Chair: Ms J Crombleholme
Enquiries to: Laura Latham
0161 426 5210
Laura.latham1@nhs.net

NHS Stockport Clinical Commissioning Group

DRAFT 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 the Cherry Suite, Bredbury Hall, Bredbury Stockport, SK6 2DH at 10.00am on 8 July 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 10 June 2015. *In approving the minutes, the Governing Body will ratify and confirm the decisions contained therein of the previously inquorate meeting.*	Attached	To receive and approve		J Crombleholme
4	Actions Arising	Attached	To receive updates		J Crombleholme
5	Notification of any items of additional business	Verbal	To consider		J Crombleholme
6	Patient Story Collaborative Care Planning: http://www.rcgp.org.uk/care-planning)	Video		10.15	J Crombleholme
7	Strategic Performance Updates • Strategic Impact Report • Planned Care • Board Assurance Framework	Written Reports		10.25	G Mullins C Briggs G Jones

8	Corporate Performance Reports a) Performance Report b) Finance Report c) Quality Report	Written Reports	To receive, assure and note.	10.50	 Gaynor Mullins Gary Jones Mark Chidgey
9	Locality Chairs' Update	Verbal Report		11.20	Locality Chairs
10	Report of the Chair	Written Report	To receive and note	11.30	J Crombleholme
11	Report of the Chief Operating Officer to include the following: • Stockport Together Funding Update **(to follow)** • Update from Q4 Assurance Meeting • Winter Schemes Lessons Learnt	Written Report	To debate and approve	11.40	G Mullins
12	Report of the Chief Clinical Officer • Aspect of paper to consider the governance arrangements between the CCG and the Greater Manchester-level groups (From action log)	Written Report	To consider and discuss	11:55	Ranjit Gill
13	Integration of Health and Social Care Resources	Written Report **(To follow)**	To debate and approve	12.10	Gary Jones
14	Reports from Committees • Audit Committee • Clinical Policy Committee	Written reports	To note	12.35	 J Greenough Vicci 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 9 September 2015 at 10:00 at a venue to be confirmed. Potential agenda items should be notified to stoccg.gb@nhs.net by 17 August 2015.

NHS Stockport Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT REGENT HOUSE, STOCKPORT
ON WEDNESDAY 10 JUNE 2015

PART 1
PRESENT

Ms J Crombleholme	Lay Member (Chair)
Mrs G Mullins	Chief Operating Officer
Dr D Kendall	Consultant member
Dr V Mehta	Clinical Director for General Practice Development
Dr J Higgins	Locality Chair: Heatons and Tame Valley
Dr V Owen-Smith	Clinical Director for Public Health
Mr J Greenough	Lay Member
Dr L Hardern	Locality Chair: Stepping Hill and Victoria
Dr P Carne	Locality Chair: Cheadle and Bramhall

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
Mr T Ryley	Director of Strategic Planning and Performance
Mr D Dolman	Deputy Chief Finance Office
Mr P Fleming	Associate Director IM&T

APOLOGIES

Dr R Gill	Chief Clinical Officer
Dr C Briggs	Clinical Director for Quality and Provider Management
Dr A Johnson	Locality Chair: Marple and Werneth (Vice Chair)
Mr G Jones	Chief Finance Officer
Miss K Richardson	Nurse Member

74/15 APOLOGIES

Apologies were received from R Gill, C Briggs, A Johnson, G Jones, K Richardson and Councillor Pantall.

74/15 DECLARATIONS OF INTEREST

There were none on this occasion.

The Chair explained that the meeting would not be quorate as the required number of clinicians were not in attendance. The Governing Body would therefore only be able to make recommendations on the matters to be considered which would then be ratified as decisions at the July Governing Body meeting.

75/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY PART 1 MEETING HELD ON 27 MAY 2015

The draft minutes of the Governing Body meeting held on 27 May 2015 were approved as a correct record subject to R Roberts being removed from the list of members who had submitted apologies.

V Metha joined the meeting.

76/15 ACTIONS ARISING

The following updates were provided:

101114 – This report would be received at the July Governing Body Meeting as part of the Chief Clinical Officers Report.
011214 - This action to be removed from the Plan.
010315 – This would be picked up as part of the Governance Review underway at the current time and should be removed as an action.
030315 – This action was completed and could be removed from the Plan.
010415 – This had been included in the Chief Operating Officer's Report to be considered as part of the agenda and could be removed.

76/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were no items on this occasion.

77/15 PATIENT STORY

The Governing Body received a patient story from a gentleman whose mother when suffering from terminal cancer had received care at the end of her life as part of the Reach Scheme. He outlined the practical support which had been provided to his mother and the mental support and kindness show to his sister, himself and the wider family. He noted that it had enabled his mother to maintain her dignity at the end of her life and remain in her own home. The Scheme had provided professional connectivity for his Mother and the wider family into a range of services, support mechanisms and individuals. He thanked those involved in the Scheme for their care, support and dedication.

D Jones noted that the patient story had been recorded prior to the creation of the enhanced end of life care team which had subsequently rolled out across Stockport to provide integrated care and support. This enhanced team meant that 90% of patients were able to die at home as the place of their choice. She explained that patient and carer feedback indicated the strong success of the team and it was anticipated that 300 individuals would access the service within a 3 year period. Access to the team was via District Nurse referrals.

V Mehta commented that the impact of integrated care made a real difference to patients and their wider families and that as a result of this, financial costs could often be reduced whilst maintaining and enhancing services and support.

T Stokes requested that Healthwatch be briefed on the work of the end of life care team so they could raise awareness of its work.

The Governing Body requested that the patient be thanked for his story.

78/15 STRATEGIC PERFORMANCE UPDATES – IM&T

The Governing Body received an overview of recent activity and developments in the area of IM&T from including at the local CCG level, work across primary care in Stockport and the Stockport economy through Stockport Together and on a wider Greater Manchester footprint from P Fleming. He highlighted the range and volume of work which had been undertaken and the challenges which still needed to be overcome, particularly to provide services across Greater Manchester.

G Mullins commented on the significant amount of work undertaken and the importance of continuing to develop ICT infrastructure across Greater Manchester. The cross border work was noted to be of importance and P Fleming described how issues of data management across a number of providers were being considered. He noted that central to this was interconnectivity of different GP IT systems and the development of a business case to work towards a single system across all Stockport practices and more widely across the economy. It was noted that work was being considered to provide wifi across all practices for both use by patients and staff working in an agile way across the Borough. IM&T was noted to be a key enabler for the CCG's neighbourhood working proposals. R Roberts noted the link between IM&T infrastructure and Primary Care Co-Commissioning and G Mullins agreed to raise the issue at regional level in particular the distribution of funding across multiple schemes.

In responding to a question from T Ryley regarding information governance and data sharing protocols, P Fleming provided a comprehensive response about how the issues were being managed through detailed data sharing agreements across a range of partners. The Governing Body considered the governance in place locally and regionally to manage the continued development of IM&T and T Stokes requested that P Fleming seek clarification as to how Healthwatch could be involved at the regional level.

The Governing Body thanked P Fleming for his hard work in taking IM&T forward both in Stockport and on a wider regional level.

It was recommended that the Governing Body note the report.

79/15 CORPORATE PERFORMANCE REPORTS

(a) PERFORMANCE REPORT

G Mullins provided an overview of the report and highlighted the continuing main risk areas of referral to treatment times (RTT) emergency department 4 hour waiting times and ambulance response times. She noted that emergency department waiting time performance had continued into April and that the decision had been taken by NHS England and Monitor to lower the level of escalation across the economy regarding this measure. Weekly meetings would be maintained to ensure oversight of performance and consider sustainability. A contract notice had been issued to the North West Ambulance Service on behalf of all commissioners and the recent outbreak of CDifficile was reported to the Governing Body. From a CCG perspective the low level of staff sickness absence was noted and it was requested that managers and staff be congratulated on this, in particular in creating such a positive working culture.

M Chidgey explained that NHSE had indicated that there would soon be a change to the national KPIs relating to 18 week access to treatment following referral. The planned change would be to remove two of the existing three measures (relating to admitted and non-admitted care) and to focus solely on the remaining measure which in effect stated that a maximum of 8% of patients could wait longer than 18 weeks. He explained that in his opinion this was the best measure to support delivery of the constitutional right.

In responding to questioning from J Greenhough regarding the number of patients not treated within 28 days of last minute elective cancellation, M Chidgey noted that this was reported as a performance hot spot to the Foundation Trust Board and the action plan would be shared with the CCG and reported through the Quality and Provider Management Committee in the coming weeks.

It was recommended that the Governing Body:

1. Notes the report.
2. Requests that the Chief Operating Officer pass on Governing Body's thanks to managers and staff for creating a positive working culture and environment in which staff sickness levels were low.

(b) FINANCE REPORT

D Dolman provided an overview of the CCG's current financial position and in doing so noted that agreement had been reached with NHS England regarding a planned surplus level for the current financial year of 0.5% which had been achieved through stretching the

savings target shown as 'unidentified CIP.' He outlined the risks faced by the CCG in light of the challenging financial position in particular relating to activity levels of elective and non-elective treatment and relating to prescribing. The total level of risk was noted to be £4.8m with mitigations of £2.8m.

In response to a question from T Stokes, G Mullins outlined the importance of Stockport Together in managing patient flow across the system and providing support and infrastructure for people to remain in their own homes and be treated within primary and community care settings as far as possible.

J Greenhough sought an understanding of the financial elements of the Vanguard Project and in particular the match funding of CCG money with that incoming from NHS England.

It was recommended that the Governing Body note the report.

(c) QUALITY REPORT

M Chidgey highlighted a number of issues for Governing Body's attention arising from the quality report and noted the revised reporting format. Key issues arising included the action plan response resulting from the CQC inspection of Looked After Children (LAC) and Safeguarding and the close of admissions to Cale Green Nursing Home.

The Governing Body considered the revised reporting format and T Ryley noted that reporting to governing body from its Committees would be a key area of focus.

Members considered the actions undertaken by the Foundation Trust to improve staffing levels of District Nurses. M Chidgey noted that a trajectory for improvement was in place as a result of rolling recruitment and the importance of this for the delivery of integrated care was highlighted by R Roberts.

With regard to the CQC Inspection of LAC, the importance of the activity being monitored by the Quality and Provider Management Committee was noted. J Crombleholme explained that mechanisms existed for escalation of matters considered at Committee Level to Governing Body Members where immediate attention needed to be raised including through the Chair of the Committee.

It was recommended that the Governing Body note the report.

80/15 LOCALITY CHAIRS REPORT

P Carne presented the report of the Locality Chairs to the Governing Body. He noted progress in relation to the care home allocation and the willingness across all localities to work as part of neighbourhood clusters. ICT was highlighted as a continued challenge to cluster working and opportunities for investment in this area were being explored. L Hardern confirmed that the reason from practices to be involved in new ways of working

had been incredibly positive but further detail was awaited about taking it forward practically.

R Roberts noted that engagement with the Locality Committees would take place at the July round of meetings to look at the future of proactive care before a report would be brought to the Governing Body.

It was recommended that the Governing Body note the report.

81/15 REPORT OF THE CHAIR

J Crombleholme provided an overview of the areas for future consideration arising from the NHS Confederation Conference held in early June.

It was recommended that the Governing Body note the report.

82/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins informed the Governing Body that the Q4 assurance meeting with NHS England would take place on Monday 15 June and she would report back to the next Governing Body on the discussions.

In highlighting a number of areas within the report she noted the positive feedback from the Vanguard visit and the related request for approval of resources of up to £600,000 to go into the Stockport Together Programme. She noted the significance of the system transformation proposed the importance of resourcing it appropriately in particular to enable the progression of detailed design work including engagement with clinicians and frontline staff. All partners would be contributing additional resources and funding would be received from the Vanguard Project but no amount had been confirmed. T Ryley highlighted the complexity of the partnership work being undertaken and the importance of the business case being developed to clarify what was sought locally by way of financial and other support from the Vanguard Project.

R Rogers leaves the meeting.

In response to clarification sought, T Ryley highlighted the resources already committed to Stockport Together by the CCG, Foundation Trust and Council and the proposal for a further 250k from both the Foundation Trust and Council. It was noted that further detail on the funding for Stockport Together would be reported to the July Governing Body meeting.
G Mullins highlighted the element of the report relating to the governance of the Healthier Together Programme. J Crombleholme sought confirmation about the timescales for the finalisation of the Organisational Development Plan. TR noted that whilst it remained a priority for the CCG, it needed to be included as part of the broader Stockport Together Programme and workforce enabler workstream.

It was recommended that the Governing Body:

- Note items 1-5 contained within the report.
- Approve items 6, 7 and 8 contained within the report.

83/15 REPORT OF THE CHIEF CLINICAL OFFICER

The Governing Body considered the update on Greater Manchester Devolution provided as part of the Chief Clinical Officer's report.

D Jones sought clarification about worklessness in the context of health priorities and how this would be taken forward as part of the Devolution work.

J Crombleholme commented that the scale of work being undertaken was significant and that despite the timescales, much of the detail had not yet been worked up. G Mullins explained that CCG Leaders were meeting weekly to progress the work at the required pace. Investment in Mental Health was raised by T Stokes as an area which should be explored. Public Health was highlighted as an area which needed to be heavily involved in the Devolution work and this had been escalated through the Directors of Public Health in Manchester and through Public Health England

It was recommended that the Governing Body note the report.

83/15 APPROVAL OF THE REVISED SECTION 75 AGREEMENT

G Mullins requested that the Governing Body comment on and recommend approval of the revised Section 75 Agreement proposed for 2015/16. She noted that it had been in place for a number of years and had been updated to reflect the existence of the Better Care Fund and its management through this agreement.

T Ryley noted that if the CCG increased the pooling of budgets in future years the Section 75 would be further revised. J Crombleholme highlighted the role of the Integrated Care Board in governing the agreement.

It was recommended that the Governing Body approve the revised Section 75 Agreement to commence 1 April 2015.

83/15 CLINICAL POLICY COMMITTEE UPDATE

V Owen Smith provided an overview of the report and brought the Governing Body's attention to the costing summary for 2014/15 and the need to raise awareness amongst clinicians of NG3 Diabetes in Pregnancy. An article would be drafted for inclusion in the GP Newsletter.

It was recommended that the Governing Body note the report.

84/15 ANY OTHER BUSINESS

There were no items on this occasion.

(The meeting concluded at 11.54am)

Public Questions

Question submitted in advance by Val Jackson, Chief Executive Officer of Action for Sick Children:

'What provision has the CCG made for Children & Young People (and their families) in the following areas?

i) Transition from childhood to adulthood
ii) Paediatric A & E
iii) GPs with a specialist Paediatric background / training
iv) CAMHS'

J Crombleholme replied on behalf of the Governing Body to acknowledge the wide ranging scope of the question. She explained that as it required a detailed answer, a meeting between Ms Jackson and the CCG's Lead Contract Manager would be arranged. A summary of the discussion would be published alongside the minutes.

Two further questions were raised at the meeting by members of the public and responded to as outlined below:

'Following on from the changes proposed to make a small saving on the cost of the community mental health service, have these been introduced and is the CCG satisfied regarding patient safety?'

M Chidgey explained that there had been a consultation process relating to the proposals the results of which were being considered by the Pennine Care NHS Foundation Trust Board. A report would be received at a future Quality and Provider Management Committee Meeting from the Trust which will in turn be reported to a future Governing Body.

'With regard to IM&T, will private sector providers have access to patient data?'

V Mehta responded to confirm that it would be necessary for some information to be communicated to a provider with patient consent being sought at the point of referral. The information would most likely be included in the referral letter. It would be confirmed whether a private sector provider would have access to the Stockport Health Record.

NHS Stockport Clinical Commissioning Group
10 June 2015

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
101114	Report of the Chief Clinical Officer To bring to the Governing Body a paper considering the governance arrangements between the CCG and the Greater Manchester-level groups	197/14	8 July 2015	R Gill UPDATE 10/06: Deferred to July
030215	Performance Report To bring a report from SRG on winter pressures and lessons learnt	12/15	8 July 2015	M Chidgey
01/06/15	Patient Story Healthwatch to receive a briefing on the Enhanced End of Life Care Team's Work.	**77/15**	8 July 2015	D Jones
02/06/15	IM&T • Link between IM&T infrastructure and	**78/15**	8 July 2015	G Mullins To raise the issue at regional level in particular the distribution of funding across multiple

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
	Primary Care Co-Commissioning. • Opportunity for Healthwatch to become involved in regional IM&T activity.			schemes. P Fleming to seek clarification re current and future involvement.
03/06/15	<u>Locality Chairs Report</u> Proactive Care report to be taken through Locality Committees at the July round of meetings	**80/15**	July 2015	R Roberts
04/06/15	<u>Chief Operating Officers Report</u> • Update on Q4 Assurance Meeting discussion to be provided in July to Governing Body • Detailed information on future funding of Stockport Together to be considered in July	**82/15**	8 July 2015	G Mullins
05/06/15	<u>Public Questions</u> 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		8 July 2015	Mark Chidgey 01/07/2015 The meeting will have taken place by the time the Governing Body meets on 8 July. M Chidgey will provide a verbal summary of the discussion.

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
	published alongside the minutes of the meeting			

NHS
Stockport
Clinical Commissioning Group

Strategic Impact 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?
No specific decision is required
Please detail the key points of this report
The CCG has set out an ambitious business plan for 2015-2016. This includes improvements in health outcomes and quality, and reductions in activity. It is important that the CCG is in the process of aligning the strategic impact report to the latest business plan. It is also important the performance against the plan is available at economy, locality and practice level. An example of a practice level report is included. These reports will form part of the practice level scorecard under development. This is work in development and attached is the first interim report with a number of indicators particularly on activity. Further data and presentations of data will be added to present a richer picture. The main purpose of the report this month is to introduce the report to the Governing Body and receive comments on how it can be developed. Given we have only one month's data it is important that the Governing Body does not read too much into this at this stage as common cause variation within a single month just as likely to be a factor rather than specific action. This report will continue to be developed over time and the whole report will be published every month including August and available to practices, managers and Governing body members. It will form part of the routine reports to Governing Body in the months that it meets.

What are the likely impacts and/or implications?
If (please note caveat on statistical reliability on one month's data) the one month performance was replicated across the year we would do better than plan on A&E attendances, Elective activity and GP referrals. Non-elective attendances would be worse than plan.
How does this link to the Annual Business Plan?
Mechanism for monitoring impact
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
In future this report and further levels of detail will be discussed at executive meetings, locality committees and QIPP Committee.
Clinical Executive Sponsor: Dr Gill
Presented by: Gaynor Mullins
Meeting Date: 9th July
Agenda item:
Reason for being in Part 2 (if applicable)

Strategic Impact Report

1. Introduction

1.1. The CCG Governing Body published its annual operational plan in April 2015. It is important that it monitors delivery of that plan and looks to ensure benefits realisation. The on-going delivery of the NHS Constitutional standards is one essential element as is meeting its legal duties. These are currently reported on in the monthly performance report

1.2. It is also important that the Governing Body monitor the impact of plans to deliver improvements in the economy's sustainability and health outcomes.

1.3. As well as monitoring delivery at economy level it is essential that the CCG and its members can monitor locality and individual practice level performance.

2. Nature of Attached Report

2.1. The attached report is not the finished article. It shows a number of business critical headline indicators for the Governing Body and has some examples of the locality and practice level information that is being utilised attached in-order to assure the Governing Body that this information is available and being monitored at practice level. There is a direct read through from the practice data to the aggregate locality and then Governing Body report.

2.2. Given we have only one month's data available it is important that the Governing Body ***do not*** draw any conclusions from this data. The variation from plan (positive or negative) is just as likely to be down to common cause variation as it is indicative of real improvement or a worsening position. As the year progresses the reliability will increase.

2.3. We are working on the basis that developing the GP level data ahead of the aggregate level data is the best approach as it will aid delivery and is the level at which action needs to be taken.

3. April Performance

3.1. Planned Care Programme –

3.1.1. Excluding Dermatology*, GP referred 1st Outpatients are 5.5% above plan but Elective Activity is currently better than plan. The CCG will need to ensure a reduction in elective activity is not as a consequence of lengthening waiting lists due to lack of capacity. Without a reduction in demand (GP Referrals) then the most likely consequence of reduced elective activity is an increase in waiting lists. This needs to be noted as a risk and is relevant to the performance report.

3.1.2.
*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

3.1.3. A dedicated team has been identified to work on GP referral management. Work has commenced with the 12 highest referring practices.. Further work on pathway optimisation including tighter management of EUR procedures is also underway led by another dedicated priority team. It is not expected the benefits of this work will show until the autumn.

3.2. Non-Elective activity

3.2.1. A&E attendances in April were lower than plan, but admissions continue above plan.

3.2.2. Work has continued on developing integrated teams. Work in Marple and Werneth continues and two GP led fully integrated teams are planned to be in place by October in Cheadle and Bramhall as part of the Vanguard programme. The end-of-life care model has now been rolled-out across the borough. The alignment of GP practices to specific nursing homes to improve patient care is expected to be completed in July.

3.3. However, note both lag between action and issue of common cause variation before drawing conclusions on actual trends.

4. Future Development

4.1. There are five further developments of the report in the next few months:

4.1.1. A greater range of data under each of the operational plan headings including health outcomes

4.1.2. A variety of charts to provide a richer picture of performance overtime

4.1.3. A much clearer connection with financial performance, impact and implications

4.1.4. Exception reporting on delivery of actions set out in the operational plan

4.1.5. Commentary at Operational Plan heading level

4.2. The report will be published to Governing Body members, GP practices, managers and localities monthly.

5. Conclusion

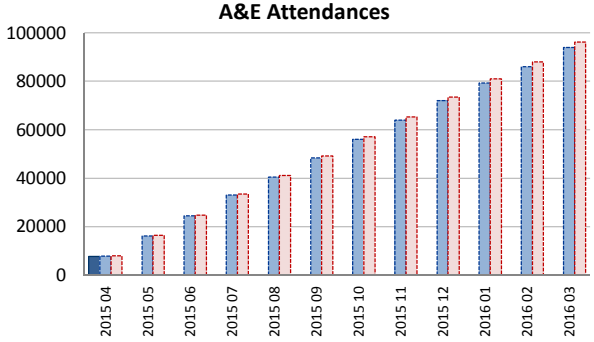
5.1. Members are asked to note the report and the further developments being undertaken.

Stockport Level Strategic Impact Report

NHS Stockport Clinical Commissioning Group

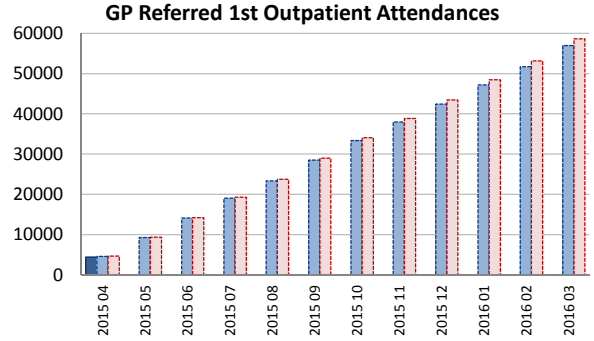
Stockport Level Cumulative Charts 2015/16

A&E Attendances



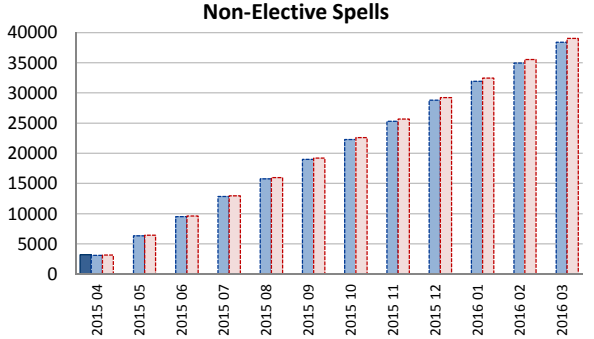
April YTD Total: Actual **7750** CCG Plan **7886** Underlying Growth **7999**

GP Referred 1st Outpatient Attendances



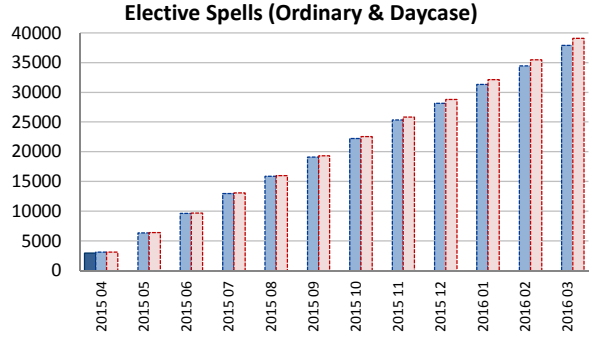
April YTD Total: Actual **4402** CCG Plan **4587** Underlying Growth **4619**

Non-Elective Spells



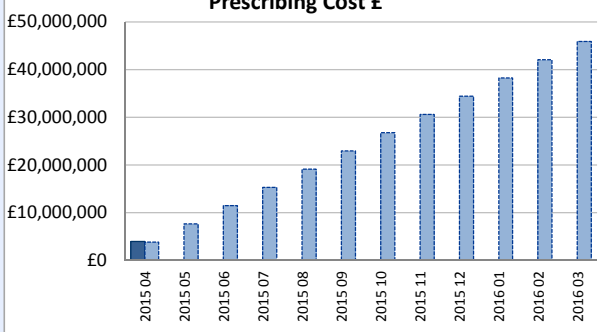
April YTD Total: Actual **3181** CCG Plan **3117** Underlying Growth **3154**

Elective Spells (Ordinary & Daycase)



April YTD Total: Actual **2936** CCG Plan **3080** Underlying Growth **3101**

Prescribing Cost £



April YTD Total: Actual **£3,995,214** Budget **£3,823,709**

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

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

List Size	
Mar-15	304218
Mar-14	298743
Mar-13	296314
Weighted list 31/10/14	297723

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		7784	7750	-34	-0.4%		**-0.4%**	**-0.4%**
Ambulance Conveyance Rate		82.0%	83.3%					
Non-Elective Admissions								
All Non-Elective Admissions		3099	3181	82	2.6%		**2.6%**	**2.6%**
Occ Bed Days per 100,000		2293	2152	-141	-6.1%		**-2.7%**	**-2.7%**
GP Direct Admissions		571	543	-28	-4.9%		**-4.9%**	**-4.9%**
LTC	**Register**							
CHD Admissions	11666	79	79	0	0.0%		**0.0%**	**0.0%**
HF Admissions	2627	38	35	-3	-7.9%		**-7.9%**	**-7.9%**
COPD Admissions	6494	46	26	-20	-43.5%		**-43.5%**	**-43.5%**
Asthma Admissions	19327	16	13	-3	-18.8%		**-18.8%**	**-18.8%**
Diabetes Admissions	13981	11	10	-1	-9.1%		**-9.1%**	**-9.1%**
LTC Admissions	54095	190	163	-27	-14.2%		**-14.2%**	**-14.2%**
AF Admissions	5416	56	38	-18	-32.1%		**-32.1%**	**-32.1%**
Care Home Admissions		171	138	-33	-19.3%		**-19.3%**	**-19.3%**
Referrals								
GP Referred 1st OPA		4101	4328	227	5.5%		**5.5%**	**5.5%**
ENT		453	477	24	5.3%		**5.3%**	**5.3%**
General Medicine		748	723	-25	-3.3%		**-3.3%**	**-3.3%**
General Surgery		877	853	-24	-2.7%		**-2.7%**	**-2.7%**
Obstetrics & Gynaecology		311	306	-5	-1.6%		**-1.6%**	**-1.6%**
Opthalmology		285	312	27	9.5%		**9.5%**	**9.5%**
Paediatrics		229	242	13	5.7%		**5.7%**	**5.7%**
Rheumatology		104	94	-10	-9.6%		**-9.6%**	**-9.6%**
Trauma & Orthopaedics		576	694	118	20.5%		**20.5%**	**20.5%**
Other Specialist Medicine		102	214	112	109.8%		**109.8%**	**109.8%**
Urology		268	254	-14	-5.2%		**-5.2%**	**-5.2%**
Other Specialties		148	159	11	7.4%		**7.4%**	**7.4%**
GP Ref Disch at 1st OPA		1004	1078	74	7.4%		**7.4%**	**7.4%**
% GP ref discharged 1st OPA		24.5%	24.9%					
Other Referred 1st OPA		2808	2943	135	4.8%		**4.8%**	**4.8%**
*Dermatology		378	74	-304	-80.4%		**-80.4%**	**-80.4%**
Planned								
Elective Admissions		3003	2936	-67	-2.2%		**-2.2%**	**-2.2%**
Prescribing		521209	547491	26282	5.0%		**5.0%**	**5.0%**

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

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

List Size	
Mar-15	88686
Mar-14	87458
Mar-13	86787
Weighted list 31/10/14	81230

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice	%Variance Locality	----------> Stkport
Urgent							
A&E Attendances		1973	1988	15	0.8%	0.8%	-0.4%
Non-Elective Admissions							
All Non-Elective Admissions		720	753	33	4.6%	4.6%	2.6%
Occ Bed Days per 100,000		1627	1496	-131	-8.0%	-5.4%	-2.7%
GP Direct Admissions		104	149	45	43.3%	43.3%	-4.9%
LTC	**Register**						
CHD Admissions	3221	15	26	11	73.3%	73.3%	0.0%
HF Admissions	668	9	9	0	0.0%	0.0%	-7.9%
COPD Admissions	1214	11	7	-4	-36.4%	-36.4%	-43.5%
Asthma Admissions	5184	3	3	0	0.0%	0.0%	-18.8%
Diabetes Admissions	4080	3	2	-1	-33.3%	-33.3%	-9.1%
LTC Admissions	14367	41	47	6	14.6%	14.6%	-14.2%
AF Admissions	1753	17	8	-9	-52.9%	-52.9%	-32.1%
Care Home Admissions		32	30	-2	-6.3%	-6.3%	-19.3%
Referrals							
GP Referred 1st OPA		1218	1399	181	14.9%	14.9%	5.5%
ENT		135	165	30	22.2%	22.2%	5.3%
General Medicine		252	278	26	10.3%	10.3%	-3.3%
General Surgery		247	241	-6	-2.4%	-2.4%	-2.7%
Obstetrics & Gynaecology		75	100	25	33.3%	33.3%	-1.6%
Opthalmology		75	90	15	20.0%	20.0%	9.5%
Paediatrics		59	88	29	49.2%	49.2%	5.7%
Rheumatology		33	25	-8	-24.2%	-24.2%	-9.6%
Trauma & Orthopaedics		174	203	29	16.7%	16.7%	20.5%
Other Specialist Medicine		35	80	45	128.6%	128.6%	109.8%
Urology		82	80	-2	-2.4%	-2.4%	-5.2%
Other Specialties		51	49	-2	-3.9%	-3.9%	7.4%
GP Ref Disch at 1st OPA		646	404	-242	-37.5%	-37.5%	7.4%
% GP ref discharged 1st OPA		53.0%	28.9%				
Other Referred 1st OPA		744	779	35	4.7%	4.7%	4.8%
*Dermatology		123	43	-80	-65.0%	-65.0%	-80.4%
Planned							
Elective Admissions		882	806	-76	-8.6%	-8.6%	-2.2%
Prescribing		128756	134661	5905	4.6%	4.6%	5.0%

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

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

	List Size
Mar-15	79407
Mar-14	76720
Mar-13	75750
Weighted list 31/10/14	78283

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		2014	2067	53	2.6%		**2.6%**	**-0.4%**
Non-Elective Admissions								
All Non-Elective Admissions		788	752	-36	-4.6%		**-4.6%**	**2.6%**
Occ Bed Days per 100,000		2295	1972	-323	-14.1%		**-8.0%**	**-2.7%**
GP Direct Admissions		160	129	-31	-19.4%		**-19.4%**	**-4.9%**
LTC	**Register**							
CHD Admissions	2853	19	16	-3	-15.8%		**-15.8%**	**0.0%**
HF Admissions	653	8	8	0	0.0%		**0.0%**	**-7.9%**
COPD Admissions	1965	12	4	-8	-66.7%		**-66.7%**	**-43.5%**
Asthma Admissions	5112	6	4	-2	-33.3%		**-33.3%**	**-18.8%**
Diabetes Admissions	3495	2	1	-1	-50.0%		**-50.0%**	**-9.1%**
LTC Admissions	14078	47	33	-14	-29.8%		**-29.8%**	**-14.2%**
AF Admissions	1181	11	9	-2	-18.2%		**-18.2%**	**-32.1%**
Care Home Admissions		54	36	-18	-33.3%		**-33.3%**	**-19.3%**
Referrals								
GP Referred 1st OPA		1029	1035	6	0.6%		**0.6%**	**5.5%**
ENT		111	105	-6	-5.4%		**-5.4%**	**5.3%**
General Medicine		170	172	2	1.2%		**1.2%**	**-3.3%**
General Surgery		227	223	-4	-1.8%		**-1.8%**	**-2.7%**
Obstetrics & Gynaecology		93	80	-13	-14.0%		**-14.0%**	**-1.6%**
Opthalmology		73	82	9	12.3%		**12.3%**	**9.5%**
Paediatrics		68	56	-12	-17.6%		**-17.6%**	**5.7%**
Rheumatology		26	25	-1	-3.8%		**-3.8%**	**-9.6%**
Trauma & Orthopaedics		137	145	8	5.8%		**5.8%**	**20.5%**
Other Specialist Medicine		30	53	23	76.7%		**76.7%**	**109.8%**
Urology		63	53	-10	-15.9%		**-15.9%**	**-5.2%**
Other Specialties		31	41	10	32.3%		**32.3%**	**7.4%**
GP Ref Disch at 1st OPA		486	237	-249	-51.2%		**-51.2%**	**7.4%**
% GP ref discharged 1st OPA		47.2%	22.9%					
Other Referred 1st OPA		735	773	38	5.2%		**5.2%**	**4.8%**
*Dermatology		82	19	-63	-76.8%		**-76.8%**	**-80.4%**
Planned								
Elective Admissions		702	681	-21	-3.0%		**-3.0%**	**-2.2%**
Prescribing		136145	149626	13481	9.9%		**9.9%**	**5.0%**

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

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

	List Size
Mar-15	56691
Mar-14	56354
Mar-13	56045
Weighted list 31/10/14	57367

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		1390	1343	-47	-3.4%		**-3.4%**	**-0.4%**
Non-Elective Admissions								
All Non-Elective Admissions		579	517	-62	-10.7%		**-10.7%**	**2.6%**
Occ Bed Days per 100,000		2227	1485	-742	-33.3%		**-32.5%**	**-2.7%**
GP Direct Admissions		104	73	-31	-29.8%		**-29.8%**	**-4.9%**
LTC	**Register**							
CHD Admissions	2587	19	12	-7	-36.8%		**-36.8%**	**0.0%**
HF Admissions	500	8	10	2	25.0%		**25.0%**	**-7.9%**
COPD Admissions	1295	6	6	0	0.0%		**0.0%**	**-43.5%**
Asthma Admissions	3779	2	1	-1	-50.0%		**-50.0%**	**-18.8%**
Diabetes Admissions	2537	1	3	2	200.0%		**200.0%**	**-9.1%**
LTC Admissions	10698	36	32	-4	-11.1%		**-11.1%**	**-14.2%**
AF Admissions	1211	10	5	-5	-50.0%		**-50.0%**	**-32.1%**
Care Home Admissions		37	39	2	5.4%		**5.4%**	**-19.3%**
Referrals								
GP Referred 1st OPA		706	763	57	8.1%		**8.1%**	**5.5%**
ENT		67	82	15	22.4%		**22.4%**	**5.3%**
General Medicine		130	99	-31	-23.8%		**-23.8%**	**-3.3%**
General Surgery		168	149	-19	-11.3%		**-11.3%**	**-2.7%**
Obstetrics & Gynaecology		52	60	8	15.4%		**15.4%**	**-1.6%**
Opthalmology		59	63	4	6.8%		**6.8%**	**9.5%**
Paediatrics		34	28	-6	-17.6%		**-17.6%**	**5.7%**
Rheumatology		20	20	0	0.0%		**0.0%**	**-9.6%**
Trauma & Orthopaedics		96	142	46	47.9%		**47.9%**	**20.5%**
Other Specialist Medicine		12	31	19	158.3%		**158.3%**	**109.8%**
Urology		41	58	17	41.5%		**41.5%**	**-5.2%**
Other Specialties		27	31	4	14.8%		**14.8%**	**7.4%**
GP Ref Disch at 1st OPA		334	186	-148	-44.3%		**-44.3%**	**7.4%**
% GP ref discharged 1st OPA		47.3%	24.4%					
Other Referred 1st OPA		531	512	-19	-3.6%		**-3.6%**	**4.8%**
*Dermatology		57	5	-52	-91.2%		**-91.2%**	**-80.4%**
Planned								
Elective Admissions		550	570	20	3.6%		**3.6%**	**-2.2%**
Prescribing		101731	105432	3701	3.6%		**3.6%**	**5.0%**

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General Practice Dashboard

NHS Stockport Clinical Commissioning Group

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

List Size	
Mar-15	79434
Mar-14	78211
Mar-13	77732
Weighted list 31/10/14	80843

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		2232	2188	-44	-2.0%		**-2.0%**	**-0.4%**
Non-Elective Admissions								
All Non-Elective Admissions		903	834	-69	-7.6%		**-7.6%**	**2.6%**
Occ Bed Days per 100,000		2249	2094	-155	-6.9%		**-4.0%**	**-2.7%**
GP Direct Admissions		186	177	-9	-4.8%		**-4.8%**	**-4.9%**
LTC	**Register**							
CHD Admissions	3005	26	24	-2	-7.7%		**-7.7%**	**0.0%**
HF Admissions	806	12	8	-4	-33.3%		**-33.3%**	**-7.9%**
COPD Admissions	2020	15	7	-8	-53.3%		**-53.3%**	**-43.5%**
Asthma Admissions	5252	5	5	0	0.0%		**0.0%**	**-18.8%**
Diabetes Admissions	3869	4	4	0	0.0%		**0.0%**	**-9.1%**
LTC Admissions	14952	62	48	-14	-22.6%		**-22.6%**	**-14.2%**
AF Admissions	1271	18	16	-2	-11.1%		**-11.1%**	**-32.1%**
Care Home Admissions		46	33	-13	-28.3%		**-28.3%**	**-19.3%**
Referrals								
GP Referred 1st OPA		1111	1118	7	0.6%		**0.6%**	**5.5%**
ENT		136	125	-11	-8.1%		**-8.1%**	**5.3%**
General Medicine		188	173	-15	-8.0%		**-8.0%**	**-3.3%**
General Surgery		229	239	10	4.4%		**4.4%**	**-2.7%**
Obstetrics & Gynaecology		87	66	-21	-24.1%		**-24.1%**	**-1.6%**
Opthalmology		77	76	-1	-1.3%		**-1.3%**	**9.5%**
Paediatrics		67	69	2	3.0%		**3.0%**	**5.7%**
Rheumatology		25	24	-1	-4.0%		**-4.0%**	**-9.6%**
Trauma & Orthopaedics		160	202	42	26.3%		**26.3%**	**20.5%**
Other Specialist Medicine		24	44	20	83.3%		**83.3%**	**109.8%**
Urology		81	62	-19	-23.5%		**-23.5%**	**-5.2%**
Other Specialties		37	38	1	2.7%		**2.7%**	**7.4%**
GP Ref Disch at 1st OPA		524	249	-275	-52.5%		**-52.5%**	**7.4%**
% GP ref discharged 1st OPA		47.2%	22.3%					
Other Referred 1st OPA		764	852	88	11.5%		**11.5%**	**4.8%**
*Dermatology		113	7	-106	-93.8%		**-93.8%**	**-80.4%**
Planned								
Elective Admissions		791	765	-26	-3.3%		**-3.3%**	**-2.2%**
Prescribing		147025	150569	3544	2.4%		**2.4%**	**5.0%**

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	P88020 C&B	1-5 Ashfield Crescent		List Size
Practice Name	Cheadle Medical Practice	Cheadle	Mar-15	11724
GP Partnership	Dr GADUZO SC & Partners	SK8 1BH	Mar-14	11566
Prescribing Name	Cheadle MP	Map: https://maps.	Mar-13	11604
		Tel reception: 0161 4269090	Weighted list 31/10/14	11093

	Register	2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		269	260	-9	-3.3%		0.8%	-0.4%
Non-Elective Admissions								
All Non-Elective Admissions		86	114	28	32.6%		4.6%	2.6%
Occ Bed Days per 100,000		1409	1834	425	30.1%		-5.4%	-2.7%
GP Direct Admissions		17	26	9	52.9%		43.3%	-4.9%
LTC	**Register**							
CHD Admissions	475	3	3	0	0.0%		73.3%	0.0%
HF Admissions	88	0	0	0			0.0%	-7.9%
COPD Admissions	188	4	1	-3	-75.0%		-36.4%	-43.5%
Asthma Admissions	794	0	1	1			0.0%	-18.8%
Diabetes Admissions	603	0	1	1			-33.3%	-9.1%
LTC Admissions	2148	7	6	-1	-14.3%		14.6%	-14.2%
AF Admissions	211	1	1	0	0.0%		-52.9%	-32.1%
Care Home Admissions		2	1	-1	-50.0%		-6.3%	-19.3%
Referrals								
GP Referred 1st OPA		141	186	45	31.9%		14.9%	5.5%
ENT		11	21	10	90.9%		22.2%	5.3%
General Medicine		32	41	9	28.1%		10.3%	-3.3%
General Surgery		26	25	-1	-3.8%		-2.4%	-2.7%
Obstetrics & Gynaecology		5	12	7	140.0%		33.3%	-1.6%
Opthalmology		11	13	2	18.2%		20.0%	9.5%
Paediatrics		12	10	-2	-16.7%		49.2%	5.7%
Rheumatology		6	3	-3	-50.0%		-24.2%	-9.6%
Trauma & Orthopaedics		17	21	4	23.5%		16.7%	20.5%
Other Specialist Medicine		3	17	14	466.7%		128.6%	109.8%
Urology		11	17	6	54.5%		-2.4%	-5.2%
Other Specialties		7	6	-1	-14.3%		-3.9%	7.4%
GP Ref Disch at 1st OPA		40	44	4	10.0%		-37.5%	7.4%
% GP ref discharged 1st OPA		28.4%	23.7%					
Other Referred 1st OPA		109	105	-4	-3.7%		4.7%	4.8%
*Dermatology		14	8	-6	-42.9%		-65.0%	-80.4%
Planned								
Elective Admissions		131	110	-21	-16.0%		-8.6%	-2.2%
Prescribing		19008	17671	-1337	-7.0%		4.6%	5.0%

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	P88043 H&TV	Brinnington Road		List Size
Practice Name	Brinnington Health Centre	Brinnington	Mar-15	8746
GP Partnership	Dr GILMAN AR & Partners	SK5 8BS	Mar-14	8634
Prescribing Name	Brinnington HC2	Map: https://maps.	Mar-13	8515
		Tel reception: 0161 4304002	Weighted list 31/10/14	10792

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		328	326	-2	-0.6%		2.6%	-0.4%
Non-Elective Admissions								
All Non-Elective Admissions		133	126	-7	-5.3%		-4.6%	2.6%
Occ Bed Days per 100,000		2594	2870	275	10.6%		-8.0%	-2.7%
GP Direct Admissions		27	17	-10	-37.0%		-19.4%	-4.9%
LTC	**Register**							
CHD Admissions	369	2	1	-1	-50.0%		-15.8%	0.0%
HF Admissions	133	3	3	0	0.0%		0.0%	-7.9%
COPD Admissions	384	1	1	0	0.0%		-66.7%	-43.5%
Asthma Admissions	827	0	1	1			-33.3%	-18.8%
Diabetes Admissions	472	0	0	0			-50.0%	-9.1%
LTC Admissions	2185	6	6	0	0.0%		-29.8%	-14.2%
AF Admissions	151	1	0	-1	-100.0%		-18.2%	-32.1%
Care Home Admissions		17	10	-7	-41.2%		-33.3%	-19.3%
Referrals								
GP Referred 1st OPA		128	143	15	11.7%		0.6%	5.5%
ENT		15	14	-1	-6.7%		-5.4%	5.3%
General Medicine		21	21	0	0.0%		1.2%	-3.3%
General Surgery		27	42	15	55.6%		-1.8%	-2.7%
Obstetrics & Gynaecology		11	12	1	9.1%		-14.0%	-1.6%
Opthalmology		12	8	-4	-33.3%		12.3%	9.5%
Paediatrics		15	4	-11	-73.3%		-17.6%	5.7%
Rheumatology		1	2	1	100.0%		-3.8%	-9.6%
Trauma & Orthopaedics		15	15	0	0.0%		5.8%	20.5%
Other Specialist Medicine		1	10	9	900.0%		76.7%	109.8%
Urology		5	10	5	100.0%		-15.9%	-5.2%
Other Specialties		5	5	0	0.0%		32.3%	7.4%
GP Ref Disch at 1st OPA		29	28	-1	-3.4%		-51.2%	7.4%
% GP ref discharged 1st OPA		22.7%	19.6%					
Other Referred 1st OPA		80	92	12	15.0%		5.2%	4.8%
*Dermatology		4	0	-4	-100.0%		-76.8%	-80.4%
Planned								
Elective Admissions		94	93	-1	-1.1%		-3.0%	-2.2%
Prescribing		22920	25645	2725	11.9%		9.9%	5.0%

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	P88031 SH&V	141 Buxton Road		List Size
Practice Name	Bracondale Medical Centre	Heaviley	Mar-15	4941
GP Partnership	Dr BARON RL & Partners	SK2 6EQ	Mar-14	4798
Prescribing Name	Bracondale	Map: https://maps.	Mar-13	4701
		Tel reception: 0161 4269050	Weighted list 31/10/14	5115

		2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		111	110	-1	-0.9%		**-2.0%**	**-0.4%**
Non-Elective Admissions								
All Non-Elective Admissions		50	42	-8	-16.0%		**-7.6%**	**2.6%**
Occ Bed Days per 100,000		1917	1902	-15	-0.8%		**-4.0%**	**-2.7%**
GP Direct Admissions		8	7	-1	-12.5%		**-4.8%**	**-4.9%**
LTC	**Register**							
CHD Admissions	180	3	1	-2	-66.7%		**-7.7%**	**0.0%**
HF Admissions	42	1	0	-1	-100.0%		**-33.3%**	**-7.9%**
COPD Admissions	156	0	0	0			**-53.3%**	**-43.5%**
Asthma Admissions	371	0	0	0			**0.0%**	**-18.8%**
Diabetes Admissions	233	0	0	0			**0.0%**	**-9.1%**
LTC Admissions	982	4	1	-3	-75.0%		**-22.6%**	**-14.2%**
AF Admissions	94	0	3	3			**-11.1%**	**-32.1%**
Care Home Admissions		7	2	-5	-71.4%		**-28.3%**	**-19.3%**
Referrals								
GP Referred 1st OPA		59	59	0	0.0%		**0.6%**	**5.5%**
ENT		6	6	0	0.0%		**-8.1%**	**5.3%**
General Medicine		9	6	-3	-33.3%		**-8.0%**	**-3.3%**
General Surgery		14	14	0	0.0%		**4.4%**	**-2.7%**
Obstetrics & Gynaecology		1	4	3	300.0%		**-24.1%**	**-1.6%**
Opthalmology		6	8	2	33.3%		**-1.3%**	**9.5%**
Paediatrics		5	4	-1	-20.0%		**3.0%**	**5.7%**
Rheumatology		1	2	1	100.0%		**-4.0%**	**-9.6%**
Trauma & Orthopaedics		8	6	-2	-25.0%		**26.3%**	**20.5%**
Other Specialist Medicine		0	2	2			**83.3%**	**109.8%**
Urology		6	4	-2	-33.3%		**-23.5%**	**-5.2%**
Other Specialties		3	3	0	0.0%		**2.7%**	**7.4%**
GP Ref Disch at 1st OPA		16	14	-2	-12.5%		**-52.5%**	**7.4%**
% GP ref discharged 1st OPA		27.1%	23.7%					
Other Referred 1st OPA		47	45	-2	-4.3%		**11.5%**	**4.8%**
*Dermatology		7	0	-7	-100.0%		**-93.8%**	**-80.4%**
Planned								
Elective Admissions		45	34	-11	-24.4%		**-3.3%**	**-2.2%**
Prescribing		10222	11102	880	8.6%		**2.4%**	**5.0%**

*There is a data shortfall for Dermatology which is being investigated with Salford Royal FT.

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

Practice Code	P88632 SH&V	1-3 Avondale Road	257 Dialstone Lane		List Size
Practice Name	Stockport Medical Group	Edgeley	Great Moor	Mar-15	12210
GP Partnership	Dr GILL RS & Partners	SK3 9NX	SK2 7NA	Mar-14	11725
Prescribing Name	Stockport	Map: https://maps.	Map: https://maps.	Mar-13	11338
		Tel reception: 0161 4265333		Weighted list 31/10/14	10990

	Register	2014-15 YTD Apr	2015-16 YTD Apr	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		353	340	-13	-3.7%		**-2.0%**	**-0.4%**
Non-Elective Admissions								
All Non-Elective Admissions		128	134	6	4.7%		**-7.6%**	**2.6%**
Occ Bed Days per 100,000		1569	1572	3	0.2%		**-4.0%**	**-2.7%**
GP Direct Admissions		24	35	11	45.8%		**-4.8%**	**-4.9%**
LTC	**Register**							
CHD Admissions	349	1	1	0	0.0%		**-7.7%**	**0.0%**
HF Admissions	126	0	1	1			**-33.3%**	**-7.9%**
COPD Admissions	294	6	0	-6	-100.0%		**-53.3%**	**-43.5%**
Asthma Admissions	825	0	0	0			**0.0%**	**-18.8%**
Diabetes Admissions	473	0	0	0			**0.0%**	**-9.1%**
LTC Admissions	2067	7	2	-5	-71.4%		**-22.6%**	**-14.2%**
AF Admissions	142	1	3	2	200.0%		**-11.1%**	**-32.1%**
Care Home Admissions		9	6	-3	-33.3%		**-28.3%**	**-19.3%**
Referrals								
GP Referred 1st OPA		123	153	30	24.4%		**0.6%**	**5.5%**
ENT		9	18	9	100.0%		**-8.1%**	**5.3%**
General Medicine		18	32	14	77.8%		**-8.0%**	**-3.3%**
General Surgery		31	29	-2	-6.5%		**4.4%**	**-2.7%**
Obstetrics & Gynaecology		13	10	-3	-23.1%		**-24.1%**	**-1.6%**
Opthalmology		4	11	7	175.0%		**-1.3%**	**9.5%**
Paediatrics		13	14	1	7.7%		**3.0%**	**5.7%**
Rheumatology		5	3	-2	-40.0%		**-4.0%**	**-9.6%**
Trauma & Orthopaedics		15	16	1	6.7%		**26.3%**	**20.5%**
Other Specialist Medicine		4	7	3	75.0%		**83.3%**	**109.8%**
Urology		6	12	6	100.0%		**-23.5%**	**-5.2%**
Other Specialties		5	1	-4	-80.0%		**2.7%**	**7.4%**
GP Ref Disch at 1st OPA		29	40	11	37.9%		**-52.5%**	**7.4%**
% GP ref discharged 1st OPA		23.6%	26.1%					
Other Referred 1st OPA		103	134	31	30.1%		**11.5%**	**4.8%**
*Dermatology		19	1	-18	-94.7%		**-93.8%**	**-80.4%**
Planned								
Elective Admissions		102	81	-21	-20.6%		**-3.3%**	**-2.2%**
Prescribing		16616	19287	2671	16.1%		**2.4%**	**5.0%**

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Planned Care

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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 asked to note the progress to date and risks to delivery of the operational plan targets outlined in this report.
Please detail the key points of this report
This report provides a progress update on the planned care programme specifically focussing on three key priorities which are: maximising adherence with the EUR policy, reducing GP referral variation and changes to the spinal pathway of care.
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?
As outlined in the report.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Ranjit Gill
Presented by: C Briggs
Meeting Date: 8 July 2015
Agenda item: 5
Reason for being in Part 2 (if applicable)
N/A

1.0 Background

As well as describing the overall Vision for planned care, the CCG's operational plan describes five change projects for planned care that will be delivered within 2015-16. These are:

1. Maximize adherence with GM Effective Use of Resources (GM EUR) policy
2. Extend EUR policy
3. Optimise pathways for Spinal, ENT, Gastroenterology and Cardiology
4. Reduce GP referral variation and improve quality
5. Improved value for money

This report provides an update on progress on planned care

2.0 Priority Areas

The Planned Care Board and the CCG prioritized the implementation of three of the five change projects and therefore this report focuses on the following: maximising adherence with the EUR policy, reducing GP referral variation and changes to the spinal pathway of care.

Maximizing adherence with the GM EUR policy

A review of secondary care activity at Stockport NHS Foundation Trust (SNHSFT) indicated that approximately £500k of activity is being undertaken that falls within the Greater Manchester Effective Use of Resources (GM EUR) Policy and should therefore be ceased.

To fully comply with the GM EUR policy it was therefore decided that a number of steps should be considered:

1. Improvements in processes in General Practice to ensure that referrals are compliant with the GM EUR policy and to stop any inappropriate EUR referrals from occurring;

2. Improvements in processes at SNHSFT to ensure that any EUR referrals received that should not be accepted due to the GM EUR policy are rejected

3. If process and behavior changes alone cannot maximize adherence with the GM EUR policy then consideration of contract changes should be undertaken.

A small team of CCG and Foundation Trust staff has been established to focus attention on changing the relevant processes to achieve the required aim. On reviewing the data the team found that this is a system wide problem with pockets of inefficiency evident across most practices and secondary care surgical specialties.

By the end of June all GP practices had been engaged in discussions regarding changes to processes as well as the appropriate application of the EUR policy. The Practice Referral Guide has been updated with a simplified version of the EUR policy and this has been disseminated to all GP referral coordinators. Referral coordinators have been offered additional support from Area Business Managers and a training session focusing on adherence with EUR policy will be undertaken in July 2015.

By the end of July SNHSFT plan to embed a referral triage and a listings process review to capture and reject any EUR referrals that are referred in. Agreement has been reached that any patients that present in out-patient clinics who do not meet EUR criteria will not be automatically listed for surgery. Instead they will be referred back to the GP where conservative treatment has not been tried prior to referral. Dates for operationalizing this change are being negotiated.

The proposed changes are resource intensive for both GP practice staff and for SNHSFT and there is a risk that the intended outcome of the process changes may not materialize if either practices or SNHSFT do not fully embed the required changes. The process changes will continue to be implemented and the outcomes monitored. If process and behavior changes alone cannot maximize adherence with the GM EUR policy then potential contract changes will be considered. .

Reducing GP Referral Variation and improving quality

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. To achieve this, a small team has been established and they are focusing their attention on the top quartile of practices in Stockport that have the highest spend on referrals per weighted population. The second and third quartiles will be monitored and any individual practices whose referral growth rate becomes higher than the mean will be selected and added to the target list for focused attention. The quartile with the lowest actual referral rates will be monitored and as long as the group's referrals do not grow at a rate above 2% no action will be taken.

In order for this project to be successful it is important to understand the specific reasons for high numbers of referrals in individual practices. It is assumed that the reason will be multifactorial and will include non-clinical factors. It will be essential that practices take ownership of the issues and are committed to look for and embed solutions. Therefore the first step in this change project is to get the buy in from the GPs and work with each of the targeted practices to identify the root causes of the higher than average spend on referrals. This will involve each practice undertaking an audit, detailed data analysis of referrals by specialty and an investigative exploration with relevant members of the practice team. The outcome of this analysis and exploratory work will lead to the development of an improvement plan that is likely to include a series of change cycles using the Plan, Do Study, Act, (PDSA) methodology.

To date the team has identified practices in the top quartile and undertaken initial meetings with GPs from the relevant target practices. Furthermore, all of these practices have agreed to undertake an audit and investigative exploratory work has begun.

Over the next 2 months the team will:

- Complete the majority of the first round of audits and investigations
- Complete the development of comprehensive action plans in agreement with the practice team for a minimum of 50% of the cohort of 12 practices.
- Ensure that the Locality Chairs have made all practices within their locality aware of the priority to flat line referrals and discuss locality performance, including sharing of good practice at every meeting
- Ensure that enhanced data packs are sent to every GP practice each month
- Act on any preliminary findings
- Establish a target reduction for each practice

There are a number of risks to the delivery of the required target including:

- Delays at the start of the project will mean that the benefits of this project are unlikely to be realized in line with the operational plan.
- The small size of the team necessitates a focus on a limited number of practices
- 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 so this may need to be reviewed

Changes to the Spinal Pathway of Care

Notice has been served by Greater Manchester to confirm the end of the contract with Care UK to provide Clinical Assessment and Treatment Services (CATS). GM CCGs therefore need to ensure that there is either sufficient capacity within current services or to establish new services to maintain access and performance and ensure that existing services do not come under undue pressure.

Within Stockport there has been limited uptake of CATS for gynaecology, urology, orthopaedics (excluding spinal services) and ENT. Therefore the CCG plans to offer patients a choice of existing secondary care services for these pathways. General Surgery had a slightly higher uptake and therefore the CCG has procured additional capacity from Beacon to manage this demand.

However, the spinal pathway was managing referrals for almost 2,200 people. Therefore, the CCG needs to reform the spinal pathway. A clinically led, collaborative workshop was held at the end of June to design a new spinal pathway. This has now been circulated for review and revision. Following this a decision will be made in July regarding the feasibility of implementing the

new pathway by the end of January 2016. If necessary additional mitigations that may be considered include:

- Further extension of the Care UK spinal service beyond January 2016
- Formal procurement of the new spinal pathway

3.0 Actions required

3.1 The Governing Body are asked to note the progress to date on planned care priorities

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Board Assurance Framework

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Stockport
SK4 1BS

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Text Relay: 18001 + 0161 426 9900

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Executive Summary

What *decisions* do you require of the Governing Body?
To comment on and review the content of the Board Assurance Framework, highlighting any areas where further attention is required by the CCG.
Please detail the key points of this report
The detail can be found in the Board Assurance Framework which has been appended to the report.
What are the likely impacts and/or implications?
The areas highlighted are the CCG's principal risks. Failure to monitor and put in place mitigating actions will impact directly on the CCG's ability to fulfil its statutory duties and responsibilities.
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?
Governing Body only
Clinical Executive Sponsor: Ranjit Gill
Presented by: T Ryley
Meeting Date: 8 July 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Detail

1.0 Purpose

1.1 The Board Assurance Framework provides a structure and process which enables the Clinical Commissioning Group (CCG) to focus on the principal risks to achieving its strategic objectives and be assured that adequate controls are in place to reduce the risks to acceptable ratings.

2.0 Content

2.1 This report provides the CCG with assurance that a review of controls and assurances has been undertaken by the risk leads and includes an assessment of the current circumstances. In particular the Governing Body's attention is directed to the events and mitigating actions listed in the Framework to be assured that risks are being mitigated as far as can be reasonably be achieved.

2.2 In line with the current Risk Management Strategy the risks are reviewed quarterly by the relevant Directorate Leads.

2.3 The framework is also underpinned by an Operational Risk Register.

2.4 The updates as at 30 June 2015 are highlighted in the Appendix to the report.

3.0 Actions required

3.1 The Governing Body is requested to comment on and review the content of the Board Assurance Framework highlighting any arrears where further attention is required by the CCG.

NHS Stockport Clinical Commissioning Group

Board Assurance Framework

Latest BAF Risk Ratings

Indicator	Meaning
▲	Extreme Risk
■	High Risk
●	Moderate Risk
★	Low Risk
↗	Risk has improved
➡	Risk has stayed the same
↘	Risk has worsened

Board Assurance Framework Summary

Drill Down	Risk	Directorate Lead	Apr 15	May 15	Jun 15	3 mth Trend	12 mth Trend	Affects:	Events and Mitigating Actions
...	1. There are inadequate systems in place for managing the quality and safety of the services which we commission.	Chidgey, Mark	●	●	▲	↘	↘	• Strategic Aim 1 - Long-term conditions • Strategic Aim 4 - Quality	• Contracts are in place for all required areas. • Quality and Provider Management Committee has a risk based Work Plan to guide its work.
Review of the focus and scope of the Quality and Provider Management Committee has been completed and reported to the committee. The Quality and Provider Management directorate has systems and processes in place for monitoring the quality of services provided. Any risks and issues are identified with action planning reported through to the Committee. The Committee prioritises and monitors significant issues. 30/06/2015									
...	2. We fail to deliver our major service reform programmes.	Jones, Diane	▲	▲	▲	➡	➡	• Strategic Aim 1 - Long-term conditions • Strategic Aim 3 - Prevention • Strategic Aim 4 - Quality	
The design phase has met with significant delays due to the length of time it has taken to secure staffing resources from within the economy. Furthermore, delays in securing external support has exacerbated the situation. The current state analysis is underway and the first design workshops will commence on 1 July 2015. However as the progamme overall has been compressed as a result of delays, this may increase risks relating to the delivery of later phases. 30/06/2015									
...	3. The members are not adequately engaged with the CCG's strategy and priorities.	Roberts, Roger	●	●	●	➡	➡	• Strategic Aim 1 - Long-term conditions • Strategic Aim 2 - Cost effectiveness • Strategic Aim 3 - Prevention • Strategic Aim 4 - Quality	
There was good attendance at the Start of the year conference in May. This was followed by over 80% of practices expressing interest in neighbourhood working including two full localities. The 360 survey of members on member engagement was however not indicating high levels of engagement and more work is required.									

Board Assurance Framework Summary									
Drill Down	Risk	Directorate Lead	Apr 15	May 15	Jun 15	3 Mth Trend	12 mth Trend	Affects:	Events and Mitigating Actions
There are plans in place to review the locality meeting format to facilitate better flow of information and the recent GP development paper is being shared through the locality meetings before going to governing body. 30/06/2015									
...	4. The adoption of clinical best practice guidance and innovation by the CCG is limited or slow (due to provider mobilisation or CCG financial contraints)	Owen-Smith, Vicci	■	●	●	↗	↗	• Strategic Aim 2 - Cost effectiveness • Strategic Aim 4 - Quality	
Clinical Policy Committee has agreed a pathway for Nalmephene so we are shortly to be compliant with the TA. There are some areas of NICE Guidance where the system is not fully displaying best practice however there are no outstanding clinical risk areas. 30/06/2015									
...	5. The organisation's capacity, capability and/or internal engagement are inadequate (Including commissioned support services).	Ryley, Tim	▲	▲	■	↗	↗	• Strategic Aim 1 - Long-term conditions • Strategic Aim 2 - Cost effectiveness • Strategic Aim 3 - Prevention • Strategic Aim 4 - Quality	• CCG review of its capacity and capability
The challenge of transforming the local economy and deliver routine performance is significant. However, the CCG has directed to specific teams to key components and identified an addition £600,000 resources as have other partners. Vanguard support will also be available. 30/06/2015									
...	6. Our providers fail to provide efficient and timely health services to the patients and public of Stockport.	Chidgey, Mark	▲	▲	▲	↗	→	• Strategic Aim 1 - Long-term conditions • Strategic Aim 2 - Cost effectiveness • Strategic Aim 4 - Quality	
SInce the last report, ED performance has improved but is not being sustainably delivered. Access improvements have been delivered at SFT for diagnostics and cancer whilst Mental Health providers have achieved the IAPT access standards. 30/06/2015									
...	7. We fail to ensure that the CCG remains within financial balance.	Jones, Gary	●	▲	▲	↘	↘	• Strategic Aim 4 - Quality	
At the time of producing month 2 reports the CCG had little or no activity data available for either acute or prescribing. We have assumed forecast breakeven in line with Plan. This will be updated when information becomes available. The CCG has reported to the Governing Body risk exposure circa £4.5m with mitigations of circa £2.6m to offset this. The CCG's net risk exposure is circa £2.2m on this basis. 30/06/2015									
...	8. The CCG fails to deliver its QuIPP targets.	Mullins, Gaynor	■	▲	▲	↘	↘	• Strategic Aim 1 - Long-term conditions • Strategic Aim 2 - Cost effectiveness • Strategic Aim 3 - Prevention • Strategic Aim 4 - Quality	• Internal Audit review provides assurance regarding QIPP arrangements
Financial targets achieved but QUIPP delivery was not achieved. For 2015/16 we have identified delivery teams for each QUIPP area and are in the process of identifying key milestones to track performance. However, risk remains high given the significant programme of change to be delivered. 30/06/2015									
...	9. The CCG fails to meet its statuatory duties for compliance (including those for procurement).	Ryley, Tim	●	●	●	→	↘	• Strategic Aim 4 - Quality	
Full compliance team now in place and performance in this area remains good. There will be slight increase in risks as we move to agile working on Health & Safety and Information Governance but plans are in place to mitigate these. 30/06/2015									
...	10. The CCG fails to deliver its planned improvements to the health inequalities of the patients and public of Stockport.	Owen-Smith, Vicci	■	■	■	→	↘	• Strategic Aim 3 - Prevention	
Repriorisation of the CCG 15/16 Plan has resulted in a number of prevention initiatives being downgraded. This is likely to impact on our achieving planned improvements in health inequalities although the Prevention and Empowerment Board and the Local Authority's Health Inequalities Pilot will help towards this objective. The focus of Stockport Together on prevention will also impact positively provided that reducing health inequalities is maintained as a focus. 30/06/2015									

Board Assurance Framework Summary									
Drill Down	Risk	Directorate Lead	Apr 15	May 15	Jun 15	3 mth Trend	12 mth Trend	Affects:	Events and Mitigating Actions
...	11. The CCG fails to deliver its planned improvements to the health literacy of the patients and public of stockport	Ryley, Tim						• Strategic Aim 1 - Long-term conditions • Strategic Aim 3 - Prevention	

The support from Vanguard on social mobilisation and the greater focus through devoloution are opportunities to improve performance in these areas. However, this is a long term plan and there is little evidence of population level change.

30/06/2015

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Resilience and Compliance Report - July 2015

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

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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: 8th July 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

NHS Stockport Clinical Commissioning Group

Chief Operating Officer's Report

Chief Operating Officer's Report

This report covers data for April 2015 for NHS Constitution targets and to May 2015 for statutory duty and compliance indicators.

The main issues are :-

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

In terms of ED waiting times, the Governing Body have already been informed that the target was failed in April 2015, and that the very poor performance in April will mean that Quarter One of 2015/16 is failed. However, there has been an improvement in May which has continued into June and the Q1 position is currently 93.3%. Due to this improved performance, we have been 'de-escalated' in terms of performance management as an economy, although continue to meet on a weekly basis to ensure that this position is maintained.

Ambulance response times remain a concern. A performance notice has been issued by the lead commissioner because of poor performance against the response times targets and we will provide an update at a future meeting on that process. Diagnostic waiting times continue to be a concern at Central and South Manchester Hospitals. This issue has been escalated to the lead commissioners and a report will be provided at a future meeting.

There has been an outbreak of cases of Clostridium Difficile in April/May.

The main risks to delivery in 2015/16 against NHS Constitution targets are:

- Referral to Treatment Times - although the targets (except non-admitted) were met in April and all delivered in May and June, we know that the backlog has increased in June and this is a risk to future delivery. The RTT targets have recently changed as outlined in the attached letter.
- ED 4 hour waits - although significant progress has been made, there is still significant further work to implement the hospital plan and ensure the system is resilient and can manage seasonal pressures
- Ambulance response times - we have not received the action plan from NWAS yet and are therefore not able to risk assess their remedial action plans
- Clostridium Dificile - we have had an outbreak in the first two months of the year.

We continue to perform well against the Statutory Duty and Resilience indicators, and have not identified any risks to delivery against these.

NHS Stockport Clinical Commissioning Group

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters									Last Three Months						Details		
NHS Constitutional Compliance Indicator	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Admitted patients to start treatment within a maximum of 18 weeks from referral	91.7	★	91.6	★	91.1	★	89.9	▲	89.2	▲	89.4	▲	90.2	★	90%	Monthly	This measure will be removed, at a future date, from the report following a recent national announcement which switches the performance focus entirely to the incomplete measure.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	96.1	★	95.8	★	92.1	▲	93.5	▲	92.4	▲	93.4	▲	93.9	▲	95%	Monthly	This measure is also to be removed following the national announcement. It should be noted that we are anticpating to achieve against this standard in both May and June.
Patients on incomplete non-emergency pathways (yet to start treatment) should have waited no more than 18 weeks from referral	94.3	★	93.1	★	93.1	★	93.3	★	93.7	★	93.4	★	93.0	★	92%	Monthly	Performance has been achieved but in the last month there has been an increase in the number of admitted patients at SFT waiting longer than 18 weeks. This places an element of risk on the target but, with the removal of the previous two RTT targets, there are no reasons why SFT cannot prioritise those patients with the longest waits.
Number of patients waiting more than 52 weeks	0	★	1	▲	0	★	1	▲	1	▲	0	★	0	★	0	Monthly	There is continued risk of long waits at UHSM and Tameside.
Urgent operations cancelled for a second time					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	5	▲	3	▲	7	▲	5	▲							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	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99.1	★	99.0	★	97.9	▲	97.2	▲	96.9	▲	99.2	▲	98.6	▲	99%	Monthly	This performance standard is being achieved at SFT but performnace at UHSM and CMFT is bringing the CCG below the required standard. We are co-ordintaing with lead commissioners for UHSM and CMFT as to their action plans to resolve these issues.

A&E waits - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator					Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Patients should be admitted, transferred or discharged within 4 hours	91.7	▲	95.2	★	90.2	▲	86.0	▲	88.5	▲	89.3	▲	89.1	▲	95%	Weekly	Performance has improved in May and June but issues of sustainability remain and are being progressed through the System Resilience Group.
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							Q4		Feb 2015		Mar 2015		Apr 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	94.8	★	94.4	★	95.5	★	95.1	★	96.8	★	96.5	★	95.6	★	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)	91.3	▲	93.7	★	98.4	★	98.2	★	98.1	★	97.5	★	96.8	★	93%	Monthly	There is no significant risk identified to threaten future performance.

Cancer waits - 31 days wait - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	99.5	★	96.9	★	98.6	★	98.6	★	97.2	★	98.4	★	99.2	★	96%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is surgery	98.2	★	95.0	★	98.8	★	98.7	★	97.2	★	98.4	★	99.2	★	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	★	100.0	★	100.0	★	100.0	★	100.0	★	94%	Monthly	There is no significant risk identified to threaten future performance.

Cancer waits - 62 days wait - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	83.6	▲	83.7	▲	75.5	▲	82.1	▲	86.8	★	91.2	★	92.8	★	85%	Monthly	This represents improved performance which needs to be sustained in May and June to achieve the quarters performance target.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	96.7	★	76.9	▲	97.2	★	88.0	▲	75.0	▲	100.0	★	100.0	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	76.9	▲	72.7	▲	80.4	★	69.0	▲	76.9	▲	80.0	★	81.3	★	80%	Monthly	There is no significant risk identified to threaten future performance.

Category A ambulance calls - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	73.5	▲	70.9	▲	65.3	▲	67.0	▲	67.5	▲	68.3	▲	71.2	▲	75%	Monthly	CCGs have provided additional funding to NWAS to deliver improved performnace. A Performance Notice has been issued by NHS Blackpool which will require an improvement plan response from NWAS.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	74.4	▲	71.5	▲	66.7	▲	65.8	▲	66.2	▲	65.7	▲	72.1	▲	75%	Monthly	As above
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95.7	★	94.9	▲	91.2	▲	91.1	▲	91.4	▲	91.2	▲	93.3	▲	95%	Monthly	As above

Mixed Sex Accomodation Breaches - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 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	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 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	91.2	▲	98.4	★	98.3	★	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	Q1		Q2		Q3		Q4		Feb 2015		Mar 2015		Apr 2015		Operational Standard	Collection Frequency	Status / Commentary
Incidence of healthcare associated infection (HCAI) i) MRSA	0	★	2	▲	2	▲	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	14	★	24	▲	24	▲	22	★	7	★	8	▲	14	▲	7.4	Monthly	This very high level of cases, primarily community, has continued into May but reduced in June. The effect of this is that the initial target of a maximum of 7.1 cases per month is now effectively a maximum of 5.8. The CCG is working with Public Health who lead on this measure to support improvement.

Key

Indicator RAG rating

- ★ Green - Performance at or above the standard
- ▲ Red - Performance below the standard

NHS Stockport Clinical Commissioning Group

Statutory Duty & Resilience Compliance

Statutory Duty and Resilience - Last Four Full Quarters									Last Three Months						Details		
Statutory Duty or Resilience Measure	Q1		Q2		Q3		Q4		Mar 2015		Apr 2015		May 2015		Operational Standard	Collection Frequency	Status / Commentary
Percentage of FoIs handled within the legal timeframe	100.0	★	100.0	★	98.0	★	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	★	0	★	1	▲	1	▲	1	▲	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	68.9	▲	75.6	▲	93.8	★	77.8	▲	71.0	▲	85.7	★	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	2.90	▲	1.67	★	2.25	★	2.23	★	2.27	★	2.24	★			2.5%	Monthly	Sick leave data is received one month later than other data.
Percentage of staff contracts which are substantive.	81.6	★	82.5	★	83.8	★	85.6	★	83.6	★	81.4	★	81.7	★	80%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of staff working with vulnerable people who have a confirmed up to date DBS check	88.5	▲	100.0	★	100.0	★	100.0	★							100%	Quarterly	There is no significant risk identified to threaten future performance.

NHS Stockport Clinical Commissioning Group

Finance Report May 2015 – Month 2

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?
1. Note the financial position as at 31st May 2015 and forecast delivery of the £1.75m surplus target. 2. **Note** that the majority of QIPP savings have been embedded within the expenditure budgets. **3. Note** that delivery of the planned £1.75m surplus is dependent on our ability to deliver c£11m saving and for all other expenditure budgets to remain within planned levels.
Please detail the key points of this report
• Actual surplus to Mth 2 (YTD) of £292k, which is in line with our plan at month 2. • CCG is forecasting achievement of its £1.75m planned surplus. • Risks with a most likely financial impact of £4.8m have been identified.
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: 8th July 2015
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

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

1.0 Introduction

This report provides an overview on the CCG's performance against its Statutory Financial Duties and Performance Targets highlighting the financial risks and challenges the CCG faces in delivering these in 2015/16.

This report provides an update on:-

- The financial position as at 31st May 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. Table 1 below RAG rates the CCG financial performance on both a 'Year to Date' (YTD) and Forecast basis.

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty	Performance YTD (Mth 2)	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 of 0.5%		
Revenue (Appendix 1)	Deliver a 1% 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		

The YTD and forecast outturn QIPP amber RAG rating is in recognition that there was very limited information available to ascertain whether activity deflection schemes and prescribing QIPP initiatives are delivering as planned.

3.0 Financial Position as at 31st May 2015

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

Table 2: Summary of Financial Position at Month 2

	Plan (Surplus) / Deficit **£000s**	**Actual (Surplus) / Deficit** **£000s**	**(Favourable) / Adverse Variance** **£000s**
Month 2 YTD	(292)	(292)	0
Year End Forecast	(1,750)	(1,750)	0

The above table shows that the CCG has delivered its planned surplus YTD and is forecasting to deliver its planned surplus of £1.75m in 2015/16. However, members should note that the delivery of the CCG planned surplus is dependent upon delivering planned QIPP savings.

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

There was limited acute contract performance data for April and May available at the time of reporting. Given this situation, the only adjustment to forecast relates to the settlement of 14/15 acute contracts based on actual activity data received after the year end closedown.

5.0 Prescribing

The latest information from the NHSBSA provides actual prescribing expenditure for March 2015 which was in line with year-end forecasts. The position reported at month 2 has been estimated in line with budget for April and May.

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	197	197	0	1,180	1,180	0
CCG Admin	814	749	(65)	5,244	5,244	0
Total CCG Running Costs	**1,011**	**946**	**(65)**	**6,424**	**6,424**	**0**

The GMCSU position reflects revised SLA values for services commissioned. The under spend on CCG administration is due to staff vacancies.

7.0 Reserves

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

Investments – this reserve includes the planned investments set aside as part of our 15/16 financial plan.

Contingency – this reserve reflects the £1.9m (0.5%) contingency required for planning purposes.

Savings & Efficiency – this £3.765m budget reflects the remaining value of QIPP savings not embedded within income and expenditure budgets. Table 4 provides details of QIPP schemes not embedded in income and expenditure budgets

Table 4: QIPP schemes not embedded in income and expenditure budgets

QIPP Scheme	Value
Unidentified	£1.815m
CHC Nation Risk Pool Under Spend	£1.500m
Quality Premium	£0.450m
Total Mitigation	**£3.765m**

8.0 Financial Risks and Mitigations not in Forecast

The April finance reported financial risks totalling c£4.4m. These financial risks are kept under constant review and have been updated to reflect an increase in identified financial risk to £4.8m with the greatest risk to delivering the CCG planned surplus still being the CCG's ability to secure c£11m QIPP saving. Identified financial risks as at 31st May 2015 are summarised in Table 5

Table 5: Financial Risks not in Forecast Outturn

Risk	Likelihood (H = High - 80%) (M = Medium – 50%) (L = Low – 20%)	Value	Mitigation
Activity QIPP do not deliver required saving	M	£2.65.m	QIPP routinely monitored and reported to Governing Body. Expedite the implementation of QIPP initiatives Establishment of Programme Management Office
Prescribing QIPP	M	£0.65m	Medicines management and GP Development schemes established to address increasing pressures on the prescribing budget.
CHC Legacy	M	£0.75m	
Specialist Commissioning	M	£0.30m	Challenge and scrutinise costs as appropriate
Transitional Support for Stockport Together	H	£0.48m	Development of "Plan B"
Total Risk			

Exposure (Adjusted by Likelihood %)		**£4.83m**	

Activity QIPP plans do not deliver required saving (Full risk value £5.3m): QIPP programmes for Elective are based on the assumption that activity in 15/16 is maintained at 2014/15 levels (growth offset by deflections @ 3.5%). For Non Elective the plans assume a net 1% reduction on 14/15 activity (deflections @ 3.5%).

At the time of writing this report recent April activity information just received showed significant growth in Trauma and Orthopaedic at BMI and Care UK which would result in a £1m overspend should this trend continue at current levels. This is already a recognised risk which needs to be managed.

Prescribing QIPP (Full risk value £1.3m): Volume and price increases continue to impact prescribing 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.

CHC Legacy (Full Risk Value £1.5m): The CCG QIPP plans assume that the national CHC pool will underspend in 15/16 at the same levels as in 14/15. There is a risk that utilisation of the national risk pool in 2015/16 is greater than the utilisation in 2014/15 and the value of underspend to be return is not at the level anticipated.

Specialist Commissioning (Full risk value £0.6m): Transfer of services from Specialist Commissioning to NHS Stockport CCG and the risk that these may not be fully funded at cost.

Transitional Support for Stockport Together (Full risk value up to £0.6m): The cost in funding extra capacity across Stockport Together / Vanguard work streams to progress delivery of implementation of programmes. There is an assumption that resources will become available to contribute to these costs.

To mitigate against the financial value of the risks identified above the CCG financial plans incorporates the mitigations detailed in Table 6.

Table 6: Planned Risk Mitigation

Mitigation	Value
Contingency	£1.71m
Better Care Fund Contingency	£0.92m
Total Mitigation	**£2.63m**

This leaves the CCG with a unfunded risk exposure of £2.2m in the event that all risks materialise at the likelihoods indicated above. However, should these risks materialise at 100% level then the unfunded risk exposure increases to c£6.5m.

9.0 Balance Sheet

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

10.0 Recommendations

The Governing Body is asked to:-

I. **Note** the financial position as at 31st May 2015 and forecast delivery of the £1.75m surplus target.

II. **Note** that the majority of QIPP savings have been embedded within the expenditure budgets.

III. **Note** that delivery of the planned £1.75m surplus dependent on our ability to deliver c£11m saving and for all other expenditure budgets to remain within planned levels.

Gary Jones
Chief Finance Officer
23rd June 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

Appendix 1

Month 2 - as at 31st May 2015

	YTD (Mth 2)				Forecast 15/16			
	Plan £000s	Actual £000s	Var £000s	Var %	Plan £000s	Actual £000s	Var £000s	Var %
Revenue Resource Limit (RRL)								
Confirmed	(60,796)	(60,796)	0	0.0%	(378,802)	(378,802)	0	0.0%
Anticipated	0	0	0	0.0%	0	0	0	0.0%
Total RRL	**(60,796)**	**(60,796)**	**0**	**0.0%**	**(378,802)**	**(378,802)**	**0**	**0.0%**
Net Expenditure								
Acute	36,653	36,790	137	0.4%	223,879	224,065	186	0.1%
Mental Health	5,255	5,255	0	0.0%	31,530	31,530	0	0.0%
Community Health	4,128	4,152	24	0.6%	24,770	24,770	0	0.0%
Continuing Care	2,495	2,497	2	0.1%	14,970	14,974	4	0.0%
Primary Care	1,967	1,979	12	0.6%	11,464	11,464	0	0.0%
Other	763	765	2	0.3%	3,089	3,086	(3)	(0.1%)
Sub Total Healthcare Contracts	**51,261**	**51,438**	**177**	**0.3%**	**309,702**	**309,889**	**187**	**0.1%**
Prescribing	8,120	8,120	0	0.0%	48,723	48,723	0	0.0%
Running Costs (Corporate)	1,011	946	(65)	(6.4%)	6,424	6,424	0	0.0%
Total Net Expenditure	**60,392**	**60,504**	**112**	**0.2%**	**364,849**	**365,036**	**187**	**0.1%**
Reserves								
Reserves - Investments	0	0	0	0.0%	14,073	14,073	0	0.0%
Reserves - Contingency	112	0	(112)	(100.0%)	1,895	1,708	(187)	(9.9%)
Reserves - QIPP	0	0	0	0.0%	(3,765)	(3,765)	0	0.0%
Sub Total Reserves	**112**	**0**	**(112)**	**0.0%**	**12,203**	**12,016**	**(187)**	**(1.5%)**
Total Net Expenditure & Reserves	**60,504**	**60,504**	**0**	**0.0%**	**377,052**	**377,052**	**0**	**0.0%**
TOTAL (SURPLUS) / DEFICIT	**(292)**	**(292)**	**0**	**0.0%**	**(1,750)**	**(1,750)**	**0**	**0.0%**

SUMMARY OF RESERVES
Month 2 - as at 31st May 2015

Table 1 - Reserves Summary

	Reserves Held Mth 2	Commits Mth 2 onwards	Forecast Bals Year End
Amounts Held in CCG Reserves	**£'000s**	**£'000s**	**£'000s**
Investments - National	11,964	11,964	0
Investments - Greater Manchester	1,809	1,809	0
Investments - Local	300	300	0
Contingency	1,895	1,708	(187)
QIPP - Saving and Efficiency not embedded in I&E budgets	(3,765)	(3,765)	0
Total Reserves	**12,203**	**12,016**	**(187)**

Table 2 - Quality Innovation Productivity and Prevention (QIPP)

QiPP Schemes - CCG Element	YTD Target	YTD Achivement	YTD Variance	Full Year Plan	Forecast
	£'000s	£'000s	£'000s	£'000s	£'000s
Recurrent					
Wet AMD	(80)	0	(80)	(500)	(500)
Prescribing Initiatives	(54)	0	(54)	(325)	(325)
VFM Procurements	0	0	0	(200)	(200)
GP Development Prescribing	(154)	0	(154)	(944)	(944)
Elective Activity	0	0	0	(2,654)	(2,654)
Non-Elective Activity	(172)	0	(172)	(2,603)	(2,603)
Unidentified	0	0	0	(1,815)	(1,815)
Sub-Total Recurrent	**(460)**	**0**	**(460)**	**(9,041)**	**(9,041)**
Non-Recurrent					
Quality Premium	0	0	0	(450)	(450)
Return of CHC Risk Pool Underspend	0	0	0	(1,500)	(1,500)
Sub-Total Non Recurrent	**0**	**0**	**0**	**(1,950)**	**(1,950)**
Total	**(460)**	**0**	**(460)**	**(10,991)**	**(10,991)**

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.	May YTD	
	Number	£000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	1,405	11,027
Total Non-NHS Trade Invoices Paid Within Target	1,369	10,524
Percentage of Non-NHS Trade Invoices Paid Within Target	97.44	95.44
NHS Payables		
Total NHS Trade Invoices Paid in the Year	395	42,480
Total NHS Trade Invoices Paid Within Target	383	42,465
Percentage of NHS Trade Invoices Paid Within Target	96.96	99.96
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,800	53,507
Total NHS Trade Invoices Paid Within Target	1,752	52,989
Percentage of NHS Trade Invoices Paid Within Target	97.33	99.03

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 4 - 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				
TOTAL ALLOCATIONS	**(378,802)**	**0**	**(378,802)**	**0**

NHS STOCKPORT CCG BALANCE SHEET as at 31st May 2015 (Month 2)

Appendix 3

	Opening Balances 1.4.15 £000s	Closing Balances 31.05.15 £000s	Movement in Balances £000s	Forecast B/S 31.3.16 £000s
Non-current assets:				
Property, plant and equipment	14	13	(1)	10
Intangible assets	0	0	0	0
Trade and other receivables	0	0	0	0
Total non-current assets	**14**	**13**	**(1)**	**10**
Current assets:				
Cash and cash equivalents	43	82	39	50
Trade and other receivables	1,363	435	(928)	500
Inventories	0	0	0	0
	1,406	**517**	**(889)**	**550**
Non-current assets classified "Held for Sale"	0	0	0	0
Total current assets	**1,406**	**517**	**(889)**	**550**
Total assets	**1,420**	**530**	**(890)**	**560**
Current liabilities				
Trade and other payables	(20,923)	(19,671)	1,252	(21,000)
Provisions	(883)	(837)	46	0
Borrowings	0	0	0	0
Total current liabilities	**(21,806)**	**(20,508)**	**1,298**	**(21,000)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(19,978)**	**408**	**(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)**	**(19,978)**	**408**	**(20,440)**
FINANCED BY:				
TAXPAYERS' EQUITY				
General fund	(20,386)	(19,978)	408	(20,440)
Revaluation reserve	0	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(19,978)**	**408**	**(20,440)**

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
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

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 – June 2015 o Q&PM June 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 committee agreed to remove the following from the issues log:-

- LD patients, annual health checks.

The following issues remain on “red” within the issues log:-

- SFT CIP plans
- St Ann’s Hospice - Safeguarding

The following issue was added to the issues log:-

- Safeguarding within maternity services. This issue was rated as amber. The committee agreed a process to reach a clear position on the level of assurance. This would be involve working with SFT and include the review of the CQC action plan.

3.0 Issues Highlighted to the Governing Body

- The action plan response resulting from the CQC review of Looked after Children and Safeguarding is being agreed and monitored through the committee.

- That the committee re-stated support for the Community Mental Health model of care agreed at the December Governing Body meeting. This model has not yet been implemented.

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

DRAFT MINUTES of the meeting held on Wednesday 17 June 2015

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

Present:

(JC) Jane Crombleholme, Lay Member, Chair of NHS Stockport CCG Governing Body
(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
(VOS) Dr Vicci Owen-Smith, Clinical Director, Public Health

In attendance:

(DK) Dr Debbie Kendall, Secondary Care Lay Consultant
(GE) Gina Evans, Joint Commissioning Lead, NHS Stockport CCG
(KMc) Karen Maneely, Operational Manager, for Stockport, Tameside & Glossop, Mental Health, NHS Pennine Care FT
(MCu) Martin Corran, Community Service Manager, Community Mental Health, NHS Pennine Care FT
(NG) Nazie Gerami, Patient Experience Officer, NHS Stockport CCG
(RG) Rachel Grindrod, Contracts Manager, NWCSU
(SW) Sarah Williamson, Clinical Quality Assurance and Performance Manager, NHS Stockport CCG for GMi
(SWo) Dr Simon Woodworth, Clinical Lead, Urgent Care, for CB

Apologies:

(CB) Dr Cath Briggs, Clinical Director for Quality & Provider Management, NHS Stockport CCG
(GMi) Gillian Miller, Deputy Director of Quality & Provider Management, NHS Stockport CCG
(SP) Susan Parker, Allied Health Professional
(TS) Tony Stokes, Healthwatch representative

Minute Taker:

(AN) Alison Newton, PA, NHS Stockport CCG

MEETING GOVERNANCE	
1. Apologies and declarations of interest	**Action**
1.1 Apologies were received from CB, GMi, SP and TS; apologies for early departure were received from VOS. 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.	
OPERATIONAL BUSINESS	
3. Minutes & actions from previous meeting (20 May 2015)	**Action**
3.1 Minutes & actions: The draft minutes of the meeting held on 20 May 2015 were approved as a correct record. It was noted that immediately following the meeting, the Chair had emailed all members to add an action to the Committee's Issue Log re: non-compliance of safeguarding training for one of the providers. The action was added to the log. **3.2 Action log** Members were referred to the action log and briefed on the progress of the actions. • 6.1.3 (17 September 2014/18 February 2015 – new action): Issues Log (glaucoma timely follow-up appointments at MREH): GMi had contacted the commissioning lead at CMFT to receive data on the number of Stockport glaucoma patients affected by a delay in follow-up appointments. The data was not available. This item would remain on the log until the data is received by the CCG. **Remain on log.** • 6.1.2 (18 March 2015): SFT Community Services Issues: The SRG risk analysis for Community Services had been received. **Remove from log.** • 3.3.2 (20 May 2015): Quarter 3 2014/15 –Mental Health Services: i. VOS had contacted Elysabeth Williams to find out more information on GP & Pennine involvement in the suicide prevention group; Elysabeth's response had been emailed out to the group. Action completed. **Remove off log.** ii. VOS to meet with JH, GMi and GE to discuss the suicide statistics further. Meeting arranged for 21 July 2015. **Remove off log.** • 4.1 a) (20 May 2015): SFT Hot Spots Report: i. SW to seek clarification on the number of insulin incidents reported. SW advised that there had been no incidents reported on STEIS (Strategic Executive Information System) for 2015/16 and three reported in 2014/15. She was seeking confirmation on the number reported on datix (patient safety software for recording incidents below the level of STEIS reportable). However, SW assured the committee that the Trust were taking all incidents very seriously and a rise in reporting may in part be due to the KPI the CCG set the Trust for increasing the number. SW informed the meeting that SFT (Stockport Foundation Trust) would be undertaking an audit of insulin incidents in September 2015. The Chair requested that this re-audit be presented to the committee in October 2015. **Remain on log.**	

Action: SW to present the Trust's re-audit of insulin incidents at the October meeting ii. SW to share the action plan for the SFT task & finish group (serious incidents); Action completed, paper circulated. It was noted that Diabetes is a focus for the Trust; **Remove off log.** iii. Submit a report to the committee following a RCA on cancelled operations; action not due until October 2015. **Remain on log.** iv. GMi to pass on the committee's comments to the Clinical Governance lead at SFT regarding the hot spots report. Action completed. **Remove off log.** • 4.2 (20 May 2015): SFT Community Services – District Nurse Service: CB had fed back the comments from the committee to the Associate Director, Community Services. Action completed. **Remove off log.** • 5.2 (20 May 2015): Mental Health: i. GMi had passed on comments from the committee to GE. Action completed. **Remove off log.** ii. VOS had provided information on change to the peer support service (PPS). Action completed. **Remove off log.** iii. CCG Comms team to alert GPs on change to the PPS; action not due until later in the year. **Remain on log.** • 6.1 a) (20 May 2015): Safeguarding Exception Report: SG had escalated the issue regarding non-compliance of training involving a provider to NHSE. Action completed. **Remove off log.** • 6.1 c) (20 May 2015): Safeguarding Exception Report: CB had discussed the issue of linking a GP Practice to Cale Green Practice with the Locality Chair but nothing has been resolved. **Remain on the log.** • 6.2 (20 May 2015): SFT 6 month review of serious incidents: Action not due for six months. **Remain on the log.** • 8.1 (20 May 2015): Issues Log: This issue would be covered under item 6.1 on the agenda. **Remove off log.** The Committee **noted** the updates. **3.3 Matter Arising – Review of Committee:** The Chair reported that she had received no further comments following the distribution of her document on the review of the committee.	**SW**
4. Service Focus – Maternity Services	**Action**
4.1 Extract from Q&PM meeting 20 August 2014: Members noted the extract from the Quality & Provider Management meeting held on 20 August 2014. Dr Johari had provided assurance to the committee regarding the quality of maternity	

services at SFT. The Chair referred to the remaining papers circulated for the service focus and asked the committee if they remained assured on the quality of maternity services. It was agreed that the discussion would focus on the context provided in the reports for items 4.2 to item 4.5.	
4.2 Maternity Overview **4.3 Maternity Services – SFT** **4.4 Morecambe Bay Investigation – Executive Summary & SFT response** **4.5 Maternity Services – Safeguarding Review:** 4.2.1 The committee agreed to consider the quality of maternity care from two perspectives: - (1) performance / outcomes (2) safeguarding. 4.2.2 The maternity outcomes overview outlined that there were no changes to the previous position and no significant causes for concern currently highlighted within Stockport services. However, the data indicated that there were gaps in knowledge with regards to quality indicators. SW informed the committee that the Trust had been asked to present internal quality outcomes for maternity at the next quality and performance meeting. Therefore it was agreed that the committee did not have any Immediate concerns. 4.2.3 It was agreed that assurance could be provided by a discrete piece of work to: 1) Check if outcomes had significantly changed from those achieved and benchmarked in 2013. 2) Information available relating to NHSLA premiums. **Action: SW to complete updated maternity performance review and report to next Q&PM meeting.** 4.2.4 The committee noted that following a review of maternity services undertaken in 2011/12, a number of recommendations remained outstanding as issues. 4.2.5 The committee considered (4.5) which was an extract of statement of incidents since 2011 which had been considered under the Learning review process. 4.2.6 MC referred to the paper containing the Trust's response to the Morecambe Bay Investigation. This was to be considered by the SFT Quality group – this is a sub-committee of the full Board and minutes are produced. 4.2.7 SW reported that Jo Ellis (Associate Director – Child & Family) would be attending the next meeting of the Quality & Performance Committee due to be held the following week, to discuss the quality of maternity services in Stockport. It was further noted that the Women & Children safeguarding team headed by the Named Nurse is responsible for community and acute but maternity has its own Named Midwife that is managed separately. **Action: Include an item on the next agenda under matters arising to review the maternity findings of both of the above meetings.**	**SW** **AN**

SWo joined the meeting (09:30 am). 4.2.8 It was further noted that the Trust had agreed to commission an external review of maternity serious incidents later in the year. 4.2.9 JC pointed out that feedback from FFT (Friends and Family Tests) remains positive regarding maternity services. SW reiterated this comment and reported that she had undertaken a familiarisation walk round of maternity with GMi and they had observed good quality of care and facilities. 4.2.10 The Chair questioned the committee as to whether they had received assurance on the quality of maternity services with regards to safeguarding. It was agreed that the committee should await the review of the action plan following the recent CQC report (of which safeguarding at the Trust was a key element) as well as the outcomes of the two meetings referenced above. However, the issue would be added to the issues log as "amber" and SG would contact Judith Morris (Director of Nursing) to advise that the Quality & Provider Management Committee are seeking assurance on safeguarding within Maternity Services. SG would share her report *(Maternity Services – Safeguarding Review)* with Judith and provide some context to the discussions that have taken place at this meeting. Members acknowledged that the priority for assurance was around safeguarding processes and not quality of care within maternity services. 4.2.11 SG asked if the actions from the CQC report had been presented to the CCG Governing Body. JC responded that they had not gone to Governing Body yet as due process is being followed first, i.e. review of the action plan following the CQC report at the appropriate forums. **Actions:** **i. SG to contact Judith Morris today and share Safeguarding Review of Maternity Services and provide a summary of discussions held at Q&PM. SG to provide feedback to MC on the outcome of the meeting with JM.** **ii. MC to email committee before the next meeting to provide an update.** **iii. MC to brief RG/CB/GM on the discussions regarding maternity services at Q&PM.** **iv. GMi to add issue of safeguarding assurance in Maternity at SFT to the Issues Log as Amber.**	**SG** **MC** **MC** **GMi**
5. Stockport Foundation Trust	**Action**
5.1 a) Integrated Performance Report (IPR): RG referred to the IPR and sought questions from the committee to be covered at the Quality & Performance meeting the following week. JH referred to chart 8 on page 6 outlining GP referred ED attendances. SWo informed the meeting that a lot of work is taking place to develop a pathway at SFT regarding speciality referrals from GPs therefore these figures are likely to reduce in the future. 5.1.1 With regards to OWL (outpatient waiting lists) and gastroenterology, SWo reported that he had received positive feedback regarding the use of Beacon GP	

group as a new provider in South Manchester. This area of concern is in the committee's issue log. RG added that a contract query has also been submitted to SFT on this issue.	
5.1 b) CCQ Quality Dashboard – May 15: RG drew members' attention to a number of points contained within the dashboard including: • CQC inspections / intelligent monitoring – the risk band has moved due to RTT and Never Event: this would be discussed further at the Quality & Performance meeting; • STEIS timescales had been increased to 60 days; • TIAs – figures had reduced but this is due to data collection issues not safety issues.	
5.2 SFT Community Services – District Nurse Service: Members noted the update report; the plan is on trajectory. This item had been escalated to the Board to ensure members are sighted on the issue.	
5.3 CQUIN 14/15 Summary: Members noted the list of CQUINS – the LD CQUIN is to be added to the list. SW asked members to note that the Trust had achieved 95% of the CQUINS included on the schedule. Karen Maneely (KM) and Martin Corran (MCu) joined the meeting (10:15 am).	
6. Mental Health	**Action**
It was agreed that item 6.2 would be considered next on the agenda: **6.2 Update on Pennine Care CIP – Karen Maneely:** The Chair welcomed KM and MCu to the meeting and invited KM to present an update on the reform of Community Mental Health Teams in Stockport that had been agreed with Pennine Care NHS FT. 6.2.1 KM explained that she wanted to provide some context to the ongoing service re-design at Pennine Care. Members were referred to a paper (copies previously circulated) outlining the various models that had been presented to staff; formal consultations had taken place on Models 1, 2 and 3 and these had been rejected by some staff. 6.2.2 Members were reminded that Model 1 had been agreed by both the committee and the CCG Governing Body. 6.2.3 KM stated that the consultation period had been extended to 45 days as the re-design involved NHS staff and LA (Local Authority) staff. Following the first consultation, staff had expressed concern at continuity of care for patients being moved to a different team. 6.2.4 KM explained that following feedback from the second consultation (Model 2), she had undertaken numerous visits, along with MCu across all the services, to	

spend time with staff and service users to better understand the impact of these proposed changes.

6.2.5 Members supported the information presented for the first consultation, outlining the need and looking to the future vision of the service, to move people through the system to better aid their potential recovery.

6.2.6 Members were referred back to the paper presented and noted comparative caseloads for other Trusts, the proposed model included a caseload that was comparable, if not less, than in other areas.

6.2.7 KM pointed out that following feedback from the third consultation, Model 4 and Model 5 had been produced. Members questioned whether there had been a consultation on these models. KM responded that there had been no formal consultation as they had been presented to a joint staff meeting over two months ago and they continued to work with staff to address the concerns raised – the next joint staff meeting is 15 July 2015. KM added that a second stress survey had also been undertaken to ensure that any changes have minimal impact on staff; drop-in sessions had also been undertaken for staff. Further negotiations continue with staff to implement the CIP (Cost Improvement Plan).

6.2.8 A member questioned why this issue could not be implemented now, the longer the process takes, the more stressful it is for staff and it could impact on service users. KM explained that they were trying to work with staff, in recognition that it involves a change to the service for staff. KM added that there is also a pressure group active in Stockport, campaigning against mental health cuts and they were actively trying to discourage any cuts in mental health services.

6.2.9 DK questioned which model is the best for service users? Members agreed that Model 1 is the best model for service users.

6.2.10 The Chair pointed out that numerous consultations had taken place with staff but questioned whether service users had been consulted on the proposed changes. GE explained that a Co-Design Forum (a strategy group for mental health), chaired independently had considered all models against the principles of service re-design and they had supported Model 1. MCu added that a management group meets every two weeks and on the alternate weeks, a project group meets (involving stakeholders from staff, service users and providers) and they had supported Model 1 – these project groups had been suspended whilst further negotiations took place.

6.2.11 In response to the initial query from the Chair, KM added that she and MCu had met with service users and carer forums to explain the process; there had been extensive communication.

6.2.12 The Chair asked if there is a deadline for implementing the CIP. Another member questioned why further consultations are taking place if it had been recognised that Model 1 is the best model for service users. MC re-stated the position of the commissioner, and the support for Model 1 to be implemented; members fully supported MC on this issue.

6.2.13 In response to a question, KM reported that the CIP had been transacted through the contract but not implemented operationally. It was further noted that similar service models had been put in place in Tameside and this had worked well, along with three other northern divisions. **Action: MC to contact Keith Walker (Director of Operations) to reiterate the Committee's support from a commissioning perspective, to the initial proposal as contained in Model 1 – the committee were assured that this is the best model for patients. The committee would like this comment to be passed on to Pennine Board.** The Chair thanked KM and MCu for their attendance and contributions at the meeting. KM and MCu left the meeting (10:50 am).	**MC**
6.1 Quality & Performance report on Mental Health – key issues: GE advised the meeting that performance data for mental health would be available at the next meeting of the committee. GE referred members to a paper, *Joint Health and Social Care Learning Disability Self-Assessment Framework* and highlighted two areas: • Annual Health Checks (by GPs) – this continues to be a challenge for Stockport; numbers recorded for 2013/14 was 34% • Review of Individual Care Packages – 47% of people known to adult social care have received an annual review, to achieve an amber rating, this figure needs to be 90% 6.1.1 VOS questioned whether data collection is an issue. GE responded that the information is provided by NHS England (NHSE) and the data relates to 2013/14 – there was a directed enhanced service. In 2015/16, the process changed and included health checks for children from the age of 14 years upwards. 6.1.2 JH pointed out that the 2013/14 list includes a separate list for LD and another list that includes those patients on QAF registration that were not targeted for a health check but had a check whilst with their GP for other issues. SWo pointed out that the new changes involve the GP making the decision as to whether a patient has a LD (Learning Disability) therefore there may be an increase in reporting. 6.1.3 GE added that a LD nurse had completed a three month secondment to work with practices to raise awareness and support them to undertake health checks. The nurse had produced a Health Check resource pack for GPs. SWo commented favourably on the resource pack, this would be useful for GP practices but he had not seen it before this meeting. GE explained that the pack had been emailed out to practices in April. GE added that each GP practice has a named worker to support patients with LD. **Action: GE to ask the CCG Comms Team to re-circulate the GP Health Check resource pack to all practices.** 6.1.4 In response to a question, GE commented that there had been progress	**GE**

made, robust plans are in place and lots of work is taking place to support this issue. Fiona Sanders (lead for Primary Care Education) has been commissioned by NHSE to undertake a project to increase health checks in practices. Members agreed that this is a vulnerable cohort and should be a focus for improvement. 6.1.5 MC commented that next year the committee needed to be better sighted on progress and that there would be a comparison of Self-Assessment standards between years. VOS left the meeting (11:00 am). 6.1.6 The Chair requested that the committee be sighted on the action plan. GE explained that the action plan is the responsibility of LA colleagues. The Chair thanked GE for her report. NG joined the meeting for item 8.1 (11:05 am).	
7. Patient Safety	**Action**
7.1 Safeguarding Exception Report: The Chair thanked SG for her report and drew members' attention to the action points for the committee: • The committee noted the progress regarding training at SFT • There is an agreed training strategy in place at St Ann's Hospice • The action plan had been submitted to CQC • Named GP for Safeguarding – SG reported that a name has been submitted but in following due process the appointment is not likely to commence until September 2015.	
7.2 CQC Action Plan: SG reported that she has not received any feedback from CQC on the action plan and pointed out that the full report was only published on the website during the previous week. MC commented that the action plan had now been received by the committee and the safeguarding issues discussed earlier in the meeting under item 4 should be considered alongside the action plan. 7.2.1 Members discussed the action plan and questioned how they could receive assurance that it had been fully implemented at the Trust. The committee supported the plan as presented but agreed that the action plan could not be signed off until there was clear evidence that the actions were fully embedded.	
7.3 Care Homes with Nursing Quality Overview – June 2015: Members noted the paper and agreed this is very informative.	
7.4 Patient Safety report: Members noted the update. At the Chair's request, item 9 was considered next on the agenda.	

9. Review Issues	Action
9.1 *Issue: Non compliance of safeguarding standards* – as covered under item 7.1. **Remain on log.** *Issue: 62 day wait cancer treatment* – The plan is on trajectory but this issue would remain on the log. **Remain on the log.** *Issue: Timely follow-up of glaucoma patients at CMFT:* The CCG had requested further information from the commissioners; the commissioners awaited receipt of the data. **Remain on log.** *Issue: District Nurse Service* – As discussed under item 4.2. This issue would be changed to amber; the plan is on track. **Remain on log.** *Issue: LD patients – annual health checks* – This issue would remain as amber. GE stated that the actual figure should read 66% of Stockport patients with LD. This issue had been considered under item 6.1. Members agreed that this issue could be removed off the log but if a review of the SAF in the following year revealed a further issue, it would be added back to the log. **Remove off log.** *Issue: Patient discharge letters* – The trajectory for this issue is August 2015. **Remain on log.** *Issue: SFT CIP* – MC reported that this issue would be escalated to Gaynor Mullins and would remain on red. **Remain on log.** *Issue: Timely follow-up of OWLs* – MC recommended awaiting the validated figures and keeping the issue on the log as amber; members supported the recommendation. **Remain on log.** It was agreed that a new issue be added to the log: Safeguarding of Maternity services, as amber until feedback is received from the Trust on the committee's comments as covered under item 4. The Committee **noted** the updates.	
8. Patient Experience – Annual Report	**Action**
8.1 Review Issues: NG referred to the report (copies previously circulated) and highlighted a few points: • One of the CCG's aims is to increase patient satisfaction with all services to top quartile – this measure is derived from the National Inpatient Survey carried out by the CQC, • Whilst SFT are in the normal range on the results of the survey, the results of other key providers are in the top quartile (Mastercall, BMI, St Ann's Hospice), • The FFT (Friends and Family Test) was officially rolled out in 2013 for inpatients, A&E and maternity – it has now been rolled out for all services;	

• Pennine Care has scored the highest (83%) –these figures are from January 2015; • Arriva – there are several action plans in place to address issues; • MECs – very good experiences. 8.1.1 The Chair thanked Nazie for her informative report and asked if walkabouts will continue to take place. NG responded that a schedule of visits for the year is being produced but there will be unannounced visits on areas of concern. The Chair recommended involving Healthwatch in these visits. 8.1.2 The Chair invited members to contact NG if they would like to be involved in these visits during the course of the year.	
10. Any Other Business	**Action**
10.1 There were no other items of business to discuss.	
Meeting Governance	
11. Date, time and venue of next meeting: Wednesday 15 July 2015 09:00 – 11:30 Room 1, floor 7, Regent House	

Quality & Provider Management Committee – Actions Arising (17 June 2015) Action Log					
Action number	**Date Agreed**	**Action**	**Owner**	**Due Date**	**Revised Due Date**
6.1.13	17September14	**Issues Log (glaucoma, timely follow-up appointments):** **New action added to original item. New action:** Await data from CMFT on the number of Stockport glaucoma patients affected by a delay in follow-up appointments	GMi	18Mar15	15July15
4.1 a)	20May15	**SFT Hot Spots Report:** i. SW to present the Trust's re-audit of insulin incidents at the October meeting ii. Submit a report to the committee following a RCA on cancelled operations	SW SW	21Oct15 21Oct15	
5.2	20May15	**Mental Health:** i. Advise the CCG Comms team to alert GPs on the change to the PPS	VOS	19Aug15	
6.1 c)	20May15	**Safeguarding Exception Report:** CB to take this concern re: Cale Green to the Locality Chair **Discussed but not resolved**	CB	17June15	15July15
6.2	20May15	**SFT 6 month review of serious incidents:** SW to bring a report on completed actions to the Committee in October	SW	21Oct15	
4.2	17June15	**Service Focus – Maternity Services:** i. SW to complete updated maternity performance review and report to next Q&PM meeting ii. AN to include Maternity findings on next agenda under matters arising. **Completed** iii. SG to contact Judith Morris and share safeguarding review of maternity services and provide a summary of discussions held at Q&PM. SG to provide feedback to MC on the outcome of the meeting with JM. **Completed.** iv. MC to email committee before the next meeting to	SW AN SG MC	15July15 15July15 15July15 15July15	

		provide an update. **Completed.** v. MC to alert RG/CB/GM on the discussions regarding maternity services at Q&PM. **Completed.** vi. GMi to add issue of safeguarding assurance in Maternity at SFT to the Issues Log as Amber. **Completed.**	MC GMi	15July15 15July15	
6.1	17June15	**Mental Health – key issues;** GE to ask the CCG Comms Team to re-circulate the GP Health Check resource pack to all practices	GE	15July15	
6.2	17June15	**Mental Health – Update on Pennine Care CIP:** MC to contact Keith Walker (Director of Operations) to reiterate the committee's support from a commissioning perspective, to the initial proposal as contained in Model 1 – the committee were assured that this is the best model for patients. The committee would like this comment to be passed on to Pennine Board.	MC	15July15	

Quality Provider Management Issues Log

Issue	Date added	Description	Action	Owner	Expected date of removal	Progress	Last Updated	Status (Open/Closed/ Overdue)	Context (papers)
1	17/06/2015	There is an issue regarding safeguarding assurance in Maternity at SFT.	SG shared safeguarding review of maternity services with Judith Morris	SG			Jun-15	Open	H:\Misc\Mark C\ QPM\Q&PM 2015-16\17June15\PDF\
2	20/05/2015	There is an issue with St Ann's Hospice non-compliance with Safeguarding standards which may put patient safety at risk.	Escalated to NHS England. Action Plan received from St Ann's.	SG	Sep-15		Jun-15	Open	St Ann's Action Plan.
3	15/04/2015	There is an issue with patients waiting beyond 62 days for cancer treatment. This exceeds the national standard.	The Stockport Cancer Board are monitoring progress for those cancers where patients are on multi-provider pathways.	MC	Aug-15 (if Q1 target achieved)	**A paper was presented to the Q&PM April meeting (embedded). The cancer lead provided assurance that no harm had come to any patients who had waited >62 days. Paper outlines plan for remedial action to achieve the target in Q2, See SFT Integrated Performance report.**	Jun-15	Open	G:\Committees\ 2015 16\Q&PM\ 15April15\Item 4.1
4	18/02/2015	There is an issue with timely follow-up of glaucoma patients at CMFT.	Data requested.	SP/GMi	Jul-15	**SP/GMi to give a verbal update**	Jun-15	Open	
5	19/11/2015	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.	An internal service review undertaken by the SFT Community Services AD.	CB	Sep-15	**SFT on track to meet trajectory to acceptable levels of staffing . On SFT Risk Register. Recommend changing to Amber .**	Jun-15	Open	Trajectory & SFT Risk rating G:\Committees\ 2015 16\Q&PM\ 17June15\Agenda
6	15/10/2014	There is an issue that 76% of Stockport patients with a LD have not had an annual health check. This may result in an unmet health need in these patients.	Recommendation to commission a service to enable all LD patients to access an annual health check in Stockport.	GE	Sep-15	**GE to advise on how progress against SAF & Health Checks is monitored.**	Jun-15	Open	
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.	This has been tracked through contract meetings with SFT.	CB	Aug-15 (if Q1 target achieved)	**Escalated concerns to SFT Director of Performance in May. Discussions taking place to mitigate the risks until performance improves.**	Jun-15	Open	

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.	CCG raised at contract meetings and through correspondence. Requested information on **1.** Quality Impact Assessments and process. **2.** Individual schemes / projects. **3.** A joint process to agree and understand impact of projects.	MC	Sep-15	**SFT still not provided QIA for CIP programmes for CCG to view. MC to add to Heads of Terms in the contract.**	Jun-15	**Open**	\\SPT-VFILER-01.pct.xstockport.nhs.uk\CCG$\
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.	CCG has written to SFT with a contract query to establish the position in terms of numbers and assessed risk. A response has been received and was considered at the September meeting.	MC	Aug-15 (if Q1 target achieved)	**See SFT Integrated Performance Report.**	Jun-15	**Open**	G:\Committees\2015 16\Q&PM\17June15\Agenda
10	01/06/2016	There is an issue with SFT's compliance to Safeguarding standards in Maternity. This may put vulnerable patients at a higher risk of harm. This was highlighted in a CQC safeguarding children's review .	CCG reviewed SFT's Action Plan and will monitor to completion.	SG		**See Action Plan, attached.**			G:\Committees\2015 16\Q&PM\17June15\Agenda

Actions removed following last meeting									
	18/03/2015	SFT report - 70 wte nursing vacancies across medicine & surgical business groups.		GMi	May-15	**Safe staffing levels are reported to be maintained. Concern over resilience and impact on staff morale - note staff survey. Has been on issues log previously - removed in October 2014.**	Will be tacked through Safe Staffing & Papers to SFT Board	**Closed MAY 15**	
	20/11/2013	There is an issue with patients receiving timely follow-ups in ophthalmology.	CCG has written to SFT with a contract query to establish the position in terms of numbers and assessed risk. A response has been received and considered at the September meeting.	MC	May-15	**See SFT Integrated Performance Report.**	SP advised Q&PM of confidence in SFT Opthalmology management to monitor follow-ups.	**Closed MAY 15**	SFT Performance Report

	18/09/2013	There is an issue with the current under performance of the high risk TIA pathway which is resulting in some patients not been seen in the 24 hour target window (60% target). This could increase a patients risk of subsequent stroke if clinic appointments are delayed over 7 days and may result in a poor patient experience.	Formal escalation from CCG Clinical Director of PM to SFT Director of Nursing.	CB	May-15	**Contract query 3 December. Action Plan received. Clinical audit completed - audit reviewed by March committee and agreed assurance that patients delayed on the TIA pathway are not at greater risk of a stroke. SFT hyper acute stroke centre from 1 April - will improve access at weekends. Performance should continue to be monitored.**	Track as a performance issue - no known quality risk.	**Closed MAY 15**	SFT Performance Report
	18/09/2013	There is an issue with the timely appointments for IAPT Counselling which may result in a compromise to patient safety, outcomes and experience.	**1.** An improvement action plan will be implemented. **2.** The CCG will commission additional capacity during 14/15.	GE	May-15	**Ongoing improvement in the counselling waiting list has been achieved. The service provider monitors waiting list on a regular basis and offers people alternative psychological treatements.**	GE advised this is not a significant issue in the wider context of mental health provision.	**Closed MAY 15**	\\SPT-VFILER-01.pct.xstockport.nhs.uk\CCG$\
	18/09/2013	There is an issue with the timely referrals within Speech and Language therapy for School Aged children which may put some children at risk of delayed development.	An improvement action plan, supported by non-recurrent funding has been implemented by SFT.	MC	May-15	**An options paper for a joint commissioning approach with schools/SMBC was presented to Q&PM in February & March. Proposal agreed and agreed to monitor through implementation.**	AC to progress and escalate any concerns to Q&PM	**Closed MAY 15**	\\SPT-VFILER-01.pct.xstockport.nhs.uk\CCG$\

NHS Stockport Clinical Commissioning Group

Chief Operating Officer's update

Chief Operating Officer's update to the July 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.

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?
This report provides an update on a number of issues.
Please detail the key points of this report
Provides an update on: 1. Resourcing of Stockport Together (to follow) 2. Q4 Assurance Meeting 3. Winter Pressures & Lessons Learnt 4. 2015/16 Planning and Delivery Challenges
What are the likely impacts and/or implications?
The CCG has committed £600k to support the Stockport Together which is a recognised unfunded pressure in 2015/16. However, it is essential that this work is taken forward to ensure we develop a clinically and financially sustainable system.
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: 8th July 2015
Agenda item: 8

Chief Operating Officer Update

1.0 Purpose

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

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2.0 Resourcing of Stockport Together

Information to follow

3. Quarter 4 Assurance Meeting

CCG representatives met with NHS England (Greater Manchester and Lancashire) senior team in June for the Q4 Assurance meeting. Governing Body members will be aware that the CCG is at the highest level of performance assurance due to the challenges facing the economy in terms of financial and service sustainability. The delivery of many of the NHS Constitution targets in 2014/15 was noted, alongside the recent improvements in the ED waiting time performance. The CCG was congratulated on its 2015/16 Operational Plan, which has been identified as an exemplar. However, due to the financial challenges and fact that the CCG is unable to plan for a 1% surplus in 2015/16 our plan has been catagorised as limited assurance.

4.0 Winter Pressures & Lessons Learnt

4.1 A key function of the System Resilience Group (SRG) is evaluation of piloted schemes and ensuring that lessons learned are communicated and embedded.

4.2 During the first quarter of 2015/16 the SRG has undertaken two workshops to review Winter 2014/15. The headline outcomes from these workshops are:-

- The SRG considered £2.4m of the 14/15 winter schemes and recommended that £930K of these schemes should continue with the remainder either non-recurrent or requiring significant re-design. The main areas that were approved for continuation were:-
    - Additional bed management capacity.
    - Extended hours access to short stay assessment.
    - Pharmacy support to wards.
    - Extended capacity within Saffron Ward.
    - Economy wide communications campaign.
    - NWAS liaison into SFT.
    - Extended hours for GP navigation scheme (Pathfinder).

  The full year effect of these schemes is funded from PbR for SFT and from the SRG allocation for non-acute schemes.

- Key messages on process and escalation were:-

- o Earlier recruitment to vacancies to minimise high cost bank and agency.
- o Earlier and better communication of alternate capacity and pathways.
- o Earlier planning events and for these to be focussed on real scenarios with agreed positions on e.g. switching assessment capacity to longer lengths of stay.
- o An absence of senior clinicians results in increased admissions.
- o To differentiate actions between a situation of increased demand (attendances) and one of increased length of stay.
- o To improve planning and investment decisions at system level as opposed to within individual organisations.
- o To focus on increasing communication at times of pressure.

4.3 The SRG is now planning for winter 2015/16 and is including actions that address the learning from winter 14/15.

5.0 2015/16 Planning and Delivery Challenges

5.1 Attached is a letter for Governing Body members' information.

6.0 Action requested of the Governing Body

1.To note items 3 – 5.

17 June 2015

NHS England (North)
6NE
Quarry House
Quarry Hill
Leeds
LS2 7UE
PA Email: kathryn.shanks@nhs.net
Telephone: 0113 825 3011

Via Email:
To North CCG Chairs and Accountable Officers

Dear Colleague

2015/16 Planning and Delivery Challenges

As we complete the planning round for 2015/16, I wanted to take an opportunity to write to you to:

- Thank you for your work over last few months, which have been some of the most challenging that most of us will ever have experienced, both because of the demand over the 14/15 Winter and the delivery challenges we faced as a result.
- Apologise for the challenges of the planning round and explain the reasons behind them.
- Share with you some information that we have been gathering about CCGs across the North and make an offer to let you have this, at the level of your CCG, if you would be interested.

To take each of these issues in turn:

Firstly, last year was one of the most difficult that the NHS has ever faced, culminating in a winter during which we made the headlines repeatedly, but for all the wrong reasons. For the first time ever the North failed the A&E target, meaning that thousands of our patients didn't get the right standard of care. I know that you will have experienced a great deal of pressure as you sought to improve services and help reduce demand on primary and acute services in a time of significant financial restraint. I wanted to thank you for your leadership and recognise the difficulty of the task, which, as we know continues.

Secondly, I know that aspects of the current planning round have been frustrating, and that our current focus on commissioning sufficient capacity will have led many to think that we have back tracked on the work we did to put in place BCF plans, and to target significant reductions in non-elective activity. I want to assure you that our BCF ambitions, and more importantly our plans to integrate services, wrapped around the patient, remain undiminished. I will be delighted if the ambitions we set out in our BCF plans can be achieved and if we can start to turn the tide of demand and non-elective growth. We need to do this to improve health and well-being and to help us close the financial gap facing the NHS set out in the 5 Year Forward View (5YFV). As we know the 5YFV

requires action on three fronts: prevention, efficiency, through new care models, and funding, to which we now have a political commitment.

However, we know that this will take time and continued effort. The experiences of last winter would advise caution in relying too much on our plans to reduce secondary care activity, without also planning for a less optimistic scenario in the very short term. We will need to ensure that we have made every effort to ensure that our plans give providers the best possible chance to deliver the care that we want for our patients this year, including the delivery of constitutional standards. The need for credible planning effectively resulted in the approach to the operational plans which we have now finalised. So whilst I can apologise for the frustration, I can also assure you that I think it is the right approach to have taken. Our focus now moves to management of in year performance and preparation for next winter.

Thirdly, I wanted to share with you some work we have been doing to analyse both our performance and the challenges ahead. So attached you will find a very short analysis which covers some key aspects of: provider delivery last year, the planning round (this year and last) and the challenges we face to improve outcomes, particularly in comparison with other parts of the country.

I hope that you find this helpful and please do let me know if you would like this, or similar information tailored for your own CCG. Please do also let me know if there are other analyses you would be interested to see.

I, together with my Directors of Commissioning Operations (Moira Dumma, Clare Duggan, Tim Rideout and Graham Urwin) would be interested in hearing your ideas on the ways in which we can learn from the experience over winter. I know many of you will already have attended events locally to do just this. If you have any feedback or thoughts about ways to share and spread good practice in building year round service resilience, please do let me know. I am committed to working closely with CCGs in the North, both as co-commissioners, but also in our assurance and support role, so it would also be useful to have your views about the ways in which we work together better going forward.

I look forward to working with you over the coming year, especially to improve services in our priority areas of cancer, mental health, learning disabilities and diabetes. I also hope to be able to see as many of you as possible, including through visits to local services. I'd be happy to attend local events if you would find that helpful to help make sure that NHS England plays its full part in improving services for our patients.

Yours sincerely

Richard Barker
Regional Director (North)

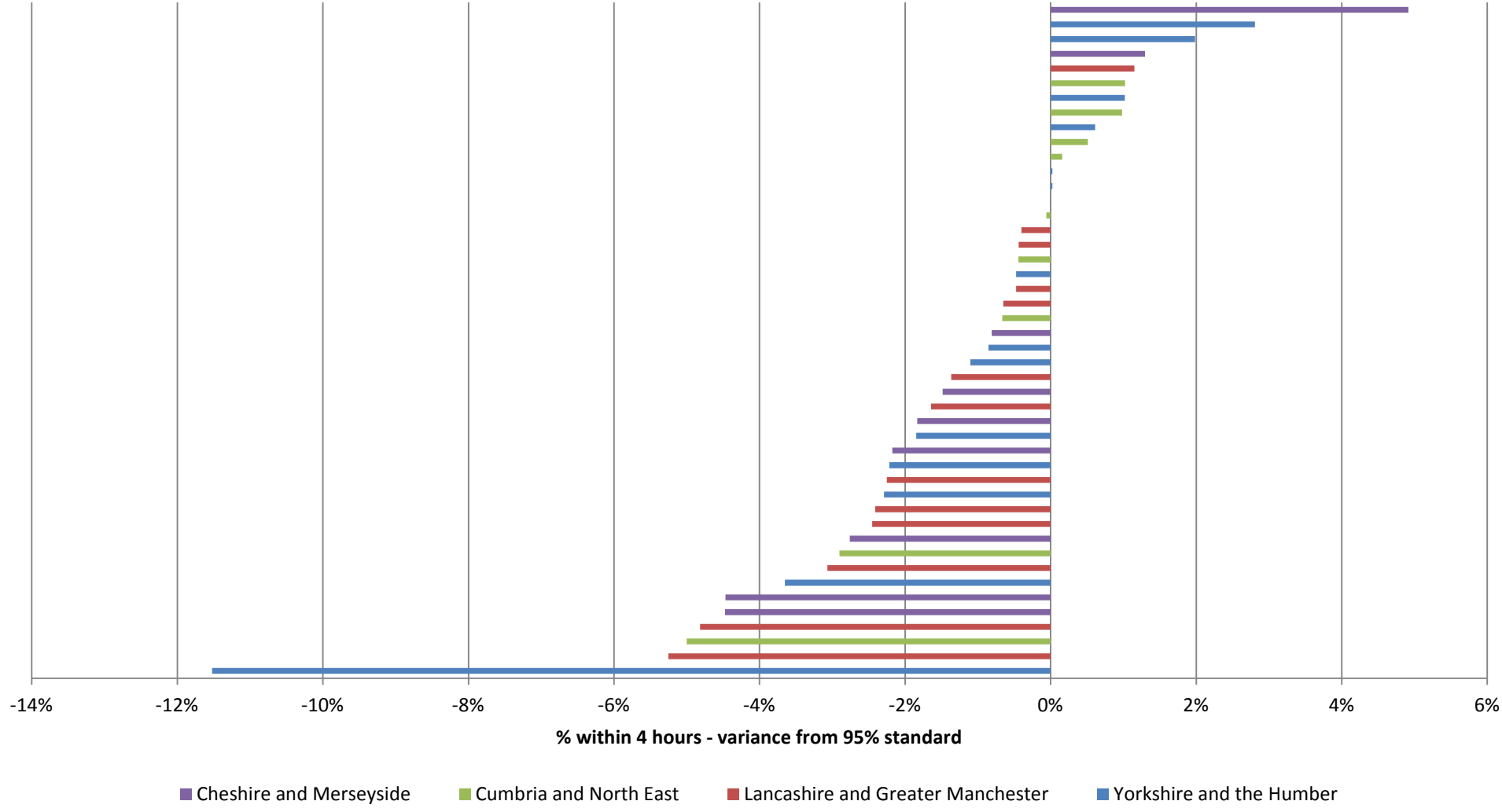
cc: Regional Management Team, NHS England (North)

At a glance

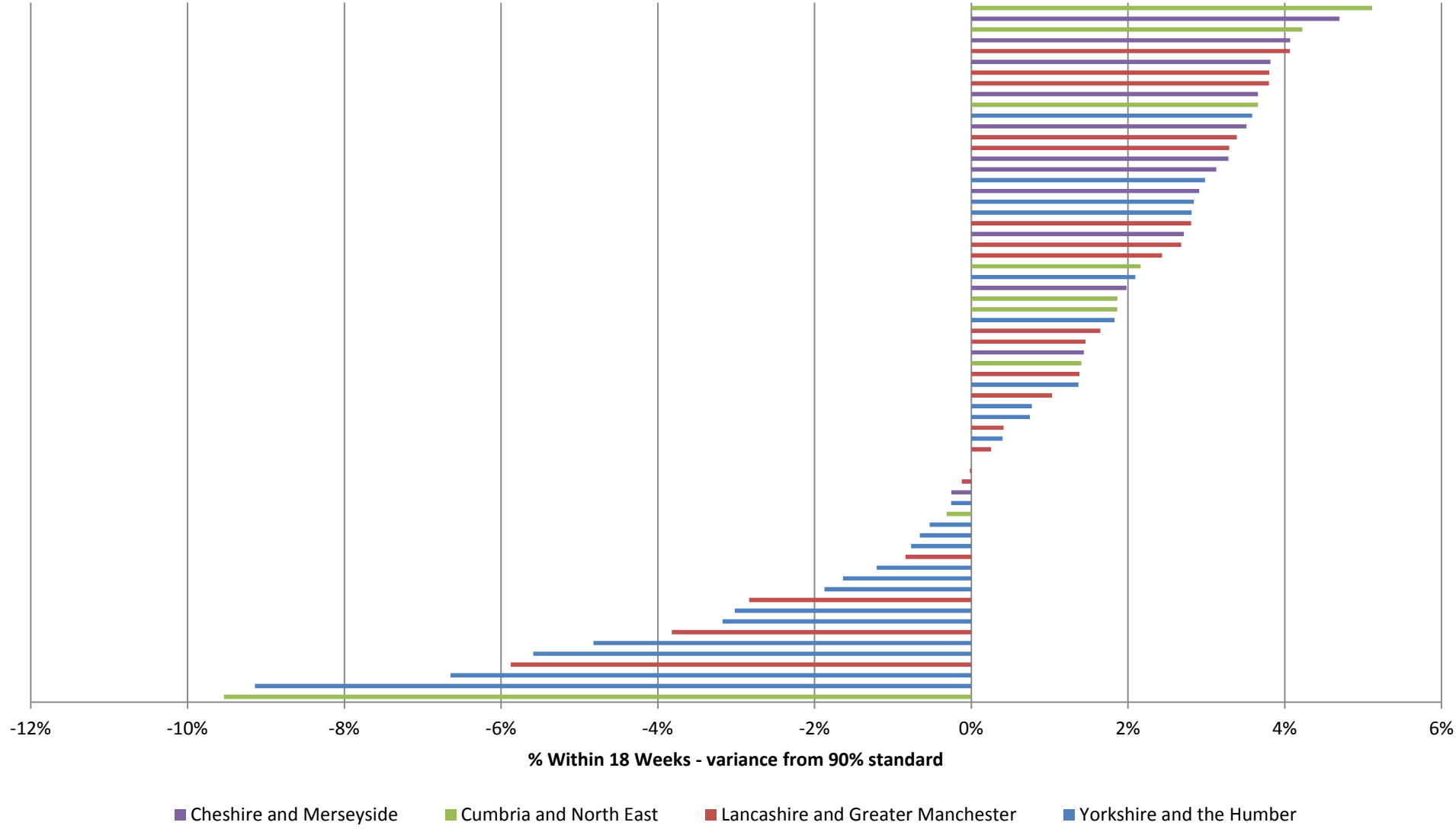
NHS England

Variation across the **North** Region

A&E Performance (All Types) - 2014-15
North Trusts March 15

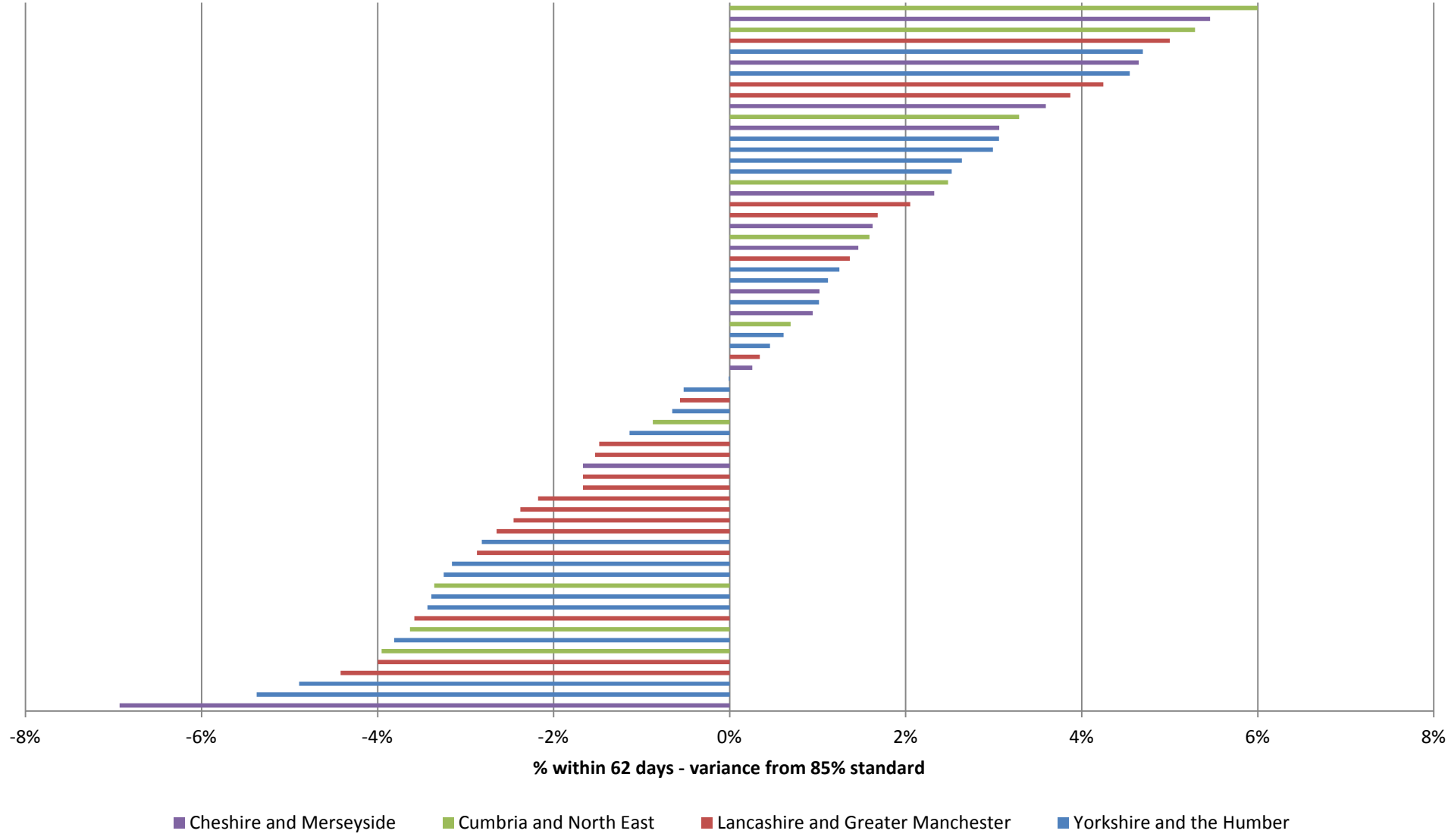


RTT Admitted Performance - 2014-15
North Trusts March 15

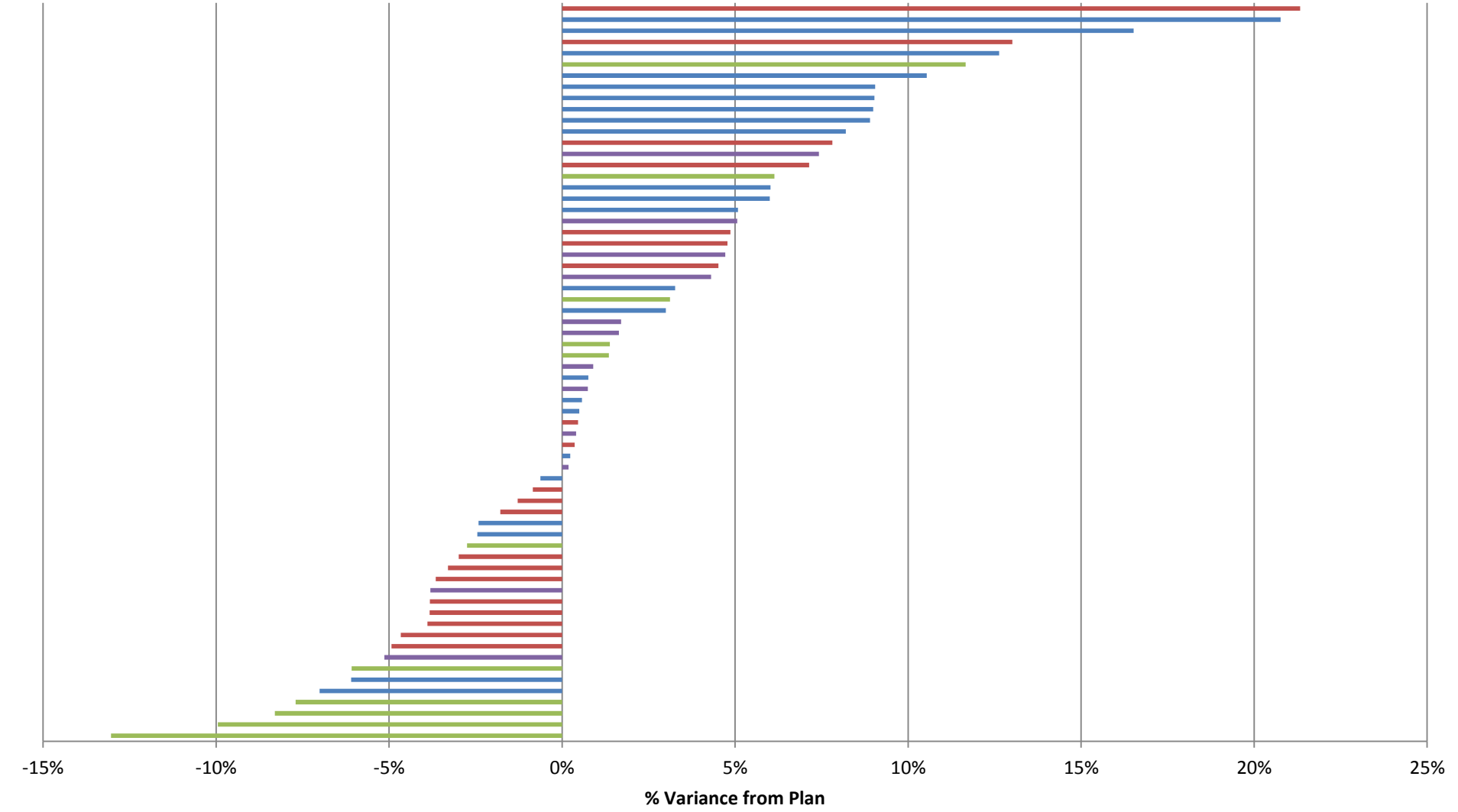


62 Day Cancer Urgent Referral - 2014-15
North Trusts March 15

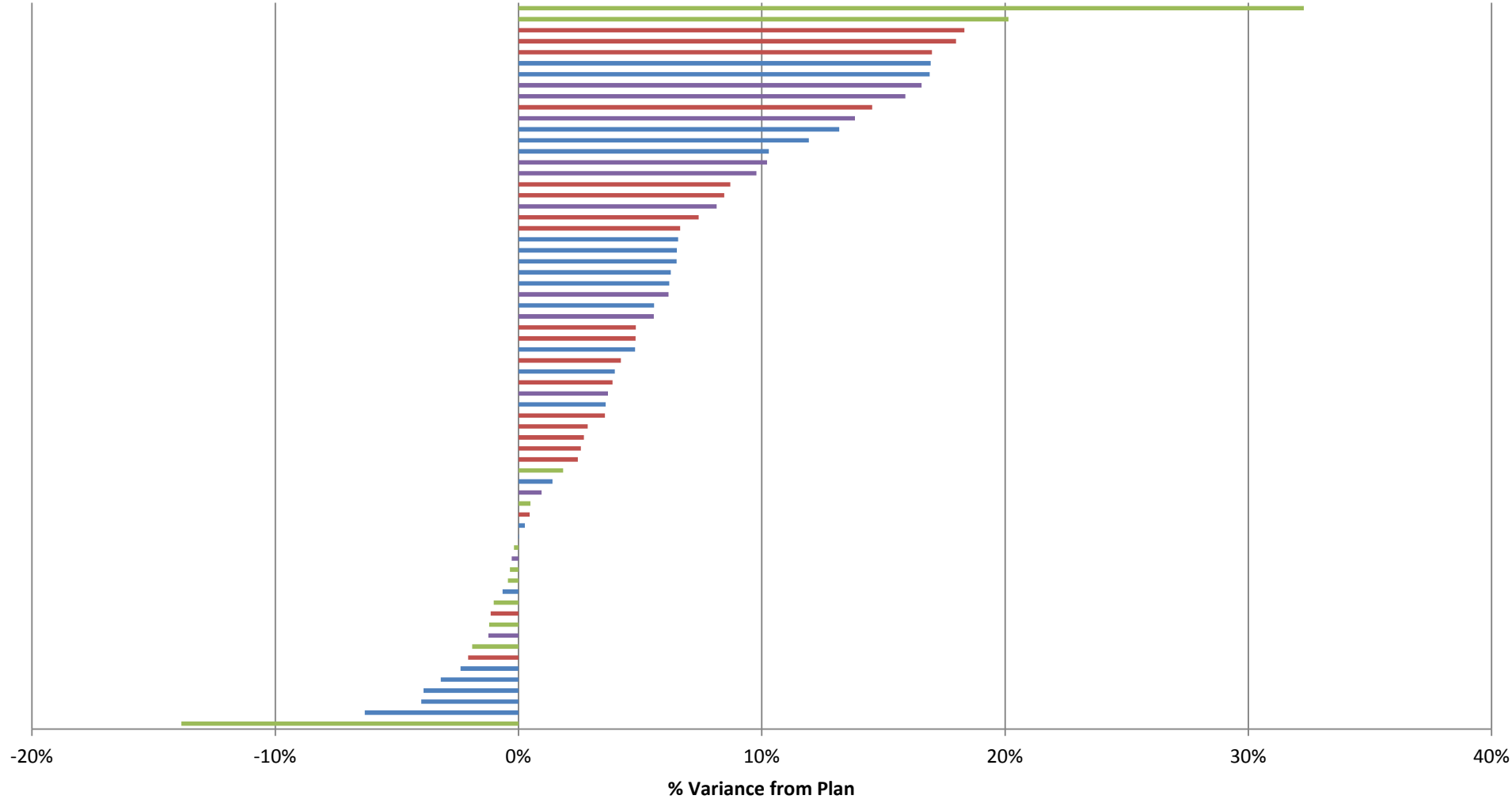
NHS England



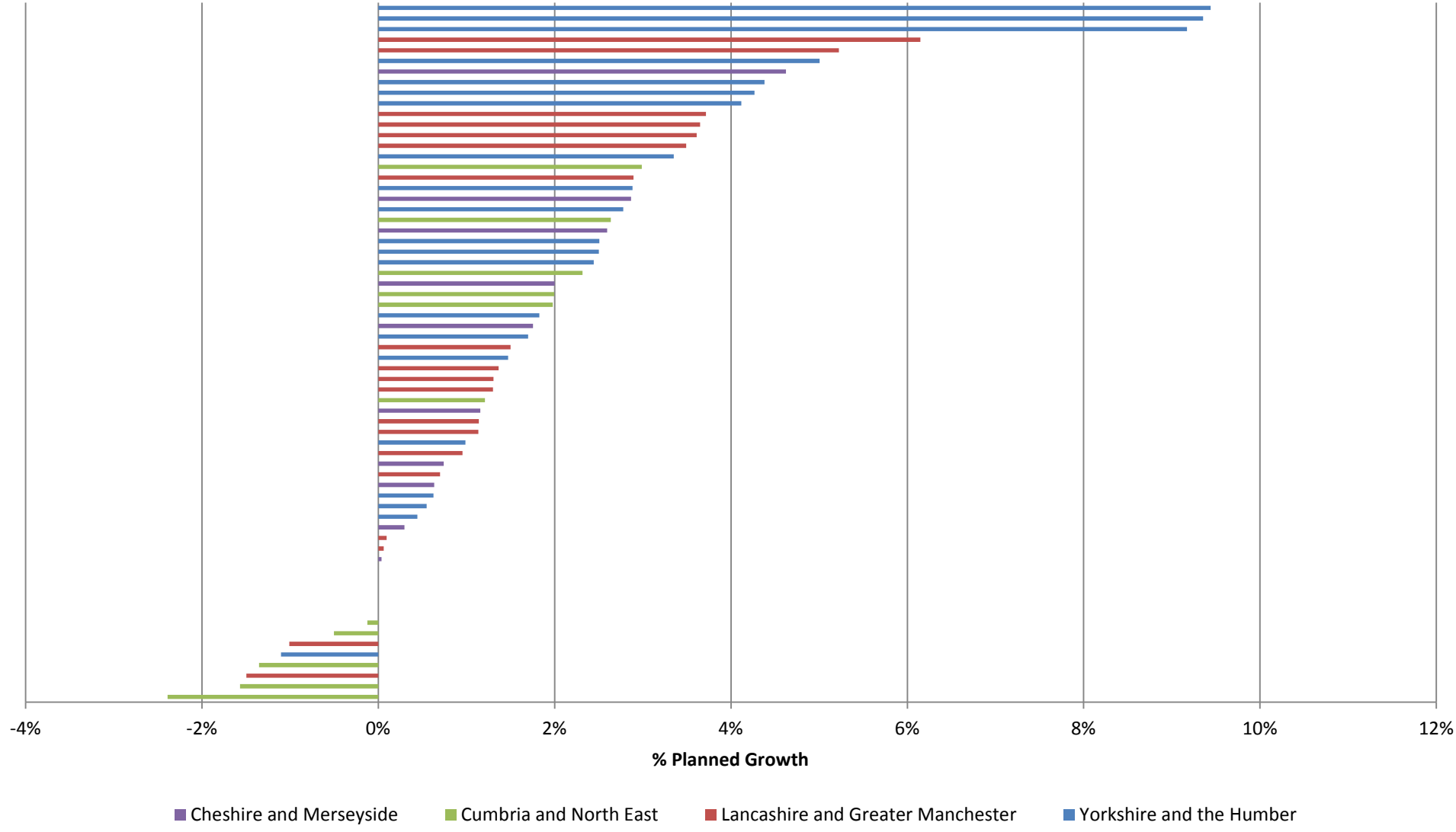
14-15 Actual v Plan - Elective (FFCE G&A)
North CCGs



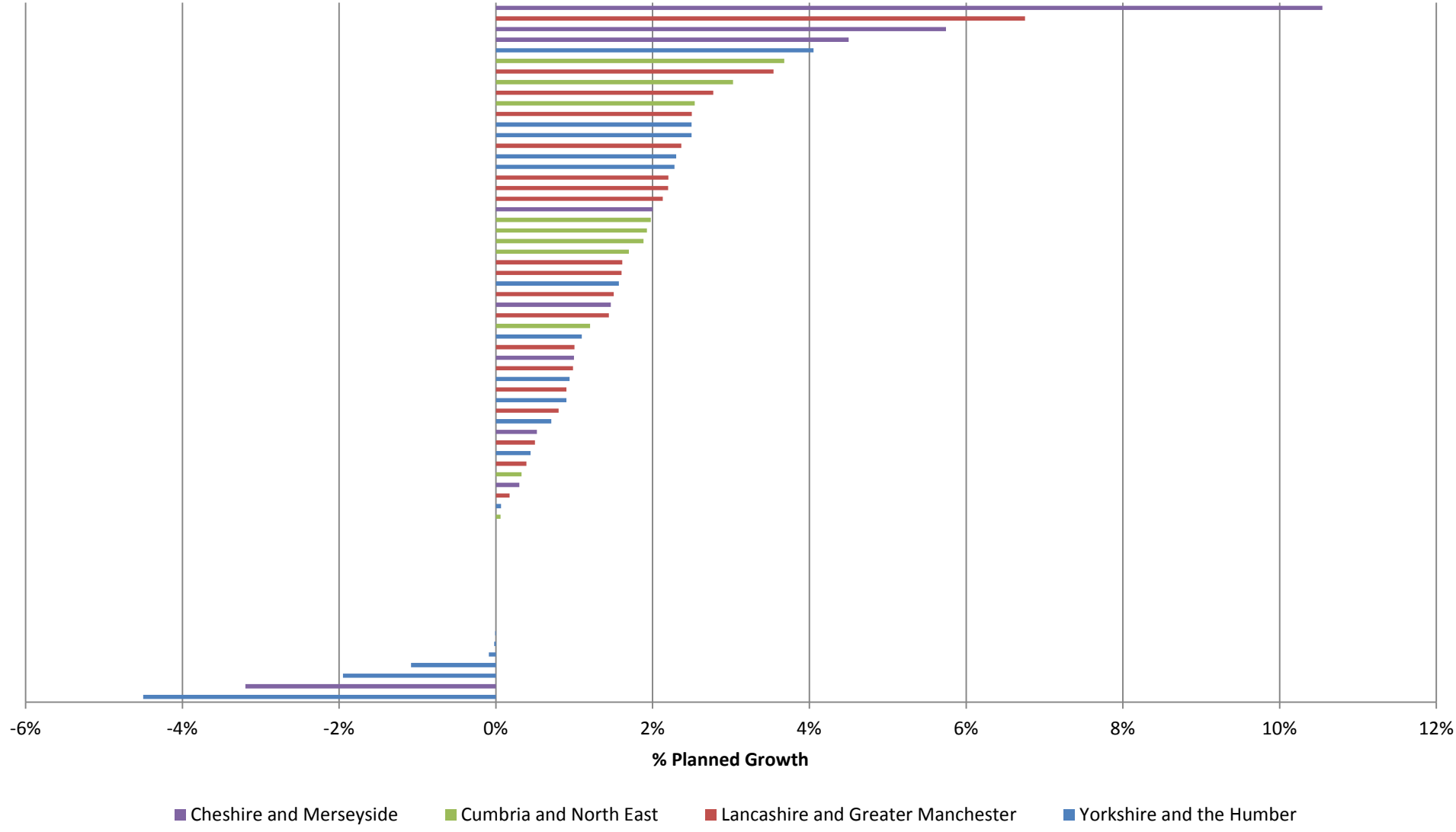
14-15 Actual v Plan - Non-Elective (FFCE G&A)
North CCGs



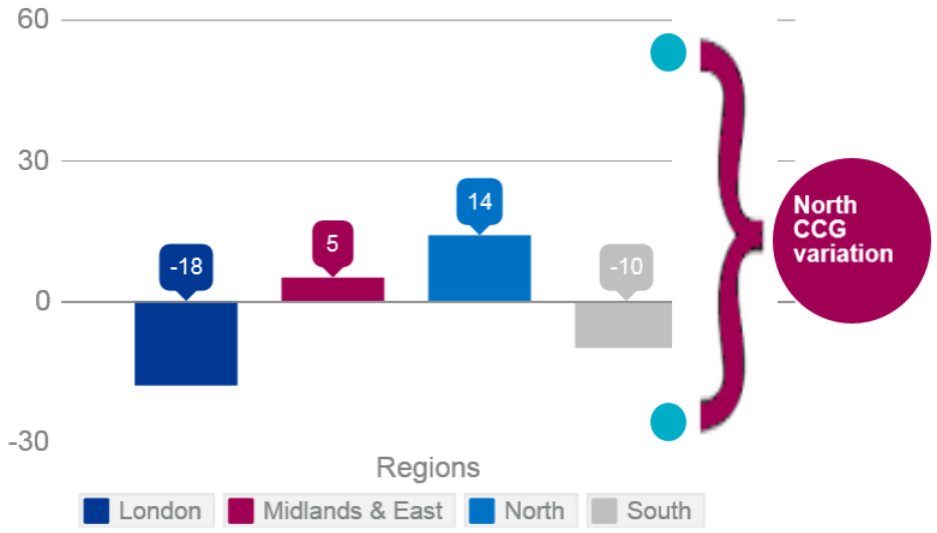
2014-15 FOT v 2015-16 Plan - Elective (Spell G&A)
North CCGs



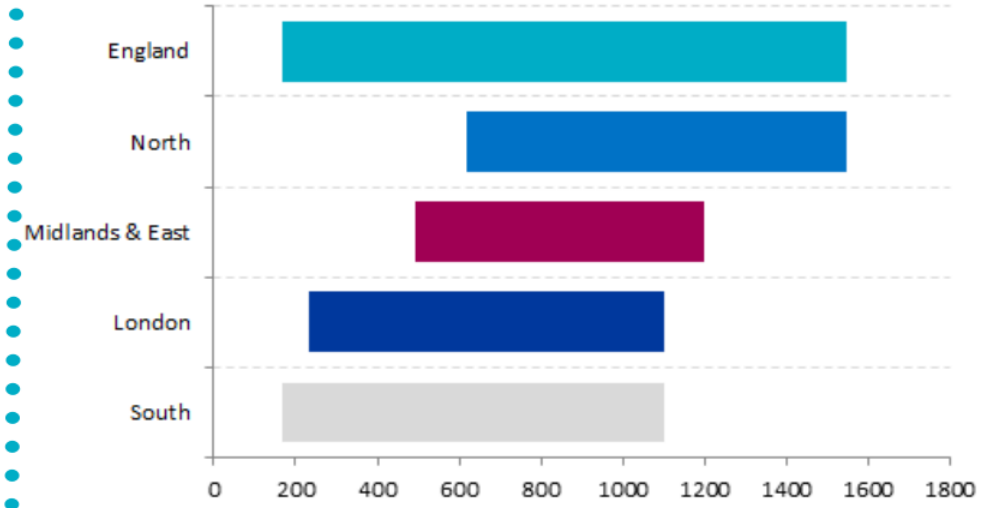
2014-15 FOT v 2015-16 Plan - Non-Elective (Spell G&A)
North CCGs



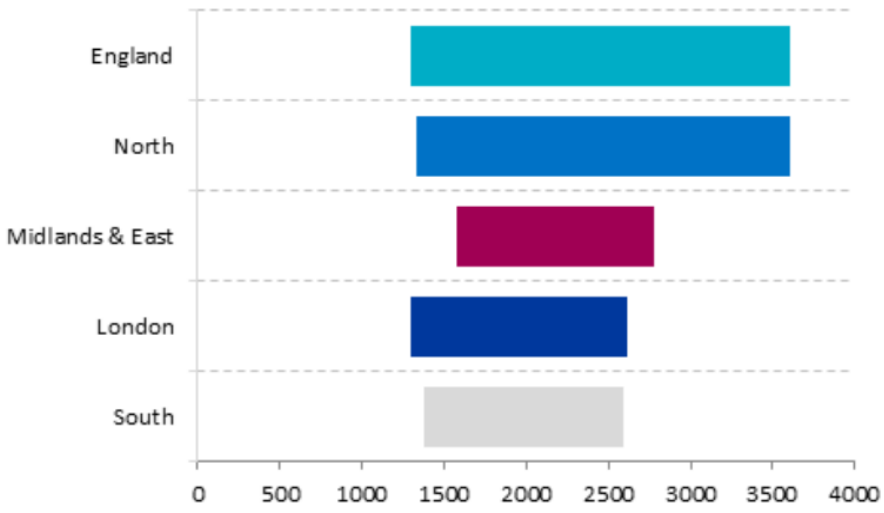
Obesity prevalence: For every hundred people who are obese in England, 2013/14



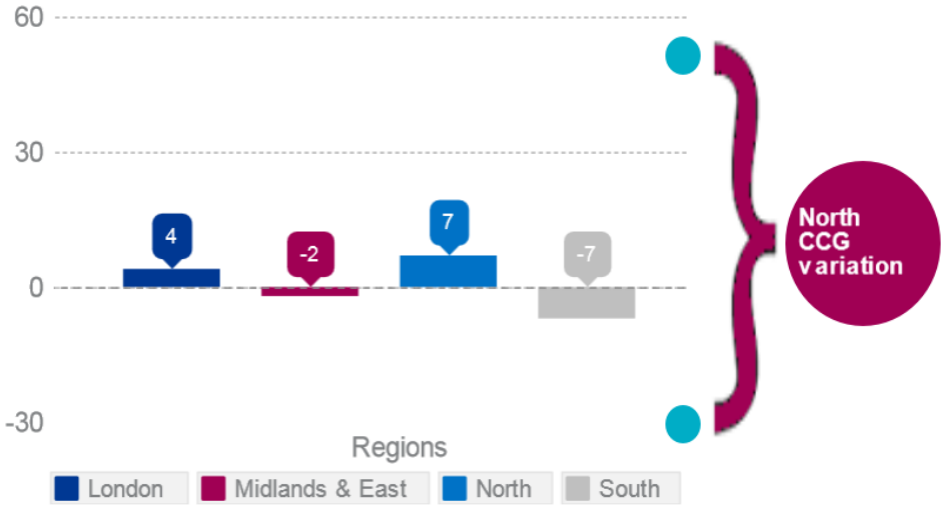
Spread of unplanned hospitalisation for chronic Ambulatory Care Sensitive Conditions per 100,000 population across all CCGs, 2013/14



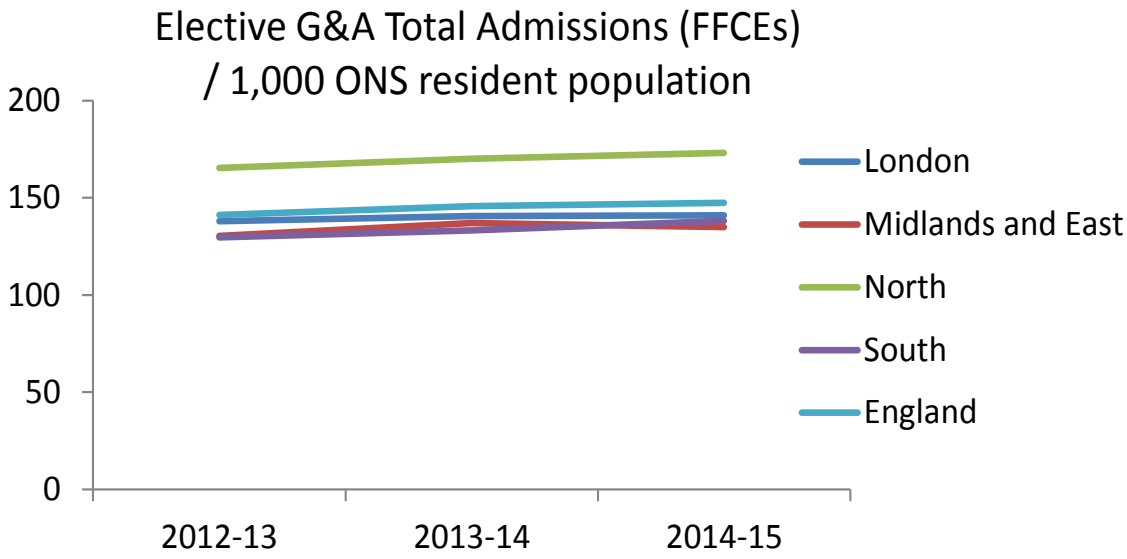
Spread of Potential Years of Life Lost (PYLL) per 100,000 population across all CCGs, 2013

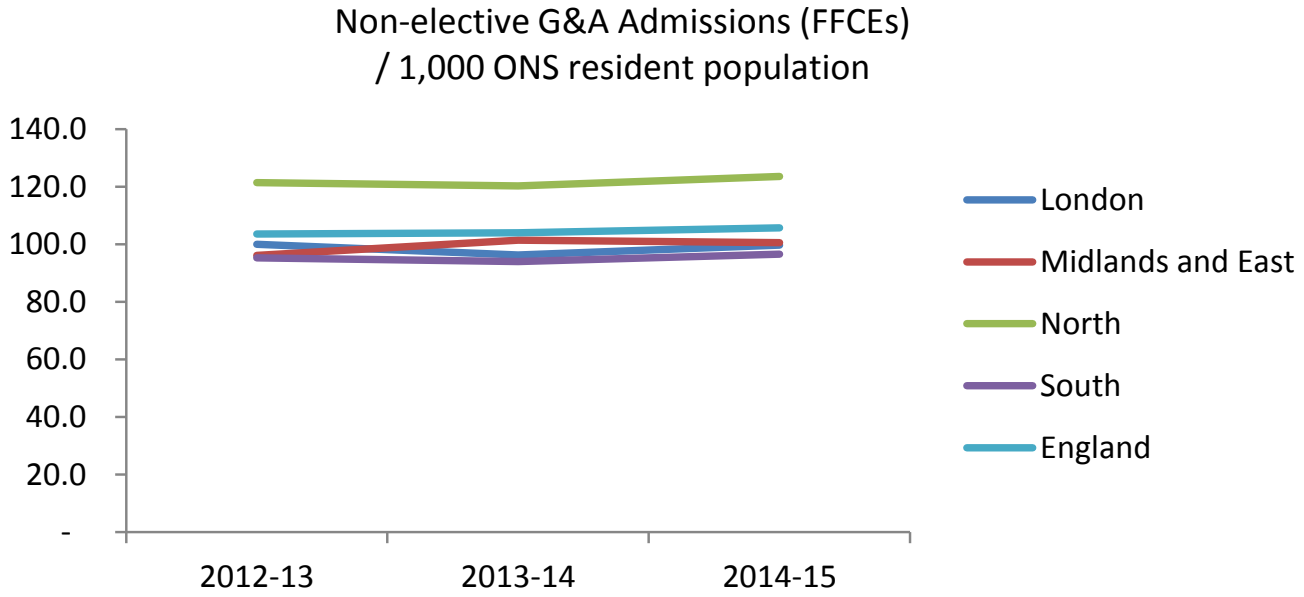


Smoking prevalence: For every hundred people who smoke in England, 2013/14



Higher hospitalisation rates





NHS England

AGMA ASSOCIATION OF GREATER MANCHESTER AUTHORITIES

NHS Greater Manchester Association of Clinical Commissioning Groups

Greater Manchester Health and Social Care Devolution
Standing Conference Executive
Thursday 4th June

Title	Establishing Leadership, Governance and Accountability Governance Update
Author	Liz Treacy
Version	v0.2
Target Audience	Standing Conference Executive
Date Created	01/06/2015
Date of Issue	03/06/2015
Document Status	Final
Outcome required (note / approve)	Note and approve (see Executive summary)

Document History:

Date	Version	Author	Notes
01/06/2015	0.2	Tim Griffiths	

Executive summary	This paper provides an overview of the bodies and governance arrangements that are set out in the Greater Manchester Health and Social Care Devolution Memorandum of Understanding ('MoU'). The paper asks the Standing Conference Executive to: ▪ Agree that work should progress to establish the proposed governance structure set out within this report. ▪ Agree, in conjunction with the proposed Terms of Reference, the role that the Standing Conference Executive will have in shaping and defining the governance structure, and the relevant roles and responsibilities set out within it. ▪ Agree the next steps, as set out at section 12 of the report.

1. Introduction

1.1 This paper provides an overview of the bodies and governance arrangements that are set out in the Greater Manchester Health and Social Care Devolution Memorandum of Understanding ('MoU'). It considers their membership and role (including shadow arrangements).

2. Recommendations

2.1 It is recommended that the Standing Conference Executive:

- Agree that work should progress to establish the proposed governance structure set out within this report.
- Agree, in conjunction with the proposed Terms of Reference, the role that the Standing Conference Executive will have in shaping and defining the governance structure, and the relevant roles and responsibilities set out within it.
- Agree the next steps, as set out at section 12 of the report.

3. Proposed governance

3.1 The MoU creates a framework for achieving the delegation and devolution of health and social care responsibilities to accountable organisations in Greater Manchester (GM).

3.2 The MOU set out the four bodies that will need to created to provide governance and accountability for the programme:

- GM Programme Board ('Programme Board') to deliver the devolution programme and oversee its development through agreed workstreams and milestones (supported by the Transition Team, Programme Office and 4 principle workstream groups)
- GM Health & Social Care Partnership Board ('Partnership Board') to oversee the strategic development of the GM health and care economy and steer the development of the GM Strategic Sustainability Plan
- GM Joint Commissioning Board ('Commissioning Board') to commission GM-wide services in accordance with strategic intent and the Strategic Sustainability Plan
- GM Provider Forum ('Provider Forum') to engage with the Partnership Board, and provide a forum for system wide engagement from April 2016.

3.3 In order to support the development of the Partnership Board, Commissioning Board, and Provider Forum; a Standing Conference and associated Executive have been developed to operate in 2015-16. The Standing Conference and Executive will carry out the functions of the Partnership Board until the Board is established in shadow or final form.

4. The Programme Board

4.1 The Programme Board has the following key roles during 2015-2016:

- To provide strategic oversight and direction to the health devolution programme
- To support the development of the Partnership and Joint Commissioning Boards
- To provide regular updates to the (shadow) Partnership Board and Standing Conference and its executive on progress made with respect to devolution

4.2 The Programme Board and its function are time limited, as such it will have no role post April 2016.

5. The Partnership Board

5.1 The Partnership Board is likely to have the following roles for 2015/2016:

- To set GM Health and Social Care strategic priorities, particularly in the context of the NHS five year plan.
- To ensure that there remains significant organisational commitment to support the devolution agenda
- To steer and support the development of the GM Strategic Plan and related investment funding proposals, ensuring that the locality plans are aligned to the same.
- To agree the GM Strategic Plan
- In shadow form, to, provide the necessary support and guidance to the Programme Board
- To work towards the establishment of a permanent Board structure from April 2016 (which may include statutory status).
- To receive regular reports from the Programme Board on implementation of devolution

5.2 From April 2016 the role will be to:

- Set the strategic priorities for health and social care in Greater Manchester
- Drive and facilitate the implementation of GM those priorities, particularly in the context of the NHS five year forward view and the GM Strategic Sustainability Plan.
- Provide system-wide management to ensure the strategic priorities are achieved
- Support locality health and social care plans to be strategically aligned and determine any allocations required of the available investment funds
- Work with local areas to ensure strategic coherence and consistency across Greater Manchester.

6. Standing Conference

6.1 A Standing Conference was convened in April 2015 engaging all parties to the MoU. It has agreed that the full Standing Conference will meet several times a year pending the establishment of the more permanent governance arrangements that will be in place from April 2016 (and in shadow form from October 2015)

6.2 The Standing Conference will provide the following key functions:

- To agree the governance structure that will be in place from April 2016 (and in shadow form from November 2015)
- To agree the composition and function of the Partnership Board
- To agree the composition and function of the Joint Commissioning Board
- To ensure there is effective engagement of all parties (in particular patients)
- To agree the proposed 'Early Implementation Priorities'
- To agree the strategic direction for the next 3/6 months

7. Executive (representative of the Standing Conference)

7.1 In considering the role that the Standing Conference has in defining and agreeing the practical operation and composition of the Partnership Board, it has been agreed that a smaller 'Executive' be established (representative of each sector represented in the standing conference). The Executive will meet more frequently than the wider Standing Conference, and will be representative of it.

7.2 Whilst the precise function and decision making capability of the Executive has yet to be agreed, the Executive will have the following overarching responsibilities:

- To take forward specific proposals and recommendations with regard to the future governance arrangements to the Standing Conference.
- To define the function and composition of both the Partnership Board, and Joint Commissioning Board making recommendation to the Standing Conference as required.
- To provide the day to day system wide support and guidance to the Transition Team to ensure that devolution workstreams progress in line with the programme plan
- To act as the appropriate vehicle to identify and rectify any challenges that present themselves with the wider system

7.3 The Standing Conference may also wish to preserve particular strategic decisions to itself and/or agree that certain decisions can be taken by an Executive on its behalf.

7.4 It has been agreed by the parties that the 'Executive' will consist of three representatives of each of the 10 GM local authorities, the 12 GM CCGs and the 10 GM Providers.

7.5 The Standing Conference and its Executive are both time limited, and will likely not have a function from April 2016

8. Joint Commissioning Board

8.1 The Commissioning Board will have the following key roles during 2015/2016.

- To have regard to the GM Strategic Sustainability Plan.
- To be engaged in all decisions affecting GM health and social care whilst in shadow form.
- To move to a formal board prior to April 2016 operating under an agreed "s.75 agreement."
- To agree an approved form of governance and mechanism for the holding and dissemination of funds.
- Share information on financial plans, budget proposals and current performance across health and social care in GM.

8.2 From April 2016 the role will be to:

- Have regard to recommendations from the Partnership Board on GM spend.
- Make commissioning decisions (or agree recommended decisions) on behalf of those bodies who have delegated commissioning functions to the Board
- Engage all commissioners in discussions on GM wide spend.

8.3 As part of the Governance workstream, the potential function and composition including roles and responsibilities of the board is now being considered. It is likely that an update will be brought to the Standing Conference Executive for consideration in due course.

9. The Provider Forum

9.1 An initial meeting of the Provider Forum has now taken place, and it will have the following key roles:

- To provide a forum to raise key issues and challenges, identifying potential options for resolution where appropriate.
- To take organisation responsibility for the implementation of relevant parts of the devolution agenda and locality plans.
- To receive regular and consistent messaging with regards to progress made on the devolution agenda.

9.2 From April 2016, the Provider Forum will become the appropriate vehicle to engage the providers of health and social care services across GM.

9.3 As part of the Governance workstream, the potential function and composition including roles and responsibilities of the Provider Forum is now being considered. It is likely that an update will be brought to the Standing Conference Executive for consideration in due course

10. Summary

10.1 Table 1, appended, summarises the following:

- The membership of each body
- The overarching role of each body as set out in the MoU
- The current role and to April 2016

- The role after April 2016

11. Delegation

11.1 NHS England, CCGs and local authorities will need to delegate relevant commissioning functions to the Joint Commissioning Board in line with the devolution agreement and Government policy of promoting joint commissioning between the NHS and local government.

11.2 The bodies delegating functions to the joint Commissioning Board will remain accountable for meeting the full range of their statutory duties.

11.3 As per the MOU: "*[Devolution] will require collaboration with national government, led by the Department of Health, to ensure that the proposed new arrangements continue to support the accountability of CCGs and NHS England for improving quality and health outcomes, delivering core operational standards, and ensuring the effective use of NHS resources. There will need to be agreement as to the precise scope and extent of the commissioning functions that can lawfully be delegated*." Where decisions cannot legally be delegated, these will continue to be taken by the relevant bodies.

11.4 Current organisational structures in acute, primary and social care have been created and are governed under different statutory regimes. There will be inevitable challenge in finding an arrangement that brings organisations together in the way they want.

11.5 Consideration will need to be given to the current health and social care landscape, the current organisations and current relationships. Governance structures and other protocols (such as information sharing arrangements) can then be built across organisational boundaries, which are both robust and flexible enough to accommodate the delivery of the aims of the Sustainability Plan.

12. Next Steps

12.1 The Leadership, Governance and Accountability sub group will now consider the following issues as part of its ongoing work programme:

- The establishment of the GM Joint Commissioning Board
- The place based agreement with Public Health England
- The Providers relationship with Monitor

12.2 A further paper will be produced for the next meeting of the Standing Conference Executive discussing the legal and accountability framework for health and social care devolution.

13. Recommendations

13.1 It is recommended that the Standing Conference Executive:

- Agree that work should progress to establish the proposed governance structure set out within this report.

- Agree, in conjunction with the proposed Terms of Reference, the role that the Standing Conference Executive will have in shaping and defining the governance, and the relevant roles and responsibilities set out within it.
- Agree the nest steps, as set out at section 12 of the report.

Table 1 - Bodies under the MOU

No.	Body	Role as per MOU	Membership	Role 2015 to March 2016	Role April 2016 +
1	Programme Board	To deliver the devolution programme and oversee the development of the programme through agreed workstreams and milestones	• Anne Barnes • Dr Hamish Stedman • Dr Nigel Guest • Graham Urwin • Ian Williamson • Jon Rouse • Liz Treacy • Michael McCourt • Paul Baumann • Simon Stevens • Sir Howard Bernstein • Steven Pleasant • Su Long • Tracy Vell	• To manage 4 principal workstreams: (i) strategic plan (clinical & financial sustainability); (ii) establishing leadership, governance & accountability; (iii) devolving responsibilities & resources; and (iv) identifying and implementing early implementation priorities. • To be supported by a Transition Team and Devolution Management Team,	• No role
2	Partnership Board	To oversee the strategic development of the GM health and care economy and steer the development of the GM Strategic Sustainability Plan	• 12 CCGs • 10 LAs • Providers* • NHS England (NHSE) • Regulators* • Healthwatch • GMCVO (* Role of regulators and	• A Standing Conference (see below) will undertake the role of the Partnership Board for this period or until the Partnership Board is established in shadow form. • The Partnership Board will not have a role until April 2016 or until otherwise established in shadow or full form...	• Set GM strategies and priorities. • Drive and facilitate the implementation of GM strategic priorities in the context of the NHS five year forward view and the GM Strategic Sustainability Plan. • Provide system-wide management to ensure the

No.	Body	Role as per MOU	Membership	Role 2015 to March 2016	Role April 2016 +
			non NHS providers to be considered and whether they should be members of the Partnership Board)	• The Standing Conference will likely not have a role after the Partnership Board is established in shadow or full form. .	strategic priorities are achieved; • Support locality health and social care plans to be strategically aligned and determine any allocations required of the available investment funds • Work with local areas to ensure strategic coherence and consistency across Greater Manchester.
3	Joint commissioning Board	To discuss and agree recommended decisions on all GM wide spend To be engage in all decisions affecting GM health and social care.	• 12 CCGs, • 10 LAs • NHSE	• To exist in shadow form comprising GM CCGs, LAs and NHSE. • To discuss and agree recommended decisions on all GM wide spend (NB. there will be no change in legal responsibility for decision making or financial accountability). • To engage in all decisions affecting GM health and social care; • To share financial plans, budget proposals and current performance across the GM health and social care economy; • To move to a formal JCB operating under agreed s.75	• Members of the JCB (GM CCGs, LAs and NHSE) will pool relevant health and social care funds to the JCB, building from existing arrangements (e.g. Better Care Fund). • The JCB will commission GM-wide services . • Each local area will commission services in line with the relevant local area plan (e.g. Integrated Care).

No.	Body	Role as per MOU	Membership	Role 2015 to March 2016	Role April 2016 +
				arrangements during 2015/16 . • To agree on the financially accountable body within the current NHS accountability framework. • To agree and approve a form of governance and fundholding.	
4	Provider Forum	To provide a collective and positive response to the requirements of the shadow JCB. To develop with Monitor and TDA a Memorandum of Agreement to underpin the operation of the provider element of the governance structure,	• Acute • Community • Mental Health • Ambulance • Primary Care (LMCs) • Social Care • Public Health • Non NHS providers?	• To receive regular messaging with regards to progress made on the devolution agenda. • To take organisation responsibility for the implementation of relevant parts of the devolution agenda and locality plans • To provide a forum to raise key issues and challenges, identifying potential options for resolution where appropriate	As 2015 to March 2016
5.	Standing Conference	(Not proposed in the MOU). To support the development of the Partnership Board but in particular to confirm the role of the Partnership Board, its membership and how it will operate.	Membership to be made up of representatives of all parties to health devolution (Local authorities, CCGs, Providers, NHS England) to meet regularly throughout the year to carry out the functions of the Partnership Board	In conjunction with the Standing Conference Executive (unless otherwise reserved to the Executive): • To broadly agree the functions and governance structure of the Partnership Board and how it is to operate.	Role will be assumed by the Partnership Board once established.

No.	Body	Role as per MOU	Membership	Role 2015 to March 2016	Role April 2016 +
			pending the full establishment of the Partnership Board in 2016 and/or to support the shadow arrangements pending.	• To agree and support the implementation of the proposed 'Early Implementation Priorities' • To agree the strategic direction and development of the devolution of the GM health and care economy • To steer the development of the GM Strategic Sustainability Plan and related investment funding proposals which will be underpinned through local area plans. • To ensure there is effective engagement of all parties to the MoU and stakeholders (in particular patients).	
6.	Standing Conference Exec Board	(Not proposed in the MOU.) To assist the practical operation of the Standing Conference it has been proposed that a smaller Executive Board could be established to preserve particular strategic decisions to itself and/or to take certain decisions on behalf of the Standing Conference.	The Executive will consist of 3 representatives of the following groups: (i) the 10 GM local authorities; (ii) the 12 GM CCGs and (iii) the GM Providers.	• To carry out those functions listed above in conjunction with the Standing Conference (unless otherwise reserved to the Conference). • To assist the practical operation of the Standing Conference. • To meet more frequently than the Standing Conference. • To bring forward specific proposals for the composition,	Role will be assumed by the Partnership Board once established.

No.	Body	Role as per MOU	Membership	Role 2015 to March 2016	Role April 2016 +
				function and governance of the Partnership Board post April 2016 to be considered by the Standing Conference. • To ensure that progress is made with regard to the delivery of the Early Implementation Priorities.	

NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group
Audit Committee
Unconfirmed Minutes

Date of Meeting:	**17 June 2015**	**Time**	**From**	**To**
			13:00	**14:50**
Venue:	**Boardroom, Floor 7, Regent House**			
Present:	(JG) Mr J Greenough, Lay Member (Chair) (BB) Mr B Braiden, Lay Member (DS) Mr D Swift, Lay Member (AJ) Dr A Johnson, GP Locality Chair			
In Attendance:	(GJ) Mr G Jones, Chief Finance Officer (CFO), NHS SCCG (DD) Mr D Dolman, Deputy Chief Finance Officer, NHS SCCG (JF) Mr J Farrar, External Auditor, Grant Thornton (LL) Mrs L Latham, Head of Governance & Board Secretary, NHS SCCG (LW) Ms L Warner, Internal Auditor, MIAA (BD) Mr B Dawson, Anti-Fraud Manager, MIAA			
Apologies:	Mr T Crowley, Mr T Ryley, Mr M Thomas			
Secretary to Committee:	(SJ) Sue Jeeves Personal Assistant, NHS SCCG			

MEETING GOVERNANCE		
Item No	**Meeting Item**	**Responsible**
37.906	**1. Declaration of Interests** There were no declarations of interest.	**JG**
37.907	**2. Apologies** Apologies were noted as above.	**JG**
37.908	**3. Minutes of the last meeting held on 01 May 2015** There was one amendment to the previous minutes. On page 7, section 8.4 (Briefing Note) it should read that **LW** informed the Committee that this could apply to CCGs…. The minutes were then approved as a correct record.	**JG**
37.909	**4. Actions & Matters Arising** *Action 37.888(i)* Propose a system of flash reporting was taken under agenda item 7. *Action 37.899(ii)* Provide members with additional information on	**JG**

	"consultancy" and "agency" expenditure was taken under agenda item 14. *37.901 – IG Toolkit evidence update.* LL reported that Stockport CCG obtained level 2 with a score of 68%. JG asked Internal Audit if the score was justified based on the information and evidence provided. LW said that she had no reason to doubt that the score was justified. *37.903 – Identify who is responsible for Security Management* GJ outlined that The Security Standards for Commissioners require CCGs to review providers' security management arrangements to ensure they meet the requirements of the standard commissioning contract. NHS Protect's quality assurance programme (Chapter 3) can provide the appropriate assurance to commissioners in respect of providers' security management work. General Condition 6 of the NHS Standard Contract requires the provider to complete an organisation crime profile and to implement NHS Protect standards for providers based on the outcome of that profile. General Condition 6 also enables the commissioner's nominated Local Security Management Specialist (LSMS), a person nominated to act on their behalf or a person nominated to act on NHS Protect's behalf, to review the security management provisions put in place by the provider. **Action:** CCG to nominate a Local Security Management Specialist (LSMS). BD outlined that a series of workshops are being held on the Standards for Commissioners – Fraud, Bribery and Corruption and a number of questions have been raised in respect of the standards and how they are to be applied. GJ requested that BD advise him, to ensure that the CCG is compliant with the standards going forward. **Action**: BD will feedback to the Committee output from the workshops once received. The following items were agreed as completed and therefore removed from the log: 37.888(i), 37.899 (i), 37.899 (ii) 37.900, 37.901(i), 37.901(ii), 37.901(iii), 37.901(iv), 37.903	**GJ** **BD**
37.910	**5. Notification of items for any other business** The following items were notified as items to be covered under any other business: • Audit Committee Annual Report for 2014/15 • Corporate Credit Card • Agency and Consultancy Fees	**JG**

37.911	**6. NHS Stockport CCG Finance Briefing** GJ updated the committee that the CCG has planned to deliver a surplus of £1.75m (0.5%) in 2015/16 which is up from the £750k previously communicated. The additional £1m surplus is to be delivered via yet to be identified QIPP schemes. The additional surplus means that there is now £1.8m of unidentified QIPP within the CCG plans. A paper is currently being written which will detail options to deliver the £1.8m unidentified QIPP, as well as mitigations against non-delivery of identified QIPP schemes. The proposals will be discussed at the next QIPP committee and will need to be approved by the Governing Body before they are shared with NHS England. DD informed the committee that NHS Stockport CCG has reported it is on track to deliver its planned surplus. However, the financial position reported at month 2 is based on limited actual data, as activity information is one month behind and prescribing information is two months behind the financial period which is being reported. DD also outlined that the delivery of the £1.75m planned surplus is dependent upon achieving a planned saving of c£11m. AJ commented that the biggest issue is the demand and expectations of the population and that until people's behaviours change, there will always be increasing demand for NHS services.	**GJ**
37.912	**7. Flash Reporting Mechanism and Template** A flash reporting template and procedure has been proposed, the purpose being to provide a quick update to Governing Body members and relevant committees of any business critical information that needs to be disseminated urgently because the scheduling of meetings does not allow for the timely dissemination of such information. The Committee supported the implementation of the Flash Reporting process.	**LL**
37.913	**8. Operational Risk Register** LL reported that this the register includes the end of year position for 2014/15 and has been presented in the CCG standard format to include risks, rating, mitigations and commentary. JG asked Internal and External Auditors for their views on the report and how it compares to other risk registers that they have seen. JF commented that the format is good and comparable to other organisations, adding that the CCG is following best practice with the register, detailing risks and mitigating actions. JF outlined that in his opinion, it is better to detail all risks even if some risks will never cease to exist. JF said that it would be useful to have a summary of extreme risks highlighted at the front of the register.	**LL**

	LW commented that the Stockport CCG risk register was comparable to other good risk registers that she had seen. LW also outlined that the full risk register should be taken to the Governing Body as part of the assurance framework. **Action**: LL to confirm that the full risk register is to be taken to a meeting of the Governing Body.	**LL**
37.914	**9. Audit Committee Work Plan** DD presented the 2015/16 Audit Work Plan, which was developed by using the Audit Committee Work Plan template detailed in Appendix B of the NHS Audit Committee Handbook. Committee members are asked to review and feedback any comments. LW asked that the Internal Audit Charter be included in the October meeting. BD requested that the Counter Fraud Annual Report be included in June rather than April. **Action:** Amend the Audit Work plan as per requests	**DD** **DD**
37.915	**10. Stockport CCG Annual Audit Letter** JF presented the Annual Audit Letter, which is a summary of the key audit findings and messages presented at the 27th May 2015 Governing Body meeting to approve the Annual report and Accounts. The Committee received the report and thanked JF and his team for their hard work and support in enabling the CCG to submit its Annual Report and Accounts to a very strict deadline and on time.	**JF**
37.916	**11.1 Internal Audit Progress Report** LW reported that since the previous meeting of the Audit Committee, no reports have been finalised. One audit in respect of Governance was carried forward from the 2014/15 audit plan and is currently underway. In respect of the 2015/16 plan reviews of Safeguarding Adults and Statement of Involvement are currently underway. LW outlined that at the request of the CCG that the Safeguarding review will be deferred until Q3. LW outlined that she has met with several CCG officers and plans to agree the Terms of Reference for reviews early in the year so that CCG officers have an early sight of when the reviews are planned and flag any issues. Agreeing the timing of the reviews early in the year with CCG officers directly involved with the review, will hopefully avoid any CCG capacity issues which resulted in many reviews being conducted in Q4 of 2014/15. LW outlined that of the 24 recommendations due to be completed, 9 were still partially implemented or not implemented. The	**LW**

	recommendations still to be completed relate to risk management training which is to be carried out by the end of July and recommendations which will require constitution changes. Due to the approval process necessary to make constitutional changes, it is not anticipated that these changes will be made until mid-October. **11.2 MIAA Insight of Losses and Compensations** LW presented a benchmarking report on Trust and CCG Losses and Compensation Registers. DD asked how much of the £714k Trust Bad Debt related to overseas visitors. DD commented that the reason for his question was that there has been a change to the policy whereby providers will now invoice chargeable non EEA patients 150% of tariff and chargeable EEA patients 100% of tariff from which CCGs will be invoiced for 50% of the bill issued. If providers recover the money, CCGs will receive a credit for the 50%. In the previous system, providers bear the full weight of the debt burden on identification but the new incentive model should reduce this and also promote commissioner engagement with the recovery process.	
37.917	**12. Anti-Fraud Annual Report** BD presented the Anti-Fraud Service Annual Report which provided a summary of the work undertaken during 2014/15. DS asked when the report on the CHC review will be complete. BD stated that the review had been deferred from last year due to staff illness. The fieldwork has now been completed and the draft report will be available for the next Audit Committee meeting. JG commented that the number of staff (54) who had completed the Staff Survey was very good and asked how Stockport compared to other CCGs. BD said that he did not have any comparative data but believed that Stockport's figures would be high when compared to other CCGs. **Action:** BD to benchmark Stockport CCG's staff survey results with other CCGs. DD updated the committee that the finance team had reviewed all National Fraud Initiative creditor matches and confirmed that there were valid reasons for the matches and there are no underlying issues to report. BD outlined that he will undertake Standards for Commissioners – Fraud, Bribery and Corruption gap analysis when the all issues in relation to the standards have been resolved.	**BD** **BD**

37.918	**13. Chief Finance Officer Routine Reports** **13.1 Losses and Special Payments** None **13.2 Receivables>£5k** There were three debtors greater than £5k as at 31 May 2015 and the risk of no payment is low as all three debtors are government organisations. DD outlined that he has asked the relevant CCG commissioning manger to contact their colleague in the relevant organisation to request payment of the invoices. There are no items over 90 days outstanding. **13.3 Register of Waivers** None. **13.4 Register of Sealing Update** None.	**DD**
ANY OTHER BUSINESS		
37.919	**15. Any Other Business** **15.1 Audit Committee Annual Report for 2014/15** It was noted that this report should have been submitted to the June Governing Body. **Action**: LW to check with TC whether he was drafting the report or just providing a template. **15.2 Corporate Credit Card** DD informed the Committee that there has been a request internally for the CCG to apply for a corporate credit card. DD outlined that his initial enquires have indicated the CCG can apply for a corporate credit card in line with the CCG constitution and detailed financial policies. DD informed the committee that before a corporate credit card is applied for, that a credit card policy will be written. JG requested that Audit Committee be kept up to date about this. **Action**: BD to provide DD with examples of corporate credit card policies. **15.3 Agency and Consultancy Fees** DD informed the Committee that of the £759k spent on consultancy in 2014/15, £670k was related to the Stockport Together/Vanguard programme of which economy partners contributed 55%. DD confirmed that the procurement of the Stockport Together consultancy was via the HealthTrust Europe Framework Agreement.	**LW** **BD/DD**

	DD brought to the committee's attention DH guidance issued on the 2nd June, which requires a business case to be summited to NHS England for approval for all consultancy expenditure above £50k. AJ also had concerns about the work being done with Consultants and asked for assurance that the organisation is getting 'value for money'. GJ outlined that the consultancy expenditure in relation to the Stockport Together programme could be viewed as being "value for money", as it supported and helped Stockport to be chosen as a Vanguard site and it facilitated a level of engagement from partner organisations that had not previously been achieved. JG asked whether the CCG had any current off-payroll engagements. DD outlined that to his knowledge that the CCG did not have any off-payroll engagements in 15/16. JG queried if the organisation is overly relying on agency workers when an employee could be appointed by the CCG. DD outlined that agency staff had been used where there was a real gap in operational capacity or during a period of transition e.g. Business Intelligence. DD outlined that the 2nd June guidance issued by the DH required that providers engaged agency workers under the NHS framework agreements. The guidance applied to providers, however NHS England plans to make the guidance applicable for CCGs. JG thanked everyone for attending. The meeting closed at 14:50.	

DATE AND TIME OF NEXT MEETING

The next meeting will take place on 21 October 2015
13.00 – 15.00 in Meeting Room 1, Floor 7, Regent House

Date of Committee	Minute Number	Action Point	Complete by Date	By Whom
17.06.2015	37.909 (i)	CCG to nominate a Local Security Management Specialist (LSMS)	21.10.2015	GJ
17.06.2015	37.909 (ii)	Provide feedback on the output from the Standards for Commissioners – Fraud, Bribery and Corruption workshops when available	21.10.2015	BD
17.06.2015	37.913	Confirm that the full risk register is to be taken a meeting of the Governing Body	21.10.2015	LL
17.06.2015	37.914	Amend the Audit Work Plan to reflect changes requested by audit committee members	21.10.2015	DD
17.06.2015	37.917	Benchmark Stockport CCG's staff survey results with other CCGs.	21.10 2015	BD
17.06.2015	37.919 (i)	Check whether TC was drafting the report or just providing a template.	21.10 2015	LW
17.06.2015	37.919 (ii)	Provide DD with examples of corporate credit card policies.	21.10.2015	BD

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.

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 CPC have endorsed the GMMMG NTS recommendations in section 2.1.
- To note CPC have endorsed the amendments to the black and grey lists in section 2.2
- To note CPC have endorsed the Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy.
- To note CPC have endorsed the GM EUR policies in section 2.4.
- To receive the minutes of the May 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: Jane Crombleholme
Meeting Date: 08.07.15
Agenda item:
Reason for being in Part 2 (if applicable) n/a

1.0 Purpose

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

2.0 General Policies

2.1 CPC endorsed GMMMG (Greater Manchester Medicines Management Group) New Therapies Subgroup (NTS) recommendations on the following: GLP1 Receptor Agonists for type 2 diabetes.

2.2 CPC approved the request from STAMP to add the following to the Greylist: Vitamin B Co Strong.

2.3 CPC endorsed the policy for Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy.

2.4 CPC endorsed the following GMEUR policies: Electrolysis & Laser Hair Removal, Hair Replacement Technologies, Invasive Treatments for Snoring, Rhinoplasty Septoplasty Septorhinoplasty, Surgical Revision of Scarring and Tattoo Removal.

3.0 Duty to Involve

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

3.2 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.

3.3 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.

4.0 Equality Analysis

4.1 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.

4.2 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

24 June 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

MINUTES of the meeting held on Wednesday 27 May 2015

10:00 – 11.00, Board Room, 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

In attendance:

(AD) Andy Dunleavy, Senior Public Health Advisor, SMBC
(DK) Dr Debbie Kendall, Secondary Care Lay Consultant

Apologies:

(JC) Jane Crombleholme, Lay Member, Chair of NHS Stockport CCG GB
(SW) Sarah Williamson, Performance Manager, NHS Stockport CCG
(RR) Roger Roberts, Director of General Practice Development, NHS Stockport CCG
(MC) Mark Chidgey, Director of Quality Management

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 25 February 2015	**Action**
3.1 Minutes: The draft minutes of the meeting held on 22 April 2015 were approved as a correct record.	
3. Action Log	**Action**
<u>Updates were received for the following actions:</u> <u>175 GE to confirm if there is capacity to accommodate additional costs associated</u>	

with psychological therapies. The following update had been provided by GE: People with depression have access to CBT and counselling for depression. The service is working to increase choice. A Bi-polar Relapse Prevention Group is provided jointly with Healthy Minds (IAPT) and secondary care psychological therapy services. Family intervention can be provided; this is dependent on capacity and the availability of care co-ordinators to undertake joint working. The CBT therapist allocated to the Early Intervention in Psychosis Team supports people with first onset/early onset bi-polar. VOS provided assurance that these services were monitored by the Quality & Provider Management Committee. **Action closed.** 198 VOS to agree a way forward re monitoring NICE compliance with SFT Medical Director. VOS advised that this action had been superseded by the new SFT monitoring tool; VOS and SW have arranged to meet to discuss. 202 VOS to gain clarification from SFT on CG132 Caesarean Section The group noted and were assured by the placenta praevia and placenta accreta compliance statement provided by SFT which confirmed that SFT are now fully compliant with CG132. **Action closed and item to be removed from the worklplan**. 209 Highlight capacity issue re TA329. VOS informed the group that this issue has been included in the CPC to Governing Body report; awaiting response from Governing Body. **Action closed**. 215 QS80 Psychosis and schizophrenia: VOS to bring Bradford best practice to CPC. VOS updated the group that she had discussed Bradford with Gina Evans who confirmed that it is commissioned and developed. **Action Closed**. 216 CG191 Pneumonia: LB to find out cost per test. LB confirmed the cost per CRP test as £16.84 though there are economies of scale depending on how many we use. Salford is looking at implementing the test for some practices; therefore we will await feedback from the Salford trial. **Action closed. Add to workplan to review in 6 months.** 217 CG192 Antenatal and Postnatal Mental Health. GE had provided the following update: Perinatal women are a priority group for accessing psychological therapies. A mental health practitioner is linked with the maternity department to facilitate early identification of anxiety and depression in perinatal women. **Action closed**. 219 IPG517 Insertion of endobronchial nitinol coils to improve lung function in emphysema. SFT have confirmed that they do not offer this procedure. **Action closed.** 222 NG7 Maintaining a healthy weight and preventing excess weight gain amongst adults and children. AD confirmed that a review has been done against the relevant standards (which are lengthy) a report has been received which highlights a few gaps; AD will circulate the report for discussion at the next CPC. **Action closed** 223 MTG24 The Sherlock 2CG Tip Confirmation System for placement of peripherally inserted central catheters. The group noted the reply from Dr Wasson, Associate Medical Director and Consultant in ICU which concluded that the guidance has been considered and that SFT will not be adopting this technology.	

The following actions were closed and removed from the log: 175,189,198, 202, 209, 215, 216, 217, 219, 222 and 223.	
4. Matters Arising	**Actions**
4.1 Policy for prescribing PDE5 inhibitors after radical prostatectomy. LB talked through the policy and explained that it proposed that following the procedure the patient is supplied, by the Trust, with a month's supply of sildenafil to be taken daily. The Trust will advise the patient of the appropriate time in post-operative recovery to start using the medication and they also advocate the use of vacuum pumps to further improve blood flow. Further supplies of medication can then be provided by the GP with daily use for a further month and thereafter in line with the ED policy. If the patient fails to respond to sildenafil then vardenafil could be provided on the advice of urology. After a total of two months of treatment, if ED is present, the usual ED policy should then be applied using sildenafil first line up to a maximum of 12 treatments per month or other PDE5 inhibitors up to 4 treatments a month. The policy was devised with support from Mr Brough from SFT. The group **approved** the draft policy. **Action: LB to frame the draft Policy for prescribing PDE5 inhibitors after radical prostatectomy and include in the treatment list**.	**LB**
5. NICE assurance / implementation (3/12 post publication)	**Action**
5.1 Update on progress on NICE CG / QS 5.1.1 Compliance updates from SFT NG3 Diabetes in Pregnancy: Management of diabetes and its complications from preconception to postnatal period. CPC received the following response from SFT regarding expectation on primary care to deliver pre-conception advice: The response advised that primary care is often best placed to deliver first line effective preconception advice to women. The majority of women with T1 and T2 diabetes enter pregnancy inadequately prepared, with poor glycaemic control, taking 400mcg instead of 5mg folic acid and/or taking potentially harmful medication for their unborn child. Last year, one of our lady's had a termination of pregnancy which could have been avoided, had she received preconception care with her GP. The group agreed to highlight this issue to Governing Body. The group were generally assured by the response as it confirms the matter is prioritised and is included in the plan. **Action: RR to arrange for an update in GP newsletter and future GP Masterclass.** QS86 Falls assessment/ post falls process – SFT CPC received a response from SFT which confirmed compliance with statements 1-4; for statement 5 SFT responded that this is work they are doing with life leisure re	**RR**

exercise programme; for statement 6 SFT responded if the patient is on the slipper project Age UK will offer to assess the home environment and possibly CAIR will be taking this role in the future. The chair invited comments from the group. VOS commented that the response was mostly re assuring and was confident that the issues identified for 5&6 will be picked up by the project. Healthwatch queried capacity for the slipper project. VOS advised this will form part of the changes due to adult social care commissioning. 5.1.2 Compliance update from Primary Care The group noted the update received from Dr Peter Carne (PC) which reviewed the following guidance from a primary care perspective: CG188 Gallstone Disease – PC confirmed that most of this guidance refers to secondary care management of gallstone disease. CG189 Obesity – PC advised that there were no new implications for primary care. QS76 Acute Kidney injury – The group discussed the update provided for statement 4: identifying the cause – urine dipstick test; PC recommended the CCG ensures primary & secondary care providers 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 that this would mostly be normal practice and agreed that an update should be included in the GP newsletter. **Action: Ask PC to write an item on statement 4 QS76 for the GP newsletter**.	**PC**
The group noted the update received from LH which reviewed the following guidance from a primary care perspective: NG1 Gastro-oesophageal reflux disease: recognition, diagnosis and management in children & young people – LH advised of no significant changes for general practice. QS77 Urinary incontinence in women – the group discussed statement 4 LH said she was not aware that GPs could refer directly for pelvic floor physiotherapy. LB responded that this was provided by the continence service. **Action: SS to ask commissioning team to confirm if GPs have access to pelvic floor physiotherapy via the continence service**.	**SS**
6. Prior notification of new NICE guidance to be added into work plan	**Action**
None this month	
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 **approved** the request from STAMP to add the following to the Blacklist: Vitamin B compound strong tablets, Naloxegol, Mysimba® and Predrusolone EC tablets and to add the following to the Grey list: Dymista nasal spray and Tapentadol modified release tablets.	

7.2.2 NTS recommendation CPC **endorsed** GMMMG (Greater Manchester Medicines Management Group) New Therapies Subgroup (NTS) recommendations on the following: Naloxegol for constipation, aclidinium/formoterol combination inhaler for COPD (Duakir®), Mysimba® recommendation for obesity, Cystistat® (sodium hyaluronate) solution for the management of pain due to interstitial cystits (updated), Tiotropium for asthma and Ultibro® combination inhaler for COPD 7.3 Amendments to EUR Policies / new GMEUR policy: new policies discussed at GMEUR. VOS explained that the following policies were out for consultation: Radiofrequency denervation for neck and back pain Facet joint injections for back and neck pain Ultrasound and pulsed electromagnetic systems (PES) for bone heating Tropic electrical stimulation (TES) Functional electrical stimulation (FES) VOS asked the group to note the implications for Stockport for Radiofrequency denervation for neck and back pain and Facet joint injections for back and neck pain as Stockport is an outlier. The group queried why Stockport is an outlier. VOS advised that Stockport agreed to offer on a prior approvals basis however NICE evidence shows it does not work; VOS recommended that Stockport should therefore be in line with the EUR policy. **Action: Ensure the pain clinic is aware of the draft policies on radiofrequency denervation for neck and back pain and Facet joint injections for back and neck pain. LB to send policies to Kevin O'Sullivan** **Action: Group to email policy feedback to SS by 24.06.15** 7.4 Equality Impact Assessment for new policies: None this month. 7.5 Ratify minutes of reporting panels / meetings: 7.5.1 Individual Funding Panel (IFP) Minutes: The minutes of the meeting held on 1st April 2015 were **ratified** by the group. STAMP minutes for the meeting held on 30th April were **ratified** by the group.LB made the group aware that STAMP are reviewing its TORs to take quoracy down to 4 members as an interim measure pending the review of CCG committees.	**LB** **All**
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 • NG3 Diabetes in pregnancy update from SFT • Policy for prescribing PDE5 inhibitors after radical prostatectomy	
9 **Any Other Business**	**Action**

9.5 Process Review Panel TORs. The group approved the amended TORs which had been circulated prior to the meeting. 9.6 EUR Mandatory Criteria guidance for GPs VOS introduced the document and explained that SS had drafted it from the commissioning guidance of the EUR policies. VOS invited comments from the group: LH agreed the document was useful from a GP perspective. VOS suggested a link is set on the contents page to take the viewer straight to the relevant section and that mandatory criteria is changed to EUR criteria. The guidance was **approved** by the group. 9.3 Deputy to CPC Chair LH confirmed that Dr Peter Carne had agreed to deputise as GP member and chair of the CPC.	
Date, time and venue of next meeting: Wednesday 24th June 2015 09:00 – 11:00am, Meeting Room 5 Floor 7, Regent House	