigated and/or over-referred. Potential risks with safeguarding when 'family' GP may have a better insight into familial/community links not visible on the medical record. Significant risk of continuity during week if GP time is to be spread more thinly across 7 days. • Potential for patients to 'doctor hop' to seek medication/referral/investigation previously declined to them. • Potential to 'sticking plaster' the patient for routine core hours care resulting in duplicating work and inconveniencing patient. • Suboptimal non-core care – impact on QoF? • Lack of governance over practice of the delegated practitioner – if we are not employing them how can we performance manage them. • Lack of access to diagnostics outside of core hours e.g. x-ray and pathology. • Increased distance of travel for patients may pose a barrier. • Increase in GP workload to manage the co-ordination of care e.g. seen at weekend and needs alteration to medications. • Practices already struggling to deliver over 5 days, let alone 7. • Low staff morale – could diminish further as there is no evidence that extending provision is what patients want or that it has positive effect on health community. • Staffing – transportation can be difficult at weekends,

	especially Sunday's. Religious beliefs may preclude weekend working. Where do the extra staff come from to cover the workload? National shortage of GPs for instance. • If practices use existing staff, who will fund the increase in hours e.g. if a nurse has a contract that states there is an entitlement to double time for weekend working? • IT – single system required but not everyone wants to move. Data sharing, read and write access to records, appointment booking. • Mastercall could be threatened if local GPs are working weekends in their neighbourhood as GPs may not want to work for OOH as well. ? Potential to increase ED attendances? • The cost?
What parts of GP2020 can be delivered and by whom?	• Urgent care – remain with Mastercall. Expand and advertise minor ailments scheme and minor eye conditions service. Potential to increase nurse specialist access outside core hours e.g. COPD and Heart failure. • Routine care – GPs to write care plans and MDT to assist in delivery. HCAs/community pharmacy – screening, high risk of DM screening, NHS Healthchecks. Medication reviews –community pharmacies. Post discharge reviews – Neighbourhood MDT – nurse/social worker primarily with GP support via Mastercall. • Chronic Disease Mgt – COPD/ASTHMA/IHD/DM reviews – practice nurses perhaps employed/based more centrally at Mastercall for example. • Routine GP care – deliverable centrally e.g. via Mastercall? Follow-ups within the same service to promote ownership mentality.
Collaboration	• Appetite for sharing clinical skills/knowledge as long as it is resourced e.g. if seeing a patient for another practice avoids a referral then this should carry a tariff to the 'seeing' practice.

NHS
Stockport
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General Practice for 2020

A discussion document for a model of general practice to support the transformation programme Stockport Together

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 is a discussion document to offer a new model of General Practice and community services. Members are invited to consider and support its further development.
Please detail the key points of this report
A proposed model of general practice is presented **This needs to fit with the wider development of services under Devolution, Stockport Together and Vanguard and link with Co-commissioning.** **Further discussion is required to develop the model to accommodate the full range of the Stockport Together design and to engage members.**
What are the likely impacts and/or implications?
This will be a key building block of future plans
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 will have a conflict at the point of making implementation decisions
Where has this report been previously discussed?

Clinical Executive Sponsor:	**Dr Gill**
Presented by:	**Roger Roberts**
Meeting Date:	**10th June**
Agenda item:	
Reason for being in Part 2 (if applicable)	

General Practice for 2020

1. Introduction

1.1. The current model of general practice is not commissioned or contracted to deliver the type of care required for the future to deliver a clinically and financially sustainable NHS and Social Care system. Devolution offers the opportunity for Greater Manchester to help shape a new primary care contractual model. The governing body endorsed commissioning for outcomes rather than activity or price as a model that they at least want to explore further and this should inform the model proposed below.

1.2. There are two models that are coming out of the five year forward view. Salford is developing the PACS (Primary and Acute Care System) model that is hospital led. The alternative model is the MCP (multi-specialty community provider) model that is being developed locally that is GP led. This is the model that is being developed in Stockport and supported by Vanguard.

1.3. The current system is the product of 'too late care' where conditions are not either prevented or detected early enough and patients' needs escalate resulting in hospital based emergency and elective care sooner or for longer than is necessary.

1.4. There is a stated desire through Vanguard that this is to change and the model will be GP led.

1.5. Stockport starts from a strong position.

- Stockport general practice is in the top quartile of performance based on diagnosis rate and treatment to target of long term conditions
- Top quartile performance nationally for treatment of CVD and Respiratory Disease
- Dementia prevalence gap is one of the smallest nationally
- GP Prescribing costs have fallen annually, now benchmark close to the England average, whilst the number of items has risen
- Highest number of training practices in North West England
- Highest rate nationally of flu vaccination coverage
- Double the "extended hours" required by the national DES
- No half day closures
- High performing (and well used) GP Out Of Hours Service still run by local GPs
- History of collaborative working in by practices, in out of hours services, practice based commissioning, premises development

and now in working in emerging groupings of 30-50,000 patients to lead proactive care teams and moving to a single electronic record for neighbourhoods.

1.6. In building a new model of care, Stockport general practice therefore provides an effective starting point.

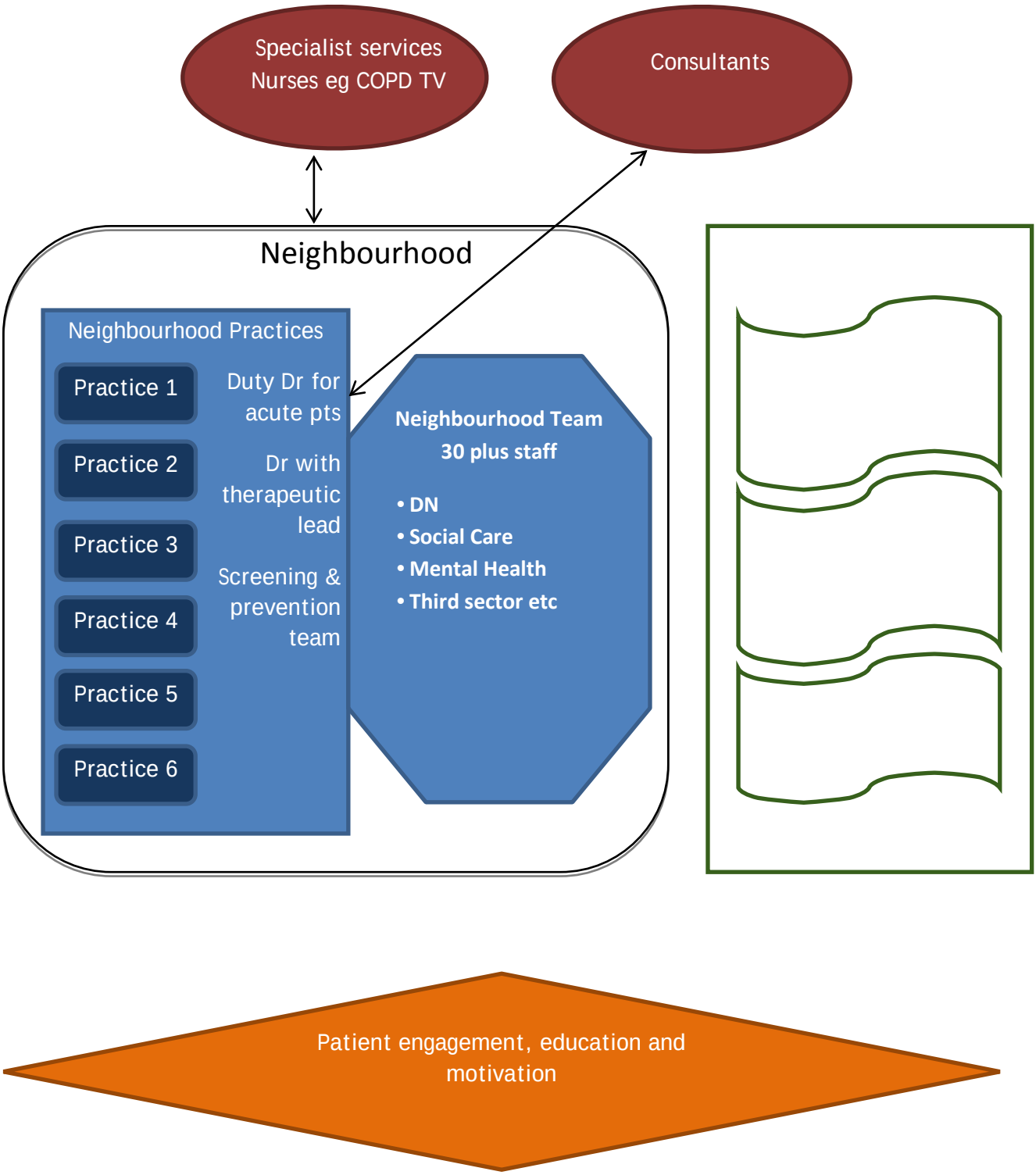
1.7. CCGs are best placed to both understand and exploit the potential of list-based primary care and the comprehensive GP medical record, and realise a new model of multi-specialty, community based general practice led integrated care.

1.8. New, advanced and extended general practice will finally be able to maximally exploit the power of both “big data” using a single electronic record, continuity of care and “people powered health”, systematically implementing primary, secondary and tertiary prevention and producing a step change improvement in outcomes.

1.9. The populations that the new model will particularly focus on would be:

- Mental Health - severe & enduring
- “Lower level” mental health(wellbeing) problems
- Those with established LTCs but sub-optimally managed
- Those with LTC(s) but not diagnosed
- Those who haven't taken up NHS screening & prevention programme offers
- Those at high risk of developing LTC(s)
- Those who are complex with multi-morbidity +/- frailty & fragmented care
- Carers
- Support for people to maintain or return to employment through rapid response to rehabilitative mental health and musculoskeletal services

2. The Model


Specialist services
Nurses eg COPD TV
Consultants
Neighbourhood
Neighbourhood Practices
Practice 1
Practice 2
Practice 3
Practice 4
Practice 5
Practice 6
Duty Dr for acute pts
Dr with therapeutic lead
Screening & prevention team
Neighbourhood Team
30 plus staff
• DN
• Social Care
• Mental Health
• Third sector etc
Patient engagement, education and motivation

2. Key Functions

2.1. Prevention and Detection

3.1.1 Prevention must be based on a much stronger public health model that makes some of the current unhealthy behaviours socially unacceptable. This will need to be led by health and social care commissioners and supported by the new model general practice being a primary Provider of Public health services.

3.1.2 New model General practice will also need to lead in the early detection of disease through screening programmes such as cytology, CVD screening etc. and support more actively the other screening programmes. It must find the missing 1000's who have disease but are not yet diagnosed. It has the patient database that would, with good data analytics support, enable some people to be identified through patterns of symptoms that have not to that point led to diagnosis or highlight those with a high risk of disease.

2.2. Optimisation and Complex Management

3.2.1 People diagnosed must, along with all the others, be educated and activated to self-manage to the best of their ability. People must be managed as a complete person within the context of their own goals and not as individual conditions (either health or social care conditions). As this becomes complex a plan might be required to coordinate the activity of a range of people in the team managed by the neighbourhood. There would be good communication across the team and no referrals enabled by a single patient record. With a care plan, supported self-care and responsive urgent care, people's needs can be managed for much longer in the community reducing the need for hospital care. The care plan through one system will travel with the patient through providers to aid in decision making and resource utilisation.

2.3. Urgent Care

3.3.1 Where people have complex conditions there will be an anticipatory plan to support them in the management of exacerbations themselves and reduce the stress that this can cause. A process will be needed to be able to respond quickly to the needs of people who might otherwise be admitted to

hospital and sufficient support available where it is required to support people though the acute phase. There is also a need to provide support in the community seven days a week for people discharged from hospital in their own home or in a temporary or permanent residential setting.

3. How does the model work

3.1. Neighbourhood

4.1.1 The general practice unit is not able to take on the range of services that the above would require in its current form and the CCG could not provide sufficient funding to support that level of care from 47 different practice sites. It is therefore proposed that the model is based on the neighbourhood. The neighbourhood model retains and strengthens the partnership general practice structure of ownership, continuity and committed clinical teams. The neighbourhood would be GP led through a management team and add to the practice system a core team of additional staff currently working in the community unit, social care, mental health and third sector.

4.1.2 Using the neighbourhood structure multidisciplinary teams are created to support the proactive care of the more complex people being cared for. This will include those in the care homes and is supported by the recent realignment of care homes to practices.

4.1.3 Working from the practice base provides a population defined as those people registered with the GP. This is then supported by a clinical record also and the possibility of working at a larger scale.

4.2 Seven day working

4.2.1 It is clear from the description of the function that the service will need to work seven days a week. Medical staffing will be required to do this and is in short supply. It is anticipated that there will be up to an additional one and a half GPs funded in each neighbourhood. This will support a number of functions.

4.3 Acute visiting team

4.3.1 A doctor from the neighbourhood will work with an element of the extended team to support the acute calls received by any of the practices in the neighbourhood about complex patients with co-morbidity and will have full access to the clinical record to see recent activity and write back any actions taken. Due to the smaller make up of neighbourhoods where required it

would be possible for a duty doctor to speak to a colleague who may have recently seen that patient if required. They would be supported by the team and may not be required to undertake all the visits. This will need to be available seven days a week at the neighbourhood level. This team would also provide support to people being discharged from hospital. This should not need GP support but will for some patients require third sector, social or nursing care. This team would however have medical back up if required.

4.4 Therapeutic management

4.4.1 GPs will provide a lot of care to people who are complex and often have multiple conditions. In a group of doctors working in a neighbourhood there will naturally be a range of therapeutic interests. It is therefore planned that there would be therapeutic leads to guide and support the care delivered to the main groups of patients. They would develop an additional expertise in this area and support colleagues with other areas of interest so that there is a levelling up of care across conditions. Uniform templates for nurse management would be used to optimise care. The lead person would act as a link between the consultant and the neighbourhood team in that particular therapeutic area.

4.5 Screening and prevention

4.5.1 For this work there is a need for some able IT support to interrogate the clinical systems to find those people who are not yet diagnosed but may require follow up, life style intervention or screening. All of this will be offered seven days a week so that there is no barrier to the working person. The interventions should be provided by a team of health care assistants (HCA), health trainers, assistant practitioners and Nurses who will have the time to educate, negotiate, motivate and support the required change and then follow that up. This will provide an additional cohort of people for medical management and nurses will be required to deliver much of this early care.

5 Key development areas

5.1 Workforce

5.1.1 Workforce in the form of both nurses and doctors is going to be a difficult issue and other groups are going to have to be considered in the delivery of care thus using the skills that are in short supply where only they can provide the care required.

5.1.2 There is a need for large numbers of lower level staff who will have the time to spend with people and do the practical tasks required. The assistant practitioners with a mix of health and social care skills are a key group for development. Allied health professionals and pharmacists may also require development to be able to fill some of the potential gaps in the medical and nursing workforce.

5.2 Information Technology

5.2.1 A key enabler is for the health part of the system to use a single IT system. It is unlikely that this will extend to the social care part of the system other than in summary form as the system in use also manages charging systems that are not required in health.

Developing muti-agency access to the care plan is pivotal to success. We also need to develop tools to track patients through the system and provide flag indicators to the neighbourhood teams for action. This needs to be automated and easy to access whenever possible. Interim solutions maybe needed until a more robust solution is obtained from providers.

5.3 Estates

5.3.1 This additional activity and the staff required to deliver it will require the space to provide it with the associated support including the IT hardware, software and support, the access estates services, pathology services etc.

5.4 Public engagement/ education

5.4.1 An element that has been raised many times is the activation of the public to use services correctly, to self-care, self-manage and to lead a healthy lifestyle. This is an essential element and some of the bigger publicity messages require that we work on a footprint larger than Stockport and would be ideal to be managed across Greater Manchester under the devolution heading to support both health and social care. There is more that can be done locally too in extending the self-help groups and making it easier to pass people to these groups so that there is more peer support. A first draft of one element of this is a "new contract" with the public that can be seen in the appendix.

5.5 Service Provision Hours

5.5.1 Extending hours as discussed above is important. It is anticipated at the moment that the acute out of hours will remain with an out of hours provider (currently Mastercall). In addition to this in the neighbourhoods will be the service that will screen, review and manage long term condition people in booked appointments. It will also provide the support to the acute visiting team for the people that it knows and is managing effectively as a ward in the community. It will accept those patients that are discharged from hospital and require additional care to enable them to stay at home. The medical component of this will be small and the service will be delivered on a neighbourhood basis

6 Questions for discussion

6.1.1 If practices work more closely together what is required to enable this e.g. IT, phones etc.

6.1.2 What sort of activity does it make sense to do together e.g. Visits, additional hours, acute care, LTC finding etc.

6.1.3 What are the key estates issues that will need to be addressed to make this style of working successful

6.1.4 How should the integrated team be managed across the neighbourhood.

Roger Roberts June 2015

Compliance Checklist:

Documentation		**Statutory and Local Policy Requirement**	
Cover sheet completed	Y / N	Change in Financial Spend: Finance Section below completed	To follow
Page numbers	Y / N	Service Changes: Public Consultation Completed and Reported in Document	n/a
Paragraph numbers in place	Y / N	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	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	n/a
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	Y / N

Appendix 1

Advice to Individual Citizens of Stockport.

1. Follow the five ways to wellbeing

- Connect – with friends, family, colleagues and neighbours – think of these people as the cornerstones of your life and invest time in them

- Be active– go for a walk, run. Step outside, play, garden or dance. Find an activity you enjoy and suits you, being physically active makes you feel good

- Take notice – be curious. Savour the moment and appreciate what matters to you.

- Keep learning – try something new or rediscover an old interest. Learning new things is fun and boosts confidence.

- Give – do something nice for a friend, or a stranger. Smile. Volunteer your time.

2. Stop Smoking: Use a smoking cessation service if you need help. If you can't give up on your own then try a Quit Smoking Group. If you are addicted to nicotine, consider other sources of nicotine, such as nicotine chewing gum or nicotine patches. You are more likely to successfully quit if you get help from the NHS Stop Smoking Service. Help is available at your GP practice, from some pharmacies in Stockport and also from our specialist advisers in the Healthy Stockport service. Visit http://www.healthystockport.co.uk/ for more information or call 0161 426 5085

3. Be physically active: Adults should aim to be active daily. Over a week, activity should add up to a minimum of 150 minutes (2½ hours) of at least moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week
Use the stairs and walk those short journeys. Cycling is a great way to get more exercise over slightly longer journeys, consider using your local leisure services for a swim or fitness class or go to a dance class with your friends.
Children over walking age should be physically active for at least three hours a day, and 5-18 year olds should be physically active for at least an hour a day. Again, this should be at least moderate intensity

This activity can be achieved in different ways, visit http://www.healthystockport.co.uk/ for more information. For babies not yet walking, physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments. Both adults and children should minimise the amount of time they spend being sedentary (e.g. sitting) for long periods (except when sleeping).

4. Drink sensibly: If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. Use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx

For example the following are all about 3 units: a pint of 5.2% lager; or a pint and a half of 3.2% beer; or a large (250ml) glass of 12% wine.

5. Eat a healthy diet: Choose low-sugar, low-fat, high-fibre versions of the foods you eat and eat less red meat. Eat at least 5 portions of fruit & vegetables each day. You should also add less salt in cooking and at the table.

6. Keep a healthy weight : Maintain, or aim for, a healthy weight (adult BMI healthy weight range is 18.5-25kg/m2; healthy BMI for children is within the 2nd-90th percentile for their age and gender). BMI can be calculated by weight (kg) divided by height (m) squared (i.e.kg/m2).

6. Use NHS screening services: Take up all opportunities for screening whenever you are invited to participate in NHS screening programmes.

7. Take up opportunities for vaccination and immunisation: Ensure children receive all the vaccinations recommended and keep your own vaccinations up to date. If you are over 65, if you are pregnant, or if you are under 65 and in an at-risk group, have your annual flu immunisation. Take health advice before overseas travel and have appropriate vaccinations, malarial protection etc.

8. Look after your sexual health: Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both. Remember that having multiple sexual partners increases the risk of HIV/AIDS, gonorrhoea and syphilis, cervical cancer and pregnancy.

9. Protect yourself from sunburn: Enjoy the sun safely. Protect yourself by using shade, clothing (including a hat, t-shirt and UV protective sunglasses) and high SPF (sun protection factor) sunscreen, and by avoiding the sun during the middle of the day. Avoid artificial ultraviolet radiation too – don't use sunbeds or sunlamps.
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10. Reduce stress: Talking things through, relaxation and physical activity can help. Find time to relax and share your worries with friends and partners. Demand training for responsibilities of which you are unsure. Try to plan your work to reduce pressure around deadlines. Developing interests outside of work can help reduce stress and improve productivity. You can also minimise stress by socialising and by contributing to your society.

11. Avoid accidents:
Install and regularly check smoke alarms in your home.

Drive at 20mph on side roads and wear seat belts in cars, crash helmets on motor cycles and cycle helmets on bicycles. talk to your health visitor about preventing home accidents to toddlers.

12. Protect the environment
You can help to protect the environment by using public transport whenever possible (this also helps you get more physically active). Use environment-friendly products and recycle wherever possible.

13. Avoid infectious diseases
Keep up to date with all vaccinations, and wash your hands regularly when visiting or caring for sick people. You should observe good respiratory hygiene (when coughing or sneezing, catch those germs in your tissue and then bin it).

For more detail about staying healthy, visit:
http://www.healthystockport.co.uk/where you can access advice, tools to help you manage your own health, and free, confidential local support to make positive lifestyle changes.

NHS
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Planned Care

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?
For the Governing Body to decide whether the CCG continues to pursue with the projects described within this paper in their current format and within their current timescales.
Please detail the key points of this report
Projected achievements of the pathway optimization, EUR and referral variation projects within the Planned Care Programme of work
What are the likely impacts and/or implications?
The impact and implications are outlined in the main body of the report.
How does this link to the Annual Business Plan?
These projects link directly to; PLC1: Maximise adherence with EUR PLC3: Optimized Care Pathways PLC4: Reduce Referral Variation PLC5: Improving Value for Money
What are the potential conflicts of interest?
None identified
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Dr Cath Briggs
Meeting Date: 9th Sept 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Background
The CCG's Operational Plan describes five change projects for planned care that will be delivered in 2015-16. This report will provide an update on four of the projects. These are:

PLC1: Maximise adherence with EUR
PLC3: Optimized Care Pathways
PLC4: Reduce Referral Variation
PLC5: Improving Value for Money

PLC1: Maximize Adherence with EUR
The CCG has set a target to reduce the number of inappropriate EUR treatments referred and accepted and by doing this £500k could be saved over the next two years. The proposal within the Plan was that this would be achieved by the following actions;

1. Reduced referrals by ensuring any potential EUR referrals are reviewed within Practices.
2. Referral triage within secondary care.
3. Listings process review within secondary care.

Progress to date:

1. EUR referrals within practices are being addressed as part of the initiative to reduce referral variation. (See PLC4 below)
2. Discussions have taken place with multiple specialties within the trust and it has been found that there is no consistent approach to triage of referrals taking place. Therefore it has been agreed that referral triage will be part of the Stockport Together system wide reform with IT enablers to support the change to process. To date the following steps have been taken
    - Initial agreement has been reached between SNHSFT and GP representatives that any patients that present in out-patient clinics who do not meet EUR criteria will no longer be automatically listed for surgery. Instead where it is found that conservative treatment has not been tried prior to referral the patient will be referred back to their GP. This will be monitored via the Planned Care Board.
    - The Planned Care Board has agreed to focus on delivering a reduction in the removal of benign lesions and of carpel tunnel surgery and there has been agreement with the orthopaedic and dermatology business managers to focus on the areas within their jurisdiction. This will be managed via the Operational Delivery Group which reports to the Planned Care Board and ultimately the Integrated Care Board.
    - Changes to the Greater Manchester EUR Policy that are due to be implemented in January 2016 will mean that treatments including facet joint injections for neck and back pain and ultrasound and pulse electromagnetic systems (PES) for bone healing will not ordinarily be available unless there is felt to be exceptional clinical circumstances.
    - Although the GM policy has been out to consultation, it is not likely that the GM policy will be fully implemented before the beginning of 2016 therefore it is recommended that the CCG formally write to SNHSFT, FES provider and practices in September to state our intention to decommission FES, TES PES, RD and FJI treatments from October 2015. It is projected that savings will be evident from December 2015.

It is projected that a reduction in activity will not be reflected in the data until October. Please see Appendix I for the projected Cumulative Benefit Realisation for PLC1, 3 and 5.

PLC3: Optimized Care Pathways

The project will streamline pathways of care, raising the quality of the patient experience and ultimately reduce the number of Outpatient First Appointments (OPFA) and Outpatient Follow Up (OPFU) and diagnostic appointments.

Progress to date:

- Primary and secondary care clinical teams across 10 specialties have worked together to identify 35 pathways of care that require re-design.
- Via the Operational Delivery Group and Planned Care Board there has been an agreement to focus on redesigning the pathways that will potentially deliver the greatest cost benefits. There will be a phased approach to delivering improvements to all the pathways identified.
- Collaborative work has been undertaken with SNHSFT to develop and agree the spinal pathway enabling patients to be seen and treated when clinically necessary. To support the trust to procure capacity within the system the CCG has extended the CCG contract with Care UK until August 2016. Once the service specification is agreed it is planned that the pathway of care will be transferred to SNHSFT.
- A protocol for the management of Consultant to Consultant referrals has been agreed with SNHSFT. Presently in the region of 33% of out-patient appointments are generated from consultant to consultant referrals. Certain clinical circumstances require patients to be referred directly from one consultant to another; however, often these conditions may be more effectively managed in the primary care or community setting. It is proposed that financial benefits to this protocol will be realised incrementally from Q3 2015 to end of Q4 2016 and that a reduction in activity will not be reflected in the data until October. Please see Appendix I for the projected Cumulative Benefit Realisation for PLC1, 3 and 5.

Risks

- At the time of this report only 10% of the pathway changes identified have had their benefits currently tracked and signed off. It was planned that this work would be completed by mid July, however this timescale has slipped due to the lack of resource at the FT to complete this piece of work and the ability to pull together the data required from reporting tools available. To mitigate this it was agreed that prevalence data would be used where Stockport specific data was not available, therefore by the end of August the completed benefit tracker and project plans will be presented to allow decisions about which areas to focus on initially and agree the phased approach to rollout/delivery (e.g. highest impact areas first).
- As a result of the above the financial targets within the benefit trackers start in Q3 2015 and this slippage will cause benefit realisation to be at risk. It is intended that pathway redesign will deliver a reduction in a £859,673 spend to the CCG but at this stage it is not possible to report the breakdown of activity to first, procedures or follow up appointments. This issue has been escalated to the SRO.
- There is a possibility that SNHSFT will not be able to meet the service specification required for the Spinal Care Pathway from August 2016. If this occurs the CCG are able to re-procure this service via AQP.
- The consultant to consultant referral protocol may increase the number of GP referred first outpatient referrals. Whilst in cost terms this should be offset by a reduction in the number of consultant to consultant referrals the Governing Body should be aware of this potential impact. However the project teams will monitor referral behaviour to ensure that this work is supportive to reducing overall referral volumes.

PLC4: Reduce Referral Variation

As set out in the CCG Operational Plan as agreed by Governing Body the aim of this project is to flat line GP first outpatient appointments ensuring that the total number does not exceed 56,503 in 15/16 or 16/17.

Approach
As reported in the last briefing, the concentration initially has been on ascertaining the specific detailed reasons for the high number of referrals in individual practices. 19 practices have been identified to work with on addressing this issue. These are either practices in the highest referring quartile or in the highest referring locality (Cheadle & Bramhall). 17 have been visited to date. 9 of these have undertaken and completed an audit based on 3 months of data for patients who had been coded as discharged at first outpatient appointment. The other 8 practices are in the process of arranging to undertake an audit. The early findings of this audit support the hypothesis that the reason behind the high number of referrals is multifactorial. Please see Appendix II for learning points.

Progress to Date

- 17 of 19 practices have been visited and action including audit agreed
- A target data monitoring spread sheet of practices in the top quartile have been developed
- Initial audit findings have been gathered.
- Solutions to issues found as a result of the audits undertaken by GP practices are being developed. These include:-
    - A simplified quick reference guide of the EUR Policy has been made available to GP Practices.
    - The EUR policy has been updated on the CCG website to include hyperlinks to prevent clinical staff having to trawl through a lengthy policy to find the correct reference point.
    - A mechanism for GPs to obtain quick access to specialist consultant advice has been identified.

Next 3 Months
In order to address the learning points a twin track approach will need to be taken. The team will work with individual practices as well as working more strategically to develop CCG wide solutions.

System wide work:

- Key target data monitoring spread sheet will be shared with practices.
- A demonstration of 'Consultant Connect' the mechanism for GPs to obtain quick access to specialist consultant advice will be arranged for consultants and GPs.
- Enhanced data packs will be sent to every GP practice monthly.
- Review of ophthalmology / ENT clinical pathways.

Work with individual practices to:

- Ensure that monthly referral peer review meetings are taking place and effective.
- Find solutions to communicating changes to individual GPs so that they are noted and understood.
- Identify and arrange specific training in specialist areas.

Current Position
The Operational Plan assumed the impact of this project would begin to be evident by summer. However, at the time of writing this report it was found that there was some inconsistency with the data provided and therefore it is not possible to provide an accurate picture of where the CCG stands currently against that projection.

Risks

- Delayed start and time to run preliminary audits and look at reasons behind the variation in referral practice has meant that the benefits of this project are not being realised.
- The small size of the team means that focussed work with individual practices can only happen with one or two practices at any one time.
- If there is significant growth in other practices in the second and third quartile there will be insufficient resource to address these in a similar manner
- Neighbourhood working has begun in Cheadle & Bramhall; this area however is also the focus of the referral project and the commitment required from GPs to develop neighbourhoods makes it more difficult to engage practices to focus on referrals.
- Inconsistency / inaccuracy of business intelligence has created some delays and difficulties when working with GP practices.
- Even with accurate data the CCG may not be able to identify, in the short term, any benefits from the way in which current performance data is collected as it is based on hospital first outpatient clinic attendance. Therefore it is probable that any capacity that this work produces will be filled by patients currently on a waiting list.

PLC5: Improving Value for Money

The current tariff system may not be ensuring best value for money across a range of services, an example of this is the ear-suction pathway of care.

Previous analysis showed that approximately 22% of the annual ENT activity at SNHSFT was consumed by ear suction clearance. During the month of January 2015, all patients on the ear suction pathway of care suitable for primary care were discharged following a Stockport GP review and collaborative work with the consultant ENT team at SNHSFT. The pathway of care has been re-designed to support GPs and secondary care clinicians to ensure that only patients meeting strict clinical criteria are referred for treatment and where possible patients, on a needs basis, should be referred to Care UK and patients are offered a one off treatment and no follow up appointments post treatment.

For the months January-March 15 there has been a 22% reduction in the number of patients treated within the SNHSFT ENT clinics, and in April-June a 16% reduction compared to the same period 13-14. To date there has been approximately 200 patients discharged.

The CCG has seen only a slight increase of 16 referrals to Care UK comparing the period Jan-Jun 2014 to Jan-Jun 2015. By observing the number of referrals to Care UK the CCG will have a good understanding of the true demand for the micro-suction clearance of ears should we decide to re-commission this following the closure of the GMCATS contract.

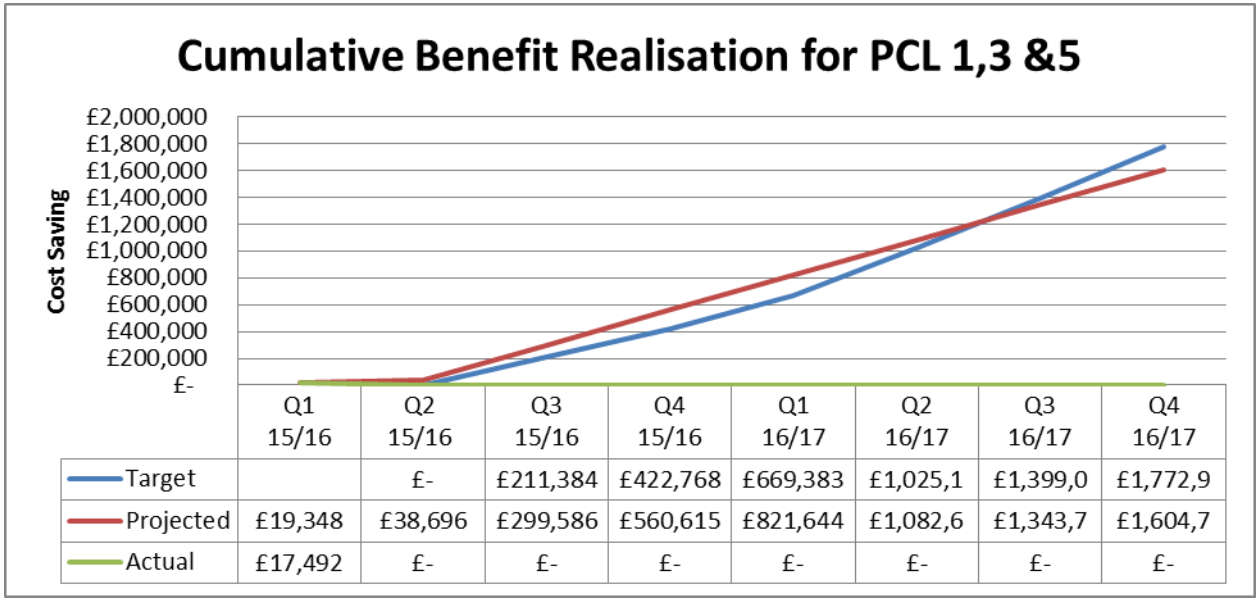
The Care UK contract will discontinue receiving referrals from the end of January 2016 and the CCG may consider producing an options appraisal paper to decide whether to re-commission this pathway of care from an alternative provider, or de-commission this pathway under the Effective Use of Resources policy.

Action

It is proposed that the Planned Care projects close at the end of Q4 2016 with activity levels reduced as part of the contract negotiation in 2017. Until that time, contracted levels will continue at the current agreed levels of activity. By 2017 it is expected that the aforementioned changes to practice will be business as usual and growth to be managed via the new way of working. Evidence of benefits will not be captured with payment for actual activity levels until Q3 and it is questioned whether the CCG is able to wait for the projects to deliver their outcomes or consider contract changes at an earlier date. The Board is asked to consider

whether the CCG continues to pursue with the projects described within this paper in their current format and within the current timescales.

Appendix I



	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Target		£-	£211,384	£422,768	£669,383	£1,025,1	£1,399,0	£1,772,9
Projected	£19,348	£38,696	£299,586	£560,615	£821,644	£1,082,6	£1,343,7	£1,604,7
Actual	£17,492	£-	£-	£-	£-	£-	£-	£-

Appendix II

Learning Points from Audit to Ascertain Specific Details for High Number of Individual Practices

- Practices' not referring to the EUR Policy because either they felt it was unclear or because the length of the document meant that clinicians did not feel that they had **time in practice** to begin reading it.
- **Long wait times for physiotherapy** has led to many practices have chosen to refer their patients to the Orthopaedic Triage Service because it is known that assessment and access to physiotherapy is quicker by this route.
- It was felt by practices that **direct access to some diagnostics** would help prevent unnecessary referrals, such as musculoskeletal ultrasound scans for elderly patients who complain of shoulder pain.
- A **review of the ENT/Audiology and Ophthalmology clinical pathways** is possibly required as practices complained that this was often unclear or that they were just acting as a 'post box' from optician to consultant ophthalmologist or from audiologist to ENT consultant.
- The **raising of patient expectations by hospital consultants** were a concern raised by GPs. It was found that GPs often receive letters either advising that a patient needed to be seen by another consultant specialist and thus patents then feel that they should not be treated in primary care.
- Having to **refer existing patients of SNHSFT back to them** for a first outpatient appointment to the audiology department because of 'patient choice' was also felt to be a waste of financial and physical resource.
- The audit flagged that the CCG needs to review the way in which it **communicates changes to pathways to GPs** as even in the small cohort of practices that we worked with over half were not aware of the microsuction service for each syringing available via Care UK.
- There were a number of patients who on review of the data had either DNA'd or turned up for the consultation to advise that the problem had resolved. This would indicate that some patients were **being referred too soon** and that a 'watchful waiting' approach would have been more appropriate, particularly in orthopaedics.
- Overwhelmingly practices identified that it would be useful to be access **consultant advice quickly** for either to avoid a referral or to ensure appropriate work up prior to referral.
- GPs identified the need for more work to be done by both the practice and the CCG around **patient expectations**, specifically with regard to patients understanding the consequences of not attending the appointment, patients understanding the possible treatment options including surgery and whether they will be prepared to proceed with their referral on this basis, patients demanding a referral to a specialist when clinically it is felt not to be necessary.

NHS
Stockport
Clinical Commissioning Group

Finance Report July 2015 – Month 4

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 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. **Acknowledge** the significant risk (£2.691k) reflected in the forecast position being:
   (i) delivery of proposed additional CIP / Draft Recovery Plan (£1,082k) and
   (ii) additional yet to be identified CIP (£1,609k) needed to ensure delivery of the planned £1.75m surplus.

3. **Note** 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. **Acknowledge:** additional net risk totalling £1.5m not within the forecast position

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

6. **Acknowledge:** 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.

Please detail the key points of this report

- Actual surplus reported as at Mth 4 (YTD) of £1k which is £584k below plan.

- CCG would be forecasting c£1m deficit without the inclusion and the assumption of full £2,691k additional recovery measures to address this.

- Risks with a most likely financial impact of £1.5m have been identified although not factored into the financial position at this stage.

What are the likely impacts and/or implications?

Delivery against statutory financial duties and financial performance targets.

How does this link to the Annual Business Plan?

As per 2015/16 Financial Plan.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?
Governing Body only
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gary Jones
Meeting Date: 9th Sept 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

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

1.0 Introduction

This report provides an overview on the CCG's performance against its Statutory Financial Duties and Performance Targets highlighting both year to date and forecast in 2015/16.

This report provides an update on:-

- The financial position as at 31st July 2015
- Forecast outturn position for 2015/16

2.0 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 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 4)	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		

3.0 Financial Position as at 31st July 2015

The financial position as at month 4 is summarised in Table 2 below with further detail provided in Appendix 1 to this report.

Table 2: Summary of Financial Position at Month 4

	Plan (Surplus) / Deficit £000s	Actual (Surplus) / Deficit £000s	(Favourable) / Adverse Variance £000s
Month 4 YTD	(585)	(1)	584
Year End Forecast	(1,750)	(1,750)	0

The above table shows that there is a £584k YTD adverse variance to plan. At this early stage of the year, the CCG is continuing to forecast to deliver its planned surplus of £1.75m in 2015/16. However, members should note that the delivery of the CCG forecast planned surplus comes with **significant risk** as this is dependent upon:

- No further deterioration in the CCG's financial position
- Delivering additional saving of £2,691k of which £1,609k is still to be identified.

4.0 Healthcare Contracts (Acute, Mental Health, Community Health, Continuing Care, Primary Care and Other)

Acute

The financial position of the CCG is largely driven by the performance of secondary care commissioned activity against contract levels which incorporated the estimated impact of Cost Improvement Programme (CIP) schemes.

As at month 4, the year to date position is £1.56m overspent with a forecast overspend of £3.9m. The YTD and forecast position reflects the deployment locally of the £0.9m performance fund held as part of the Better Care Fund to support NEL over performance. Our performance against our main contract areas is as follows:-

Stockport FT – as at month 4 the reported position for Stockport FT is a year to date overspend of £535k. This is largely due to forecast pressures within:

- Elective - £1.45m
- Outpatients - £1.2m
- Non-elective - £0.9m

The above pressures are partially offset by underspends within:

- Critical care – (£1.45m)
- Maternity – (£0.3m)
- Neuro-Rehab – (£0.3m)

University Hospital South Manchester FT – the month 4 position for UHSM is a year to date overspend of £257k which is largely attributable to pressures within Non-Elective (£744k).

Central Manchester FT – the year to date position for CMFT is £215k overspent in the following areas:

- Drugs and devices - £341k
- Fertility - £248k
- Macular - £246k

These pressures are partially offset by underspends within Elective (£222k) and Non-Elective Non-Emergency (£406k).

Independent Sector – Overspend within independent sector continues to be a key risk area for the CCG. As at month 4 the year to date position for sndependent sector is £490k overspent against plan in the following areas:-

- Trauma & Orthopaedics
- General Surgery
- Gastroenterology
- Ophthalmology

Community Health

This area of spend is in line with plan. Members should note that this budget area incorporates the majority of the services funded from the Better Care Fund. The financial position of the Better Care Fund is agreed with SMBC and reflects the position reported to the Health & Wellbeing Board.

Continuing Care

This budget line includes the cost of continuing care placements for both children and adults. This budget also reflects the CCG's contribution to the National CHC risk share of £2.1m. Members should refer to the narrative on CIP to make the links between this £2.1m contribution to national pool and £1.5m CIP target (section 7 refers).

Mental Health

As at month 4 there is an underspend of £217k with a forecast underspend of £583k. This is due to the cessation of the contract with Calderstones with effect from 31/08/2015 where charges will 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.

5.0 Prescribing

The latest information from the NHSBSA provides actual prescribing expenditure for April and May 2015. As this information is published 2 months in arrears, an estimate for June and July has been made in arriving at the cumulative position to July 15.

As at month 4 the prescribing budget is £350k overspent year-to-date with a forecast overspend of £1.0m based on local projections (as the NHSBSA only issue prescribing forecasts from August onwards).

Prescribing continues to be a key risk for the CCG with costs increasing by c8% compared to 2014/15 and a planned increase of 3%. The main reasons for the prescribing overspend are Cardiovascular drugs (Anticoagulants and Protamine) and Endocrine (Drugs in Diabetes), largely as a result of patients switching medication following recently released NICE guidance.

A significant investment was made through the GP development scheme to support GP Practices whose prescribing levels are above the national average to reduce growth. It is not anticipated that the full impact of this initiative will not be realised until the second half of the financial year once pharmacists have been recruited.

6.0 Running Costs (Corporate)

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	353	289	(64)	1,060	1,060	0
CCG Admin	1,669	1,671	2	5,364	5,364	0
Total CCG Running Costs	**2,022**	**1,960**	**(62)**	**6,424**	**6,424**	**0**

The under spend on running costs is largely attributable to a reduction in charges received from the GMCSU as a result of the revised SLA for 2015-16.

7.0 Reserves

Table 1 of Appendix 2 sets out the reserves held at month 4.

Investments – include national "must do's and those agreed collaboratively at a local GM level i.e. GM Risk share (£1.8m). 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

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

Savings & Efficiency – the (£3.765m) reserve reflects the remaining value of CIP savings not yet embedded within expenditure budgets. Table 4 below provides details of these CIP schemes.

Table 4: CIP schemes not yet embedded

QIPP Scheme	Value
1) Other Funded CIP	£1.815m
2) CHC National Risk Pool	£1.500m
3) Quality Premium	£0.450m
Total Mitigation	**£3.765m**

The CHC Risk pool CIP is planned to be delivered via a combination of
(i) GM Risk pool support £0.5m and;
(ii) return of underspend on national pool of £1m.

In addition to the above CIP, the forecast assumes that the proposed recovery plan measures of £1,082k are agreed and delivered in 15/16 as well as further saving of £1,609k yet to be identified.

8.0 Financial Risks and Mitigations not in Forecast

The table below illustrates the key financial risks facing the CCG which and £1.5m of unmitigated risk which has not been incorporated into the forecast position as at month 4. These financial risks are kept under constant review.

Financial risks and mitigations not in forecast position:

Risks	Risk Value	Reason
Acute SLAs	£1.0m	Case mix / price pressures
Prescribing	£0.5m	NICE TAs, Volume & Prices increases
Total Risk Exposure	**£1.5m**	

Acute SLAs: There is a potential risk that there is continued overperformance on the Acute and AQP/IS contracts above levels reported within the month 4 forecast position. This is on a worst case basis.

Prescribing: Volume and price increases continue to impact prescribing spend. Recently released NICE guidance has also resulted in significant increases in Cardiovascular and Endocrine spend. There is also the added risk of price increases in Category M drugs (this risk materialised in 14/15) which will result in additional cost pressures for same level of volume for these drugs.

In addition to the above risks members should note that the forecast position assumes £1,609k of additional unidentified CIP will be delivered and the therefore there is significant risk of the CCG not achieving its planned £1.75m surplus.

9.0 Balance Sheet

Appendix 3 details the CCG opening balance sheet as at 1st April 2015, closing balance sheet as 31st July 2015 and a forecasted balance sheet as at 31st March 2016.

10.0 Recommendations

The Governing Body is asked to:-

I. **Note** the year-to-date underachievement of £584k against plan surplus as at 31st July 2015 and forecast delivery of the £1.75m surplus target.

II. **Comment and Acknowledge** the significant risk (£2.691k) reflected in forecast position being
   a. delivery of additional CIP schemes (£1,082k) and
   b. additional yet to be identified CIP schemes (£1,609k) needed to ensure delivery of the planned £1.75m surplus.

III. **Acknowledge:** additional net risk totalling £1.5m not within the forecast position

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

V. **Acknowledge:** 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.

Gary Jones
Chief Finance Officer
28th August 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

NHS STOCKPORT CCG - FINANCIAL PERFORMANCE REPORT 2015-16

Month 4 - as at 31st July 2015

	YTD (Mth 4)				Forecast 15/16				
	Plan £000s	Actual £000s	Var £000s	Var %	Plan £000s	Actual £000s	Var £000s	Var %	RAG RATING
Revenue Resource Limit (RRL)									
Confirmed	(127,968)	(127,968)	0	0.0%	(378,802)	(378,802)	0	0.0%	G
Anticipated	0	0	0	0.0%	(598)	(598)	0	0.0%	G
Total RRL	**(127,968)**	**(127,968)**	**0**	**0.0%**	**(379,400)**	**(379,400)**	**0**	**0.0%**	G
Net Expenditure									
Acute	73,333	74,897	1,564	2.1%	219,974	223,880	3,906	1.8%	R
Mental Health	10,475	10,258	(217)	(2.1%)	31,503	30,920	(583)	(1.9%)	G
Community Health	11,976	11,966	(10)	(0.1%)	35,929	35,929	0	0.0%	G
Continuing Care	7,096	7,088	(8)	(0.1%)	17,073	17,070	(3)	(0.0%)	G
Primary Care	4,081	3,953	(128)	(3.1%)	12,374	12,212	(162)	(1.3%)	G
Other	1,257	1,254	(3)	(0.2%)	3,857	3,257	(600)	(15.6%)	G
Sub Total Healthcare Contracts	**108,218**	**109,416**	**1,198**	**1.1%**	**320,710**	**323,268**	**2,558**	**0.8%**	R
Prescribing	16,241	16,591	350	2.2%	48,723	49,723	1,000	2.1%	R
Running Costs (Corporate)	2,022	1,960	(62)	(3.1%)	6,424	6,424	0	0.0%	G
Reserves (Ref: Appendix 2 - Table 1)	902	0	(902)	(100.0%)	1,793	926	(867)	(48.4%)	A
Total Net Expenditure and Reserves	**127,383**	**127,967**	**584**	**0.5%**	**377,650**	**380,341**	**2,691**	**0.7%**	R
Additional Proposed CIP	**0**	**0**	**0**	**0.0%**	**0**	**(1,082)**	**(1,082)**	**0.0%**	A
Additional Unidentified CIP	**0**	**0**	**0**	**0.0%**	**0**	**(1,609)**	**(1,609)**	**0.0%**	**R**
TOTAL (SURPLUS) / DEFICIT	**(585)**	**(1)**	**584**	**(99.8%)**	**(1,750)**	**(1,750)**	**0**	**0.0%**	R

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**

SUMMARY OF RESERVES
Month 4 - as at 31st July 2015

Table 1 - Reserves Summary

	Reserves Held Mth 4	Commits Mth 4 onwards	Forecast Bals Year End
Amounts Held in CCG Reserves	**£'000s**	**£'000s**	**£'000s**
Investments - National	3,371	2,454	(917)
Investments - Greater Manchester	1,809	1,809	0
Contingency	365	0	(365)
In-Year Allocations	13	13	0
CIP - Not embedded in budgets	(3,765)	(3,350)	415
Total Reserves	**1,793**	**926**	**(867)**

Table 2 - Cost Improvement Programme (CIP)

CIP Schemes	YTD			Forecast			Recurrent			Non Recurrent			RAG Rating
	Plan	Achivement	Variance	Plan	FOT	Variance	Plan	FOT	Variance	Plan	FOT	Variance	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
CIP Embedded in Expenditure Budgets													
Wet AMD	(164)	(103)	61	(500)	(103)	397	(500)	(103)	397	0	0	0	
Prescribing Initiatives	(108)	0	108	(325)	(269)	56	(325)	(269)	56	0	0	0	
VFM Procurements	0	0	0	(200)	0	200	(200)	0	200	0	0	0	
GP Development Prescribing	(312)	0	312	(944)	0	944	(944)	0	944	0	0	0	
Elective	0	0	0	(1,504)	(334)	1,170	(1,504)	(334)	1,170	0	0	0	
Outpatient	(72)			(1,150)	0	1,150	(1,150)	0	1,150	0	0	0	
Non-Elective Activity	(391)	0	391	(2,603)	(1,227)	1,376	(2,603)	(1,227)	1,376	0	0	0	
Sub-Total	**(1,047)**	**(103)**	**872**	**(7,226)**	**(1,933)**	**5,293**	**(7,226)**	**(1,933)**	**5,293**	**0**	**0**	**0**	
CIP not Embedded in Expenditure Budgets													
Quality Premium	0	0	0	(450)	(450)	0	0	0	0	(450)	(450)	0	
Return of CHC Risk Pool Underspend	0	0	0	(1,500)	(1,500)	0	0	0	0	(1,500)	(1,500)	0	
Other CIP Schemes	0	(1,400)	(1,400)	(1,815)	(1,400)	415	(1,815)	0	1,815	0	(1,400)	(1,400)	
Sub-Total	**0**	**(1,400)**	**(1,400)**	**(3,765)**	**(3,350)**	**415**	**(1,815)**	**0**	**1,815**	**(1,950)**	**(3,350)**	**(1,400)**	
Total	**(1,047)**	**(1,503)**	**(528)**	**(10,991)**	**(5,283)**	**5,708**	**(9,041)**	**(1,933)**	**7,108**	**(1,950)**	**(3,350)**	**(1,400)**	

Table 3 - 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.	July YTD	
	Number	£000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	3,088	24,178
Total Non-NHS Trade Invoices Paid Within Target	3,014	23,566
Percentage of Non-NHS Trade Invoices Paid Within Target	97.60	97.47
NHS Payables		
Total NHS Trade Invoices Paid in the Year	779	85,569
Total NHS Trade Invoices Paid Within Target	755	85,538
Percentage of NHS Trade Invoices Paid Within Target	96.92	99.96
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	3,867	109,747
Total NHS Trade Invoices Paid Within Target	3,769	109,104
Percentage of NHS Trade Invoices Paid Within Target	97.47	99.41

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 3 - Summary of Notified and Anticipated Allocations

	Recurrent Budget £'000	Non Recurrent £'000	Total £'000	Still Held in Reserves £000.s
Opening Baseline Allocation	(378,802)		(378,802)	
In Year Notified Allocations				
Month 3 - GPIT		(777)	(777)	
Month 3 - GPIT - Transition Funding		(158)	(158)	
Month 4 - Vanguard: MCP - Stockport Together		(150)	(150)	
Month 4 - MH PbR Risk Share		500	500	
Month 4 - IAPT Waiting list validation & improving processes		(13)	(13)	(13)
TOTAL ALLOCATIONS	**(378,802)**	**(598)**	**(379,400)**	**(13)**

NHS STOCKPORT CCG BALANCE SHEET as at 31st July 2015 (Month 4)

Appendix 3

	Opening Balances 1.4.15 £000s	Closing Balances 31.07.15 £000s	Movement in Balances £000s	Forecast B/S 31.3.16 £000s
Non-current assets:				
Property, plant and equipment	14	12	(2)	10
Intangible assets	0	0	0	0
Trade and other receivables	0	0	0	0
Total non-current assets	**14**	**12**	**(2)**	**10**
Current assets:				
Cash and cash equivalents	43	106	63	50
Trade and other receivables	1,363	554	(809)	500
Inventories	0	0	0	0
	1,406	**660**	**(746)**	**550**
Non-current assets classified "Held for Sale"	0	0	0	0
Total current assets	**1,406**	**660**	**(746)**	**550**
Total assets	**1,420**	**672**	**(748)**	**560**
Current liabilities				
Trade and other payables	(20,923)	(19,646)	1,277	(21,000)
Provisions	(883)	(767)	116	0
Borrowings	0	0	0	0
Total current liabilities	**(21,806)**	**(20,413)**	**1,393**	**(21,000)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(19,741)**	**645**	**(20,440)**
Non-current liabilities				
Trade and other payables	0	0	0	0
Provisions	0	0	0	0
Borrowings	0	0	0	0
Total non-current liabilities	**0**	**0**	**0**	**0**
Total Assets Employed:	**(20,386)**	**(19,741)**	**645**	**(20,440)**
FINANCED BY:				
TAXPAYERS' EQUITY				
General fund	(20,386)	(19,741)	645	(20,440)
Revaluation reserve	0	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(19,741)**	**645**	**(20,440)**

MOVEMENT OF FORECAST OUTTURN POSITION - MONTH 3 TO MONTH 4

Appendix 4

	Month 3 Forecast Var £000s	Month 4 Forecast Var £000s	Movement Year End Forecast £000s
FUNDING			
Revenue Resource Limit (RRL)			
Confirmed	0	0	0
Anticipated	0	0	0
Total RRL	**0**	**0**	**0**
EXPENDITURE			
Mainstream I&E Budgets			
Acute	2,979	3,906	927
Mental Health	(430)	(583)	(153)
Community Health	0	0	0
Continuing Care	(4)	(3)	1
Primary Care	(145)	(162)	(17)
Other	111	(600)	(711)
Sub Total Healthcare Contracts	**2,511**	**2,558**	**47**
Prescribing	500	1,000	500
Running Costs (Corporate)	0	0	0
Reserves	(2,174)	(867)	1,307
Total Net Expenditure & Reserves	**837**	**2,691**	**1,854**
Recovery Plan - Plan B	**(837)**	**(1,082)**	**(245)**
Unidentified Mitigations	**0**	**(1,609)**	**(1,609)**
TOTAL (Positive) / Adverse Variance	**0**	**0**	**0**

NHS
Stockport
Clinical Commissioning Group

Resilience and Compliance Report - September 2015

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

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

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

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

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
Note the report.
Please detail the key points of this report
Performance on NHS Constitutional targets and legal compliance indicators
What are the likely impacts and /or implications?
Continue to monitor measures and compliance, especially ED, RTT, Cancer (62 days) and ambulance response times.
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

This report covers data to June 2015 for NHS Constitution targets and to July 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, as we approach winter the Governing Body has requested a report on resilience of the system. The SRG is in the process of completing a national return on assurance of the system, this will be considered by the SRG in September and a report subsequently issued in October to the Governing Body.

Diagnostic waiting times are being met at Stockport FT but not at either UHSM or CMFT. Both Trusts have issued plans for recovery by October 2015.

The number of Clostridium Difficile cases has returned within target levels in June. However, the cumulative position remains significantly above plan. Low levels will need to be sustained across the rest of the year if the annual target is to be achieved.

Ambulance response times have improved in recent months, the SRG will review the extent to which this represents sustained improvement and resilience.

The revised national RTT standard is being achieved but the number of patients waiting for admitted care is higher than planned. There is a concern that this position could deteriorate over the summer if capacity is not maintained over the summer. The SRG are sighted on this risk and will seek to ensure that treatment within 18 weeks is the norm.

We continue to perform well against the Statutory Duty and Resilience indicators, we have not identified any risks to delivery against these, with the exception of the percentage of staff on permanent contracts which has been impacted by the Stockport Together programme.

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters									Last Three Months						Details		
NHS Constitutional Compliance Indicator	Q2		Q3		Q4		Q1		Apr 2015		May 2015		Jun 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	★	93.0	★	93.2	★	93.2	★	92%	Monthly	Performance has been consistently achieved across Q1. There is some risk in Q2 should the lower activity levels of last summer be repeated.
Number of patients waiting more than 52 weeks	1	▲	0	★	1	▲	1	▲	0	★	0	★	1	▲	0	Monthly	This breach relates to an ENT patient at Stockport FT. A full RCA is due from SFT and will be considered by the Q&PM committee.
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		Apr 2015		May 2015		Jun 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	▲	98.7	▲	98.6	▲	99%	Monthly	SFT achieved this target in June. Of the 71 breaches for Stockport patients, 67 of these were at either CMFT or UHSM. Improvement plans for these two trusts have now been shared with Stockport CCG with both forecasting achievement from October 2015.

A&E waits - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q2		Q3		Q4		Q1		Apr 2015		May 2015		Jun 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	▲	89.1	▲	96.1	★	94.2	▲	95%	Weekly	Performance year to date remains above 2014/15 but below the national standard. SRG has agreed with SFT a 90 day improvement plan which will significantly reduce admission rates from ED. The main risks to the plan revolve around recruitment.
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		Apr 2015		May 2015		Jun 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	★	95.6	★	97.9	★	94.6	★	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	★	96.8	★	96.5	★	93.4	★	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	Apr 2015	May 2015	Jun 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	99.5	99.2	98.2	97.7	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	98.8	98.5	97.4	94%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	100.0	100.0	100.0	100.0	100.0	100.0	100.0	98%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	100.0	100.0	100.0	90.0	100.0	85.7	87.5	94%	Monthly	Across the quarter, 20 patients were treated of whom two breached. Both breaches related to patient choice of treatment dates.

Cancer waits - 62 days wait - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q2	Q3	Q4	Q1	Apr 2015	May 2015	Jun 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	92.8	88.1	82.7	85%	Monthly	The standard has been achieved for Q1. The low performance in June has been attributed to a cohort of complex patients. Should the target not be achieved in July then further review will be undertaken.
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	100.0	100.0	94.4	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	81.3	84.6	73.3	80%	Monthly	There is no national operational standard set for this indicator and numbers are small, which means performance can be volatile. For the quarter, there were 44 patients treated and 9 breaches. The reasons for the breaches are similar to those for the overall 62 days standard, a mix of complex pathways and patient choice.

Category A ambulance calls - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q2		Q3		Q4		Q1		Apr 2015		May 2015		Jun 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	★	71.2	▲	81.5	★	79.8	★	75%	Monthly	This represents significant improvement.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	71.5	▲	66.7	▲	65.8	▲	76.6	★	72.1	▲	79.4	★	78.2	★	75%	Monthly	This represents significant improvement.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	94.9	▲	91.2	▲	91.1	▲	95.2	★	93.3	▲	96.4	★	95.9	★	95%	Monthly	This represents significant improvement.

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

Mental Health - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q2		Q3		Q4		Q1		Apr 2015		May 2015		Jun 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	★	100.0	★	100.0	★	95%	Monthly	There is no significant risk identified to threaten future performance.

Healthcare associated infection (HCAI) - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q2		Q3		Q4		Q1		Apr 2015		May 2015		Jun 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	▲	14	▲	14	▲	6	★	7.4	Monthly	June is the first month of the year that is below target. The CCG is 12 cases above target which is the equivalent of an additional two months of cases. As such there is a significant risk that this target will not be achieved in 15/16.

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	Q2		Q3		Q4		Q1		May 2015		Jun 2015		Jul 2015		Operational Standard	Collection Frequency	Status / Commentary
Percentage of FoIs handled within the legal timeframe	100.0	★	98.0	★	100.0	★	100.0	★	100.0	★	100.0	★	100.0	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Number of limited assurance reports received from auditors	0	★	1	▲	1	▲	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	75.6	▲	93.8	★	77.8	▲	84.6	★	50.0	▲	80.0	★	100.0	★	80%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of days lost to sickness in the last 12 months	1.67	★	2.25	★	2.23	★	2.01	★	1.94	★	1.84	★			2.5%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of staff contracts which are substantive.	82.5	★	83.8	★	85.6	★	80.7	★	81.7	★	79.1	▲	79.3	▲	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.
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.

To: System Resilience Group Chairs

CC: CCG Accountable Officers,
Acute Trust Chief Executive Officers,
Ambulance Trust Chief Executive Officers,
Mental Health Trust Chief Executive Officers,
Tripartite ALB Regional Directors

11 August 2015 NHS England Publications Gateway reference: 03815

Dear colleague,

Preparation for winter 2015/16

Since we wrote to you regarding resilience planning on 24 April 2015, we are aware that there has been a great deal of work done to progress resilience planning, preparations for winter, and wider transformational changes in line with the Urgent and Emergency Care Review.

We expect all systems to have robust plans in place for winter, and we are now writing to set out the next steps and goals for the rest of the year. This will cover System Resilience Group (SRG) assurance, support available, development of mental health services, surge management, this years' winter marketing campaign, and flu preparation.

As discussed previously, with money now in CCG baselines there is no additional resilience funding for this year and the focus is now on implementation.

System Resilience Group assurance

Recognising that SRGs are maturing and evolving, assurance has been underway since operational plans were submitted in May. We would now like to assess progress that has been made to ensure resilience planning is in a stronger position than last year.

As part of the assurance, SRGs are asked to provide the following updates:

- Progress on implementation of the eight high impact resilience interventions (following communication of these in the letter of 24 April)
- A baseline assessment of plans to implement the nine high impact actions to improve ambulance performance

- Acute and out of hospital capacity and demand projections ahead of winter, building on work already underway with regional teams
- A baseline assessment of plans to implement 24/7 liaison mental health services in A&E departments
- Key actions being taken to improve upon last year's resilience plan

A number of resources have been developed to support this, and to progress all of the above your regional contacts will be in touch shortly to discuss the next steps, timescales, and exact expectations based on risk stratification. This will build on processes that are already underway, and will conclude in mid-September.

This process will help SRGs to determine where the gaps in service and planning exist locally against nationally identified priorities, and to then produce plans to address these gaps. Please send any queries regarding assurance to the following e-mail address:

england.nonelectiveperformance@nhs.net

This letter also confirms that the remit of SRGs should be explicitly expanded to cover operational performance on the cancer waiting time standards, in particular the 62 day cancer standard given the need to drive better and sustained performance. Specifically, SRGs will be responsible for taking forward the recommendations of the national Cancer Waiting Times Taskforce and the Cancer Waits Action Plan.

High impact actions to improve ambulance performance

Similar to the 'high impact interventions' for general operational resilience, a set has been developed for ambulance services. We expect every ambulance trust to address these, in partnership with local SRGs. These are set out at Annex A.

They have been developed from the good practice in *Safer, Faster, Better*, (upcoming best practice guidance on delivering urgent and emergency care) which will be published by NHS England shortly. It is expected that all organisations will be clear, through the SRG arrangements, about their responsibility for delivering all or any part of any of these services, and will have taken these into account in their planning. Progress on these will be addressed through wider SRG assurance.

Capacity and demand

Capacity and demand planning remains a critical part of preparing for winter pressures, and there is an expectation that all systems will conduct an exercise to gauge acute and non-acute capacity and demand ahead of winter. The first phase of this work is already underway, and you will be contacted again in the next few weeks by regional teams to complete a more detailed return.

We have been working with KPMG and small number of SRGs to develop a capacity and demand tool for use by SRGs. We will now be testing roll-out and support with a wider group of SRGs and the Urgent and Emergency Care (UEC) Vanguard sites. Phase two of development on this will take place over the autumn before we issue the tool for use more widely alongside the planning round.

24/7 Liaison mental health (LMH) services in A&E

More than 25% of people admitted to acute hospitals have a mental health co-morbidity (rising to 60% for older adults), with a 45-75% increased cost per patient. We also know that people with mental ill health have double the emergency department (ED) attendance rate of the general population. CQC's recent thematic review into crisis care revealed significant variation, with considerable progress needed. Improving mental health crisis care is also a key priority in the Government's Mandate to NHS England.

CQC reported 'unacceptable' findings for people experiencing mental health crisis who present at A&E, with only 36% of people reporting that they felt respected by A&E staff. Adequate provision of LMH services in ED settings is essential not only for ensuring that people with urgent mental health needs receive a timely and skilled assessment, but also for ensuring that all staff working in EDs become confident in working with people with mental health needs.

CQC will now have a specific focus on ensuring adequate 24/7 LMH services in acute hospital settings, supporting the expectation set out in the planning guidance that by 2020 all acute trusts will have in place LMH services for all ages across all pathways appropriate to the size, acuity and specialty of the hospital.

It is anticipated that, from 2016/17, an access standard for 24/7 LMH services in ED settings will be introduced, for implementation from April 2017.

To aid preparation this year in advance of the introduction of LMH access standards, £30m non-recurrent, ring-fenced funding will be made available, which will be in addition to resilience monies already in baselines. This will be allocated to CCGs by regional teams on a targeted basis. Part of this money will also to be apportioned directly to the UEC Vanguard sites. Funding will be allocated in September, but regional teams will be in contact in August to discuss the next steps and the basis of their targeted approach, expectations, and tracking.

Crisis Care Concordat (CCC)

Every SRG and UEC Network is expected to have mental health representation as a core part of their membership and their resilience plans. As well as LMH, all SRGs will be expected to ensure:

- 24/7 community-based crisis response and assessment (through Crisis Resolution and Home Treatment Teams);
- adequate provision of health-based places of safety to ensure that people experiencing mental health crisis (especially children and young people) are not detained in police cells;
- that local 111 directories of service (DoS) include a complete and up-to-date list of mental health crisis services for all ages.

Every CCG has signed up to a local CCC action plan, which is being overseen by a local CCC group. We would expect all SRGs and UEC Networks to work closely with their local group, who are already seeking to implement actions that will form part of the SRG assurance process.

A mapping of contacts for every area will be made available as part of the SRG assurance resources made shared by regional teams.

Enhanced support team

To assist the most challenged urgent and emergency care systems, we are developing a programme of support that will run over winter 15/16. It will expand and enhance the improvement work already being done by the existing Emergency Care Intensive Support Team (ECIST) by:

- Expanding the ECIST team and supplementing it with experts from other parts of the urgent care pathway, including social care;
- Creating four learning collaboratives, where trusts can come together with their peers to share improvement knowledge and provide mutual support;
- Matching up challenged systems with higher performing ones in buddy arrangements, similar to those already developed for local government; and
- Providing additional capacity, where necessary, to help systems embed and sustain performance improvements.

In addition, the programme will look for ways to share across the sector information, tools and any other resources developed as part of its work to help all systems identify and implement improvements to the way they deliver urgent care.

More information on this programme will be sent out in September.

Delayed Transfers of Care

To provide clarity on definitions and responsibilities around delayed transfers of care (DToC), NHS England alongside the Department of Health and the ECIST, will be updating the technical definitions and guidance on DToC to provide clarity and share best practice. This is currently under development, and will be published (alongside supporting materials) later in August. The launch of this refreshed guidance will be supported by regional workshops teaching good practice on discharge being run by ECIST.

Communications and marketing campaign

For 2015/16, NHS England, the NHS Trust Development Agency, Monitor, Public Health England (PHE), and the Department of Health are joining up our winter campaigns. This will bring together PHE's successful flu vaccination, 'Catch it, kill it, bin it' and "Keep Warm, Keep Well", with NHS England's effective 'Feeling under the weather' campaign and materials to promote NHS 111, into one combined strategy.

This focused behaviour change programme will be developed through a single campaign approach, covering a variety of media including television, radio, outdoor and social media, as well as materials for local teams to use.

To ensure that this campaign is as effective as possible, it is important that all organisations use nationally consistent messaging to guide patients and the public. SRGs and CCGs are requested to align their local activity with the national campaign rather than initiating individual campaigns, therefore making best use of resources and avoiding duplication. National materials can be adapted for local use as needed.

Campaign materials will be available at the beginning of September through NHS Comms Link and PHE's campaign resource centre**.** These will include posters, leaflets, campaign designs, and toolkits. The national campaigns will begin in September 2015.

Please send any queries to england.marketing@nhs.net.

Declaring a Critical Incident or Emergency

All providers of NHS funded care are encouraged to communicate early over pressures faced, keeping in mind that:

- Business continuity arrangements are put in place for circumstances which organisations are able to manage within their own internal capacity; and

- As outlined in the EPRR framework, incidents that cannot be managed within routine service arrangements are planned for and as such will have trigger points in place locally to instigate escalation.

Emergencies (major incidents) are defined in the EPRR framework and the Civil Contingencies Act as instances which represent a serious threat to the health of the community or cause such numbers or types of casualties, as to require special arrangements to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

To assist consistency and clarity over definitions across the country we are currently in the process of revising the EPRR framework which will be published in October 2015 along with examples of communications messages for use in critical incidents.

Almost any critical incident for the NHS will generate media interest, and therefore requires close working between communication colleagues. NHS England regional media teams should be contacted for further support and guidance at the earliest available opportunity.

National Flu Programme

NHS England working with PHE has a well-defined delivery and action plan for the 2015-16 seasonal flu programme, integrated into the communications and marketing plan discussed earlier. The flu programme will be launched on 5 October and for the first time, this year it will include a national contract for community pharmacy for eligible over 18 year olds, which will help to reduce the variation of access across England, and play a part in reducing the burden on general practice.

Although continuing activity for the over 18 year olds is key, the programme plans to achieve a step change in population protection by focussing on the childhood programme, as vaccination rates for older people and clinical risk groups have reached a steady state. Planned activity includes engagement with CCGs, and staff within general practice, targeting the 2 to 4 year olds and a national roll out of delivery to all school children in year's 1 and 2. CCGs will be asked to ensure that messages and resources are shared within their practice nurse and GP forums.

The expectation continues that all NHS organisations will work towards improving the uptake of flu vaccinations amongst their workforce. All organisations should be working towards a minimum coverage rate of 75% for staff vaccinations. Improvement support will be focused on organisations with low rates from previous years.

We would like to thank you again for your continued efforts. We look forward to our continued work together, and to ensuring the system is in as strong a position as possible ahead of winter.

Yours sincerely,

Sarah Pinto Duschinsky
NHS England

Lyn Simpson
NHS TDA

Adam Sewell–Jones
Monitor

Annex A – High Impact Actions to Improve Ambulance Performance

Introduction

The ambulance service is a core component of the NHS in England; trusted by patients to provide a timely and effective response to sudden illness and injury at any time of the day or night. However as demand continues to increase in a resource-constrained environment all ambulance services in England are experiencing ongoing challenges in meeting operational performance standards.

NHS England is addressing this in a number of ways, including the introduction of new models of care, as outlined in the "Five Year Forward View", the implementation of the Urgent and Emergency Care Review and an extension of work to examine the impact of "dispatch on disposition" and related initiatives on clinical outcomes, operational efficiency and performance.

As a result of these initiatives a number of actions have been identified that have the potential to improve performance within the ambulance service. Implemented together they will reduce A&E conveyance and hospital admission, improve the availability of ambulance resources and increase operational efficiency and performance. These actions are outlined below, and recognise in particular that the ambulance service is part of a much wider system, which should be fully embedded in the Urgent and Emergency Care Networks that are currently being established throughout England.

Nine high impact actions

Action	Description
1. Establishing urgent care clinical hubs	All services to progress Clinical hub development – with wider MDT and specialist input. The expertise accessible through an urgent care clinical hub, on a 24/7 basis, could include (but is not limited to): pharmacy; dental; midwifery; mental health crisis and liaison psychiatry; end of life care; respiratory (including COPD); paediatrics; care of the elderly; drug and alcohol services; social care; secondary care expertise including general medicine and general surgery.
2. Improving access to community health and social care rapid response, including falls services.	Ambulance services should have (or have plans to put in place) direct access to these services, through simple routes of referral (e.g. a single point of access for professionals/single phone call) as an effective alternative to A&E conveyance and/or hospital admission.
3. Increasing direct referral to all other components of the Urgent and Emergency Care Network	Registered healthcare professionals in the employment of ambulance services (e.g. paramedics and nurses) should be empowered and supported to refer patients that they have assessed in person to all other components of the urgent and emergency care network. This includes referral to primary care and hospital-based expertise, combined with conveyance to non-A&E destinations including urgent care centres, assessment units and ambulatory emergency care units.
4. Enhanced working with community	Ambulance services should work with SRGs, commissioners, community mental health teams and other system partners to

mental health teams	improve access to early triage and assessment by mental health professionals following referral from the ambulance service. This should be supported by timely access to crisis care at home and in community-based settings.
5. Enhanced working with primary care	In addition to the referral and transport actions outlined under point 3 above, consideration should be given to: paramedic practitioners undertaking acute home visits on behalf of GPs, to avoid unnecessary admission and admission surges; 'call back' schemes whereby in-hours and out-of-hours primary care staff follow-up patients who have been managed at home and not transported by ambulance clinicians (within agreed time-frames); joint planning with GPs and other relevant system partners (e.g. acute trusts) to agree management plans for high-volume service users/frequent callers.
6. Workforce development	The development and up-skilling of the ambulance workforce (particularly paramedics) and the employment of a wider range of healthcare professionals (e.g. nurses, midwives and pharmacists) will increase the rates of both "see and treat" and "hear and treat" by enhancing the skills of the ambulance workforce.
7. Enhanced use of information and communication technologies	This includes (but is not limited to): sharing and access to electronic patient records to support clinical decision-making; implementation of electronic patient handovers; sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation protocols.
8. Increased use of alternative vehicles to convey patients	Ambulance services should consider the use of alternative vehicles to transport patients, whenever it is safe and appropriate to do so, thereby freeing up and improving the availability of "front line" ambulance resources.
9. For patients who do need to be taken to hospital, ambulance services should seek to minimise handover delays	Handover delays to be minimised by • Reviewing patients' conditions and needs en-route and sending details ahead to the receiving emergency department in the case of any special requirements/circumstances. • Avoiding the use of ambulance trolleys for patients who are able to walk into the department. • Using alternative vehicles to convey patients to the emergency department (e.g. patient transport service vehicles to transport patients, thus keeping paramedic staffed ambulances available. • Implementing electronic patient handovers. • Sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand rises.

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.

NHS Stockport Clinical Commissioning Group
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Stockport
SK4 1BS

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

Website: www.stockportccg.org

Executive Summary

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 Q&PM committee. **Decisions** None **Attachments** o Draft Q&PM Minutes – August 2015 o Q&PM July 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?
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Mark Chidgey
Meeting Date:
Agenda item: 8
Reason for being in Part 2 (if applicable)
Not applicable

2.0 Decisions of the Quality & Provider Management Committee

The following issues remain on "red" within the issues log:-

- Safeguarding assurance in Maternity at SFT
- SFT CIP plans

3.0 Issues Highlighted to the Governing Body

- The updated Safeguarding Accountability and Assurance Framework issued in June 2015 has additional requirements for commissioners. This highlights gaps/risks to the CCG including:
  - Requirement to undertake more than one contact per year for all (lead) commissioned services– need to map capacity to this requirement.
  - Requirement for a Designated Adult Safeguarding Manager – need to map CCG's existing JD
  - Requirement for a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements and to sit on both the children and adult's safeguarding boards.

  Additional pressures on the CCG's Safeguarding team have arisen due to 4 children's serious case reviews commissioned in the last 3 months. In addition the CCG's Adult Safeguarding Lead unfortunately experienced two long periods of health in the last 12 months.

  Further work is being undertaken to quantify the capacity shortfalls.

- Stockport Foundation Trust has reported 3 surgical Never Events since April 2015. The Trust has responded by commissioning an external review by Professor Brian Toft OBE who has undertaken a similar review at Sheffield Teaching Hospitals in June 2014. The Trust has already reviewed the published Sheffield report and has implemented some immediate changes to procedures as a result.

- 7-Day Services. Stockport Foundation Trust has mapped its ability to implement the 10 Clinical Standards and specifically the 4 standards identified by NHS England as having the biggest impact on weekend mortality. The Trust has identified some key challenges to achieving the standards. In addition it has been agreed there is a need for a shared vision for the future of seven day services, across the health and care community. A workshop has been set up on 23rd September.

4.0 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 15 July 2015)

Issue	Date added	Description	Action / Progress	Owner	Expected date of removal	Q&PM RAG rating	Last Updated	Status	Context (papers)
1	19/08/2015	There is an issue regarding the capacity within the safeguarding team in the light of the increased responsibilities in the safeguarding accountability & assurance framework	Issue raised within the Quality Report for Governing Body	SG	Dec-15		Sep-15	Open	
2	17/06/2015	There is an issue regarding safeguarding assurance in Maternity at SFT.	JM working with SG developing a new action plan which reflects all the concerns raised, this action plan to be tracked by SG and progress to be brought back to the October Q&PM. Discussed at AUGUST Q&P, trust board aware of concerns.	SG	Nov-15		Aug-15	Open	H:\Misc\Mark\QPM\Q&PM 2015 16\17June15\P G:\Committees\2015 16\Q&PM\17June15\Agenda
3	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 under monitoring by SG.	SG	Nov-15		Aug-15	Open	St Ann's Action Plan.
4	15/04/2015	There is an issue with patients waiting beyond 62 days for cancer treatment. This exceeds the national standard.	Trust has achieved target for Q1, but performance dipped in June due to a complex cohort of patients who required several pathways, this will be tracked through the bi-monthly performance meetings- recommend removal wih re-escalation as appropriate	MC	Oct-15		Aug-15	Open	IPR
5	18/02/2015	There is an issue with timely follow-up of glaucoma patients at CMFT.	CB to write to the Medical Director at CMFT.	CB	Nov-15		Aug-15	Open	
6	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 on track, monitored at community contract meeting	CB	Sep-15		Aug-15	Open	Trajectory & SFT Risk rating G:\Committees\2015 16\Q&PM\17June15\Agenda
7	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.	SFT reported progress at August Q&P meeting, this will be monitored through the bi-monthly performance meeting. Performance increased in June to 83% against a target of 95%.	CB	Sep-15		Aug-15	Open	IPR
8	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.	No QIAs received. Escalated to COO.	MC	Sep-15		Jul-15	Open	

Quality Provider Management Committee Issues Log
(Following Q and PM Committee of 15 July 2015)

9	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.	Discussed in August Q&P contract meeting, the trust will supply an options appraisal for reduction of backlog with risk assesment for CCG to agree.	MC	Sep-15		Aug-15	**Open**	G:\Committees\ 2015 16\Q&PM\ 17June15\Agenda

NHS
Stockport
Clinical Commissioning Group

Quality & Provider Management Committee

DRAFT MINUTES of the meeting held on Wednesday 19 August 2015

09:00 – 11:26 am, Room 1, Floor 7, Regent House

Present:

(DK) Dr Debbie Kendall, Secondary Care Lay Consultant
(JH) Dr James Higgins, Locality Chair, Heatons & Tame Valley
(KR) Karen Richardson, Nurse Lay Member of the Governing Body **(Chair)**
(MC) Mark Chidgey, Director of Quality & Provider Management, NHS Stockport CCG
(SG) Sue Gaskell, Safeguarding Lead Nurse, NHS Stockport CCG
(SP) Susan Parker, Allied Health Professional
(VOS) Dr Vicci Owen-Smith, Clinical Director, Public Health

In attendance:

(MK) Maria Kildunne, Chief Officer, Healthwatch Stockport
(NG) Nazie Gerami, Patient Experience Officer, NHS Stockport CCG for item 7
(RG) Rachel Grindrod, Contracts Manager, GM Shared Services, (NWCSU)
(SC) Sue Carroll, Acting Chair, Healthwatch Stockport
(SW) Sarah Williamson, Clinical Quality Assurance and Performance Manager, NHS Stockport CCG for GMi

Apologies:

(CB) Dr Cath Briggs, Clinical Director for Quality & Provider Management, NHS Stockport CCG
(GE) Gina Evans, Joint Commissioning Lead, NHS Stockport CCG
(GMi) Gillian Miller, Deputy Director of Quality & Provider Management, NHS Stockport
(JC) Jane Crombleholme, Lay Member, Chair of NHS Stockport CCG Governing Body CCG
(TS) Tony Stokes, Chair, Healthwatch Stockport

Minute Taker:

(AN) Alison Newton, PA, NHS Stockport CCG

MEETING GOVERNANCE	
1. Apologies and declarations of interest	**Action**
1.1 Apologies were received from Dr Cath Briggs, Gina Evans, Gillian Miller, Jane Crombleholme and Tony Stokes; MC would arrive late for the meeting. KR welcomed MK and SC to the meeting. There were no further declarations of interest in addition to those previously made and held on file by the Board Secretary.	
2. Notification of items for Any Other Business	**Action**

2.1 There were no additional items for discussion.	
3. Items of Business	**Action**
3.1 Minutes from the previous meeting – 15 July 2015: The minutes were approved as a true record. 3.1.1 JH referred to item 3.1.9 in the previous minutes and clarified that ideally there should be direct communication between GPs and midwives, but he was unsure as to whether this happens routinely at present or not.	
3.2 Action log – update on progress: *Item 6.1.13* Members noted that data had not been received from CMFT to advise on the number of Stockport glaucoma patients affected by a delay in follow-up treatment at MREH (Manchester Royal Eye Hospital). It was noted that a number of requests had been submitted by MC and GMi. SP reported that she had met with the Clinical Lead at Manchester CCG and he would keep her updated on any issues that could affect Stockport patients. SP highlighted that 31% of patients had experienced a delay in follow-up treatment in 2014 but pointed out that this statistic is for all patients. A discussion ensued on the issue; it was agreed that as the item is also included on the Issues Log, it should be removed from the action log. It was also agreed that CB should write to the Medical Director at CMFT to request data on the number of Stockport glaucoma patients experiencing a delay in follow-up treatment. **Remain on log.** **Action: CB to write to the Medical Director at CMFT to request data on the number of Stockport glaucoma patients experiencing a delay in follow-up treatment** *Item 4.1 a)* Due October 2015. **Remain on log.** *Item 5.2* The CCG Comms team had alerted GPs on the change to the PSS. **Remove off log.** *Item 6.2* Due October 2015. **Remain on log.** *Item 3.1.30* CB had sent a letter to Judith Morris following the discussion at the previous meeting (copy attached in papers). **Remove off log.** *Item 3.2.1* JC had contacted Laura Latham regarding governance issues. **Remove off log.** *Item 4.1.2* SW advised that the minutes from the Quality Governance Committee at SFT could be located on their website. **Remove off log.** *Item 5.1* SG made members' aware that it would be the November Governing Body meeting when she is able to present the annual safeguarding report and Domestic Homicide Report due to a change in format for the September and October Governing Body meetings. It was acknowledged that the Governing Body would still receive updates from the Committee in September and October. **Remove off log.** *Item* 8.2 This action was deferred until the next meeting. **Remain on log.** *Item 9* The Issues Log had been updated following the previous meeting. **Remove off log.** **Noted:** That the Annual Safeguarding Report and Domestic Homicide Review would not be presented to Governing Body until the November meeting.	**CB**

It was agreed that item 4 be deferred until later on the agenda.	
4. Service Focus – Urgent Care	**Action**
To be covered later in the meeting.	
5. Stockport Foundation Trust (SFT)	**Action**
5.1 CCG Quality Dashboard – August 2015: RG drew members' attention to a number of items contained in the dashboard including: • Monitor – still red for ED; continuity of services has been removed; • SW continues to work with the Trust to close off serious incidents from 2014/15; 18 incidents remained open from 2014/15; • There had been an increase in reporting incidents, as reported on STEIS (Strategic Executive Information System) following the revised guidance (Serious Incident Framework); • There remains an issue of community reports arriving late; this issue had been escalated to a Community Contract meeting; • Never Events – there had been three reported; SW briefed the meeting on the nature of the incidents. The Trust had commissioned Professor Toft to undertake an external review of Never Events. SW reported that a surgical steering group had been convened and actions had been put in place to address issues prior to the publication of the commissioned report. The Committee would receive feedback on the outcome of this report following its publication. MK reported that Healthwatch had sought assurance from the Trust on these incidents; KR requested feedback from Healthwatch on their response from the Trust; • One of the CDiff incidents had been reported as due to lapse of care; the remaining incidents were unavoidable; • Two performance notices had been issued for TIA's (the Trust had complied with targets for May and June); • There had been one breach of the 52 week target; RG explained the circumstances for the breach; • 62-day wait for first definitive treatment for cancer – this continues to be monitored and had been failed in June. MC joined the meeting (09:19 am). 5.1.1 **Integrated Performance Report (IPR):** RG questioned what information members' required for future meetings. It was noted that the IPR is very comprehensive and the report prepared by NWCSU is also informative. RG pointed out that the IPR is also considered at the Quality & Performance meetings. KR sought further comments from the ISR: • SG commented that she is assured if performance data triangulates with recorded incidents • SC made a number of observations: o Sickness is recorded as "unknown" – there should be a reason for all sickness absences reported; it was commented that this could be a	

coding issue; o There are a high number of DNA's (Did Not Attend) for training courses. She stated that it is good practice to send apologies and prevent it being recorded as a DNA. SW explained that there had been recruitment issues and some staff may not have been able to be released for training but it was hoped that this figure will improve due to the reduction in the number of staff vacancies; o The importance of staff appraisals cannot be understated; • KR requested that these observations be raised at the next Quality & Performance meeting; • KR drew members' attention to page 14 and the note that the Trust needs to make £31k of savings every day from 1 July 2015 to 31 March 2016 as part of its Cost Improvement Programme and commented that against these challenges, the Trust needs to maintain quality. SP commented that other CCGs have found it useful to place figures against items to make staff aware of costs and this has proved effective in reducing wastage; • VOS referred to page 57 – CQUIN performance and highlighted the red forecast for Acute Kidney Injury. RG explained that this graph depicts the figures from the first initial data collection but she would clarify the data and feedback to VOS; • In answer to a query as to why a number of operations had been cancelled in June, MC reminded the meeting of the significant IT issue when all clinical systems went down. Continuity plans were successfully implemented, 5.1.2 It was agreed that the Committee would continue to receive the IPR and Exception Report and other relevant reports and discuss any priority issues at the meeting. KR volunteered to revisit the item again if members felt that they were overloaded with paperwork.	
5.2 SFT Community Services Quality Contract meeting – key issues: RG briefed the meeting on the main items of discussion at the last community contract meeting (these are bi-monthly meetings): • Discussions are taking place on re-alignment of services between the community and acute contracts; discussions are taking place as to whether there should be one integrated contract meeting (community and acute); • Actions continue regarding the DN (District Nurse) Service; there had been an increase in staffing due to a recruitment process; • Orthotics – there is work taking place as part of the proactive care programme to communicate with patients regarding purchasing their own equipment; • Primary Care physio waiting times have significantly reduced. Work is underway developing the new spinal pathway. The re-design work will include setting up a community spinal service supported by clear referral protocols in place for GPs and rapid access to physio; • OAS (Orthopaedic Assessment Service) – work has taken place on this service (excluding the spinal pathway). Members noted that the Care UK contract will end in April 2016. SC briefed the meeting on experiences she had been advised on related to a transfer of diagnostic reports between Care UK and the Trust. MC commented that this was an issue at the start of the	

Care UK contract but that SFT can now access radiology reports from Care UK and acknowledged the need for integrated diagnostics reporting across Stockport.	
5.3 SFT Acute Services Quality Contract meeting – key issues: SW advised that the Quality Strategy is being monitored by the Quality Governance Committee at the Trust. Key areas of discussion at the Acute contract meeting included: o 7-day service – working on implementing 5 of the 10 clinical standards; a gap analysis will be undertaken with a focus on priorities; o The Board had been alerted to the discussions that had taken place regarding safeguarding in maternity; a new action plan had been prepared; o Safe staffing – the Trust had recruited to substantive posts to reduce the reliance on agency staff; o Never Events (as covered earlier in the meeting) – RCA (Root Cause Analyses) were due. The Chair referred members' back to item 4 on the agenda.	
4. Service Focus – Urgent Care	**Action**
4.1 MC provided an update on a significant change to the urgent care system including changes to the model of care. 4.1.1 Members were referred to the SRG agreed RCA explaining why the current urgent care system needs to change and the 90 days 4 hour recovery plan (copies circulated). MC advised that this document had been discussed at length at SRG (Systems Resilience Group) involving multi-agencies. There were three elements to the 90 day plan: • Front door – This includes GP access to clinician advice and a joint decision as to whether the patient needs to be referred to the hospital (red – immediately to the Medical Assessment Unit, amber – the next day with pre-booked appointment, green – not required); this should reduce the number of ED attendances by 20 patients a day. JH questioned whether the Plan also included a link for the Surgical Assessment Unit (notably orthopaedics and ENT); MC would confirm with the Trust; • ED Escalation Policy. The UM review showed that 80% of hospital delays were due to waits for diagnostics. As an interim measure ward trackers will be deployed to improve patient flow. JH asked whether patients need to remain in hospital awaiting diagnostics. MC acknowledged that direct access needed to be improved to ensure this only happened if clinically necessary, reduced demand for diagnostics would be managed through the introduction of diagnostic menus by condition. SP added that as well as ward trackers there would need to be sufficient porters to transport patients to their diagnostic tests. MC responded that the staffing structure would be considered during the current planning phase. • Short Stay Older Patient – a white board process had been introduced to facilitate effective discharge; this process is being embedded across the Trust.	

4.1.3 DK questioned whether the Plan included access to weekend diagnostics. MC reported that a business plan is being prepared as part of 7-day access but this is not likely to be implemented before Q1 2016. DK pointed out that in the RCA, it stated that there are not enough consultants but this had not been included in the 90-day plan. MC reported that additional physician capacity had been included in the plan but not ED consultants. It was recognised that this would remain a risk for the Trust. 4.1.4 SG questioned whether paediatric ED had been considered in the Plan. MC reported that there were no significant changes planned for paediatric ED. SG highlighted the importance of having paediatric trained nurses. A discussion ensued on staffing capacity. It was noted that medical vacancies had been removed off the issues log. Members questioned whether this needs to be added back on the issues log. MC would bring a report on staffing levels at SFT back to the Committee. 4.1.2 MC shared the KPIs (Key Performance Indicators) that had been agreed for the plan. MC asked for any gaps that the Committee needs to monitor, suggestions included: o Quality indicators for patient experience (FFT – Friends & Family Test) o Incidents/Risk Assessments/Complaints MC would raise these items for monitoring with SFT. 4.1.3 MC advised the Committee that the Plan had been revised since the papers had been circulated and he would distribute a revised copy. 4.1.4 KR questioned whether the Committee were assured about the quality of care in ED. Members commented that they would be more assured if the additional items (FFT, RAs, complaints) were included as part of the quality monitoring process. **Actions:** **(i) MC to confirm with the Trust that the Surgical Assessment Unit is linked to the 90-day plan and report back to JH** **(ii) Include additional items for the Committee to monitor – FFT, Risk Assessments, Complaints** **(iii) MC to bring a paper to the Committee on staffing levels at SFT.** **(iv) Circulate updated 90-day Plan to Committee members**	**MC** **MC** **MC** **MC**
6. Patient Safety	**Action**
6.1 Safeguarding. **6.1.1 a) Exception Report:** SG highlighted the main issues contained within he Report. o She had received self-assessments from the providers listed but the assessments and supporting evidence still require reviewing by the team. o There were three recommendations for the CCG in the draft report of Domestic Homicide Review 3 which has been approved by Stockport Safer	

Partnership. The safeguarding team is progressing these recommendations.

- SG pointed out that there had been four serious case reviews commissioned in the last three months creating a significant pressure on the providers and the team. SP questioned whether any learning from these cases could be put in place now. The providers should respond to any issues identified following their own internal reviews, not wait for the multi-agency report.
- SG informed the meeting that discussions have taken place between Andrew Webb and Gaynor Mullins to explore if there needs to be an additional piece of work to determine if there needs to be an economy wide review. It was agreed that this is a responsibility for the Safeguarding Board.
- SG commented that if any gaps in commissioning were identified following the reviews, she would bring them to the Committee's attention. In response to a question, SG confirmed that she would scrutinise all health aspects contained within the reviews.

MC advised the meeting that the team has significant capacity issues in light of the added responsibilities therefore there may be a delay in other reports being submitted to the Committee.

Noted: Three recommendations for the CCG contained within Domestic Homicide Review 3.
Noted: Due to the capacity issues within the safeguarding team, some reports may be delayed in coming to the Committee.

6.1.1 b) Safeguarding Accountability and Assurance Framework: SG highlighted the relevant changes and additional responsibilities for the CCG including requiring more than one contact per year for all commissioned services and changing the job description of the Designated Nurse Vulnerable Adults to include the changes. SG pointed out that the role of the Executive is more explicit and also pointed out that there is currently no CCG executive representative on the Adult Safeguarding Board. MC would include a focus on capacity of safeguarding team in the next Quality Report to Governing Body in the light of the additional duties included within the framework. The capacity of the safeguarding team would also be added to the Issues Log.

6.1.2 Maternity Update: Members noted that the maternity issue had been raised at the Trust Board meeting; an extract had been included within the papers. SG informed the meeting that she had met with Judith Morris and agreed that SG would meet with Julie Estcourt (Head of Midwifery) on a monthly basis. Judith had informed SG that Julie Estcourt (Head of Midwifery) would be submitting a weekly progress report to her. SG reported that the Trust had attempted to commission an external review of maternity services but had been unable to find anyone; KR requested an update at future meetings on the outcome of this process.

Actions:

(i)	**Include a summary on capacity of safeguarding team in next Quality Report to Governing Body**	**MC**
(ii)	**Add capacity of safeguarding team to issues log (red)**	**SW**

NG joined the meeting (10:33 am).

6.2 Harm Free Care: SW briefed the meeting on a number of highlights: • Falls prevalence had risen above the national average – this is monitored as part of the Quality Strategy; • VOS referred back to the IPR page 57 and the graph marked red for AKI (Acute Kidney Injury) and sought clarification on the data; SW would find out more information on this data; • New VTEs are currently above average – this is being monitored. In response to a question from VOS, SW explained that risk assessments for KPIs are being managed and the Trust has over 95% compliance. A thrombosis committee undertakes the assessments. VOS requested an update on actions taken to address the VTE trajectory. • CDiff – this is above trajectory for the year but following scrutiny it had been determined that the majority of cases were unavoidable. SW pointed out that trajectory is based on numbers therefore each case is being reviewed to determine if there is a lapse of care that is avoidable. Members were asked to note that some of these involved complex cases involving patients with co-morbidities. SW would provide additional context for future summaries. 6.2.1 SW informed the meeting that NHSE (NHS England) had sent a matrix for CCGs to complete on maternity services. She had met with Julie Estcourt to complete the assurance form and they would present the outcomes to the Trust's Quality & Safety Committee later in the year. SW offered to provide feedback to the Committee following the presentation of the report later in the year. **Actions:** **(i) SW to clarify the data for AKI on page 57 of IPR and report back to VOS** **(ii) Update VOS on actions taken to address VTE trajectory** **(iii) SW to feedback to the Committee following presentation of the NHSE maternity report to the Trust.**	**SW** **RG** **SW**
7. Patient Experience	**Action**
7.1 Walk round programme 2014/15: KR welcomed NG to the meeting to present her report on the walk round programme from the previous year. NG referred to the report and briefed members on the format of the report. NG invited questions from the Committee: • Members thanked NG for an informative report; • SG queried why there was only one unannounced visit to SFT whereas the majority of visits to other providers were not announced. SW commented that as it was a new process last year, a lot of the visits were familiarisation visits therefore they were not unannounced; • KR encouraged members to be involved in at least one visit per year and asked members to email NG with any suggestions for areas of focus; • NG referred to the walk round plan for 2015/16 and advised that this is a working document that could be changed according to the priority areas of focus – it could be linked in with the priorities contained on the issues log. • KR questioned whether there were any plans to have walk rounds in primary care and was advised that these would be better placed to commence	

following the implementation of the new neighbourhood teams as lots of work was currently taking place in this area; • It was suggested that the Committee liaises with Healthwatch with visits to avoid duplication. MK welcomed the suggestion and reported that discussions were ongoing regarding themes to focus on for Healthwatch visits. In response to a further question, MK reported that further consideration has been given to having a linked person for care homes. KR thanked NG for her update; NG left the meeting (10:51 am).	
8. Clinical Effectiveness	**Action**
8.1 Update from CPC: There were no further updates from CPC (Clinical Policy Committee).	
8.2 Suicide prevention meeting – feedback: VOS briefed the meeting on the discussions that had taken place. Lots of work is taking place including a new website developed by Stockport LA (Local Authority) that will be launched. VOS explained that the purpose of the group is to ensure services are known and shared, particularly with young people following a suicide attempt. VOS pointed out that there is currently no CCG rep on the group; VOS would raise this issue with Gaynor Mullins and GE. VOS added that it would be useful to receive coroner and police reports on suicide attempts (currently, information is only received following a death); this would enable the group to map the areas where they occur. Members were reminded that work had taken place with Network Rail in relation to access to the viaduct. SG pointed out that the Children's Safeguarding Board have produced self-harm work and asked if there is a link between the two groups; VOS would clarify this issue. **Actions:** **(i) VOS to highlight to Gaynor Mullins and GE that there is no CCG rep on the Suicide Prevention Group.** **(ii) VOS to clarify whether there is a link between the Children's Safeguarding Board and the Suicide Prevention Group and report back to SG.**	**VOS** **VOS**
9. Mental Health	**Action**
9.1 Mental Health Exception Report – key issues: This item was deferred until the next meeting. KR requested that Committee members contact GE if they had any specific questions.	
10. Making Safety Visible	**Action**
10.1 Update: SW updated the meeting on the workshops attended by CCG and Trust staff; these had been positive sessions. It was noted that re-admissions had been a focus for the Trust at these workshops. There is a Summit in October – SW would circulate the date to VOS; KR encouraged other members to contact SW if they would like to attend the Summit.	
11. Issue Log	**Action**
11.1 Issues Log: Members were reminded that the RAG (red, amber, green) rating reflected the agreed (subjective) view of the meeting as pure objective rules for categorisation were not feasible. Red would indicate that the Committee is seriously	

concerned, amber moderately concerned. A green rating would reflect an issue that had been addressed. *Issue 1: Safeguarding assurance in maternity at SFT* – it was agreed that this issue should remain on the log until an action plan has been received. **Remain on log.** *Issue 2 St Ann's Hospice – safeguarding* – it was noted that the trajectory for this issue is over twelve months but it could be re-visited in three months to determine whether it could be removed off the issue log. **Remain on log.** *Issue 3: 62 day wait cancer treatment* – there had been a reduction in performance in June therefore this issue would remain on the log. **Remain on log.** *Issue 4: Timely follow-up of glaucoma patients at CMFT* – this issue had been covered under item 3.2 and an action had been assigned to CB to write to the Medical Director at Manchester CCG to escalate the issue. It was agreed that the item be changed to red on the log. **Remain on log.** *Issue 5: District Nurse Service* – this item is on trajectory and would be reviewed at a Community Contract pre-meet the following week. There were 8% vacancies for August 2015. **Remain on log.** *Issue 6: Patient discharge letters* – performance had increased; this item would be reviewed in September before a decision is taken to remove it off the list. **Remain on log.** *Issue 7: SFT CIP* – This issue would remain on red. **Remain on log.** *Issue: 8 Timely follow-up of OWLs* – assurance had been received for cardiology and ophthalmology but not gastroenterology. MC briefed the meeting on the process that had been followed and explained that the date for re-visiting the plan had been extended. **Remain on log.** A discussion ensued as to whether Never Events should be included on the log. SW reported that there is a process in place to review RCAs on a monthly basis but she would bring back any themes to the Committee where appropriate. The Committee **noted** the updates.	
12. Any Other Business	**Action**
12.1 There were no other items of business to discuss.	
Meeting Governance	
13. Date, time and venue of next meeting: Wednesday 16 September 2015 09:00 – 11:30 Room 1, floor 7, Regent House	

NHS
Stockport
Clinical Commissioning Group

Report of the Chair

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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Stockport
SK4 1BS

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

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
None. This is an update following a public question raised at a previous meeting of the Governing Body.
Please detail the key points of this report
Following a question from a member of the public at the June meeting of the CCG Governing Body meeting, there was a meeting on 1st July between Val Johnson (CEO, Action for Sick Children) and Alison Caven (Commissioning Manager, Stockport CCG). At this meeting:- Val Johnson explained that as an organisation Action for Sick Children were reviewing their purpose and focus and looking for new areas where they could make a contribution. Historically they had been been a lobbying organisation at a national level for improvement in health services for children, notably campaigning for the rights of parents to stay with their children in hospital and more generally for child and family focused services in the NHS. Their most recent campaign has been around promoting good child dental health. Alison Caven set out the CCG's priorities in children's health care along with overview of local services. The issues discussed included the relatively high acute hospital admission rate for infants, the integration of children's health and LA services at a locality level, the SEND reforms, and the programme for CAMHS transformation. Val Johnson was provided with the contact details for each of the services. The meeting was an introductory / familiarisation meeting and no further specific actions were agreed.
What are the likely impacts and/or implications?
None at the current time.
How does this link to the Annual Business Plan?
N/A
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
N/A
Clinical Executive Sponsor: N/A
Presented by: Jane Crombleholme
Meeting Date: 9 September 2015
Agenda item:
Reason for being in Part 2 (if applicable)

NHS
Stockport
Clinical Commissioning Group

Chief Operating Officer's update

Chief Operating Officer's update to the September 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.
Please detail the key points of this report
Provides an update on: 1. Value Proposition 2. Specialist Weight Management Procurement Outcome 3. ECG Procurement Process 4. EPRR assurance of NHS England Core Standards 5. Co-Commissioning Level 3 update
What are the likely impacts and/or implications?
The move to level 3 co-commissioning will require the CCG to review its management arrangements to support this area of work.
How does this link to the Annual Business Plan?
Supports delivery.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 9th September 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 September 2015.

2.0 Vanguard - Value Proposition

2.1 Each Vanguard site has been asked to submit a value proposition to NHS England New Care Models Team. The CCG has led the development of this locally. It was submitted on the 21st August 2015.

2.2 The Value Proposition describes the Multi-specialty Community Provider model we envisage (MCP); the approach we are taking to transformation; the intended impact on Triple Aim outcomes – health improvement, quality and financial sustainability; and the ask in terms of short term resources to deliver change and pump prime new services. All spend identified against the £600,000 the Governing Body previously agreed has been included in the request. In total we have asked for c£6m in 2015-16 and similar again in 2017-18. We believe that our Value Proposition is in line with those submitted in other areas, and we are expecting to hear the outcome during September. It is likely that we will be asked to do further work and/or any support will be conditional at this stage. The submission builds on and is in line with the CCG's strategic and operational plans as previously published and the Stockport Together vision decision document agreed by the Governing Body in March. The submission will be available in the Governing Body members' library.

3.0 Specialist Weight Management Procurement Outcome

3.1 The evaluation for the Specialist Weight Management Service is now complete. The full evaluation report has been considered by a meeting of CCG Directors, and the Directors supported the recommendation in the report of which bidder should be awarded the contract. Notification of the outcome will be sent to the two bidders and following the stand still period, the identity of the successful provider will be published on the CCG website. In accordance with CCG practice an anonymised summary scoring grid will also be published on the procurement pages of the website.

4.0 ECG Procurement Process

4.1 Following the initial conclusion of the procurement process, the CCG noted that some information submitted had not been evaluated. The CCG has taken legal advice and as a result the CCG has written to all providers confirming that there will be a rewind of the procurement process and all bids will be re-evaluated.

5.0 Emergency Preparedness Resilience and Response (EPRR) assurance of NHS England Core Standards

5.1 Greater Manchester Local Health Resilience Partnership (LHRP) requested NHS organisations to:

1. Undertake a self-assessment against the relevant core standards
2. Review any EPRR action plan developed from the 2014-15 assurance process
3. Complete a statement of compliance identifying the organisation's overall level of compliance and the results of the self-assessment
4. Present the statement of compliance to the Governing Body

5.2 Self-assessment was undertaken by the GM Shared Services Resilience Team and the position for Stockport CCG for the 2015-16 EPRR Core Standards is one of full compliance. This is attached for note by the Governing Body.

5.3 In addition, NHS provider organisations were requested to inform their relevant commissioning organisation(s) as to the outcome of their self-assessment. Stockport NHS Foundation Trust and Pennine Care NHS Foundation Trust have assessed themselves as substantial compliance.

6.0 Co-Commissioning Level 3 update

6.1 NHS Stockport CCG is currently operating at level 2 GP Co-Commissioning. The CCG applied for level 2, with a view to reviewing this and moving to level 3 (full delegated commissioning) at a later date. There is the opportunity to review these arrangements and apply to commission at level 3. The application would need to be made by early November. It is recommended that the CCG starts the process of engaging with member practices and stakeholders to seek support for a move to level 3. As the Governing Body will not meet formally again until after the date of the application, the Governing Body is asked to give the Chief Operating Officer delegated approval to make the application.

7.0 Action requested of the Governing Body

1. To note items 2 – 5.
2. To approve the move to level 3 co-commissioning.

Emergency Preparedness, Resilience and Response (EPRR) Assurance 2015-16

STATEMENT OF COMPLIANCE

Stockport CCG have undertaken a self-assessment against the NHS England Core Standards for EPRR (v3.0).

Following self-assessment, and in line with the definitions of compliance stated below, the organisation declares itself as demonstrating **Full** compliance against the EPRR Core Standards.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the Core Standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more Core Standard that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address multiple Core Standards that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address several Core Standards that the organisation is expected to achieve.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**[1]	Standards rated as **Amber**[2]	Standards rated as **Green**[3]
30	0	0	30
Acute providers: **47** Specialist providers: **38** Community providers: **38** Mental health providers: **38** CCGs: **30**	[1] *Not complied with and not in an EPRR work plan for the next 12 months*	[2] *Not complied with but evidence of progress and in an EPRR work plan for the next 12 months*	[3] *Fully complied with*

I confirm that the above level of compliance with the EPRR Core Standards has been or will be confirmed to the organisation's board / governing body.

Gaynor Moore

Signed by the organisation's Accountable Emergency Officer

9.9.15.

Date of board / governing body meeting

4.8.15.

Date signed

Healthier Together
A review of health & care in Greater Manchester

Healthier Together Implementation - Summary

Purpose of document

The AGG received a draft paper regarding the Healthier Together Implementation activities required following the Committees in Common decision in July. This paper summarises the remaining GM implementation conditions not included in the original agreement with the Service Transformation Team.

Two supporting papers have also been provided to support the AGG which cover the wider roles and responsibilities:

- Implementation Conditions
- Implementation Overview

Background

The Greater Manchester Service Transformation team was commissioned to support Healthier Together decision making until at a cost of £3.09m per annum. In April 2015, the AGG supported a proposal for the Greater Manchester Service Transformation team to support some elements of the Healthier Together implementation (the Oversight & Assurance and Greater Manchester Delivery functions) at an agreed staffing cost of £c.600k per annum. The supporting financial breakdown was reviewed and agreed by the CFO Group at their meeting in June 2015.

This means that the amount of resources from the Greater Manchester Service Transformation team supporting Healthier Together will reduce and their role will change to deliver the Oversight & Assurance and Greater Manchester Delivery functions of implementation. It is agreed that an in-year return will be agreed with CCGs to recognise this change.

When the decision to select an option for implementation was taken, a number of **implementation conditions** were also set. Delivery of a number of these conditions was not included in the original agreement with Service Transformation. This paper outlines a proposed approach and costs for Greater Manchester Service Transformation to deliver these additional activities.

Summary of implementation roles agreed by AGG in April 2015

This agreement included Greater Manchester Service Transformation team **staffing costs** to deliver the following activities:

1. Oversight and Assurance of Healthier Together implementation

- Overseeing the sequencing decision
- Programme Management and oversee governance (CIC, Programme Board, Clinical Alliance, HR & Workforce group)
- Coordinate programme level assurance activities e.g. Office for Gateway Commerce reviews
- Assure single service Outline Business Cases and go-live readiness
- Oversee management of clinical risk via Clinical Alliance
- Design GM benefit framework and collect data pre and once post implementation
- Manage programme communications e.g. with HSJ, MEN and national stakeholders

- Undertake post implementation lessons learnt

2. Greater Manchester Delivery

- Emergency planning
- Liaison with NWAS
- Facilitate development of repatriation policy
- Facilitate social care discharge arrangements
- Greater Manchester workforce planning including recruitment, TUPE policies etc

(NB: design and implementation of changes at single service level are not included in this and will be delivered by each single service implementation team)

The current agreement with the Greater Manchester Service Transformation could be expanded using the existing resources to cover :

- Condition 6 – Research hubs – scoping and design
- Condition 7 – Governance – on-going management of patient panels

Scope of GM implementation activities not included in original agreement

The current agreement does not include the following which are anticipated to be required for implementation and could be included in the agreement with Greater Manchester Service Transformation:

- On-going funding for the Healthier Together Senior Responsible Officer
- On-going funding for the Independent Chairs of CIC and Programme Board
- Greater Manchester Service Transformation resource overheads
- Legal advice (anticipated to be significantly lower than previous phases)
- Equality Advisory Group Support (Conditions)

- Condition 3 – Clinical Alliance – funding of clinical posts not covered
- Condition 5 – Clinical implementation roles – funding of clinical posts not covered

Proposed costs to deliver these additional elements are included below:

Additional costs	Gross annual cost
SRO role	£48,000
Independent Chair CIC (Monthly)	£28,956
Legal advice (as required)	£10,000
Equality Advisory Group Support	£10,000
Clinical leadership roles	£68,000
Contribution to ST overheads	£42,777
Total	**£207,733**

It is proposed that an economy of scale is gained by adding this additional role to the existing agreement and covering all the GM level implementation conditions, rather than each CCG being responsible.

A separate paper is being presented to the CFO Group in August 2015 detailing the proposed amount of resource that will be released back to CCGs as the programme resource reduces. Accordingly, if this proposal is supported, the CCGs will not incur any additional cost in 2015/16; it will reduce the in-year return.

Summary

This summary and supporting paper seek to identify the specific roles and responsibilities for the Healthier Together Implementation phase. It is proposed that the transition occurs before the end of 2015 ensuring that the momentum and pace of the programme is maintained.

AGG members are requested to:

- Review the contents of the papers;
- Consider the proposal to increase the resource to the service Transformation Directorate to cover all GM Implementation Conditions;
- Consider the roles and responsibilities of all parties.

Supporting Papers:

Supporting Paper 1: Implementation Conditions

Supporting Paper 2: Implementation Overview

Title	**Healthier Together Proposed Implementation Considerations**
Author	Leila Williams
Version	1.0 Final Draft
Target Audience	Committees in Common
HTP Reference	
Date Created	08/07/2015
Date of Issue	14/07/2015
Document Status (Draft/Final)	Final
Description	This document includes proposed conditions of the decision to ensure that the stated aims of the programme are fully achieved during implementation.
File name and path	S:\Transformation\SERVTRAN\HealthierTogether\Boards&SubGrps\Committee in Common (HTCiC)\2015 Meetings\2015 07 15

Document History:

Date	Version	Author	Notes
08/07/2015	0.1	AH	Initial draft following CCG Concluding Workshop
09/07/2015	0.2	SH	Amendments incorporated from CCGs
10/07/2015	0.3	AH	Further amendments in advance of AGG and CiC meeting
14/07/2015	Final Draft	AH	Further amendments following AGG and in advance of CiC Meeting
20/07/2015	1.0	JM	Inclusion of amendments as recommended at July CIC as condition of endorsement of the included Implementation Conditions.
Approved by:			Leila Williams

1.0 Introduction and Purpose

On 15th July 2015 the Healthier Together Committees in Common (CIC) will be asked to vote on a preferred option for implementation under the in hospital proposals. This document includes proposed conditions of the decision to ensure that the stated aims of the programme are fully achieved during implementation.

This document should be read in conjunction with the Healthier Together Decision Making Management Report and supporting appendices which are available on the Healthier Together website.

2.0 Background

The vision for Healthier Together is as follows:

For Greater Manchester to have the best health and care in the country

The In-hospital proposals aim to:

Ensure everyone in Greater Manchester has access to the best standards of care for the in scope services

This means:

- Achieving the Greater Manchester Quality and Safety standards at all relevant sites
- Improving quality and safety outcomes at all relevant sites
- Reducing the variation in attainment of standards and outcomes that currently exists across Greater Manchester

3.0 Selecting an option for implementation

On 15th July 2015 Committees in Common (CIC), the decision makers for Healthier Together made up of GPs from the 12 Clinical Commissioning Groups (CCGs) in Greater Manchester, will be asked to select a preferred option for implementation.

What is an option?

The Healthier Together model of care proposes that 'single services' will be formed. Single services are networks of linked hospitals working in partnership to deliver better care for patients for A&E, Acute Medicine, and General Surgery (with all sites continuing to provide a full A&E where they currently do so). On 17th June 2015, CIC voted unanimously to commission 4 single services. All hospitals specialise in providing certain types of care – for example some hospitals specialise in stroke care, others in cancer care. **Similarly, one of the hospitals within each of the single services will specialise in general surgery for patients with life threatening conditions.**

An "option" describes the location of the sites that will specialise in general surgery.

4.0 Achieving the stated aims of the programme

Following decision making, the programme will move in to implementation of the selected option. To ensure that the stated aims of the programme are achieved, CIC members will also be asked to vote on a set of

implementation conditions. If endorsed these conditions will need to be in place before implementation can go ahead.

4.1 Principles of implementation

The following principles will be adhered to during implementation:

- National targets must continue to be met before, during and after implementation
- All single services must evidence how they will meet or exceed the Greater Manchester Quality and Safety standards as set out in the Healthier Together model of care
- Providers, Commissioners and Regulators will need to work differently and collectively. This aligns to changes to ways of working under the proposed arrangement outlined in the Health and Social Care Devolution Programme
- Success will be measured at a local and Greater Manchester level: quality and safety should be improved across **all** localities, **all** relevant sites and **all** single services

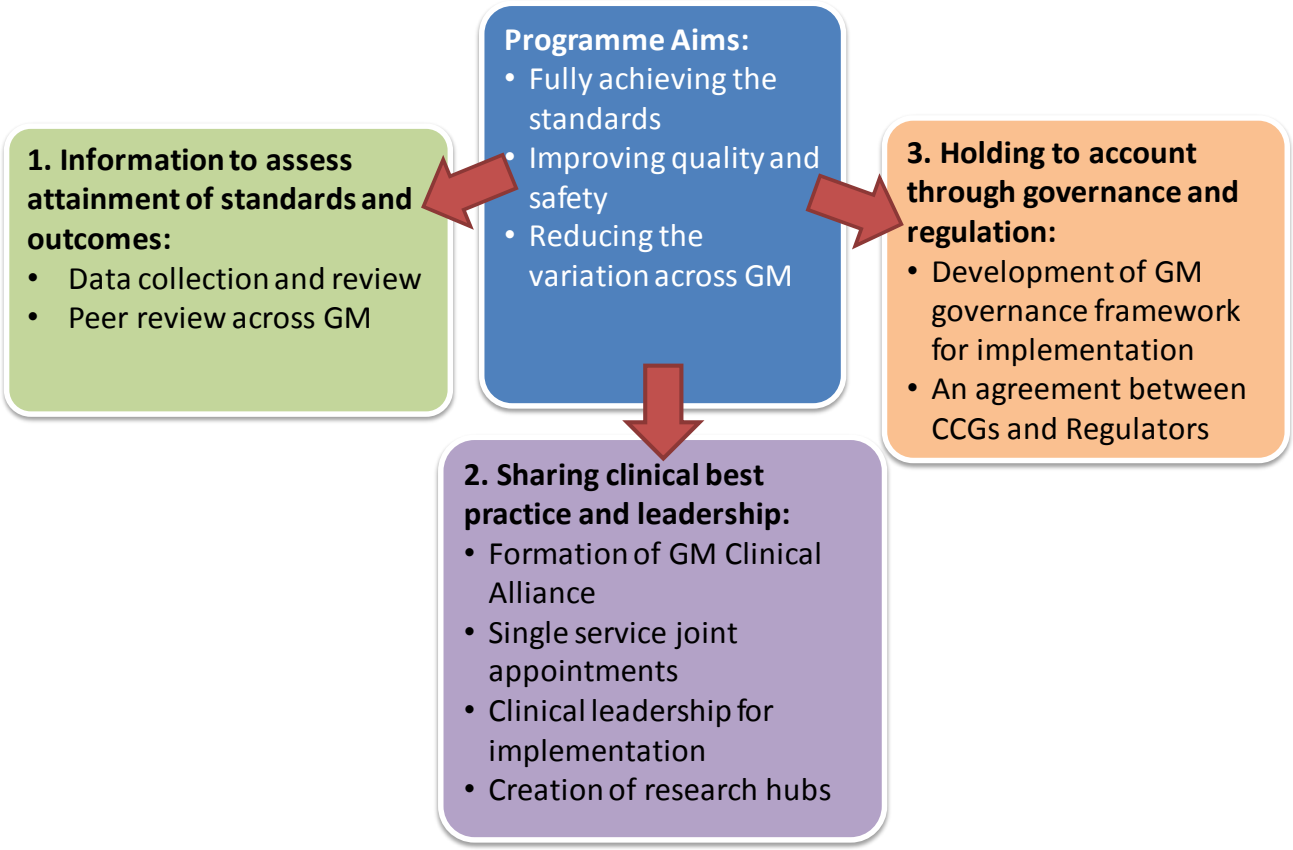
4.2 Implementation conditions

These implementation conditions will be assessed prior to implementation of each single service part of the "Go Live" planning arrangements. The conditions will be underpinned by contractual agreements. The conditions are designed to ensure the stated aims of the programme are achieved:

- Achieving the Greater Manchester Quality and Safety standards at all relevant sites
- Improving quality and safety outcomes at all relevant sites
- Reducing the variation in attainment of standards and outcomes that currently exists across Greater Manchester

The conditions are summarised in the diagram below, further information on each is provided in subsequent sections of this document.

Figure 1.0 Summary of Healthier Together Implementation Conditions



The conditions are summarised below:

- Condition 1 – Regular data collection, review and monitoring is implemented
- Condition 2 – Structured process of peer review across GM
- Condition 3 – Establishment of a Greater Manchester Clinical Alliance
- Condition 4 – Joint appointments to Single Services
- Condition 5 – Appointment of GM clinical leadership for implementation
- Condition 6 – Formation of Single Service Research Hubs
- Condition 7 – Development of a GM governance framework
- Condition 8 – Formation of a CCG and Regulatory Body Alliance to support implementation

Further detail on each is provided overleaf.

4.2.1 Conditions related to Information

Condition 1 - Regular data collection, review and monitoring is implemented

What does this mean?

- Mandated data collection and submission from all GM providers (on standards, outcomes, productivity)
- Data to be analysed independent of providers
- All Trusts to publish outcomes (e.g. mortality data) on an agreed timetable to support implementation
- Data to be made available to patients commissioners and providers to drive improvement

How does this contribute to achieving the aims?

- Allows a deeper understanding of the service provision
- Identifies areas of best practice and areas for improvement
- Enables benchmarking of performance
- Allows analysis of the relationship between standards and outcomes

Condition 2 – Structured process of peer review across GM

What does this mean?

- A commissioner mandated, structured process of peer review to support the transition and implementation phases
- Conducted in advance and post implementation of changes to in scope services
- Peer review undertaken of each single service by clinicians from across GM
- Outcomes of peer review shared with all GM providers and commissioners

How does this contribute to achieving the aims?

- Allows an understanding of whether the standards will be/ are being achieved
- Identifies areas of best practice and areas for improvement
- Facilitates sharing of best practice and innovation
- Builds and maintains the clinical community across Greater Manchester

4.2.2 Conditions related to sharing clinical best practice and leadership

Condition 3 - Establishment of a Greater Manchester Clinical Alliance

What does this mean?

- Independently chaired (e.g. by Non-GM Trust) clinical alliance, made up of senior clinicians from all GM Trusts
- **Mandated** by commissioners; governance through the Programme implementation architecture
- Working collaboratively as guardians of the Healthier Together standards and model of care during the implementation phase
- Acting as an Expert Scrutiny Panel responsible for assuring whether detailed single service models of care, pathways and workforce plans comply with the Healthier Together Quality and Safety standards; advising commissioners
- During implementation responsible for reviewing quality and safety issues and providing assurance on solutions identified
- Peer review findings are reported at the Clinical Alliance

How does this contribute to achieving the aims?

- Ensures design of single services complies with Quality and Safety standards
- Facilitates sharing of best practice and innovation
- Builds clinical ownership and community across Greater Manchester

Condition 4 – Joint appointments to Single Services

What does this mean?

- Each single service to appoint a Clinical Director to work across all sites within the Single Service - recruitment to be a joint process between Trusts and agreed lead CCG
- Clinical Director to lead the formation of single service teams, oversee design of single service model of care and pathways, and be responsible for clinical performance of the single service
- All new clinical (medical) appointments to be single service wide
- An identified provider Executive Lead for each Single Service to be in place during the implementation phase
- Consider GM level recruitment plans to increase exposure and wider sharing of resources

How does this contribute to achieving the aims?

- Facilitates standard model of care and pathways across each single service
- Provides accountability for attainment of standards and improved outcomes

Condition 5 – Appointment of GM clinical leadership for implementation

What does this mean?

- Appointment of a small number of clinical leadership roles to support implementation; similar to existing clinical champions
- Responsibilities will include chairing of sub-groups to support the Clinical Alliance e.g. for General Surgery
- Responsibilities may include 'buddying' of single services – providing clinical leadership during the implementation of single services

How does this contribute to achieving the aims?

- Promotes sharing of best practice
- Visible leadership; unifying all 4 Single Services
- Enables best practice from one single service to be utilised in the implementation of another single service

Condition 6 – Formation of Single Service Research Hubs

What does this mean?

- All single services to be aligned to a Teaching Hospital/ University to facilitate research , clinical audit, training and workforce development and to share innovation
  - Alignment could be for research, teaching and / or service delivery e.g. clinics or theatre sessions
  - Shared best practice clinical governance processes and learning
  - Sharing of best practice to support the implementation
  - Formal link to the proposed to GM Academic Health Science System
  - Sharing of knowledge and expertise to support the training and development of the future workforce

How does this contribute to achieving the aims?

- Continues to strengthen the research and academic input to the Single Services
- Increases access to on-going research and innovation
- Supports the development of a sustainable future workforce required for the long term delivery of Healthier Together.

4.3 Commissioning leadership and collaboration

It is recognised that the strength of the Healthier Together governance has been the collective **clinical** leadership of the 12 Greater Manchester CCGs. It is proposed that this continues through implementation. The following conditions are proposed to strengthen the governance of the implementation:

Condition 7 – Creation of GM implementation governance

What does this mean?

- Commitment to on-going Greater Manchester-wide governance for the Healthier Together programme
- Commitment to on-going joint governance with commissioners, providers and regulators
- Commitment to ensure that lay and patient representation will be at the forefront of governance arrangements.

How does this contribute to achieving the aims?

- Continues to provide robust governance and oversight to the programme post decision
- Provides accountability for achievement of the publicly stated aims

Condition 8 – Formation of a CCG and Regulatory Body Alliance to support implementation

What does this mean?

- An agreed joint process between CCGs and Regulators for holding Providers to account during the implementation phase
- Strengthening existing governance arrangements between commissioners, regulators and providers (e.g. HT Programme Board)
- Commitment to work on a long term basis with the healthcare regulators to ensure Healthier Together is fully achieved.

How does this contribute to achieving the aims?

- Ensures full alignment between CCGs, Providers and Regulators on key issues (e.g. Capacity, Capability, Leadership)
- Enhances openness and transparency between all parties

Further areas of CCG collaboration to support implementation could include:

- A commitment from all CCGs to commission the Quality and Safety standards for all providers via a GM Service Specification
- Creation of a GM Common Framework for commissioning Single Services
- Consideration of the requirement for, and agreement of, the most appropriate lead commissioning arrangements
- Continuation of lead commissioner arrangements for NWAS
- Sharing of commissioning arrangements for each single service with all Greater Manchester commissioners to ensure parity
- Agreed common commissioning approaches (for example to payment mechanisms)

5.0 Actions

- CiC Members are requested to:
- Note the contents of this report;
- Identify any amendments or additional implementation conditions;
- Endorse the implementation conditions.

Supporting Paper 2

Title	**Healthier Together Implementation Overview**
Author	Alex Heritage
Version	Final
Target Audience	AGG
HTP Reference	
Date Created	13/07/2015
Date of Issue	01/08/2015
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Document History:

Date	Version	Author	Notes
13/07/2015	0.1 – 0.11	M. Patterson & K. Coope	Draft
23/07/2015	0.12	S. Hargreaves	Amends following SMT review
01/08/2015	Final		Amends following AGG review and comments from Stuart North & Steve Allinson
Approved by:			A. Heritage

1. Purpose of this paper

This supporting paper provides an overview of the Healthier Together Implementation Phase

2. The implementation challenge

Healthier Together (HT) proposes changes to A&E, Acute Medicine and General Surgery services across Greater Manchester (GM) to achieve the GM Quality and Safety Standards and improve outcomes. These changes will also necessitate changes to Critical Care, Anaesthetics and Support Services. They will require updates to pathways, policies, ways of working and training.

The implementation of Healthier Together will also require the creation of cross-organisational teams working across Single Services (site rotation and changes to working patterns) as well as recruitment of a large number of Consultants into (often hard to fill) vacancies. Substantial HR, change and communications effort will be required to achieve this.

IT systems will need to be adjusted to adapt to the above changes (for example to allow access to patient records and to reflect new pathways).

Each single service will also need to plan for changes in patient flows, necessitating changes in estate and demand for supporting services (for example, changes in critical care bed capacity). As an indication of the scale of this programme, the capital cost of option 4.4a is £63.3m. The programme is also predicated on £20m of efficiencies by 2018/19 from reducing length of stay, reducing admissions and deflecting activity that is not best managed in hospitals away from hospital based care. This could be the largest reconfiguration of services currently in England.

The challenge extends beyond the Trust site; implementation of Healthier Together is predicated on ambulances transferring patients to different sites for specialist care. This means that a North West Ambulance Service/East Midlands Ambulance Service Pathfinder, which is a transfer decision making tool, will need to be tested and refined and crews trained and prepared.

GM Resilience/Emergency Plans will need to be tested and in place across Greater Manchester at all points in the staged roll-out.

Patients and a complex mixture of GM stakeholders must be engaged throughout.

Perhaps most importantly, learning from other substantial change programmes tells us that the programme will not be successful if it is not effectively managed at both a local and GM level. Following the options decision, requirements will immediately be made of a central oversight body (for example, sequencing decisions). Governance and assurance will be important; the clinical design should be overseen to minimise design “drift” and benefits managed closely to achieve sustainability.

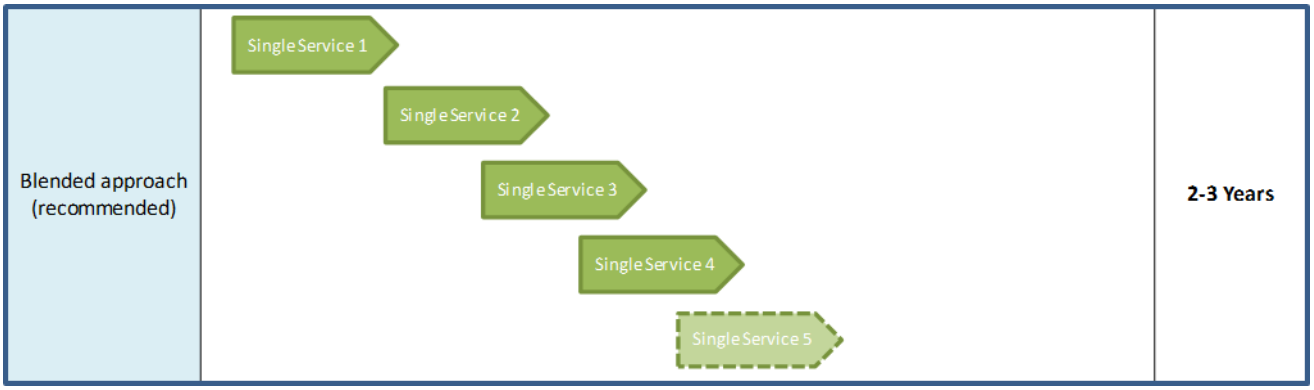
Based on the complex improvement activities described, the AGG supported the following principles as a basis for the implementation:

- Implementation should be led at a Single Service level wherever possible: the formation of single teams of clinicians for General Surgery, A&E, critical care and anaesthetics (and potentially some diagnostic services) will require considerable operational, cultural and behavioural change.

- Some elements of implementation or design will only need to be 'done once' for Greater Manchester but will need to be tested locally (e.g. implementation of NWAS Pathfinder and GM Workforce Planning).
- Other elements of the implementation will require oversight and management at a GM level (for example during Making It Better, negotiation with staff unions and GM recruitment was managed in this way) and there will be an on-going requirement for programme assurance, programme management, clinical leadership, and decision making.

The AGG also agreed a "blended" approach, meaning that once the first single service has been fully implemented (and learning captured), others will be initiated sequentially, but delivery will overlap as described in the diagram below.

Figure 1: Blended implementation approach



The following implementation principles will apply:

- national targets must continue to be met before, during and after implementation;
- all single services must evidence how they will meet or exceed the Greater Manchester Quality and Safety standards as set out in the Healthier Together model of care;
- Providers, Commissioners and Regulators will need to work differently and collectively. This aligns to changes to ways of working under the proposed arrangement outlined in the Health and Social Care Devolution Programme; and,
- success will be measured at a local and Greater Manchester level: quality and safety should be improved across all localities, all relevant sites and all single services.

Organisations are also bound, under the Committees in Common decision taken on 15/7/15, to achieve the following implementation conditions, each of which will need to be monitored.

Figure 2: Implementation conditions

Condition 1 - Regular data collection, review and monitoring is implemented

- Mandated data collection and submission from all GM providers (on standards, outcomes, productivity)
- Data to be analysed independent of providers
- All Trusts to publish outcomes (e.g. mortality data) on an agreed timetable to support implementation
- Data to be made available to patients, commissioners and providers to drive improvement

Condition 2 - Structured process of peer review across GM

- A commissioner mandated, structured process of peer review to support the transition/ implementation
- Conducted in advance and post implementation of changes to in scope services
- Peer review undertaken of each single service by clinicians from across GM
- Outcomes of peer review shared with all GM providers and commissioners

Condition 3 - Establishment of a Greater Manchester Clinical Alliance

- Independently chaired (e.g. Non-GM Trust) clinical alliance, made up of senior clinicians from all Trusts
- Mandated by commissioners; governance through the Programme implementation architecture
- Working collaboratively as guardians of the standards and model of care during the implementation phase
- Acting as an Expert Scrutiny Panel responsible for assuring whether detailed single service models of care, pathways and workforce plans comply with the HT Quality and Safety standards; advising commissioners
- During implementation responsible for reviewing quality and safety issues and providing assurance on solutions identified
- Peer review findings are reported at the Clinical Alliance

Condition 4 – Joint appointments to Single Services

- Each single service to appoint a Clinical Director to work across all sites within the Single Service- recruitment to be a joint process between Trusts and agreed lead CCG
- Clinical Director to lead the formation of single service teams, oversee design of single service model of care and pathways, and be responsible for clinical performance of the single service
- All new clinical (medical) appointments to be single service wide
- An identified provider Executive Lead for each Single Service to be in place during the implementation phase
- Consider GM level recruitment plans to increase exposure and wider sharing of resources

Condition 5 – Appointment of GM clinical leadership for implementation

- Appointment of a small number of clinical leadership roles to support implementation; similar to existing clinical champions
- Responsibilities will include chairing of sub-groups to support the Clinical Alliance e.g. for General Surgery
- Responsibilities may include 'buddying' of single services – providing clinical leadership during the implementation of single services

Condition 6 – Formation of Single Service Research Hubs

- All single services to be aligned to a Teaching Hospital/ University to facilitate research , clinical audit, training and workforce development and to share innovation
- Alignment could be for research, teaching and / or service delivery e.g. clinics or theatre sessions
- Shared best practice clinical governance processes and learning
- Sharing of best practice to support the implementation
- Formal link to the proposed to GM Academic Health Science System
- Sharing of knowledge and expertise to support the training and development of the future workforce

Condition 7 – Development of a GM governance framework

- Commitment to on-going Greater Manchester-wide governance for the Healthier Together programme
- Commitment to on-going joint governance with commissioners, providers and regulators
- Commitment to ensure that lay and patient representation will be at the forefront of governance arrangements.

Condition 8 - Formation of a CCG and Regulatory Body Alliance to support implementation

- An agreed joint process between CCGs and Regulators for holding Providers to account during the implementation phase
- Strengthening existing governance arrangements between commissioners, regulators and providers (e.g. HT Programme Board)
- Commitment to work on a long term basis with the healthcare regulators to ensure Healthier Together is fully achieved.

These have been amended to reflect discussions at CIC on July 15th 2015. The final wording will be agreed by the CIC in September following the August Programme Board.

3. Implementation roles and responsibilities

In April the AGG agreed the tasks required to implement Healthier Together. It should be noted that these were agreed before the implementation conditions were agreed and not all are covered will be delivered under this agreement. See page 15 for an assessment of which of the conditions are covered within this agreed set of tasks.

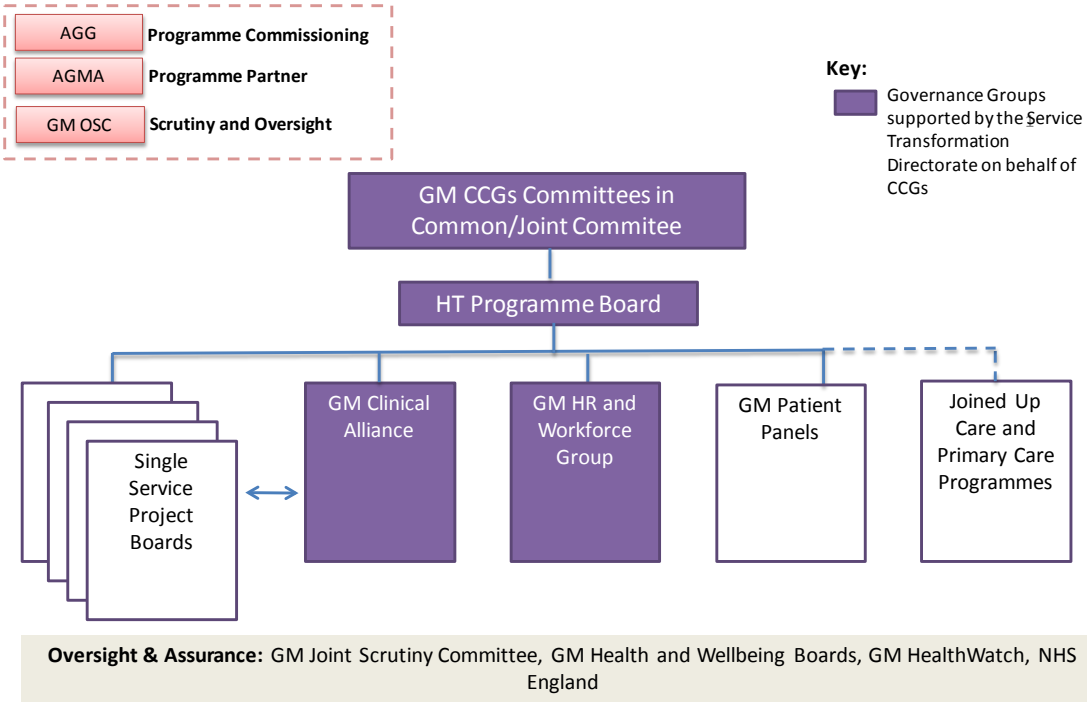
These fell into four categories:

1. Trusts will work together in **Single Service Teams** to lead and deliver the implementation of each Single Service.
2. There will also be some **Commissioner specific tasks,** such as changing commissioning intentions.
3. In addition, there are some tasks that will only need to be planned and designed once for Greater Manchester; **GM delivery** projects. These will be overseen by the Service Transformation Directorate.
4. GM delivery will need to be managed centrally. Additionally, delivery of the model of care should be overseen (to minimise design "drift") and benefits monitored at a GM level. Some decisions will need to be taken at a GM level (e.g. sequencing) and there will be ongoing assurance and governance requirements. These requirements will need to be managed centrally through an **Oversight & Assurance** function, which will be delivered by the Service Transformation Directorate.

These roles were detailed in the April AGG paper and are summarised in the example governance diagram below (with roles delivered by the Service Transformation Directorate highlighted in purple). NB this is to be agreed.

Figure 3: Example governance structure highlighting groups supported by the Service Transformation Directorate

Example Project Implementation Governance (to be confirmed)



These roles were detailed in the April AGG paper and are summarised in the diagram below (with roles delivered by the Service Transformation Directorate highlighted in purple).

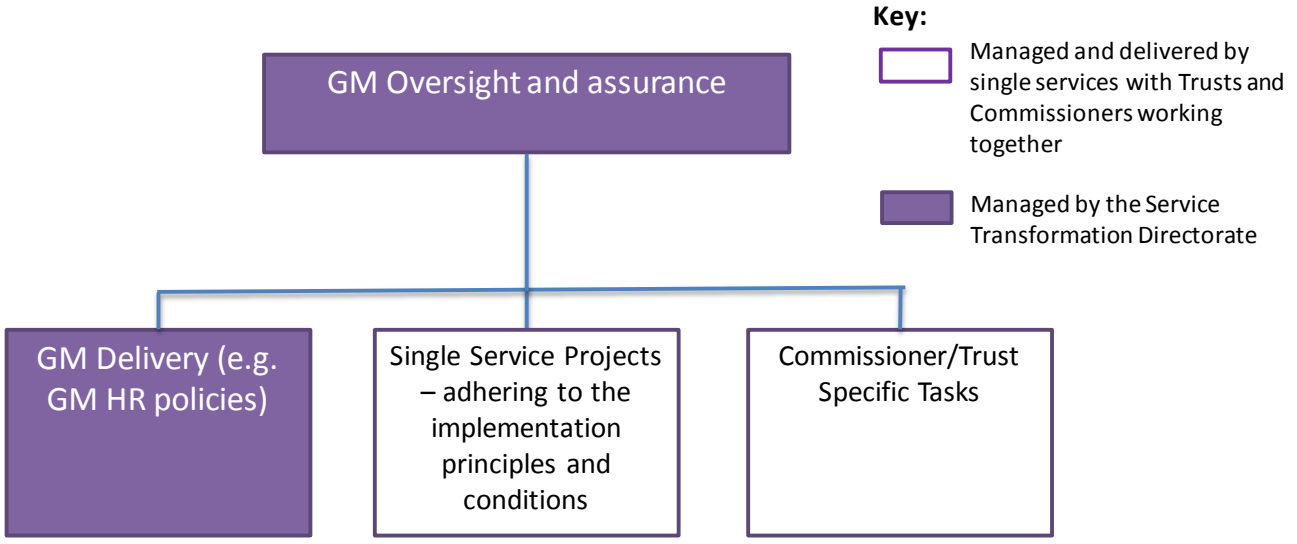
Figure 4: Implementation roles and responsibilities

1. Oversight and Assurance	2. GM Delivery Projects
• Programme planning and governance (e.g. sequencing of resource availability) • Sequencing of implementation • Management of clinical risk • GM benefits realisation plan and approach • Risk sharing agreements • Management of GM wide 'Do it once' tasks • Assurance of single service OBC / FBCs and go live readiness • Completion of assurance processes (OGC, IRP, NHS England) • Programme communications and engagement • GM liaison with stakeholders (e.g. Monitor / TDA / NHSE, Mental Health, Treasury) • Post implementation review, lessons learnt and sustainability planning	• Emergency Planning • Ambulance changes implementation • Repatriation policy • Social Care discharge arrangements • GM workforce plan • HR and workforce policies, for example recruitment, TUPE arrangements etc.

3. Single Service Project Management	4. Trust / Commissioner Specific Tasks
• Single service pathways • Development of standard operating procedures and protocols • Development of appropriate governance and risk protocols • Single service workforce models including job plans and rotas • Formation of single service teams – assigning of roles and responsibilities • Training and communication to staff • Change management • Development of shared IT • Data sharing / Caldicott Guardian agreements • Data protection arrangements • Development and management of local governance arrangements • Development of local benefits realisation plans • Go live and transition planning • Local communications and engagement • Local liaison with Monitor / TDA • Hand over to business as usual	Trust: • Capital build Outline Business Case/Financial Business Case • Management of capital programmes Commissioners: • Agreement of joint commissioning arrangements • Commissioning intentions / contracts • Agreement of how standards and outcomes will be measured • On-going audit and assessment of standards

In summary, this means that implementation work will be made up of the following elements:

Figure 5: Implementation roles summary



In delivering the **Single Service Projects** and **Trust / Commissioner Specific Tasks**, Trusts and Commissioners are responsible for delivery of the implementation conditions and adhering to the principles of implementation set out in section 2.

The table set out on the following page describes the **GM Oversight and Assurance** and **GM Delivery tasks.** In April the AGG agreed that these will be undertaken by the Service Transformation Directorate. The table also describes the inputs required from Trusts and Commissioners to enable that work. The following table provides a breakdown of the roles and responsibilities for implementation:

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
Management of any Judicial and Independent Reconfiguration Panel review;	• Ensure all documentation is archived and stored for transfer to CCGs	N/A unless specifically related to implementation	CCGs will be required to coordinate process and documentation submission to IRP Panel/ High Court
Oversee the sequencing decision	• Design an approach to taking a single service implementation sequencing decision. • Test this approach with stakeholders, obtain legal advice to ensure it is legally sound and agree it with the Committees in Common (CiC). • Design a readiness assessment for each single service to complete. • Collate that information and present it to the CIC to enable them to make an implementation sequencing decision. • Inform stakeholders and communicate to the public about next steps.	Complete a readiness assessment and input into the sequencing decision as required. Resource the single service team and provide an indicative Single Service Implementation Plan.	Ownership of implementation principles and conditions
Oversee programme management	Programme management roles will include: • Collating Single Service project plans, GM Delivery project plans and Commissioner/Trust task plans to produce an overarching Healthier Together programme plan; • Highlighting any material challenges relating to programme planning to the CiC, Clinical Alliance or Single Service Project Board (as appropriate) *for their attention / action* • Maintaining a strategic risk register for the programme and reporting material	Set up single service risk and reporting processes that feed into the programme processes. Manage risks raised through the governance structure as required. Provide evidence of delivery of implementation principles and conditions as required.	Regular communication of programme status to Boards Communicate programme progress to all stakeholders

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	issues to the CiC, Clinical Alliance or Single Service Project Board (as appropriate) *for their attention / action* • Conducting a pre and post go-live review of whether implementation principles and conditions have been planned for and delivered by the Single Service Teams and the programme as a whole and report progress to the CiC, Clinical Alliance or Single Service Project Board (as appropriate) *for their action* • Planning and sequencing Healthier Together Resources (to support the above agreed roles).		
Oversee governance	Design and manage the new governance structure, including: • Drafting a proposed new governance to be agreed with the CIC; • Organising the meetings; • Managing membership; • Writing the Terms of Reference for each group; • Setting agendas; and, • Setting work schedules. This will include the groups shown on figure 3. Production of regular programme reports for the Programme Board and AGG including: • a quarterly GM Programme Highlight Report and • a quarterly Finance Report.	Identify one single service Clinical Director and an Executive Director for each Trust. Develop an appropriate governance structure that feeds into the central governance arrangements. Provide evidence to inform programme assurance processes as required. Input into programme reporting as required.	Nominate and sponsor attendance of senior leaders to attend meetings regularly

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
Coordinate programme assurance processes of Healthier Together	• Assess if any GM or national programme assurance is required e.g. from Office for Gateway Commerce, NHS England • Coordinate work to provide to, and relationship with, assuring body • Coordinate work of Single Services (Trusts and Commissioners) to fulfil any assurance requirements.	Provide evidence to support assurance processes as required.	Provide evidence to support assurance processes as required
Provide assurance of single service Outline Business Cases	Design and undertake a business case assurance process, reporting to the GM governance structure, *for their action*. This will assure the Business Case approach (i.e. that the elements of the Business Case are in place and have been appropriate signed off and technically assured). It will not include assurance of financial information or data used. Collation of plans into overall programme plan, oversight of sequencing and coherency, highlighting of risks and issues through the governance structure and assurance to the CIC that adequate planning for implementation conditions has occured	Provide evidence to support assurance processes as required.	Development of and sign off of Single Service Plans to include provision for implementation conditions
Assurance of single service go-live readiness	Design and oversee a go-live readiness process to ensure the CiC receive assurance of readiness prior to the go-live of each Single Service and ambulance service go-live.	Provide evidence against go-live readiness assessment.	Scoping or delivery of Commissioner/Trust Specific tasks, such as changes to commissioning contracts
Oversight of implementation		Implementation of each single service, for example: o project initiation and Planning and delivery of ambulance changes (only liaising with NWAS and EMAS	

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
		who will deliver this work);resourcing; o project, change and risk management in relation to each single service implementation; o set up and management of Single Service governance and decision making (e.g. capital and funding decisions); o project delivery (e.g. analysis, business case preparation, design work, training, recruitment, go-live preparations and go-live management); o HR and financial advice other than provision of GM-level policies; o local communications, stakeholder management, engagement and consultation; o assurance and testing of the design (e.g. pathways, working practices and financial planning), other than ensuring, through a GM Clinical Alliance, that the design meets the specification set out in the model of care which is a role of the Service Transformation Directorate; o benefits management (other than receiving and collation and reporting of data received from single services which is a role of the Service Transformation Directorate);	

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
		o capturing knowledge and learning to share with other Single Services (e.g. deciding what should be shared and where necessary documenting best practice) o project closure and sustainability management (other than oversight by Service Transformation Directorate which will continue to receive and collate GM benefits information).	
Oversee management of clinical risk	Establish and run a GM Clinical Alliance that will: • Oversee design compliance with the model of care (to minimise "design drift" where it is material); • Manage GM-wide clinical design issues (e.g. challenges relating to changes to NWAS) and • Oversee benefits delivery and sustainability of benefits. This may include a strategic group meeting less regularly (e.g. quarterly) and a working group, which would meet more regularly (e.g. monthly).	Conduct local clinical engagement and nominate senior clinicians from suitable disciplines to join the GM Clinical Alliance from each Trust. Raise GM clinical issues (and provide updates as requested) to the GM clinical Alliance as required.	Identify relevant clinical input to Single Service Team
Delivery of Greater Manchester benefits management	• Design a set of measures and outcomes to be reported by single services to demonstrate attainment of standards and benefits through engagement with stakeholders. • Design templates for single services to	Monitor Single Service and Trust compliance with the GM Quality and Safety standards and delivery of benefits. Share appropriate data with the Service Transformation Team in the required	Input to benefits management process

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	report data • Collation of data received by single services and reporting of this to CIC pre go-live, during implementation and once post go-live of this evidence	format.	
Programme communications and engagement	• Liaison and management of national / Greater Manchester media • Attendance at single service Communications and Engagement meetings • Coordination of cross Greater Manchester communications issues • Establishment of Greater Manchester patient panels	Manage single service communications, engagement and any local consultation.	Manage CCG/ Trust communications, engagement and any local consultation.
Conduct GM liaison with stakeholders (e.g. Monitor, TDA and NHS England)	Manage and deliver a GM Programme Stakeholder Plan (requesting support from Single Service Executive Directors and team members as required to fulfil this).	Provide support to GM stakeholder management (e.g. attendance of key meetings and preparation of reporting information) as requested.	Provide support to GM stakeholder management (e.g. attendance of key meetings and preparation of reporting information) as requested.
Oversee a post implementation review, lessons learnt and sustainability planning	Design an approach for each Single Service to deliver lessons learnt exercise following each implementation. This should identify material that could be "packaged" and shared by the Single Service with other single services (such as new policies and pathways). Complete an options appraisal of mechanisms to ensure sustainability of model of care, standards and benefits for	Conduct a lessons learnt exercise following implementation. Package useful "products" (e.g. pathways and policies) and share these with other Single Services as required following the exercise.	Input to lessons learnt process

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	consideration by CIC.		
Management of GM Projects ('Do it once for GM' tasks)	The Service Transformation Directorate will manage six GM Delivery projects, as described in the following section.	Receive regular updates on GM projects through the governance structure and ensure local plans reflect GM project inputs (for example provision of HR policies).	Input to GM projects (information and personel)
	Emergency Planning • Scope GM resilience work with the NHS England Emergency Planning team and agree key milestones and outputs that are coherent with the programme plan. ***Day to day project management and delivery will be undertaken by the NHS England GM Emergency Planning Team, with Single Service Teams undertaking defined elements of the work (such as local capacity creation planning).*** o NHS England and Trust work is likely to include designing the Gold Command approach (plans for how patients will be transferred in the event of a major incident, including roles and responsibilities) and plans to create capacity at each site. These will be tested with stakeholders and scenario planning will be undertaken. • Report progress and highlight progress risks and issues to the CiC, Clinical Alliance or Single Service Project Board	Work with NHS England Emergency Planners to develop local Emergency plans that feed into the GM Emergency Plan prior to go-live. Update local Emergency Plans when other Single Services go live as necessary.	• Development and delivery of GM Emergency Plans (only liaising with the NHS England Emergency Planning experts who will deliver this work);

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	(as appropriate) *for their action.* • Facilitate the sign off of GM Resilience Plans (by the Clinical Alliance and CiC, as appropriate).		
	Ambulance changes and GM transfer policy • Hold a number of scoping meetings with the North West Ambulance Service and East Midlands Ambulance Service (NWAS and EMAS) to agree the scope of the work required to change ambulance transfer processes and a go-live approach. We will test this with key stakeholders and sign it off with the Clinical Alliance and CiC. • Agree key milestones and outputs with NWAS/EMAS, ***who will project manage and deliver the work*.** These are likely to include: o Refining and testing a "Pathfinder" tool that will be used by ambulance crews to make decisions on where to transfer patients. This is may include using historic patient data from a selected hospital to analyse how the Pathfinder would have transferred that patient, followed by refinements of the Pathfinder and, closer to go-live, a live audit test; o Preparing staff for go live (e.g. communications, supporting materials and training); and, o Managing the go-live (e.g. go-live oversight and contingency planning). • Report progress and highlight issues to	NWAS and EMAS will: Project manage and deliver this project. Conduct a go-live readiness assessment prior to go-live using a GM standard format as required. Conduct ambulance go-live contingency planning and oversee go-live (e.g. a Gold Command approach). The first Single Service to implement will: Work with NWAS/EMAS to develop a Single Service transfer protocols (including bed availability) and, through the governance structure, refine these with other Trusts to create a GM approach.	

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	the CiC, Clinical Alliance or Single Service Project Board (as appropriate) for their action. • Design a pre-go-live readiness assessment (to be undertaken by NWAS and EMAS) to provide assurance to the Clinical Alliance and CiC that changes have been adequately prepared. • Ccollate this report and ensure it is signed off by the appropriate governance groups (any resulting actions will be owned by NWAS/EMAS or the Clinical Alliance as appropriate). • Oversee, through the governance structure, agreement of a GM internal Single Service Transfer Policy (including bed availability upon transfer).		
	Repatriation policy • The first single Service to implement will develop the first draft of a GM policy for treatment of patients at their local hospital following specialist care at another hospital in the Single Service (and accountability approach). • Test this with the Clinical Alliance (who will oversee amendments as necessary), Single Service Project Board, NWAS, EMAS and other stakeholders as appropriate. Oversee development of the policy by those groups and sign of the final GM policy.	The first Single Service to implement will: Develop the first draft of a repatriation policy (including bed availability or outpatient planning), in consultation with local clinicians and patients to inform the GM policy.	Development of policies for repatriation, social care etc (only testing of policies developed locally, overseeing their development and sign off as GM policies through the governance structure and development of the specific GM HR policies listed);
	Social Care discharge arrangements	The first Single Service to implement	

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	The first single Service to implement will develop in conjunction ***with the Greater Manchester Directors of Adult Social Care*** the first draft of a policy for discharge patients into social care when patients are receiving specialist care at a hospital that is not their local hospital. Test this with the Clinical Alliance, Single Service Project Board and other stakeholders to determine if it would be beneficial to create a GM policy (or if local variation would make this too challenging). If it is determined that it is beneficial to create a GM policy, Service Transformation will then test the local policy with the Clinical Alliance (who will oversee amendments as necessary), Single Service Project Board and other stakeholders as appropriate and oversee sign off of the GM policy with the appropriate governance groups and CiC (as required).	will: Develop the first draft of a policy for social care discharge following treatment at a hospital that is not the patients' local hospital.	
	GM workforce plan including Management of recruitment etc. Extend the GM workforce model from Consultants to incorporate other members of the single service team Work with Trusts and other stakeholders to develop a strategic GM Workforce Plan that	Provide workforce information in a timely and consistent manner to facilitate the production of the strategic GM Workforce Plan. Develop a Single Service Workforce Model (including job descriptions, plans and rotas) that describes how the GM Workforce Plan will be delivered locally. Recruit staff using that approach.	

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	describes the "gap" at each level at each site/single service and the recruitment (or L&D) required ensuring that each single service is safely staffed and able to meet the standards. Facilitate the review and approval of the Single Service Workforce Models (which will describe **how** the GM Workforce plan will be delivered locally) through the governance structure to ensure that they are consistent with the strategic GM Workforce Plan. During implementation, maintain oversight of GM recruitment as it progresses and ensure risks are raised and managed through the governance structure as required. Develop a consistent GM template/approach to a Training Needs Analysis and L&D plan that can be used by each Single Service team to develop and deliver L&D prior to go-live. Facilitate the review and assurance of these through the governance structure. In addition, identify any GM impacts on the workforce and design an approach to these. For example, liaise with Health Education England with regard to changing junior doctor training to take into account rotation and the different types of experience that might be achieved at different sites. Work closely with the first (and subsequent	Conduct a Training Needs Analysis using the GM approach to identify areas of development. Prepare and deliver learning and development plan to ensure the GM Quality and Standards are met.	

CIC	Service Transformation Directorate	Single Service Teams	CCGs/Trusts
	Single Service teams) to help them understand where HR design work can be shared with other single services.		
	GM HR and workforce policies Develop and agree, in consultation with Trusts and other stakeholders, GM HR Policies including: • an HR Policy Framework; • a framework for managing recruitment during implementation; and • a Cross Boundary Working Framework to promote a flexible workforce. This will enable consistent application of HR policies and fair equitable treatment of staff. Laise with staff groups (Unions) on behalf of GM Trusts (working closely with the Trusts) to achieve a single agreement to these policies.	Deliver contract changes and practical arrangements (e.g. Single Service inductions, parking, expenses), in consultation with staff, staff groups and other stakeholders.	

4. Sequencing of Service Transformation implementation tasks during 2015

It is proposed that the Service Transformation Directorate organise their tasks into four packages of work:

1. **Decision phase finalisation – mid-July to end September 2015 (c. 11 weeks)** , including:
    - management of requests for information following the decision (e.g. Freedom of Information requests, media enquiries, MPs requests, Secretary of State queries) and
    - documentation of the rationale for the decision in a publically available detailed Decision Making Business Case, supported by a variety of communications materials (e.g. video and Easy Read).

Figure 9: Why do we need to produce a Decision Making Business Case and Communications?

Why do we need to produce a Decision Making Business Case and communications?
There are a number of government guidelines that require documentation of the decision making rational and process. In 2008 Lord Darzi (in "NHS Next Stage Review: Leading Local Change") wrote that consultations must be clear, accessible, transparent, open, inclusive, responsive, sustainable, proactive and focused on improvement. These themes were reiterated in the formal guidance "Real involvement; working with people to improve Health Services" (2008) and fit closely with the requirements set out in the 2013 Cabinet Office Principles (which do not have legal force).

Compliance with many of these requirements has been documented in the Decision Making Management Report. For example, publication of an Equalities Assessment demonstrates inclusivity.
However, there are elements of these requirements that are not met by the Management Report, necessitating a Decision Making Business Case. For example, Darzi requires that public bodies must:

- ensure that "it must be easy to find out what decisions have been taken and the reasoning behind them." This has not been met by the Management Report
- "show how users have been involved and how your organisation has listened and responded". Whilst consultation responses were captured in the Management Report, the requirement to show how CCGs listened and took views into account when making the decision will only be fully discharged when the rational for decision has been documented
- "share the information and knowledge you have, so people can understand the issues". Whilst the management Report does share the information that was used to make a decision, it is complex and inclusivity requirements (set out in all of the above guidance) would be best met by producing a variety of communications that will reach a range of protected and hard to reach groups across Greater Manchester

Failure to do this could mean that the public and stakeholders do not understand how the decision was taken, leading to increased risk of judicial review, referral to the Independent Reconfiguration Panel and public opposition.

2. Sequencing decision – October to December 2015 (c. 13 weeks including Christmas)

The sequencing decision approach will be agreed with the CIC by November 2015. It is proposed that each single service will complete a short readiness assessment, designed by the Service Transformation Team and assessed by the CIC in December.

Change management principles tell us that **successful roll-out will be dependent on the success of the pathfinder.** Therefore, ability to mobilise quickly, with high likelihood of success and impact could be priorities.

Example categories might include:

Figure 10: Potential Sequencing Decision Approach

Topic	Readiness Requirement
Implementation team readiness	Project initiation plan on a page (including resourcing) and estimated earliest readiness date (including a list of any preparatory work already completed)
Scale of challenge - capital	Short description of scale of capital build requirements, likely timeline, funding and top risks
Scale of the challenge - HR	Gap between current resourcing and required resourcing (at Consultant level and below), high level proposed plan
Scale of the challenge - Baseline quality and safety standards	Replication of the NCAT assessment against each standard and outcomes for each in-scope service (with written updates of any material changes implemented since)
Local strategic coherence	Short assessment of coherence with other local changes

3. Oversight and assurance – October 2015 onwards

The implementation phase will be launched in October 2015, immediately after queries have been managed and the DMBC has been published (and in tandem with sequencing decision making). Of the tasks listed under the oversight and assurance role above, the first three months will include completion of the following:

- scoping, agreement of and set up of the governance and assurance arrangements (the first groups will run this year, including the GM Clinical Alliance and Patient Panels);
- GM communications, engagement and stakeholder management; and,
- setting up programme risk and reporting arrangements.

The team will also:

- start liaising with the single service teams to develop the programme plan (including assurance that plans will include delivery of the implementation conditions)
- start to scope the benefits realisation plan (including designing practicalities of reporting arrangements with the first single service to implement). This will be signed off in early 2016.

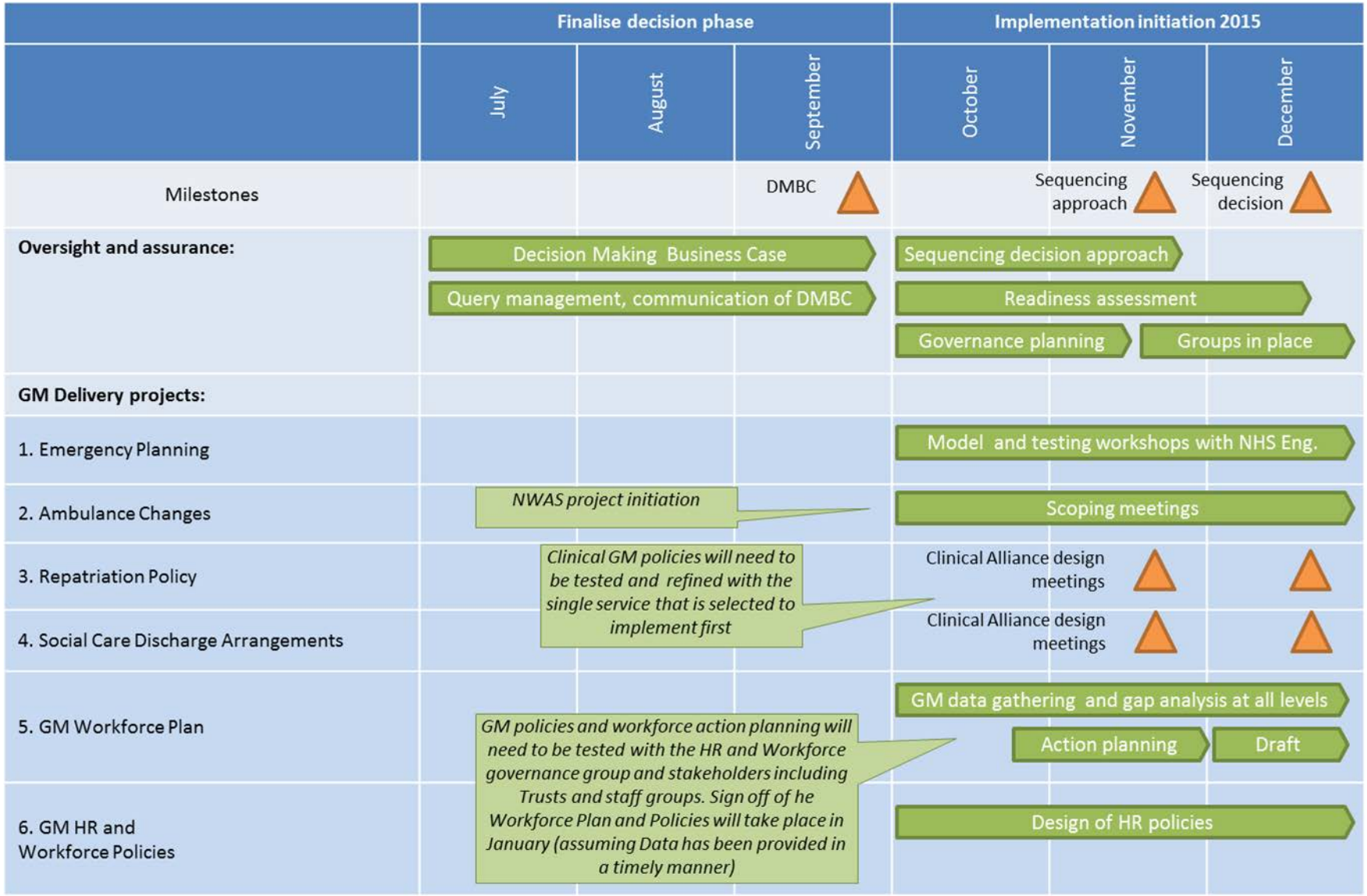
4. Initiate GM Delivery projects

In addition to oversight and assurance there are a number of pieces of work that will need to be "done once" for GM. Each of the six projects (described above) will be resourced by the Service Transformation Team, planned and initiated in October 2015.

1. Emergency Planning
2. Ambulance changes implementation
3. Repatriation policy
4. Social Care discharge arrangements
5. GM workforce plan
6. HR and workforce policies, for example recruitment, TUPE arrangements etc.

Indicative timescales (dependent on the planning phase) are provided on the following page.

Figure 11: Indicative 2015 timescales (TBC)



NHS
Stockport
Clinical Commissioning Group

Investing in Stockport - Draft

Draft Stockport Borough Plan 2015 – 2020

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

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

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

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
The Governing Body are recommended to endorse the Borough Stockport Plan attached as reflective of our ambition for the health of the population and improved integration of public service delivery.
Please detail the key points of this report
The plan encompasses all areas of the borough's activity and public sector work. It sets out the strengths and weaknesses of the borough and then outlines the key areas of actions including Stockport Together.
What are the likely impacts and/or implications?
Further alignment of organisational plans and outcomes Greater joint ownership of all plans across the borough
How does this link to the Annual Business Plan?
The Business Case as it reflects Stockport Together is a component of this borough wide plan
What are the potential conflicts of interest?
No
Where has this report been previously discussed?
The health related components have been discussed widely within the governing body and across the CCG.
Clinical Executive Sponsor: Gaynor Mullins
Presented by: Gaynor Mullins
Meeting Date: 9th September 2015
Agenda item:
Reason for being in Part 2 (if applicable)

Investing in Stockport - Draft Stockport Borough Plan 2015 – 2020

1.0 Summary:

The Stockport Borough Plan has been led by SMBC with partner contributions and is intended to provide a high-level vision, based on the Investing in Stockport Shared Outcomes Framework, that all partners can work towards over the next five years.

The Plan needs to be supported by a range of organisational and partnership plans and strategies, including the CCG Strategy, which outline in more detail how individual public agencies are contributing to outcomes in the Borough.

The Borough Plan focuses in addition on those key programmes that must be progressed in partnership.

The Governing Body will recognise some of the content, in particular those elements related to health & social care in the section entitles Stockport Together. The plan sets our plans in these areas within the broader context of the public sector as a whole within Stockport.

The CCG has contributed to the formation of this plan in particular through Stockport Together and therefore the Governing Body is asked to endorse the draft plan that has been attached.

INVESTING IN STOCKPORT

A PLAN FOR OUR BOROUGH 2015-20

DESIGN & FORMATTING WILL CHANGE.

IF WE SUCCEED IN DELIVERING THIS PLAN, BY 2020:

PEOPLE WILL BE ABLE TO MAKE POSITIVE CHOICES AND BE INDEPENDENT; AND THOSE THAT NEED SUPPORT WILL GET IT	• PEOPLE WILL BE LIVING LONGER, HEALTHIER LIVES • PEOPLE WILL BE BETTER QUALIFIED
COMMUNITIES WILL BE SAFE AND RESILIENT	• THERE WILL BE FEWER VICTIMS OF CRIME • PEOPLE WILL FEEL SAFE • PEOPLE WILL BE INFLUENCING DECISIONS ABOUT THEIR AREA
STOCKPORT WILL BENEFIT FROM A THRIVING ECONOMY	• ECONOMIC ACTIVITY IN STOCKPORT WILL HAVE GROWN AT OR ABOVE THE GM AVERAGE • UNEMPLOYEMENT WILL REMAIN LOWER THAN THE NATIONAL AVERAGE, AND WILL BE LOWER IN OUR POOREST AREAS THAN IN SIMILAR AREAS ELSEWHERE
STOCKPORT WILL BE A PLACE PEOPLE WANT TO LIVE	• PEOPLE WILL BE SATISFIED WITH THEIR LOCAL AREA AS A PLACE TO LIVE • THERE WILL BE MORE HOUSING, WITH GROWTH ACROSS ALL TYPES AND TENURES

A GREATER PROPORTION OF PUBLIC MONEY WILL BE SPENT HELPING PEOPLE EARLY, TO PREVENT MORE SERIOUS ISSUES OCCURING

There are loads of great things about Stockport.

Situated between the Peak District, the Cheshire Plain and the UK's fastest growing city, we're a borough with independent spirit, home to great schools, thriving businesses and lively communities.

But we have challenges too.

Some people need help from family, friends and public services in order to live well. As we prosper, we'll need more houses, schools and local healthcare, and with investment, our town centre could be even better.

This Plan sets a vision for the future of Stockport

It's a vision that will only be achieved if families, communities, local businesses and public agencies aspire to achieve the same outcomes. From this shared aspiration, a closer alignment of our effort and resources must emerge.

It's a Plan for sustainable growth…

Maintaining and growing our economy is essential to provide residents with the jobs they need to live better, more fulfilling lives. At the same time, we need to reform and improve our public services, and our housing and transport infrastructure, so Stockport people have the stability, skills, confidence and access that will allow them to compete for these jobs.

Stockport is fortunate to have a mix of businesses across growing sectors of the economy, and residents who can both create and support growth. Our Plan is to create the conditions for and harness the benefits of a thriving local economy, while seeking to maintain the essential character of the Borough.

But this will, inevitably, mean change. It will only be possible to balance the interests on both sides of this change if business and civic leaders work with communities to understand their aspirations for the future, and if local communities in turn understand how to achieve these aspirations and take responsibility for the needs of future generations.

… and public service reform

We know that the Council, the NHS, Police and other public agencies have to change the way we work. We want to find new ways to enable communities to come together to form a vision for their own future, and to shape and direct the services they use.

In return, we believe people in Stockport will increasingly accept the responsibilities that come with this influence and will themselves find new ways to support each other and adapt to the future they have helped create.

It's a Plan for action

This is the recipe for promoting and supporting independence that sits at the heart of Investing in Stockport, and at the heart of our shared plans for the Borough. People, families and communities are the engine of our economy *and* the heart of our society, and the best and most authentic source of support and aspiration for future generations.

Over the next two years we will undertake four joint programmes; each has defined and measurable indicators of progress and success. Together, these programmes will promote sustainable growth and reform how public services work together and with local people and communities. Our most senior public leaders will assure delivery of these actions in a highly transparent and accountable way.

Along the way we will also make the most of new opportunities offered through the devolution of funding and powers from national government to Greater Manchester.

AN INCLUSIVE VISION FOR STOCKPORT

Stockport is home to many local communities. The difference in life chances for those living in the most deprived communities, compared to those living in the most affluent, is significant. It is particularly stark compared to other places in the North-West and nationally.

Any successful vision for the future of the Borough must address these concentrations of deprivation, and ensure resources and efforts are focused accordingly (whilst recognising that there are people in every community that need some help and support).

Improving outcomes in deprived communities is fundamental to our vision for Stockport.

This Plan sets out an inclusive vision for Stockport

It recognises that the peoples' socio-economic situation is both determined by, and can determine, their life chances – their health, work, education, safety and access to housing – and sustained improvement in life chances is best made by working with those affected to target support at specific issues in a way that promotes personal independence and community resilience.

In seeking to promote both sustainable growth and public service reform, this Plan recognises that poverty is an economic but also a complex social problem. It can only be tackled by action at both city and community level.

Our strategy 2015-20

Over the next five years we will pursue a two-pronged strategy:

- We will bring together our intelligence and understanding about the factors and patterns of deprivation across the Borough and about what evidence suggests are the best interventions we might make to address these; and
- We will make coordinated and concerted efforts through mainstream and additional services that will create measureable and lasting improvements in a small number of key areas.

Through this action we will ensure that, by 2020, the most deprived people and places will see absolute improvements across our shared outcomes. We will publish a detailed report in 2017 showing progress towards this ambition.

INVESTING IN STOCKPORT

UNDERSTANDING OUR SHARED OUTCOMES

People will be able to make positive choices and be independent;
And those that need support will get it

Most people rely on their own skills and knowledge, and on friends, families and their local community, to stay healthy and to deal with most of what life throws at them.

Clearly, there are also times in a person's life when they will need access to more support, and in some cases specialist services, in order to get the best start in life, to learn and fulfil their potential, and to live well. This support must help people live as independently as possible and offer choice and control. Where there is risk of harm, appropriate steps to safeguard and protect people will be needed in order to achieve this outcome.

2015 baseline and key issues

The health of Stockport is broadly similar to that of the country at large with life expectancy of 79.7 years for men and 83 years for women. There are however considerable inequalities due to the borough boundaries including both affluent and deprived areas. Overall the health of Stockport has improved by 10% more than the health of the country as a whole in the last quarter of a century, largely due to the reduction in inequalities in the 1990s.

The main causes of death are heart disease, cancer and respiratory disease causing between them three quarters of all deaths. The main causes of disability are mental illness, sight and hearing impairments and musculoskeletal conditions. The next six major determinants of health are smoking, high blood pressure, obesity, physical activity, alcohol and diet.

There are fewer looked after children in Stockport compared to the national average. However, there are more child protection plans in place (2.5% higher than nationally) reflecting the intention to more actively manage the risk of children being taken into care. 19.2% of children in the Borough have special educational needs and 13.9% are receiving free school meals. The number of children from the priority areas of the borough that receive free school meals is 39.6%

Over two-fifths (40.2%) of Stockport's residents are qualified to HND, degree or higher degree levels, above both the Greater Manchester (31.8%) and national (35.2%) averages. Stockport also has fewer residents with no qualifications than both the Greater Manchester and national averages (7.3% compared to 11.5% and 9.3% respectively).

Outcomes 1 & 2:
People Are Able to Make Informed Choices and Look After Themselves and People Who Need Support Get It

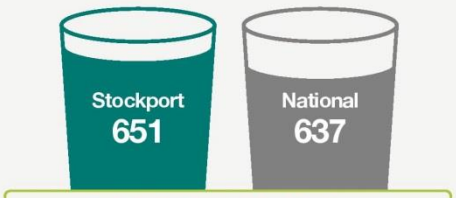
Health

Life Expectancy

Stockport	Priority Areas	National
Females 83	Females 76.3	Females 83.1
Males 79.7	Males 73.2	Males 79.4

Life expectancy is increasing in all areas

Alcohol Related Hospital Admissions



Alcohol-related hospital admissions per 100,000 adult population

Major Causes of Death

All Ages		Early Deaths (under 75)	
Cancer	29%	Cancer	42%
Heart Disease	28%	Heart Disease	22%
Lung Disease	14%	Accidents/Suicide	14%

These figures are similar to the national figures but lower than Greater Manchester and the North West

Avoidable Hospital Admissions

Admissions for long term conditions

Stockport	1,111.2
National	799.6

Admissions for asthma, diabetes and epilepsy (under 19s)

Stockport	495.6
National	313.4

Avoidable emergency admissions per 1,000 population

Healthy Lifestyles

Smoking Rates

Stockport	18%
Priority Areas	37.9%

Not Active Enough

Stockport	74%
Priority Areas	74%

Unhealthy Drinking

Stockport	26%
Priority Areas	20%

Low Mental Wellbeing

Stockport	12%
Priority Areas	23%

Adult Obesity

Stockport	25%
Priority Areas	30%

Multiple Risks

Stockport	32%
Priority Areas	43%

Childhood Obesity

Reception Year

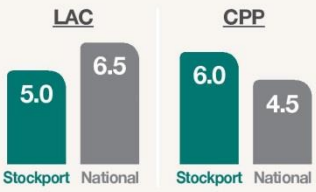
Stockport	20.8%
Priority Areas	26.3%
National	22.4%

Year Six

Stockport	31.6%
Priority Areas	38%
National	33.6%

Supported Children

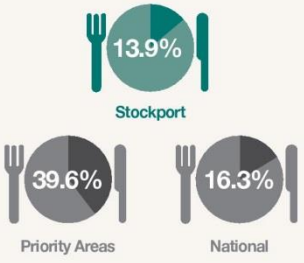
Looked After Children & Child Protection Plans



Numbers per 1,000 of 0-17 year olds.

Special Educational Needs

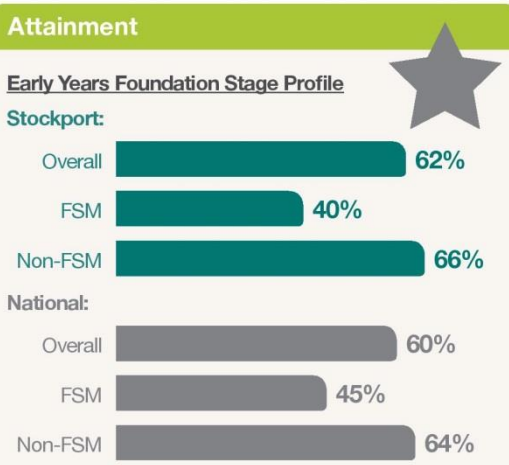
Free School Meals



Children's Education, Employment and Training

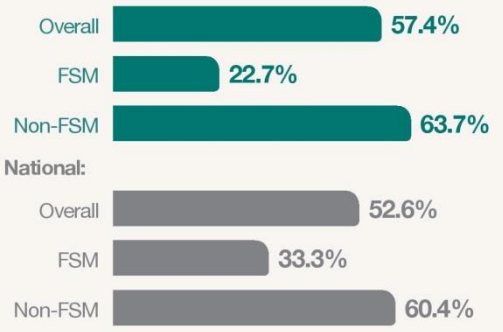
Attainment

Early Years Foundation Stage Profile



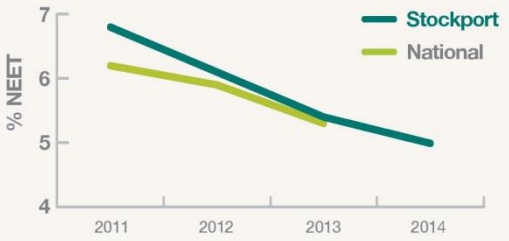
Percentage of children achieving a good level of development in the EYFSP teacher assessments

Key Stage Four

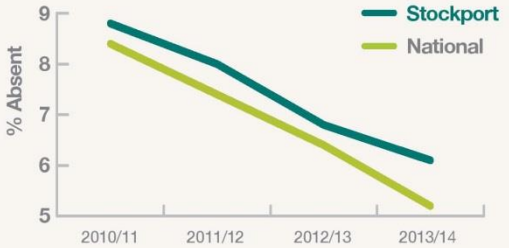


Percentage of children achieving a 5+ A*-C incl English & maths at key stage 4 first entry. FSM refers to pupils that are eligible for free school meals

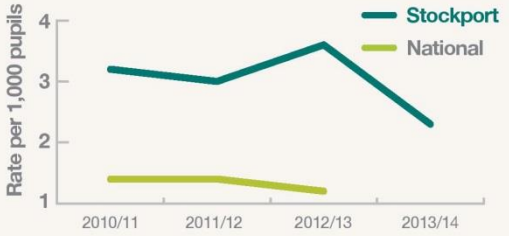
16-18 years olds not in Education, Employment or Training (NEET)



Persistent Absence

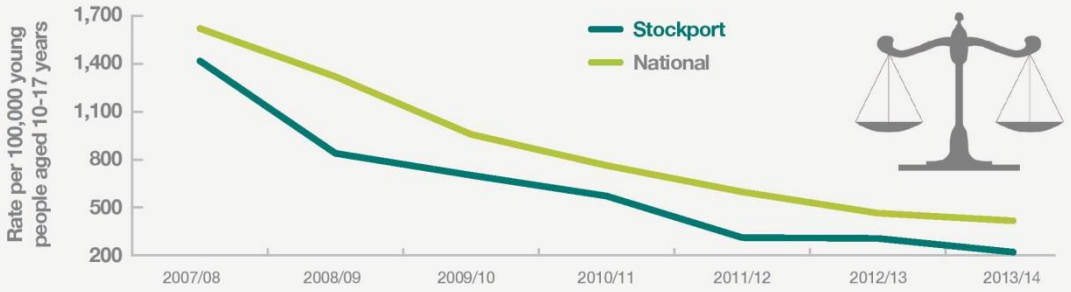


Permanent Exclusions (Secondary Schools)



Crime (under 18 years)

First Time Entrants to Youth Justice System



Adult Social Care and Support

Quality of Life

Maintaining Independence

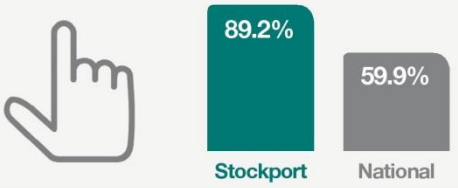
Older people aged 65+ who were still at home 91 days after discharge from hospital

Older People Permanently Admitted to Residential and Nursing Care Homes

Rate per 100,000 population aged 65+

Older People Delayed in Being Transferred from Hospital to Home

People managing their own support through personal budgets and direct payments



Communities in Stockport are safe and resilient

Strong communities make people feel safe and give them the confidence to cope with change. We want to help people in Stockport's communities to look after each other and to use the resources they have collectively and as individuals to meet daily challenges.

A safe, resilient community is one in which democracy thrives and people understand the impact of their decisions on others.

2015 baseline and key issues

Crime in Stockport is lower than the average for Greater Manchester. Violent crime is also lower in Stockport than in the city-region. The borough also has lower levels of anti-social behaviour than Greater Manchester generally. However, this figure rises significantly for those living in priority areas.

In terms of engagement, around a quarter of people in the borough are active in their communities volunteering on a regular basis. Election turn-out is also slightly above the national average – although it differs between the highest and lowest turn-out wards by as much as 18%. In addition, only a quarter of residents feel that they can effectively influence decisions affecting the area they live it.

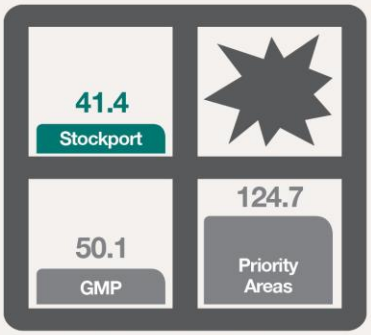
Outcome 3: **Stockport Communities are Safe and Resilient**

Crime and Anti-Social Behaviour

Recorded Crime

Crime types per 1,000 population. There were 15,813 crimes recorded in Stockport last year, with the borough being the only area in GMP to record a reduction in overall crime rates during 2014/15. There is, however, a large variation between the borough average and some of the more priority areas in Stockport.

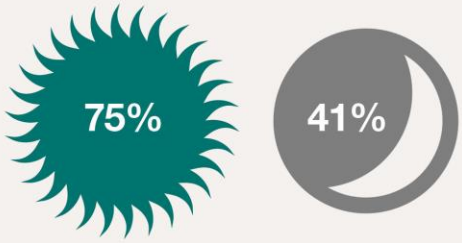
Anti-Social Behaviour



Incidents recorded per 1,000 population.

11,721 incidents in Stockport last year, with the most common types being neighbour nuisance, juvenile nuisance and off-road motorcycles.

Feeling Safe



Three quarters of people feel safe outside in their local area during the day, but only four in ten feel safe after dark.

Engaged and Involved Communities

Volunteering

Around a quarter of people provide unpaid help to a group, club or organisation at least once a month.

Influencing Decisions

24% of people agree that they can influence decisions affecting their local area.

Local Election Turnout 2014

Stockport benefits from a thriving economy

Stockport plays a key role in the economy of Greater Manchester, and many residents both benefit from and help create a thriving local economy. The Borough though still has pockets of above-average deprivation, where better skills and training are needed to reverse long-term unemployment and the impact this can have on wider social issues.

Achieving this outcome means making the right investments across the Borough, and particularly helping our Town Centre fulfil its potential to be the best in the southern part of Greater Manchester.

2015 baseline and key issues

Stockport is one of the most successful local economies in Greater Manchester, with 125,000 people working in 11,000 businesses and more than two million people living within a 30-minute drive time. The town centre forms an important part of Stockport's economy, offering the potential to combine commercial property opportunities with the town's distinctive history and character.

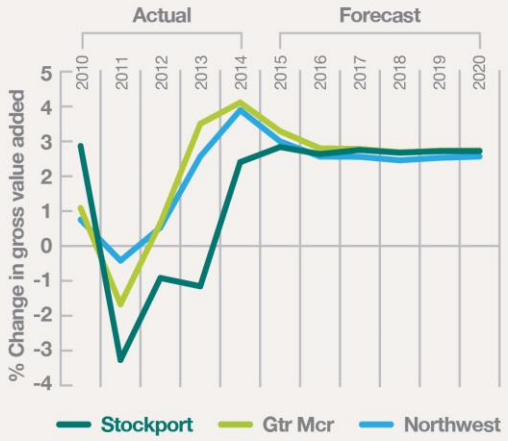
Stockport's highly skilled workforce is a key asset both for the local economy and for Greater Manchester as a whole. Overall, more residents commute out of the Borough for work each day than commute into Stockport, but local businesses also provide employment for more than 55,000 residents.

The Borough's benefits from exceptional transport links. The M60 motorway, the West Coast Mainline, and Manchester Airport are easily accessible from all parts of the Borough and provide Stockport with local, national, and international transport connections.

Outcome 4: **Stockport Benefits from a Thriving Economy**

Economic Activity

Economic Activity



Gross value added (GVA) is a measure of the total value of profits & wages in a given area. Stockport is ranked 4th highest in Gtr Mcr in terms of total GVA.

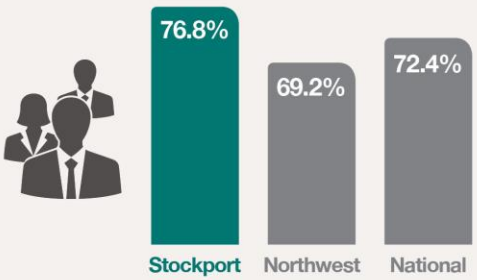
Industrial, Office and Warehouse Floorspace

Forecast increase in floorspace over the period 2014-2034.

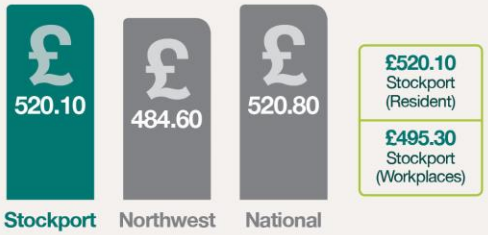
Occupancy of Town Centre Commercial Premises

Employment and Skills

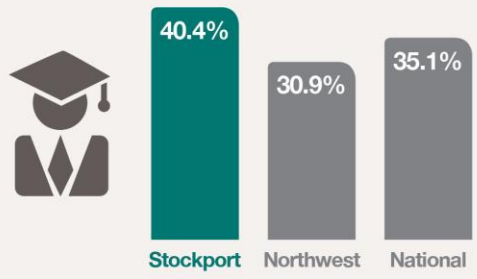
Employment Rates in 2014



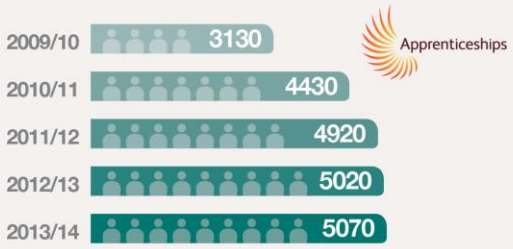
Weekly Pay



Qualifications at NVQ Level 4 and Above



National Apprenticeship Programme



Stockport is a place people want to live

Situated between the Peak District, the Cheshire Plain and the UK's fastest growing city, Stockport is one of the most attractive places to live in Greater Manchester.

Increasing prosperity in some parts of the Borough can lead to challenges that communities and public agencies will need to manage. In other places this outcome will only be achieved if there is investment to build more sustainable communities.

2015 baseline and key issues

Stockport remains one of the most desirable places to live in Greater Manchester. The diversity of the Borough means that Stockport is home to a range of vibrant local communities with their own unique identities and sense of civic pride. The strength of Stockport's local centres ensures that the Borough has a broad appeal.

The attractiveness of Stockport as a place to live means that the local housing market is strong with prices well above the Greater Manchester average.

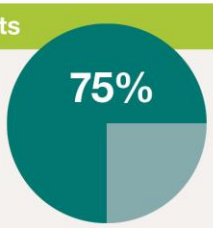
The success of Stockport's residential areas however can present challenges to local working families, particularly in terms of increasing house prices. The last decade saw lower population growth in Stockport than in any other Greater Manchester district with a resulting decline in working-age population. Providing housing that working age residents can afford in order to remain in the Borough is one of the key challenges Stockport faces.

People in Stockport are well served by leisure and recreation opportunities, with significant open countryside in the east and south of the Borough, and river valleys extending into the urban areas. The proximity to the Peak District provides also residents with informal recreation, walking, and cycling opportunities.

Outcome 5: **Stockport is a Place People Want to Live**

Satisfaction with Local Area

% of Satisfied Residents



Green Spaces

Parks and Open Spaces

Percentage assessed as satisfactory (based on locally derived measure)

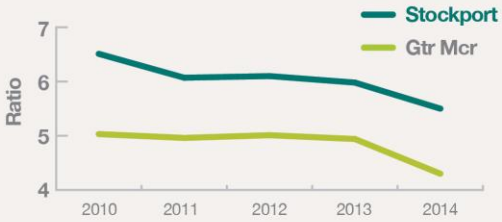
Housing

New Homes Built

374 Total Homes

136 Affordable

Housing Affordability



The average house price as a ratio of average wages has fallen over the last five years, although housing demand remains higher in Stockport than across Greater Manchester.

Waste & Recycling

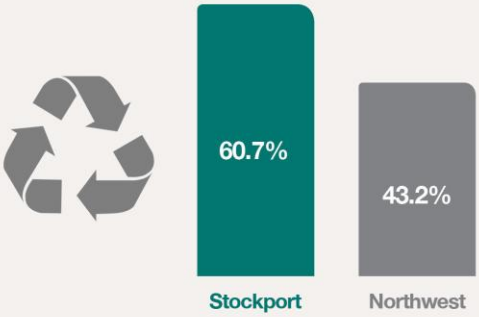
Household Waste Collected

Stockport

Northwest

Amount of non-recyclable waste collected per household.

Household Waste Recycled



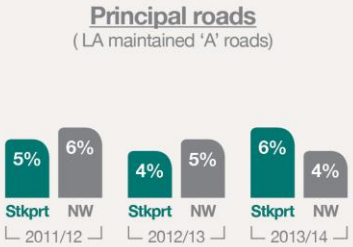
Stockport

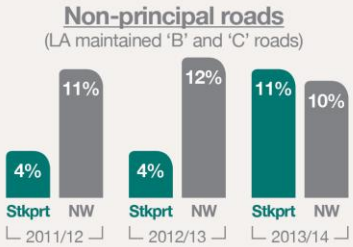
Northwest

Highways

Road Maintenance

Percentage of roads in need of maintenance





INVESTING IN STOCKPORT

2015-17 – OUR PRIORITIES FOR ACTION

- A stronger voice for communities in the custody of their local area and the design and delivery of the services they use.
- Promoting community social action and making the space for it to thrive.

- Investing in key regeneration projects in the Town Centre and elsewhere, to ensure Stockport continues to build its position as a key business location.
- Improving local transport networks to make it easier to get in and around Stockport, bringing jobs and opportunities closer.

STOCKPORT TOGETHER

- Work to create an integrated, efficient and sustainable health and social care system that provides the best possible care for the population of Stockport.

- Working with parents, carers, schools and others to promote a strengths-based, restorative approach to supporting families
- Joining up our efforts to give children the best start in life, and to provide protection from harm where it's needed

THE INSTITUTIONS AND SERVICES WE SHARE ARE CHANGING

There are hundreds of public services that support people and help make Stockport a great place.

A huge challenge

Since 2010, the Government has provided less funding for a range of public services, including Council services (such as care and support for children and older people, waste collection and libraries); police, probation and criminal justice services; fire and rescue services; and further and higher education.

There has also been significant reform of the welfare system, including the introduction of new restrictions.

At the same time, because people are living longer, there has been a significant increase in demand for services used by older people, particularly the NHS. These cuts, reforms and demand pressures will continue throughout 2015-2020, even though we expect our economy to get stronger. Together, they present a huge **public service reform** challenge.

Public agencies in Stockport are working in close partnership to adapt to this challenge by joining up the management and delivery of services, and by finding new ways, working together and with service users, to help people earlier to prevent more serious issues occurring.

The period 2015-17 in particular will see the introduction of new service models across the Borough, including many approaches that have not been taken before and that will be carefully piloted and evaluated. Throughout 2015-20, public service reform will impact how people perceive and use services.

Three huge opportunities

At the same time, there are three huge opportunities that we will exploit in creating and delivering our new public services.

Stockport People

The first and most important opportunity is for public agencies to work more closely and productively with people across Stockport.

We want to promote community social action, and to change how public agencies work so that they are more open to the influence of local people and service users, and so they work with and utilise the strengths and assets of people and places across the Borough.

We still need the highest quality professional expertise in public service. But we will find new ways to blend this expertise with the experience and knowledge of local people so that we work together to target real problems early.

Devolution

Throughout 2015-20, Stockport people, and their elected representatives, will enjoy a greater say on the decisions that affect them, as a range of powers and funding are devolved to the region from national government. This will include the election of a Greater Manchester Mayor in 2017.

Devolution offers new opportunities to drive local growth and to reform public services, through increased local leadership and influence. This new influence cannot wholly mitigate the impact of existing and anticipated funding cuts. But, if we can meet the leadership challenge it poses, we have an opportunity to create innovative solutions to entrenched problems that few other places will enjoy.

Digital

New digital technologies have huge potential to keep people informed and connected, and to reduce the cost of services.

Throughout 2015-20 we will adopt and adapt these technologies to modernise our organisations and make them more productive, and to improve the quality of service people receive.

We will promote the take-up of this new digital offer, with assistance where necessary, and better join-up the provision of information and advice about self-help and access to public services.

ACTION 1: INVESTING IN COMMUNITIES

Our approach

We want to build a platform for change in neighbourhoods across the Borough, through the development of a new locality working model.

This model will ensure that public resources of people, information, assets and funding can both:

- Align with and complement existing strengths found in Stockport's communities; and
- Be influenced by the priorities and interests of these communities

The approach will be supported by changes to policy that regulate and shape how communities are able to come together to advance their interests.

We will:

- Involve more local people in discussions about local needs and priorities, and how we can work together to address them;
- Explore innovative ways of working to enable community capacity to grow and strengthen;
- Promote community social action and make the space for it to thrive; and
- Develop new approaches to how a range of local services, such as Community Safety and Libraries, are delivered

Measuring performance

If successful, our approach to Investing in Communities will strengthen a range of indicators of positive community indicators, including those linked to our aspiration to create safe and resilient communities.

There are two challenges in measuring this change. The first is that it will take a number of years for trends in community behaviour to become significant enough to measure. The second challenge is in capturing data at the community level, in order to measure differences over time and between communities.

We will invest in our capability to measure performance in this way and will set out appropriate performance frameworks.

Oversight and governance

In line with the integration of a range of local services, we will explore options for appropriate partnership governance of this work.

ACTION 2: INVESTING IN GROWTH

The case for change

Delivering successful outcomes for individuals and places means reshaping public services alongside our efforts to drive greater economic growth. Access to jobs and training is key to helping people lead independent lives.

Stockport is fortunate in that it already has many of the conditions required to encourage business investment and job creation. Its growth potential is clear. To ensure economic and demographic growth is sustainable it must be promoted in dialogue with communities.

Effective partnerships between public and private sector leaders locally and across Greater Manchester will help create the conditions to encourage private investment in the Borough realise our local growth ambitions. They must also coordinate the provision of the business support, training and infrastructure needed to ensure that this growth directly benefits residents across the Borough.

Our approach

- Investing in Stockport Town Centre to increase the supply of Grade A office space and to diversify the retail and leisure offer
- Working with housing developers to increase choice across all types and tenures across the Borough
- Providing infrastructure improvements to support changing connectivity needs
- Ensuring that the supply of skills and training in the Borough helps businesses grow and residents to contribute to and benefit from that growth

Monitoring progress 2015-17

The delivery of Investing in Growth will be monitored through progress made on its component schemes including:

- Transport infrastructure projects such as A6-MARR, Stockport Interchange, Stockport Town Centre Access Package

- Town Centre regeneration schemes such as Stockport Exchange, Redrock, Gorsey Bank, and Market Place and Underbanks
- Housing developments including Covent Garden / Hopes Carr, Woodford, and the Brinnington Regeneration scheme

Measuring performance 2015-17

We will know we have been successful when we see:

- Increased employment opportunities for people across the Borough, including in our priority neighbourhoods
- Increased business investment in the Borough
- A greater mix of housing which meets the diverse needs of local communities across the Borough
- Improved transport, green, and digital infrastructure in Stockport

Together, the schemes within our Investing in Growth programme are estimated to create at least 5,000 new jobs and 1,100 new homes in the town.

Oversight and governance

There will be detailed and appropriate oversight and governance of each Investing in Growth scheme. In addition, key cross-cutting issues will be shaped and led by the Council working closely with local businesses and other representative groups, including through the Stockport Economic Alliance.

ACTION 3: STOCKPORT TOGETHER

The case for change

Locally, there are several organisations that work together to plan and deliver our National Health Service. People that use these services, particularly older people, also often rely on social care services delivered by Stockport Council, and other services delivered by voluntary and community organisations. Together these agencies act as the health and care system for the Borough.

Demand for and the cost of health and care services are increasing, in-part because people are living longer. Funding for services is not keeping up with these increases, and in some parts of the system (social care for example) is being significantly reduced. There are also quality improvements that should be made to best serve the population of the Borough. This creates a 'whole-system' challenge.

If we were to continue to manage and access these services as we currently do, by 2018, we would be spending £113m a year more than is expected to be available. So the system has to be transformed.

Our approach

Our ambition is to create an integrated, efficient and sustainable health and social care system that provides the best possible care for the population of Stockport. This ambition is being pursued through the Stockport Together programme, by:

- NHS Stockport Clinical Commissioning Group
- Pennine Care NHS Foundation Trust
- Stockport Metropolitan Borough Council.
- Stockport NHS Foundation Trust

A significant amount of work has already gone into to aligning the leadership of the health and care system, and to build the case for and understanding of the necessary change. Over 2015-17 we will develop and begin to implement detailed plans for change in:

- How people are empowered to live well and stay healthy, preventing and delaying the need to use services

- How those with elevated and/or long-term needs are proactively supported, closer to home, by their local community and health and care professionals, in order to reduce their need to attend hospital
- How those for whom specialist support is planned can be better supported
- How those that require urgent care, including through Accident and Emergency, can be better supported, for example by strengthening links with those providing a patient's out of hospital care.

Monitoring progress 2015-17

Early and priority improvements will commence during 2015, whilst the full transformation will be complete by March 2019. Key stages include:

- Detailed design of the Stockport Together Model (October 2015)
- Creation of integrated locality teams at a neighbourhood level (March 2016)
- Design of new pathways into specialist services (March 2016)
- Implementation of a new model for supporting people who require urgent care (March 2016)
- Move to whole system commissioning for an outcomes based service (March 2019)

Measuring performance 2015-17

The ultimate objective for Stockport Together is to secure high-quality, safe and sustainable services across Stockport, we believe the best way of doing this is by moving from a reactive to a preventative and person centred approach. We will know we have achieved this when we see:

- A reduction in emergency attendances and admissions
- A reduced reliance in 'acute' based planned care
- Improvement in Life Expectancy across Stockport and within our deprived areas
- An Increased quality of life for individuals across Stockport
- More people in Stockport making active and positive choices to improve their health and wellbeing
- Reduction in mortality from preventable causes
- More community capacity and increased empowerment
- Improved experience of joined up/ integrated working for both staff and individuals

Oversight and governance

Governance of this work will be through the Health and Social Care Leaders' Group and Integrated Care Board. This is underpinned by programme boards for each of the programmes of work and supported by the Stockport Together Portfolio Office.

Some aspects of the Programme are also externally monitored as part of the Better Care Fund (BCF), NHS Vanguard and by NESTA.

ACTION 4: STOCKPORT FAMILY

The case for change

Outcomes for children and families in Stockport are good, and are sustained by high quality practice in schools, family support, health, social care and voluntary and community services. But, while this practice has been aligned through close joint working, there are still too many repeat assessments from different services. This is inefficient, unpopular with users and can provide a partial view of need and limit our ability to allocate services.

The strengths within a family unit can often get lost because of attitudes, service gaps, and fragmented relationships between professionals and those families. Services can spend too much time discussing who should take responsibility, which wastes money and causes problems for users.

We now want to push forward towards fuller and deeper integration. Building on the Supporting Families Programme and Integrated Children's Service, we are proposing a transformation in the way that social work is delivered to and with children and families. This can further improve outcomes for people in the Borough, through better targeting of support, and can reduce the cost of delivering services. This is our best hope of sustaining outcomes as central funding for some services reduces.

Our approach

- We will continue to build a 'single front door' to access support. We will also continue to integrate the management and operation of some services, and to align others; this will be supported by integrated information and case management systems and better analysis.
- There will be shared allocation meetings, developing personal trust between professionals and reducing the bureaucracy, time, and wasted effort of much of the 'internal referral' process.
- We will also establish, via training and supervision, a professional attitude, competencies and a common language across services, rooted in a restorative approach that acknowledges and builds on the assets of families and communities.

Monitoring progress 2015-17

Stockport Family has adopted a 'Design by Doing' approach to enable the development of integrated and restorative practice across all four localities. This approach will run throughout the following key rollout points:

- **Phase.1:** Early Adopter in Heatons and Tame Valley (Already operating)
- **Phase.2:** Co-located Teams in Heatons and Tame Valley (September 2015); Stepping Hill and Victoria (October 2015); Bramhall and Cheadle; and Marple and Werneth
- **Phase.3:** Roll out of integrated teams adopting restorative practice (March 2016)

Measuring performance 2015-17

As we change, we will rigorously monitor, using agreed shared metrics, the costs and benefits of the new ways of working, and in future years will seek to ensure these costs and benefits are aligned across providers.

The Stockport Family Model is aiming to achieve the following outcomes:

Primary outcomes

- Reductions in the numbers of children coming into care (and associated costs)
- Reductions in court proceedings (and associated costs)
- Reductions in Child Protection Plans (and associated costs)
- Increased professional confidence for the workforce and staff morale (influencing the culture of work with children and families)
- More "effective working" and collaboration (timeliness, resource use, efficacy, shared knowledge and skills base)

Secondary outcomes

- Reductions in internal transfers and re-referral rates
- Improvements in the effectiveness and efficiency of young people's transition from care
- Improvements in health and educational outcomes
- Reductions in crime and antisocial behaviour

These outcomes will be monitored through an independent evaluation.

Oversight and governance

Governance of this work will be through by the Children's Trust and the Supporting Families Executive Steering Group.

A PARTNERSHIP FOR STOCKPORT

We've set clear objectives for our Borough over the coming five years. But we know that the route we take to achieve these will change over time, including in response to what we hear from local people about their interests and priorities.

So this plan isn't set in stone. It's needs to be a living plan, owned by those of us working together to keep Stockport a great place. This ownership, and work to align our efforts and focus on shared outcomes, can take place in homes, businesses, schools, charities, faith groups, sports clubs, pubs and elsewhere, as well as in every part of our public services.

In any of these places, when we're working together, we are a partnership for Stockport. And this is our Plan.

Signatory logos to follow

NHS
Stockport
Clinical Commissioning Group

Governance Review Final Report

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

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

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

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
The Governing Body is asked to approve the recommendations contained within the report and endorse those resulting in Constitutional Changes for forwarding to the Annual General Meeting for approval and recommendation to the NHS England as part of the Constitutional Change process.
Please detail the key points of this report
The report contains the findings and recommendations arising from a review of the CCG's Governance structures and underpinning support processes. The report outlines the rationale for the review, the key areas which were considered in detail and the governance outcomes against which the review was carried out.
What are the likely impacts and/or implications?
In approving the report, the CCG will be consenting to a number of operational changes / developments and recommending to the Annual Council of Members some broader changes to the Governance Structure which will require constitutional amendments and approvals. Once any proposed changes have been embedded and implemented it is anticipated that the CCG's governance framework will improve in efficiency, effectiveness and robustness. The framework and underpinning governance processes will remain under review to ensure the framework continues to adapt in light of the CCG's continued evolution, particularly in light of the Stockport Together Programme and Greater Manchester Devolution.
How does this link to the Annual Business Plan?
The governance processes which underpin the CCG's operations are central to the delivery of the organisation's strategic aims and objectives.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
This report has been considered internally by the CCG's Executive and Strategic Leadership Teams.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 9 September 2015
Agenda item:
Reason for being in Part 2 (if applicable)

Detail

1.0 Background and scope of the review

1.1 The CCG has been operating its current model of Governance since its formal establishment in 2013.

1.2 There has been a significant amount of change since the organisation's establishment. Given the continuing nature and pace of change on the horizon regionally and nationally and the focus on more clearly defining the CCG's local purpose and priorities at the current time, it was opportune to review the organisation's governance arrangements to ensure they were robust and flexible for the future.

1.3 The review focused on supporting the existing aims of the CCG and those of the future including:

- Focussing on being clinically led as an organisation and in its decision-making.
- Agile in its ability to take decisions at pace without compromising principles of good governance and remaining accountable to its Membership.
- Distributive in its leadership across the whole formal governance structure through appropriate delegations.
- Collaborative in its approach to working with partners and taking decisions jointly.
- Focussed on the quality of information provided to decision-makers and the processes which underpin the smooth running of meetings

1.4 The scope of the review was broad and captured both strategic corporate governance principles and operational matters. It was carried out in line with the Internal Audit Plan for 2015/16 where activity proposed to review Committee Effectiveness and a number of elements of Corporate Governance and with knowledge of the Governing Body's ongoing Board Development Programme.

1.5 The scope of the review focussed around the following key priority areas:

- Structure and coherence of the governance model
- Governing Body delegation and Committee autonomy and reporting
- Compliance
- Locality Committees
- Meetings support arrangements
- Maximising use of technology
- Joint governance arrangements

1.6 Excluded from the scope of the review at the current time is the future membership and operation of the CCG's Governing Body. However, given the significant changing landscape within Stockport and more widely across Greater Manchester, the Governing Body will need to reflect on the implications arising and consider how it can continue to operate effectively in its strategic leadership role in the future.

2.0 Guiding Principles and Measures of Success

2.1 The Good Governance Institute, working on behalf of CCG's nationally in 2014 and with its partner Capsticks, developed a range of principles against which the Governance of a CCG could be reviewed in the short term and its progress and outcomes measured in the longer term. The principles and underpinnings used as relevant to the scope of this review in line with local priorities were:

- Clarity, purpose and roles (including delegations) of all elements of the governance structure – is the governance model widely understood by those who operate within it and those externally? Are the delegations clear and are Committees and Sub-Committees able to operate independently and with confidence?

- Organisational Effectiveness and adding value – How does the governance structure and its component parts add value to the organisation and provide the leadership steer, assurance and decision making capacity required? Is the outcome proportionate to the resources applied? Are meetings managed effectively and the best use made of individuals and meeting time?

- Risk and Compliance – how well does the organisation's governance meet Constitutional, internal and wider external compliance and regulatory requirements? What is the level of risk in this area and how can it be mitigated through changes to procedures and processes across the organisation?

2.2 The above measures will also be used to determine local performance indicators to measure the continued operation of the CCG's governance framework and also to guide future governance reviews to ensure consistency of approach.

2.0 Information

2.1 Current Governance Arrangements

2.1.1 The formal* Governance Arrangements of the CCG currently comprise:

- Council of Members
- Governing Body
- 4 Locality Committees (Heatons and Tame Valley, Marple and Werneth, Stepping Hill and Victoria, Cheadle and Bramhall)
- Audit Committee
- Clinical Policy Committee
- Quality and Provider Management Committee
- Remuneration Committee
- Healthier Together Committee in Common
- Primary Care Joint Committee
- QIPP Committee

*Under these Committees sit a range of sub-groups and Task and Finish style meetings.

2.1.2 Although not directly part of the CCG's Governance Framework, the CCG is also represented on and feeds into a range of joint meetings with partners which include the Health and Wellbeing Board, Integrated Care Board and others which are emerging relating to the Greater Manchester Devolution work and the Stockport Together Programme.

2.1.3 It is the time which is spent preparing for, attending and following up from all the above meetings and related underpinning governance processes which form the governance framework of

the CCG and therefore the basis for the review of the structure and related governance support processes.

2.1.4 Since 2013 there have been a number of reactive tweaks and amendments to the overall governance structure to provide for changes to CCG responsibilities, provide for greater assurance and ensure compliance in priority areas. There have also been additional governance commitments arising from national developments such as Primary Care Co-Commissioning. This review is the first whole sale look at all areas of the CCG's Governance. It is proposed that a review be undertaken annually commencing in 2016 (light touch or more substantial) based on the needs of the organisation.

2.1.5 The formal governance structure of the CCG is also underpinned by a range of internal Executive meetings which provide leadership, strategic input and manage the operation of the organisation's activities. These did not form part of the governance review but the arrangements have been considered to ensure the efficient flow and management of information across the whole CCG.

2.1.6 Robust governance is at the heart of the CCG and as a public body, it is crucial that the governance arrangements provide for efficient and effective discharge of the CCG's statutory responsibilities in line with local and national priorities. Resource is applied across the organisation's Executive and Clinical staffing and support to ensure the smooth running of the governance framework and support decision-making. The application of this resource was reviewed to ensure opportunities for increased efficiency and effectiveness were maximised and issues which had constrained governance at the CCG could be overcome to ensure flexibility and agility in decision-making.

2.1.7 The CCG remains focussed on delivering the highest quality of care for patients in Stockport and working individually and collaboratively with partners to ensure the future financial and clinical sustainability of health and social care within the local economy. In light of this, the recommendations of this review provide for a strengthening and re-focusing of the application of the NHS Governance Framework for CCG's and locally applied governance support to maximize the potential for the organisation to achieve its current strategic and longer term objectives.

2.2 Activity Undertaken

2.2.1 The Governance Review comprised of the following activities undertaken by the CCG's Board Secretary and Head of Governance:

- Benchmarking governance models across Greater Manchester and more widely (including structures, support levels, costs and outcomes)
  Discussions with Lead Directors about the formal Committee meetings and related work currently in place across the CCG.
- Sessions with the Chairs of Committees to discuss their views on current effectiveness of operation and areas for future development.
- Observations of a range of Committee meetings.
- Audits of agendas and comparisons across to Committee Terms of Reference.
- Review of Committee documentation with a view to standardising the presentation of information.

- Constitutional compliance review.
- Review of practical staffing support arrangements and capacity.
- Review of the Constitution and detailed look at scheme of delegation and Standing Orders.
- Review of existing and potential future links between the CCG's governance framework and that of external partners and regional developments such as Greater Manchester Devolution.

3.0 Findings and Recommendations

3.0.1 The findings and recommendations have been graded in terms of impact in two ways:

- Strategic / External – those areas where recommendations have been highlighted which require Governing Body / Council of Members approval where changes have been proposed impacting directly on the structural form of the CCG's Governance Framework.
- Operational / Internal – those areas where recommendations have been highlighted which do not require Governing Body / Council of Members but require organisational operational changes to be made to support the operation of the CCG's Governance Framework

3.0.2 Governing Body's attention is drawn in particular to recommendations falling within those areas of strategic / external impact.

3.1 Structure and Coherence of Governance Model

3.1.1 In reviewing the structure and coherence of the overall governance model, the rationale was to ensure it was fit for purpose for the organisation's current operation and enabled the efficient and effective transaction of business in light of current and future changes both regionally and nationally. To enable the CCG's Governing Body to provide the strategic leadership required by it across the organisation and in specifically leading its governance, it was acknowledged that maximum benefit must be achieved from the Committee structure derived from the Governing Body. Success in this area could be achieved through clarity in roles and responsibilities of all relevant bodies through their Terms of Reference and confidence in delegation and escalation processes. This brings strengths to the organisation in terms of awareness of matters being discussed across the whole model by a number of individuals, in particular those on the Governing Body.

3.1.2 To avoid duplication and align the Committees of the Governing Body to the key strategic and operational priorities of the Governing Body the following recommendations have been proposed:

(a) All Committee Terms of Reference to be reviewed and standardised and aligned to the proposals outlined below.
(b) Audit Committee – This Committee would retain its current functions and remit and provide assurance around some of the governance elements currently sitting within the remit of QIPP Committee.
(c) Clinical Policy Committee and Quality and Provider Management Committee to be combined with a remit to bring all 3 strands of quality together (patient safety, patient experience and clinical effectiveness) to provide strategic leadership of quality matters within Stockport and across wider partners and enable comprehensive assurance to be maintained over all 3 areas. The Committee would meet on a monthly basis alternating between formal committee

meetings and deep dive quality reviews bringing commissioners and providers together to consider quality matters. One of its key aims would be to focus on embedding a cycle of continuous improvement and shared learning through assurance in pursuit of excellence. Remuneration Committee – The remit of this Committee to remain as currently determined.

(d) Primary Care Joint Committee – This Committee should retain its current remit and will need to be reviewed in line with the expectation that CCG's within Greater Manchester will assume Level 3 responsibility in line with timescales for Devolution. The frequency should be reduced to bi-monthly with the option (as with any Committee) to convene additional meetings should workload require.

(e) QIPP Committee – This Committee should be refocused as a Finance and Performance Committee to provide for greater focus on the CCG's delivery of QIPP and financial monitoring. The membership should be reviewed to provide for greater clinical representation and the Director of Finance should report to the Committee and be responsible for holding those at the CCG responsible for the delivery of QIPP efficiencies.

3.1.3 A diagram of the proposed revised Committee structure is attached at Appendix A

3.1.4 Overall recommendations relating to the operation of all Committees and Sub-Committees of the CCG are outlined below:

(f) A calendar of meetings each year be drawn up for approval by the Governing Body at its March meeting along with the Forward Plan of Governing Body business and appointments to the CCG's Committees and Sub-Committees.

(g) The scheduling of meetings within the calendar be undertaken so that information flow and timely reporting of financial, performance and other matters through the model can be maximised meaning that Governing Body meetings move to the end of the month.

3.2 Governing Body delegation and Committee autonomy and reporting

3.2.1 In order to maximize capacity within the Governance Framework of the CCG, delegations need to be clear and Committees and Sub-Committees empowered to operate independently within their areas of responsibility. This needs to be carried out in the knowledge that powers delegated can also be escalated through to Governing Body where Committees require a strategic steer for their work, they wish to share information or concerns with the Governing Body and where a wider discussion regarding an area of work or decision is required.

3.2.2 The review, through reviewing the activity of Committees as compared to the Terms of Reference did highlight some areas where there was evidence of duplication of effort within the Committee structure and where inter-links between Committees did not always provide for efficient transfer and sharing of information.

3.2.3 The proposals to amend the Committee Structure in line with section 3.1 should allow for greater focus and delegation of information from the Governing Body to its Committees and Sub-Committees. In addition to this, the way Committees report to the CCG Governing Body should be standardised with greater focus on holding Committee Chairs to account and escalating issues in place of receiving matters for information.

3.2.4 The following recommendations have been proposed in line with the findings of the review:

(h) Committees to operate autonomously as far as fulfilling the requirements of their Terms of Reference. Matters reported to Governing Body should be on an exceptions basis where action by way of a decision is required or a matter has been escalated for a more strategic input.
(i) Committee Chairs (including Locality Chairs) should be held to account by the Governing Body for the work of their Committees. An item entitled ' Matters Escalated by Committees' will become a standard item on all Governing Body agendas to provide for discussion on Committee work either via verbal updates or written reports on an exceptions basis.
(j) Minutes from all Committee meetings will be made available through the Governing Body resource area and CCG's website to ensure information is disseminated but these should not be presented in full to Governing Body.

3.3 Compliance

3.3.1 The Constitution of NHS Stockport Clinical Commissioning Group acts as the legal document which establishes the Governance Framework of the organisation and ensures its operation is controlled, robust and transparent. As part of the review it was reported that some areas of the Constitution's drafting inhibited the smooth transaction of the CCG's business where flexibility could be provided. It is in such cases, minor changes to the information contained within the Constitution could prevent avoidable issues of non-compliance. Such amendments would still provide for the robust and transparent governance operation the CCG seeks to sustain and would create consistency in application across all formal meetings.

3.3.2 Examples of these issues include existing levels of quorum, consistency in the distribution of documents for all Committees and Sub-Committees of the Governing Body (in line with arrangements for the Governing Body itself) and the lack of arrangements for pre-notified substitutions.

3.3.3 The following recommendations have been proposed (all will require approval by NHS England through the Constitutional Change Process) to apply to all meetings as outlined:

(k) Quorum for the Governing Body and all its formal Committees and Sub-Committees be set at a minimum of one third of the total Committee membership (with the quorum to include within it clinical representation as determined by the Governing Body). This would translate as an example:
Governing Body (14 members) – quorum 5 (with at least 1 Clinical Representative and 1 Locality Chair representative)
(l) Standing Orders governing the operation of all the formal Committees and Sub-Committees of the Governing Body be standardised and based on those applied to the Governing Body itself to provide for consistency of approach.
(m) The Constitution to include provision for named substitutes to attend Committees in place of substantive appointees. These would be agreed alongside the appointments to Committees as per recommendation (g) and the requirements relating to Declarations of Interest relating to the substantive appointees would need to be fulfilled by the substitute also.

3.4 Locality Committees

3.4.1 The arrangements for the discharge of CCG functions within the localities and main and most regular governance link between the Governing Body and its member practices is currently carried out through a combination of Constitutionally bound Locality Councils and more flexible Locality Meetings, both held on the same date within each of the 4 Localities. The meetings are led by the Locality Chair and Vice Chair with support from the Area Business Team and have developed in line with locality need / flavour.

3.4.2 The link between the Governing Body and Localities is a key one and information flow is managed largely through the Locality Chairs who sit on both bodies.

3.4.3 Feedback from those involved in attending and supporting the governance work in Localities strongly indicated that the current split in meetings did not make for the most efficient or cost effective use of clinical time and to enable sufficient focus and detailed discussion of CCG strategic priorities and changes affecting primary care. In line with the CCG's approach to working in neighbourhoods in primary care and future fully delegated co-commissioning of primary care, it is important the meetings are used to maximum effect. There may be future scope to develop the work in localities further as the CCG continues to develop and the impact of Greater Manchester Devolution locally is more clearly known.

3.4.4 The review identified that whilst there was a requirement for a mechanism for decision making in localities which was robust and bound by some Constitutional constraints, they should not inhibit innovative and flexible working at the locality level. It was also identified that there was scope to improve 'real time reporting' from CCG members at the Locality Level through to the Governing Body and the CCG's leadership and vice versa.

3.4.5 In line with an approach to continuing review of the arrangements for Locality working alongside the strategic development of the CCG the following recommendations have been proposed:

(n) The requirement for 4 Locality Council meetings to be held annually be replaced with a single Locality Council AGM (to carry out procedural items only eg election of Chairman / Vice-Chairman, approval of Locality Annual Reports etc) with additional meetings being called in year for procedural matters only.
(o) The Locality Meeting element of the current arrangements be strengthened on the existing basis of 4 per year.
(p) Existing Locality Representatives be invited to submit written quarterly reports from their respective areas (Public Health, Optometry, SMBC Social Services etc) to be circulated electronically to members to keep them informed of developments and work which may compliment that of general practice.
(q) Based on the agendas set for Locality Meetings, those existing Locality Representatives would be invited to take part in relevant discussion items and / or present relevant information. This would allow for the continuation of primary care led conversations with the valuable contributions of other specialisms operating in different professional fields.
(r) GP remuneration be linked to attendance at the Locality Meetings to be held quarterly and Locality Council AGM
(s) In proactively planning for the work of the Governing Body, the Board Secretary and Head of Governance to collaboratively plan with the Locality Chairs and Area Business Team to

maximise the opportunity for information flow, collaboration and discussion between the Governing Body and Locality Committee meetings.

(t) Locality Chairs to remain the main link between Locality Committees and the Governing Body and be held to account for work within Localities in line with recommendation (j)

(u) The operation of Locality AGM's and Meetings be reviewed again in Summer 2016 in light of the development of neighbourhood working and Primary Care Co-Commissioning to see whether delegations can be further strengthened through areas such as enhanced decision making powers or financial delegations.

3.5 Meetings Support Arrangements

3.5.1 A fundamental part of maintaining a robust, transparent and effective governance function is ensuring a high quality, proactive and professional approach to meetings support. The review focussed on understanding the current support arrangements and discussing with relevant parties how elements of existing work could be further developed to aid the smooth and efficient running of meetings.

3.5.2 Meetings observations have identified a number of areas where continued training and support for staff supporting the governance of the CCG would enable a more proactive meetings support service to be provided covering areas such as horizon scanning of Committee related knowledge, forward planning, advice and guidance in meetings and support for swift follow up.

3.5.3 These recommendations are viewed as those for management but have been included as part of this report for completeness:

(v) All Committee documentation (including agendas, action sheets, forward plans and minute style) to be standardised to ensure consistency in quality and provision of information.

(w) A rolling programme of skills and knowledge development be put in place for all those staff supporting meetings across the CCG.

(x) The Committee Support Handbook to be refreshed in line with the recommendations arising from this report.

3.6 Maximising Use of Technology

3.6.1 There are many opportunities where the use of technology can support the smooth and efficient management of governance within the CCG and increase transparency of meetings for the public.

3.6.2 Many of these solutions would incur a cost if rolled out so these recommendations have been made with a view implementing technological improvements where there are no financial implications and seek a commitment to investigating those areas where a business case could prove need in efficiency and timesaving areas.

3.6.3 The recommendations proposed are as follows:

(y) A Governing Body virtual resource library be established to provide for the storage and circulation of documents of interest to Members by the CCG and by Governing Body

Members themselves in addition to the information provided by the CCG on its public website.

(z) Governing Body Meetings be Tweeted live, starting in early 2016 to increase dissemination of information to the public.

(aa) The CCG commit to operating paperless Committee meetings across the Governing Body and all its Committees by April 2015.

(bb) The requirements for software to support the management of Committee information, reports workflow and other elements of Governance including Declarations of Interest be drawn into a specification to be progressed at an appropriate time in the future.

3.7 Joint Governance Arrangements

3.7.1 The CCG operates within a complex external governance environment within Stockport and also on a regional level. These will be significant changes arising at a regional level as a result of Greater Manchester Devolution and there is not clarity at the current time about the confirmed impact of regional governance on Stockport CCG.

3.7.2 Central to ensuring the CCG's governance is robust, fit for purpose and importantly for joint governance work enables the organisation to be agile in its decision making is the Scheme of Delegation. The review assessed the Scheme of Delegation as providing for efficient local decision making at the current time however it will need to remain under constant review in light of the changes outlined in paragraph 3.7.1.

3.7.3 It was identified as part of the review that the Scheme of Delegation needs to maintain the right balance between the decision making components of the CCG's governance arrangements (Council of Members, Governing Body, Committees and individual Executive Decision Makers) and provide for transparency in a system where decisions are taken by the right body / individual at the right level to maintain appropriate pace.

3.7.4 In light of the significant changes on the horizon for joint governance the recommendations have been proposed as short term. The area will remain under continuous review in the light of the development of governance underpinning Devolution.

(cc) The CCG calendar of meetings be aligned as far as is practicable to the meetings Calendar of partner organisations including Stockport Metropolitan Borough Council (encompassing the Health and Wellbeing Board, Health and Wellbeing Integrated Commissioning Board and other meetings) and Stockport Together meetings to ensure complimentary flow of information through the various structures to increase efficiency.

(dd) The Scheme of Delegation to remain under review in light of future changes to joint governance structures locally and arising from Greater Manchester Devolution and changes enacted as appropriate.

(ee) Where sub-delegations exist within the Scheme of Delegation, an internal scheme of management should be developed to clarify where responsibility for decision making sits to be complemented by a mechanism for recording delegated decisions.

(ff) A delegation and influence matrix to be developed to clarify the links / modes of influence and delegation of decision making power between the CCG, its partners and regional bodies.

4.0 Conclusion

4.1 The recommendations arising from this review it is anticipated will improve the flexibility, efficiency and robustness of the CCG's governance as a result of taking a holistic view of overall framework. Those recommendations which require constitutional amendment will be put before the Council of Members at the CCG's Annual General Meeting on 30 September 2015

4.2 In light of the significant local collaborative health and social care sector transformation underway in Stockport and wider regional Devolution governance proposals being developed some elements of the governance review cannot be fully realised at the current time. These areas will remain under constant review and will be the subject of future deep dive governance reviews into particular areas where amendments are required.

4.3 In light of the continuing need to keep the CCG's Governance framework under review a final recommendation is proposed that:

(gg) A light touch annual review of the CCG's Governance arrangements be undertaken annually with a full review being undertaken as and when required by internal and external factors or on a 3 year cycle.

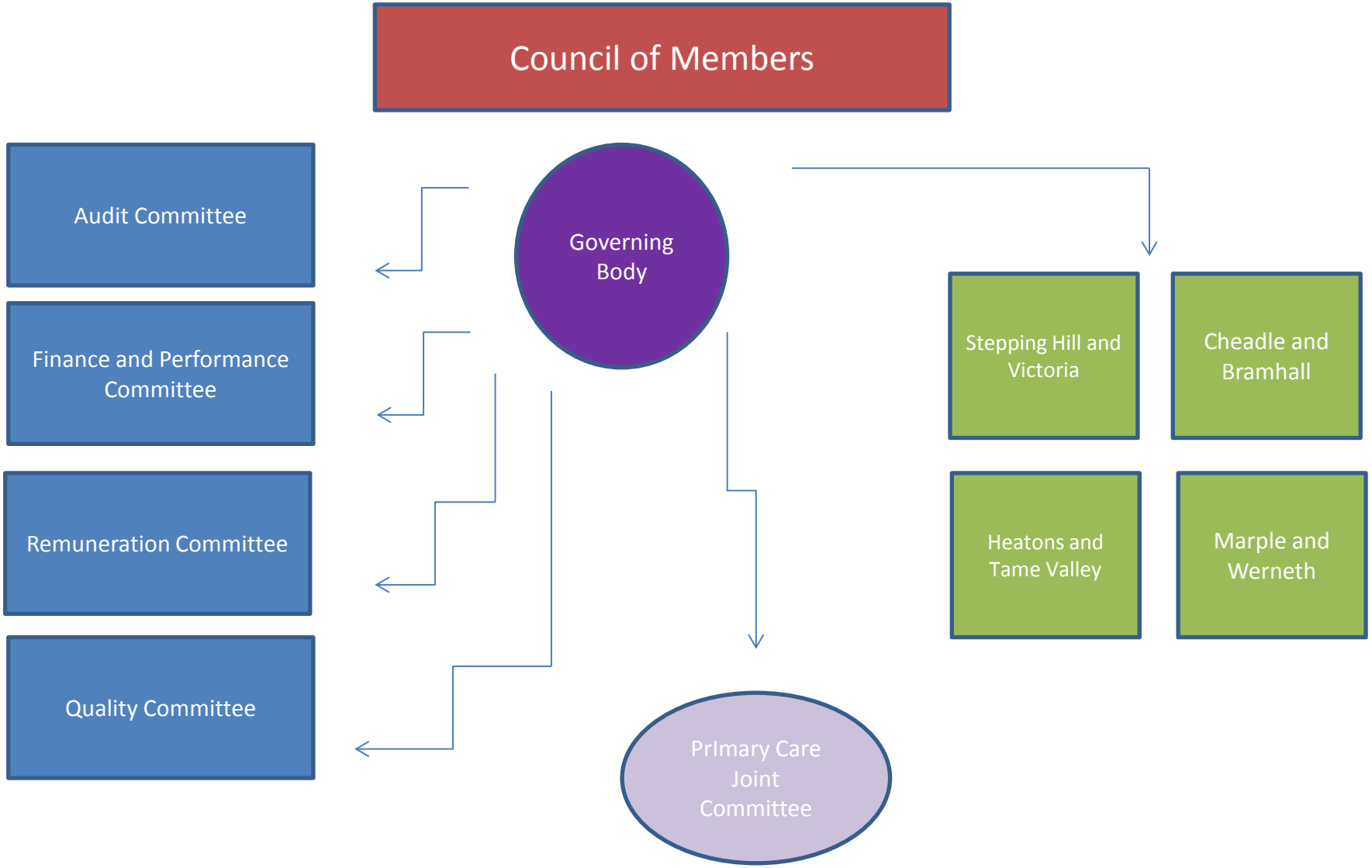
5.0 Action Required

5.1 Governing Body is requested to:

1. Note the contents of the Governance review.

2. Approve the recommendations (a) – (hh) covering both strategic / external and operational internal governance matters.

3. Endorse 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.



Quality Committee (combined Clinical Policy Committee and Quality and Provider Management Committee)
Finance and Performance Committee (formerly QIPP Committee)

NHS
Stockport
Clinical Commissioning Group

Statement of Involvement

Annual Statement – April 2014 to March 2015

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

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

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

Website: www.stockportccg.org

Executive Summary

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

To note and review the activity and methods used for public engagement in 2014-2015.

Please detail the key points of this report

The CCG has a duty to involve and consult local people and stakeholders in the planning and development of services. The clinical leadership of the CCG has been very clear that it wants patient views to be at the heart of everything the CCG does. From the 1 April 2014 to the 31 March 2015 NHS Stockport Clinical Commissioning Group spoke to 5702 people about a range of topics, including:

- Deaf health services
- Blood pressure
- Chronic Obstructive Pulmonary Disorder (COPD)
- Healthier Together consultation
- Urgent care services
- Winter resilience
- Self-care

A wide variety of communication methods were used, to reach more people, and different groups within Stockport's community and give the CCG a better understanding of local views on the health service and priorities for change.

What are the likely impacts and/or implications?

Local people influencing strategic priorities and being involved in decisions that affect their health and social care. People more empowered to take control of their own health.

How does this link to the Annual Business Plan?

The statement of involvement is a statutory duty.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

N/A

Clinical Executive Sponsor: Jane Crombleholme

Presented by: Tim Ryley

Meeting Date: 9th September

Agenda item:

Reason for being in Part 2 (if applicable)

N/A

Statement of Involvement 2014-2015

1.0 Purpose

1.1 NHS Stockport Clinical Commissioning Group is responsible for making sure that the 290,000 people living in the borough have access to the healthcare services they need.

1.2 We recognise that our decisions, policies, and services have a major impact on the lives and wellbeing of the local people, so we actively seek to engage with all sectors of the community to ensure that everyone has an equal chance to have their say before we make major decisions.

1.3 The purpose of this report is to outline what work the CCG has undertaken over 2014-15 to engage local people, involve them in decision making and consult on major changes to local health services.

2.0 Why do we consult with patients, carers and the public?

2.1 We are committed to making evidence-based decisions that take into account the views and experiences of all those affected by them.

2.2 In 2006 patient involvement was strengthened by the NHS Act. Sections 242 and 244 of the Act place a duty on NHS organisations to involve and consult local people and stakeholders in the planning and development of services. It also included a duty to report on this activity in an annual 'statement of involvement (section 24A of the NHS Act 2006). The report should cover:

- who we consulted
- what information we gave them
- what questions we asked
- what people told us
- what we did with the information they gave us
- and where more information about the consultation can be found.

2.3 Over the period from 1 April 2014 to 31 March 2015 we spoke to 5,702 local people about the wide range of services we commission and decisions taken on behalf of local people. This report summarises that engagement and how local views have shaped our work.

3.0 Our approach to public engagement

3.1 Our approach to public engagement and consultation is to make sure that we use a wide variety of different mechanisms, methods and approaches to engage with people. We need to understand how we can best involve people, when they need or want to be engaged.

3.2 We have a 'Communications and engagement strategy' which sets out how and why we engage with people. Alongside this we produce individual communications and engagement plans to reflect the different needs of each service change or project.

3.3 We have a number of ways of engaging with the public and gathering views including:

- Citizen Space 'have your say' website
- CCG Patient Panel meetings
- Public meetings
- Consultation events
- Prevention and screening events
- Focus groups
- Information stalls at supermarkets and events
- Self-care education classes
- Presentations at local groups
- Patient story podcasts
- Healthwatch attendance at governing body and committees

4.0 Key messages of the year

The following table provides examples of the key messages from the year under four headings:

Prevention and Self care	Mental Health	Primary Care	Hospital care
• Over the course of the blood pressure testing events, 1794 blood pressures were taken. One third of people that were seen were recorded as having high blood pressure levels. This is higher than the predicted '1 in 4'. • In terms of self care people are most keen to learn first aid and about back care. • The different organisations should use the consistent lifestyle messages	• There should be more support for people with mental health issues and their carers. • People are concerned about the effect that drug and alcohol problems are having on the NHS and social care. • Mental wellbeing is a topic that has been raised during a number of conversations at prevention and self care events	• Telephone systems need to be improved • There should be better access to GP appointments • Patients should be made more aware of online services.	• People want more information about where to go or what to do when they are ill – they want alternatives to A&E. • Concerns raised about distance of travel for people in High Peak (Healthier Together)

5.0 Types of Engagement Undertaken

5.1 In line with the CCG's communication principles, a number of different communication and engagement methods - tailored in accordance with the target audience - are used to capture patient insight and ensure that as many people as possible can feed in their views. Where necessary a combination of methods is being used in order to achieve maximum coverage.

5.2 Patient and Public Involvement is the responsibility of the whole organisation, with work undertaken across teams and fed into the Governing Body as intelligence to drive tangible improvements to local services.

5.3 ***Lay Membership of committees:***

To ensure that patient views are heard at every level of the organisation, the CCG has appointed lay members to sit on our committees and present a patient perspective to discussions and decisions:

- the Governing Body has 2 lay members recruited from the community: one of whom chairs the meetings and takes responsibility for patient engagement, while the other leads on audit, remuneration and conflict of interest matters.
- the Governing Body has also co-opted a representative of Healthwatch Stockport and the Chair of the Health & Wellbeing Board to attend all meetings and feed in local views.
- the Clinical Policy Committee is attended by the lay chair of the CCG and a Healthwatch representative
- the Quality & Provider Management Committee includes the Lay Member with a remit for Public Involvement and a Healthwatch member
- the Audit Group is chaired by the lay member responsible for audit and finance
- the Remuneration committee is chaired by the lay member responsible for audit and finance

5.4 ***Patient Stories:***

Patient story podcasts have been used at the beginning of CCG Governing Body meetings since March 2012. The patient or carer describes their experience of healthcare in their own words in a short video. The idea is to gain a snapshot view of what it is like as a patient, what was good, what was bad and what would make their experience of healthcare in Stockport more positive. Below is a list of all the patient stories which have been shown during 2014-2015 and the actions that the Governing Body requested as a result.

Meeting	Patient Story Topic	Actions
April 2014	Cancer diagnosis and treatment	To be shown on GP TV screens and more widely
June 2014	Weight reduction	Messages about healthy weight loss to be shared in schools
July 2014	Inhaler techniques for	Asthma self management included

	asthmatics	in business case
September 2014	Mental health issues and impact on families	GP practice Masterclasses on the topics of parity of esteem and on dementia.
October 2014	Diagnosis, treatment and managing pain	Video to be shared with relevant consultants in Foundation Trust
November 2014	Alcoholism	To check agreed protocol for handling substance misuse and mental health

Where experiences were negative, they have been shared with the service provider and used as a learning tool for continuous improvement. Some people give consent for the film to be shown at the Governing Body only, some agree for it to be shared with health and social care staff to help improve services and others agree to the much wider sharing on websites and at conferences and events.

With consent some of the patient stories have been uploaded to Youtube.

5.5 ***Healthwatch***

The CCG have always worked closely with Healthwatch – to get our messages out to as wide an audience as possible and to feed in their views into CCG decision.

The CCG's Chief Operating Officer holds monthly meetings with the Healthwatch chair who sits as a representative on the Governing Body. Where changes are being planned, commissioners attend Healthwatch briefing sessions to get feedback on plans.

Members and officers of Healthwatch are also involved in our committees and workshops.

5.6 ***Customer Services Monitoring:***

In 2014-2015 the CCG's Customer Services team handled queries, compliments, comments and complaints for the public on a daily basis. In addition, the CCG's communications team manage requests for information submitted under the Freedom of information Act. All of these contacts from the public are monitored and analysed so that trends in requests or issues are fed into the Governing Body and the relevant commissioning team to ensure that improvements are made as a result of local contacts. Over 2014-2015, NHS Stockport received:

- 67 Complaints
- 34 MP letters
- 202 Freedom of Information requests

Any tweets or facebook messages about patient care are also reported to our patient experience officer in the Quality and Provider management team.

6.0 Work of the Public Engagement Team

6.1 Functional and operational responsibility for engagement sit with the CCG's corporate and planning function which leads and supports work across all directorates; providing cohesion and consistency in messages, communications and engagement activities.

6.2 During 2014 the CCG merged the communications and engagement teams. Engagement itself is a form of communication therefore its merger ensures that messages are consistent across all communication channels and that they reflect public views.

6.3 In addition to the work across the organisation, the Public Engagement team utilises a range of methods to ensure that the public voice is heard in decision making:

6.4 ***Patient Panel:***
The CCG has its own Patient Panel, of individuals from across Stockport's four localities. The Patient Panel has bi-monthly meetings where CCG representatives present and ask for their views on plans and priorities. Some work was undertaken with the panel this year to ascertain their views on the future running of the panel.

They discussed the need for better flow of information between the panel and Governing Body and they asked for more meetings and involvement in decision making. Since this meeting the work on Stockport Together has grown which requires more input from the public. The panel members will be invited to take part in the transformation plans in a number of ways including focus groups, design sessions and surveys. A Citizens Representation panel will also be set up and two members of the panel will be invited to become members on this. This will sit as part of the Stockport Together governance structure.

6.5 ***Public Engagement:***
Where possible public engagement work is varied to meet the requirements of the stakeholders we want to target. In 2014-2015 the bulk of the work was on the Healthier Together engagement and consultation and the prevention work on hypertension and COPD.

- 2, week long prevention campaign events in the town centre
- 19, workplace prevention events
- 12, surveys
- 6, self-care education events
- 5, borough wide public meetings (including the Annual General Meeting)

6.6 ***Support to GP Practices' Patient Reference Groups:***
As a membership organisation, the CCG has also supported its Member Practices by enabling them to use the CCGs online survey site.

6.7 ***Major Consultations***

Healthier Together consultation

The Healthier Together Programme is a key part of the wider programme for Health and Social Care reform across Greater Manchester, which aims to provide the best health and care for Greater Manchester. There were three elements to the Healthier Together programme – Integrated Care, Primary Care and In Hospital care.

The Healthier Together programme was launched in February 2012 and commenced pre consultation in August 2012. Throughout the pre-consultation period, the programme undertook comprehensive engagement with local clinicians, stakeholders, patients and the public as part of initiatives to help shape the model of care leading up to the development of viable options that were taken forward to consultation.

July 8th 2014 saw the launch of the Healthier Together public consultation across Greater Manchester on the future of health and care services. The consultation asked the public about the number and location of the hospitals that should provide specialist abdominal surgery. The consultation ended on 30th September 2014, but responses were still accepted until 24th October 2014.

The CCG communications and engagement team ran an extensive programme of activity to encourage involvement in the consultation. This included public meetings, face to face engagement in public places (ie. Supermarkets) and at local groups (ie. Carers for Adults with learning disabilities, residents associations etc). They also supported a number of events ran by the central Healthier Together team.

4098 responses were obtained from the people of Stockport which accounted for 20% of the overall number of responses in Greater Manchester.

Links to the public consultation write ups and evaluations can be found in the table below.

6.8 *Evaluation of the methods*

- The prevention work such as high blood pressure testing and lung age monitoring provided good avenues for discussion about other issues. For example, during blood pressure testing the team were able to gather views on the Healthier Together consultation and provide information about self care.
- Face to face engagement has provided better results in terms of uptake. For example, the street activity prompted more downloads of the mobile app than the billboard advertising.
- Using local groups remains an effective way of increasing involvement. For example, the winter campaign survey was distributed in this way and over 700 people completed it.
- Supermarkets a good place to catch people who wouldn't normally have the time to come along to presentations or complete surveys.

7.0 Impact of Involvement

7.1 All feedback from engagement exercises is reported to the CCG's Governing Body as a key piece of evidence for consideration in decisions and showing how the views of individual patients are translated into commissioning decisions and how the voice of each practice population is sought and acted upon. One of the key tools for feeding back to local people is the CCG's new engagement website: *www.citizenspace.com/stockport-haveyoursay*.

7.2 For those without access to the internet, write-ups of events are also sent out to local groups after they have met with the NHS. Sign-up sheets are also taken at all public events so people who wish to receive a write-up of the event can have this sent to them in their preferred format. Articles summarising formal consultations are included in the local Council publication that is delivered to all households in Stockport. In addition, feedback reports are sent to the Healthwatch for inclusion in their regular newsletter and targeted feedback articles are also included in a wide range of local newsletters.

7.3 A full breakdown of engagement events, surveys and activities can be found in Appendix one, which outlines:

- what we did
- when
- how many local people were consulted
- what people said
- what we did as a result of local feedback
- and where to go to get a full write-up of the consultation and results.

8.0 Equalities

The core principle of the NHS is to deliver free healthcare for all. We recognise, however, that we are not all the same and that different groups in society will need different things at different times. We want to ensure that our services meet the needs of the individuals and communities we serve.

Since the Clinical Commissioning Group took over the local NHS budget in April 2013 equality has been a major priority for our work.

Duty to reduce inequalities

The CCG has a legal duty under the Equality Act (2010) to ensure that when carrying out our functions we give due regard to reducing inequalities between different patient groups in terms of their ability to access services and their health outcomes.

Over the past year a number of projects have been undertaken to target resources and information at those populations with the greatest need and reduce inequalities in access to our services:

- All GP Practices were given free access to skype interpretation for sign language users
- We extended access to the Child and Adolescent Mental Health Services from 16-18 years
- The CCG took part in the Deaf Health Champions project and was used as a best practice case study for their national conference
- An integrated health and social care team was piloted in Marple in Werneth to support people with multiple, complex care needs
- Care Plans were created for around 4,500 people with multiple healthcare needs to better manage their conditions (2% of over 18s);
- An End of Life Care pilot successfully tripled the percentage of patients (from 30-90%) who were able to die in the place of their choosing;
- We increased local access to IAPT services from just 8% to the national standard of 15%
- Equality Impact Assessments were undertaken on new projects, including health apps and online patient services
- We undertook tailored campaigns to promote flu vaccines for pregnant women, children, older people and ‘at risk’ groups of people with long-term conditions and disabilities
- A specialist dementia nurse was recruited for end of life care services
- A new healthcare app was launched, providing information in a more accessible format for deaf, hard of hearing and young people.

Equality disclosures:
Each year the CCG produces equality report and publishes information on the breakdown of our workforce by protected characteristics, as defined in the Equality Act 2010. For a full break down of our workforce and our equality & diversity achievements, go to: http://stockportccg.org/equality-diversity/public-sector-equality-duty/

9.0 Plans for Next Year

The public engagement plans for the next financial year (2015-2016), will focus on:

- The Stockport Together public engagement and consultation
- Any engagement required for the four transformational projects – Urgent care, planned care, proactive care and prevention/empowerment
- Increasing access to primary care
- GM Devo locality plan
- Winter resilience campaigns
- Digital empowerment

10.0 Where to get more information

If you would like more information about the work we do, or if you would like to get involved in future engagement and consultation work, please contact our Communications and Engagement Team on:

0161 426 5895 - stoccg.haveyoursay@nhs.net

Or visit our consultation website at www.citizenspace.com/stockport-haveyoursay

Louise Hayes
02 September 2015

When?	Who did we consult?	Format	No. we spoke to	What did we do as a result?	Where can I get more information?
01/04/2014	Older people	CCG Consultation	18	Results to planning team	https://www.citizenspace.com/stockport-haveyoursay/consultation-and-engagement/ccg-plans-at-the-older-peoples-forum
01/04/2014	Deaf people	Online Survey	5	Results to service providers	https://www.citizenspace.com/stockport-haveyoursay/consultation-and-engagement/ccbe2b2e
03/04/2014	Strategic Plans Consultation H&TV	CCG Consultation	10	Results to planning team	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/copy-of-ccgstrategic-plans2014h-tv
28/04/2014	Public	Prevention/Hypertension Stall	1000	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
14/05/2014	Patient Panel	Workshop	6	Views reported to Governing Body	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/ppmay14
21/05/2014	Deaf people	Information Stalls	100	Results to service providers	https://www.citizenspace.com/stockport-haveyoursay/corporate-services/deaf-health-event
21/05/2014	Angiography Service	Online Survey	4	Results to commissioners	https://www.citizenspace.com/stockport-haveyoursay/quality-and-provider-management/angiography-service
05/06/2014	Urgent Care Reform patients	Patient Survey	72	Results to commissioners	https://www.citizenspace.com/stockport-haveyoursay/commissioning/urgent-care-strategy-consultation
10/06/2014	Dying Matters	Online Survey	66	Results to end of life team	https://www.citizenspace.com/stockport-haveyoursay/consultation-and-engagement/dmyouonlydoitonce
12/06/2014	Public	Prevention/Hypertension Stall (BT)	65	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
17/06/2014	Public	Prevention/Hypertension Stall (Shomes)	11	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
21/06/2014	Public	Prevention/Hypertension Stall (Lhill)	11	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
24/06/2014	Carers	Prevention/Hypertension Stall (Carers Event)	35	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
01/07/2014	Public	Prevention/Hypertension Stall	8	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
09/07/2014	Public	Prevention/Hypertension Stall (Foodbank)	23	Results sent to GPs for records or follow up	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/hypertension-stall-chelwood
15/07/2014	Patient Panel	Workshop	7	Views reported to Governing Body	https://www.citizenspace.com/stockport-haveyoursay/consultation-and-engagement/patient-panel-july-2014
19/07/2014	Public	Prevention/Hypertension Stall (Shill)	64	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
23/07/2014	Public	Prevention/Hypertension Stall (Stagecoach)	43	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
26/07/2014	Public	Prevention/Hypertension Stall (Carnival)	105	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
31/07/2014	Carers	Healthier Together Presentation (CALD)	11	Results sent to GPs for records or follow up	https://www.citizenspace.com/stockport-haveyoursay/consultation-and-engagement/cald-ht-meeting
31/07/2014	Public	Prevention/Hypertension Stall Towers)	14	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
07/08/2014	Cheadle Hulme U3A	Healthier Together Presentation	60	Included in consultation responses	https://www.citizenspace.com/stockport-haveyoursay/consultation-and-engagement/cheadle-hulme-u3a-htconsultation
11/08/2014	Staff	HT Briefing	122	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htstaffbriefingeventsh
12/08/2014	Healthier Together Public Consultation	Formal Public Consultation	110	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htmeeting4-9-14
14/08/2014	Public	Healthier Together Stall	100	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htsainsburys
15/08/2014	Public	Prevention/Hypertension Stall inc HT Woodley)	35	Results sent to GPs for records or follow up	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/hypertension-stallwoodleyhealthfair
19/08/2014	Public	Healthier Together Stall (Edgeley Castle st)	70	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htedgeley
20/08/2014	Public	Healthier Together Stall (Morrisons)	30	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htcheadle
01/09/2014	Public	Prevention/Hypertension Stall	35	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
04/09/2014	Healthier Together Public Consultation	Healthier Together Consultation Village cheadle	50	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htmeeting4-9-14
10/09/2014	Public	Prevention/Hypertension Stall (BG)	48	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
10/09/2014	Public	Online Survey (Hypertension Feedback)	9	Comms&team used when planning next camp	https://stockport-haveyoursay.citizenspace.com/communications-team/1365d6fa
16/09/2014	Patient Panel	Workshop	12	Views reported to Governing Body	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/patient-panel-september-2014
17/09/2014	Public	Prevention/Hypertension Stall (BG)	38	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
24/09/2014	Public	Healthier Together Consultation (after AGM)	50	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htccgagm
25/09/2014	Public	Healthier Together Question Time	110	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/htpubmeetingstcollege
26/09/2014	Public	AGM Feedback	30	Used to plan 2015.2016 AGM & sent to Public	https://stockport-haveyoursay.citizenspace.com/communications-team/agm-2014-feedback
01/10/2014	PRG	Springfield Surgery PRG	7	Included in consultation responses	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/springfield-surgery-prg-meeting
08/10/2014	Public	Prevention/Hypertension Stall (RB)	41	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
09/10/2014	Public	Prevention/Hypertension Stall (Pips)	76	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
15/10/2014	Public	Prevention/Hypertension Stall (RB)	39	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
16/10/2014	Public & Stakeholders	Winter Publicity Campaign	748	Views used to plan winter campaign	https://stockport-haveyoursay.citizenspace.com/communications-team/wpc2014
23/10/2014	U3A Group	Focus Group	70	Results used in prevention planning	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/romiley-u3a
03/11/2014	Public	Prevention/Hypertension Stall (AB)	62	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
06/11/2014	Public	Prevention/Hypertension Stall (AB)	48	Results sent to GPs for records or follow up	P:\COMMS\Campaigns\Hypertension\General
17-21/11/2014	Public	Prevention/ COPD campaign	566	Overview of results sent to COPD team	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/copd-awareness-event-kct4
28/11/2014	Public	Prevention/ App promotion	200	People advised to download app	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/carers-rights-day-2014
04/12/2014	Public & Stakeholders	Online Survey	52	Results used in planning change	https://stockport-haveyoursay.citizenspace.com/communications-team/self-care-classes
08/12/2014	Care Home Residents	Online Survey	665	Results used in planning change	https://stockport-haveyoursay.citizenspace.com/service-reform-team/d71fc91e
09/12/2014	Students	App Promotion (College)	40	People advised to download app	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/appskcollege
19/12/2014	Public	App Promotion (Town Centre)	300	People advised to download app	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/apppromtowncentre
30/12/2014	Staff & stakeholders (FRAN)	Online Survey	11	Results used in planning change	https://stockport-haveyoursay.citizenspace.com/service-reform-team/end-of-life-care-training-post-questionaire
12/01/2015	Patient Panel	Workshop	10	Views reported to Governing Body	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/ppjan15
14.01/2015	Springfield PRG	PRG	11		https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/presentationtospringfield
09/02/2015	Public & Stakeholders (ANGELA)	Online Survey (ongoing)	54	Views used in planning	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/patient-confidentiality-survey-2015
11/02/2015	Public & Stakeholders	Stockport Together presentation	30	Views used in planning	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/cf-ltcs-integration
17/02/2015	Public	Prevention/Hypertension Stall (BG)	18	Results sent to GPs for records or follow up	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/copy-of-hypertension-stall-bgas-bakeries-2
24/02/2015	Public	Prevention/Self Care Classes (BL)	4	Comments used in planning future information	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/90822ef5
25/02/2015	Public	Prevention/Self Care Classes (HG)	7	Comments used in planning future information	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/self-care-class-hazel-grove

04/03/2015	Public	Prevention/Self Care Classes (BL)	1	Comments used in planning future information	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/c6b6be67
10/03/2015	Public	Prevention/Self Care Classes (Brm)	7	Comments used in planning future information	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/bramleycentre-2
16/03/2014	GP TV Screens	Online Survey	21	Views used to decide whether to continue to p	https://stockport-haveyoursay.citizenspace.com/communications-team/gptvsurvey
17/03/2015/	Public	Prevention/Self Care Classes (SR)	5	Comments used in planning future information	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/sccstmarys
18/03/2015	Stepping Hill PRG	Focus Group	5	Views used in planning campaign	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/stop-before-the-op-prgshill
25/03/2015	Patient Panel	Workshop (awaiting minutes)	8	Views reported to Governing Body	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/patient-panel-march-2015
27/03/2015	Public	Prevention/Self Care Classes (Brm)	9	Comments used in planning future information	https://stockport-haveyoursay.citizenspace.com/consultation-and-engagement/bramleycentre
			5702		

NHS
Stockport
Clinical Commissioning Group

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 CPC have endorsed the GMMMG NTS recommendations in section 3.1.
- To note CPC have endorsed the amendments to the black and grey lists in section 3.2
- To note the anticipated cost impact of a new high drug for hypercholesterolaemia.
- To note the impact of NG13 Workplace policy and management practices to improve health and wellbeing of employees.
- To note the update on NG5 Medicines optimisation the safe and effective use of medicines to enable best outcomes.
- To note the update on QS93 Atrial fibrillation: treatment and management.
- To note the updated costing summary for NICE TA's.
- To receive the minutes of the July meeting.

Please detail the key points of this report
This paper informs the Governing Body of new policies that have been agreed at Clinical Polices Committee (CPC), best practice gaps around NICE guidance and costing implications for new NICE technology appraisals.
What are the likely impacts and/or implications?
Impacts on budget identified in NICE costing tool. All other measures are in place to manage clinical cost effectiveness
How does this link to the Annual Business Plan?
Effective use of resources is an essential part of QIPP. This process ensures innovation by systematic and timely dissemination and adaptation to new NICE guidance and the control of new developments in-year.
What are the potential conflicts of interest?
None.
Where has this report been previously discussed?
Clinical Policy Committee (CPC)
Clinical Executive Sponsor: Dr Vicci Owen-Smith
Presented by: Dr Vicci Owen-Smith
Meeting Date: 09.09.15
Agenda item: 13
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 summary has been adjusted to £403,167 to reflect the cost impact of TA346 Afibercept for treating diabetic macular oedema identified as £137,145 and TA349 Dexamethasone intravitreal implant for diabetic macular oedema identified as £266,022.

3.0 General Policies

3.1 CPC endorsed GMMMG (Greater Manchester Medicines Management Group) New Therapies Subgroup (NTS) recommendations on the following: Simbrinza®, Edoxaban and Probiotics position statement.

3.2 CPC approved the request from STAMP to add the following to the blacklist: Lactulose sachets and to add Rifaximin to the greylist.

3.3 CPC noted a new high cost drug for hypercholesterolaemia is due out in October 2015. The TA is due out early 2016 and early estimations of the cost impact for Stockport are that it could be as much as £4.5 million pounds.

3.4 CPC has reviewed the guidance in NG13 Workforce policy and management practices to improve the health and wellbeing of employees. CPC felt that workplace health shoud be a priority but that it has not been treated as such because of staff/ resource constraints . CPC advise that the provision of health and well-being services for CCG staff and access to occupational health for primary care and CCG staff should be prioritized and suggest that the other organisations in Stockport Together have good practice to learn from.

3.5 CPC reviewed NG5 medicines optimisation the safe and effective use of medicines to enable best outcomes. CPC agreed that the CCG is not currently complaint with standard 1.1.3 which states organisations should ensure that robust and transparent processes are in place to identify, report, prioritise, investigate and learn from medicines related patient safety incidents, in line with national patient safety reporting system. CPC are alerting Governing Body to the significant risk that harm will be repeated because we are not learning systematically from mistakes. CPC believe that, although implementing the guidance will require investment, as it will reduce admissions it is likely to impact on the CCGs financial position beneficially, as well as improving patient health outcomes.

3.6 QS93 Atrial fibrillation: treatment and management. CPC agreed that primary care is not complaint with this standard but are aware of some work being done to identify the numbers of patients at risk of stroke because of inadequate anticoagulation. Discussions are being held with SFT regarding their anticoagulation services as SFT have raised concerns that demand cannot be met; CPC wish the Governing body to note that this is an area of risk to patient safety and a likely financial pressure and will require prioritization for investment in 16/17.

4.0 Duty to Involve

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

policies to the CPC.

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

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

5.0 Equality Analysis

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

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

Dr Vicci Owen- Smith
26 August 2015

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

Clinical Policy Committee

DRAFT MINUTES of the meeting held on Wednesday 22 July 2015

9:00 – 11.00am, Meeting Room 5, Floor 7, Regent House

Present:

(VOS) Dr Vicci Owen-Smith, Clinical Director, Public Health
(LB) Liz Bailey, Medicines Optimisation Lead, NHS Stockport CCG
(LH) Dr Lydia Harden, Locality Chair, (Stepping Hill and Victoria) **Chair**
(ML) Mike Lappin, Healthwatch
(PM) Peter Marks, Community Pharmacist, Chair of LPC
(JC) Jane Crombleholme, Lay Member, Chair of NHS Stockport CCG GB
(SW) Sarah Williamson, Clinical Quality Assurance and Performance Manager, NHS Stockport CCG

In attendance:

(DK) Dr Debbie Kendall, Secondary Care Lay Consultant

Apologies:

(MC) Mark Chidgey, Director of Quality Management
(RR) Roger Roberts, Director of General Practice Development, NHS Stockport CCG
(AD) Andy Dunleavy, Senior Public Health Advisor, SMBC

Minute Taker:

(SS) Sarah Smith, EUR/Clinical Board Administrator

MEETING GOVERNANCE	
1. Apologies and declarations of interest	**Action**
1.1 Apologies were noted as above. The meeting was quorate.	
2. Agree minutes from 24th June 2015	**Action**
2.1 Minutes The draft minutes of the meeting held on 24th June 2015 were approved as a correct record.	
3. Action Log	**Action**
3.1 Actions	

Updates were received for the following actions: 191 QS64 Feverish illness in children: SW to request more up to date information and seek clarification on antibiotic prescribing. SW informed the group that SFT are auditing the standard; the outcome will be reported to the CCG. The group agreed it was assured by this process and agreed to close the action. 203 SW to seek clarification on what education plans are in place for CG135 Organ Donation SW will ask the Trust to clarify if education plans are covered by the audit. 206 SW to ask SFT to re assess CG152 Crohn's disease SW noted this CG is not on the Health Assure database as an open audit. SW will contact the Trust to find out when this will be done. 220 NG5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes: RR and LB to review and benchmark. LB updated the group that a baseline assessment has been done. The assessment needs to go to STAMP to consider prioritisation and to link it to the SFT baseline assessment. LB advised deficits will be identified; CPC will need to decide if they are acceptable. An update will be brought back to CPC in August. LB advised the group that the guidelines have different levels, one at organisation level and one regarding services we commission. LB asked the group if they were happy to leave this out e.g. treatment in practices can lead to admissions. The group agreed to advise STAMP that we need to ensure practices are aware of the guidance (in a user friendly form) and spot checks are done. LB suggested we wait for publication of the Quality Standard and then mandate, this was agreed by the group. 227 QS76 Acute Kidney injury The group noted the review submitted by Dr Peter Carne. The review recommended primary care providers should ensure they have protocols in place for urine dipstick testing to be carried out as soon as acute kidney injury is suspected or detected, and for appropriate responses to abnormal results. The group agreed the recommendations are expected to be normal practice, no further action is required. 233 SW to feedback group's comments on Health Assure Database, insert dates and holding statements. Update on agenda under item 5.1, Closed. 234 RR to check if GPs have access to Children's SATS monitors. This question had been referred to Dr Mehta. Dr Mehta had advised that whilst most GP's have their own adult SATS probes, children's SATS probes are very expensive and there is no requirement for practices to have them. However there is some evidence that SATS probes can reduce paediatric admissions for croup/asthma/bronchiolitis. The group discussed the merit of putting costly monitors in practice for low usage. LH advised that GPs would consider clinical signs. The group agreed there was no clinical risk by not having them and agreed to ask Mastercall (out of hour's provider) if they have access to the monitors. **Action: SS to write to Mastercall to ask if they have paediatric SATS monitors including infants.** The following actions were closed and removed from the log: 93,191,227, 230, 233, 234, 237, 238 and 239.	
4. Matters Arising	**Actions**

4.1 NG5 Medicines Optimisation: the safe & effective use of medicines to enable the best possible outcomes Updated under agenda item 3 – action log.	
5. NICE assurance / implementation (3/12 post publication)	**Action**
5.1 Update on progress on NICE CG / QS 5.1.1 Compliance update from SFT on progress on NICE Guidance SW referred the group to the NICE guidance compliance spreadsheet (previously circulated) and explained that it has been updated to include dates and holding statements. SW invited question from the group. VOS noted that risks had been identified for QS43 Smoking cessation and queried what these risk were. SW agreed to check this with the Trust and to update CPC. **Action: SW to bring risks identified by SFT under QS43 Smoking cessation to August CPC.** LB informed the group that a new high cost drug for hypercholesterolaemia is due out in October. The TA is due out early 2016 and the estimated cost impact for Stockport is 4.5 million pounds. Consideration is being given to the implementation of a joint service across GM but this needs to be clarified. **Action: SS to ask MC if there have been any further discussions at Heads of Commissioning regarding the implementation of a GM service.** **Action: Notify Governing Body that there will be a cost we need to invest in.** LB observed the spreadsheet does not include National Guidance. SW responded that this will be included with Clinical Guidance. **Action: SW to forward SFT planned audits for this year to the group.** ML observed that the advanced breast cancer CG had not been assessed but that the QS are reported as fully compliant. SW confirmed that the CG had been published at a later date and was therefore an update and was different guidance. ML queried why TA 307 and 308 had been listed as not compliant when TA's are mandatory. The group agreed TA's should be reported as either not assessed or not applicable, LB offered to raise this with Paul Buckley, SFT and to ask SFT to notify any issues to VOS so they can be flagged to the SFT Medical Director. The group agreed the Trust need to confirm that they are ad hearing to the guidance; if they will use applicable TA's and that they do not use on those it is not applicable to. **Action: SW to ask SFT to confirm that they are ad hearing to TA guidance.** JC commented that she felt much more assured by the new system.	
6. Prior notification of new NICE guidance to be added into work plan	**Action**
6.1 National Guidance (NG) NG8 Anaemia management in people with chronic kidney disease	

The group agreed this guidance was mainly applicable to secondary care.
Action: SS to run costing tool for NG8 and circulate to the group.
NG12 Suspected cancer: recognition and referral
VOS raised concern regarding the criteria for referral for an urgent chest X-ray to assess lung cancer or mesothelioma.
VOS queried the availability of urgent direct access to MRI and CT scans. SS confirmed this was discussed at Cancer Board and is being discussed further by SFT who have agreed to report back to the CCG Cancer Board.
LH noted that pro forma's would need amending. SS informed the group that Dr Karen McEwan, Macmillan GP Cancer Care Commissioning Lead has agreed to send out a communication to GPs regarding pro forma's.
The group agreed user friendly guidance is needed for GPs. SS informed the group that Dr McEwan has agreed to update GPs and disseminate Macmillan guidance (which is distilled from NG12) after this week's SFT Cancer Board.
VOS identified opportunities to put a prevention element in to the 2ww pathway, by using the opportunity of the 2 week wait referral to offer advice about healthy behaviours (smoking, alcohol, diet, activity) for patients seen but not diagnosed with cancer; a secondary care health behaviour type intervention.
Action: SS to feedback suggestion to use the opportunity of the 2ww referral to offer advice about healthy behaviours for patients seen but not diagnosed with cancer

NG13 Workplace policy and management practices to improve the health and wellbeing of employees
VOS informed the group that SFT have a Health and Wellbeing Group which is led by a HR rep. The CCG does not have a Health and Wellbeing Policy. LH queried primary care access to occupational health. VOS queried if health services run by providers are available to CCG staff.
Action: VOS to discuss provision of health services for CCG staff and access to Occupational health for primary care staff with Gaynor Mullins.

6.2 NICE Technology Appraisals (TA)
TA339 Omalizumab for previously treated chronic spontaneous urticarial.
This will be done by Salford Royal FT. NHS England is the commissioner.
TA340 Ustekinumab for treating active psoriatic arthritis.
The group noted the cost impact which has been identified by NICE as not significant.
TA341 Apixaban for the treatment and secondary prevention of deep vein thrombosis and/or pulmonary embolism.
The group noted the cost impact which has been identified by NICE as not significant.
TA342 Vedolizumab for treating moderately to severely active ulcerative colitis.
NICE advise the cost impact needs to be locally assessed. SS confirmed this has been requested.
TA343 Obinutuzumab in combination with chlorambucil for untreated chronic lymphocytic leukaemia.
This TA is commissioned by NHS England.
TA344 Ofatumumab in combination with chlorambucil or bendamustine for untreated chronic lymphocytic leukaemia
This TA is commissioned by NHS England.

6.3 NICE Quality Standards (QS)
QS37 Postnatal care
This is updated guidance. LH confirmed that the changes had been circulated to primary care.
QS87 Osteoarthritis
The group agreed to disseminate headline statements to GPs.
Action: SS to ask Dr McEwan to write a summary for GP's
QS88 Personality Disorders: borderline and antisocial
The group agreed this guidance is applicable to the Mental Health Trust.
Action: SS to ask GE to review QS88 Personality Disorders: borderline and antisocial
QS89 Pressure Ulcers
SW confirmed that SFT (including District Nursing) were compliant with all statements. The group were assured by the work that had been done locally with nursing and care homes and that a higher level of reporting was done. SW added that SFT complete quarterly reports. SFT have KPi's which are seen monthly and monitored by the CCG Quality Committee, it is also reported to FT board on a regular basis. No concerns were raised by the group.

QS90 Urinary tract infection in adults
LB raised concern regarding statement 5 informing the group that care homes are asking for antibiotics for women. In response to this an item will be put into the next newsletter.
LH will review implication for primary care and update November CPC. Add to work plan.

QS91 Prostate cancer
The group agreed this guidance will affect tertiary care/specialist services.

6.4 NICE Clinical Guidance (CG)
CG92 Venous thromboembolism in adults admitted to hospital: reducing the risk.
This guidance mainly affects secondary care.
Action: SW to follow up CG92 Venous thromboembolism in adults admitted to hospital: reducing the risk with SFT

CG97 Lower urinary tract symptoms in men: assessment and management
The group agreed the guidance is in line with current CCG policy.

6.5 NICE Diagnostic Guidance (DG)
DG17 Diagnosing prostate cancer: PROGENSA PCA3 assay and Prostate Health Index.
The group noted this procedure is not recommended.

6.6 NICE Interventional Procedure Guidance (IPG)
IPG519 Insertion of an epiretinal prosthesis for retinitis pigmentosa
These procedures are not commissioned without prior approval of the CPC

IPG520 Radiofrequency ablation for gastric antral vascular ectasia
These procedures are not commissioned without prior approval of the CPC

IPG521 Suture fixation of acute disruption of the distal tibiofibular syndesmosis If SFT are not already performing the procedure; an outline business case is required. **Action: SW to ask SFT if they offer this procedure.** IPG522 Hysteroscopic morcellation of uterine leiomyomas (fibroids) These procedures are not commissioned without prior approval of the CPC **Action: SW to flag concern with SFT regarding this procedure.** IPG523 Ultrasound-enhanced, catheter directed thrombolysis for deep vein thrombosis These procedures are not commissioned without prior approval of the CPC IPG524 Ultrasound- enhanced, catheter-directed thrombolysis for pulmonary embolism. These procedures are not commissioned without prior approval of the CPC IPG525 Electrotherapy for the treatment of grade I to III haemorrhoids If SFT are not already performing the procedure; an outline business case is required. **Action: SW to ask SFT if they offer this procedure.** IPG526 Cyanoacrylate glue occlusion for varicose veins These procedures are not commissioned without prior approval of the CPC IPG527 Sphenopalatine ganglion stimulation device for chronic cluster headache These procedures are not commissioned without prior approval of the CPC. The group agreed it would like to feed its assessment of IPGs into the FT assure system. SW agreed to ask SFT are they are happy to do this.	
7. New policies	**Action**
7.1 Business Cases or clinical pathway changes: None this month. 7.2 Amendments to prescribing lists: 7.2.1 Considerations for the Black / Grey list: CPC **endorsed** the request from STAMP to add the following to the Blacklist: Lactulose Sachets *7.2.2* NTS recommendation CPC **endorsed** the GMMMG (Greater Manchester Medicines Management Group) New Therapies Subgroup (NTS) recommendations on the following: Simbrinza® eye drops 7.3 Amendments to EUR Policies / new GMEUR policy: new policies discussed at GMEUR. None this month.	

7.4 Equality Impact Assessment for new policies: None this month. 7.5 Ratify minutes of reporting panels / meetings: Individual Funding Panel (IFP) Minutes: The minutes of the meeting held on 03.06.15 were **ratified** by the group. 7.5.1 Individual Care Panel (ICP) Minutes: The minutes of the meeting held on 06.05.15 were **ratified** by the group. 7.5.3 STAMP minutes for the meeting held on 26.06.15 were **ratified** by the group. 7.5.3.1 Shared Care Guideline – Lithium CAMHS. LB explained that this is a GM wide version of what Stockport has had in place for some time. The guideline was **approved** by the group. 7.5.3.2 SIP feed Guidelines LB talked through the revised guidelines. There is no longer a need to routinely provide SIP feeds for care homes but instead will give recipes to them so that they can make their own. VOS queried provision for diabetics. LB advised there is a section in the guidance for diabetics; give milk based or savoury supplements to be sipped slowly and avoid fruit based supplements. LH commented that problems could be referred to a dietician. DK asked if the guidance had been costed. LB responded that it had; costs are in the guidance. ML asked if supplements can be purchased. LB confirmed that they could at a cost of £2 per carton. LB agreed to send the recipes to PM so that he can circulate them to pharmacies. LB is taking the updated guidelines to the Care Home Forum. LB has agreed a 25% rebate for Fregubin®. The guidelines were **approved** by the group.	
8 **Agree report from CPC to SCCG**	**Action**
8.5 Items to be included within the Governing Body report: • NTS recommendations listed under item 7.2.2 • Black/Grey list amendments listed under item 7.2.1 • Workplace policy guidance • TA for hypercholesterolaemia cost impact due early 2016.	
9 **Any Other Business**	**Action**
There was no other business.	
Date, time and venue of next meeting: Wednesday 26th August 2015 09:00 – 11:00am, Meeting Room 5 Floor 7, Regent House	