Chair: Ms J Crombleholme
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NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group Governing Body
Part 1

A G E N D A

The next meeting of the NHS Stockport Clinical Commissioning Group Governing Body will be held at Regent House, Stockport at 10am on 9 March 2016.

	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 13 January 2016	Attached	To receive and approve		J Crombleholme
4	Actions Arising	Attached	To comment and note		J Crombleholme
5	Notification of Items for Any Other Business	Verbal	To note and consider		J Crombleholme
6	Patient Story	Video		10.15	J Crombleholme
7.	Corporate Performance Reports a) Strategic Impact Report b) Finance Report c) Performance Report d) Quality Report	Written Reports	To receive, assure and note.	10.30	 T Ryley M Chidgey G Mullins M Chidgey
8.	Locality Chairs' Update	Verbal Report	To receive and note	11.00	Locality Chairs
9.	Report of the Chair	Verbal Report	To receive and note	11.15	J Crombleholme
10.	Report of the Chief Operating Officer to include the following: • JSNA • Planning Update 2016/17	Written Report	To discuss and approve	11.20	G Mullins

	• Stockport Together Update • Delegated Commissioning Update • CCG Assurance Framework				
11.	Report of the Chief Clinical Officer to include the following: • Greater Manchester Strategic Plan • Specialised Services Commissioning Update • South East Sector Implementation Governance	Written Report	To discuss and review	11.45	R Gill
12.	Governance Matters • Committee Terms of Reference • Governing Body Forward Plan 2016/17	Written Report	To approve	12.10	T Ryley
14.	Compliance Report – 2015/16 Year and Action Plan	Written Report	To approve	12:20	T Ryley
15.	GP Development Scheme – Review	Written Report	To discuss	12:30	V Mehta
16.	Reports from Committees • Finance and Performance Committee • Audit Committee • Remuneration Committee	Written reports	To note	12:40	P Carne J Greenough J Greenough
17.	Any Other Business	Verbal		12:55	J Crombleholme
	Date, Time and Venue of Next meeting The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 30 March 2016 at Regent House, Stockport. Potential agenda items should be notified to stoccg.gb@nhs.net by 1 February 2016.				

NHS Stockport Clinical Commissioning Group

NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT REGENT HOUSE, STOCKPORT
ON WEDNESDAY 13 JANUARY 2016
PART 1

PRESENT

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

IN ATTENDANCE

Mr M Chidgey	Director of Quality and Provider Management
Mr R Roberts	Director for General Practice Development
Mr T Ryley	Director of Strategic Planning and Performance
Mrs L Latham	Board Secretary and Head of Governance

APOLOGIES

Dr D Jones	Director of Service Reform
Dr V Mehta	Clinical Director for General Practice Development

157/15 APOLOGIES

Apologies were received from V Mehta and D Jones.

158/15 DECLARATIONS OF INTEREST

J Higgins made a new declaration to the Governing Body which would be submitted as a formal amendment to his registered interests. The nature of the interest being that he had been appointed as the GP Representative for the Tame Valley Neighbourhood under the Viaduct Health locality arrangements.

159/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 9 DECEMBER 2015

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

- Sue Carroll from Healthwatch be shown as in attendance
- Lydia Hardern's apologies be noted
- Amendment to Public Question to read ' Primary Care Trust was dissolved and the Clinical Commissioning Group was established.'

160/15 ACTIONS ARISING

The following updates on actions were provided:

- 08072015 – Strategic Impact Report – completed and to be removed from action log.
- 12112015 – Report of Chair – completed and to be removed from action log.
- 12112015 – Chief Operating Officers Report – Q1 assurance letter circulated and action complete.
- 09122015 – The CCG had met with the representatives from the Sir Joseph Whitworth Community Centre and invited them to become involved with the work being undertaken by Stockport Together relating to mental health.
- 09122015 – Patient Story – action completed and to be removed from action log.

161/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were none.

162/15 PATIENT STORY

The Governing Body watched a patient story from a lady who had accessed support from the Stockport Psychological Wellbeing Service following a number of personal life events which had caused her significant stress and anxiety. She explained how she had been feeling isolated, lonely and wanted to hide away from her friends and family. A phone call to her doctor started to turn her life back around and she explained that she reluctantly accepted a referral to a Counsellor. Despite her negative perceptions of what might be involved and initial concern about the conversations she explained how quickly she felt her emotions beginning to change and how she began to rebuild her life within a small number of weeks. She thanked all those involved in the service for the positive impact they had had on her life and noted its importance in providing a non-medical alternative to mental health illness.

C Briggs noted the importance of continuing to promote Improving Access to Psychological Therapies (IAPT) as non-medical alternatives to anti-depressants. A discussion took place regarding the access to such services within Stockport, including patient numbers and the importance of ensuring services remained within localities to ensure ease of access.

L Hardern noted how isolating mental health conditions could be for individuals and the importance of allowing self-referral into IAPT services through a variety of means, including online. P Carne noted that GPs encouraged self-referral and passed on contact details to patients who they felt would benefit from the support provided.

V Owen Smith requested that the patient's permission be sought to place the video on the website of the Stockport Psychological Wellbeing Service to show the positive message portrayed about the benefits of counselling and support.

Resolved: That the Governing Body:

1. Notes the content of the patient story and requests that thanks be passed on to the patient for sharing their views.
2. Requests that the patient's permission be sought to place the video on the website of the Stockport Psychological Wellbeing Service to show the positive message portrayed about the benefits of counselling and support.

163/15 STRATEGIC IMPACT REPORT

The Governing Body considered a report which outlined the activity against the CCG's strategic and operational plans. T Ryley outlined the continued improvement in emergency department performance and care home admissions and noted that there had been several areas including elective activity and GP direct admissions which had shown decreasing performance in line with plan.

Members considered the overall positive trajectory across a number of areas and the impact on the financial planning currently underway for future years. In considering the data relating to hospital admissions it was noted that all admissions including ambulatory care were included and the data linked to existing systems and processes in place at the Stockport Foundation Trust. M Chidgey explained that analysis of December activity data would provide further understanding of the issues and trends would be reported to Governing Body through the Strategic Impact Report as relevant in future. A discussion took place regarding figures for dermatology and the recent Masterclass which had taken place with a number of practices to assist with diagnosis and on-going management of dermatology cases within primary care settings where appropriate.

P Carne sought clarification about the increase in prescribing rates and costs. R Roberts noted that increases were in line with national trends and linked to increasing drug costs in a number of specialist areas including diabetes, COPD and anti-depressants. C Briggs explained that data relating to the orthopaedic triage service had been reviewed and it was noted that the delays in access to physiotherapy could be impacting on referral rates within that area. This issue had been considered as part of the spinal pathway redesign work. The opportunity for services such as physiotherapy to be provided within Neighbourhoods as part of the Stockport Together work was being progressed .

T Ryley concluded by highlighting the strategic nature of the report and the link between the move to commissioning for outcomes and the way commissioners would interrogate and monitor activity and performance data in future.

Resolved: That Governing Body:

1. Notes the content of the Strategic Impact Report.

164/15 FINANCE REPORT

The Governing Body considered the current financial and forecast positions of the CCG as a month 8 of the 2015/16 financial year. G Jones explained that the CCG was back on track to deliver its required surplus of £1.75m largely due to reductions in the acute forecast overspend and forecasting of

additional Continuing Healthcare underspend due to a decrease in the average number of placements during the financial year. He outlined the recurrent position of £9.6m impacting in 2016/17 took the financial challenge overall to approximately £18.5m and explained that the CCG was working through the detail of the recent financial allocations.

The Governing Body sought confirmation about the underspend in the primary care budget. G Jones explained that the money related to elements of monies pooled centrally for Greater Manchester initiatives. A discussion took place regarding spend with AQP (Any Qualified Provider) contracts and the opportunities available to commissioners through the setting of treatment thresholds and review of access to related clinical pathway areas. M Chidgey explained that activity was driven by demand and it was noted that as part of the move to commissioning for outcomes, the focus would not be on monitoring referral levels but patient outcomes.

A Johnson noted that the Neighbourhood Working Model would provide opportunities for management of referrals and peer review across a wider area and it was hoped would include other areas of primary care including optometry which impacted on referral rates.

G Jones explained that the CCG financial position had been monitored closely in conjunction with NHS England and the submission of month 8 and 9 figures would be assessed to determine the next steps in relation to the Financial Turnaround status.

Resolved; That Governing Body:

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

   (i) Year-to-date - As at 30th November an actual £1,172k surplus compared to plan surplus of £1,166k.
   (ii) Forecast Outturn 15-16 – delivery of planned surplus of £1.75m.

2. Note the additional net risk totalling £1.35m not reflected within the forecast position (Ref – Table 8).

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

4. **Note** that the anticipated return of £1m from underspending national CHC legacy risk pool has been removed from our forecast position, this was actioned in month 7.

5. **Note** the additional recurrent cost pressures of £9.0m arising in 15/16 are treated as carry forward spend commitments into 16/17. The revised recurrent CIP requirement for 16/17 has also been remodelled to deliver a 1% recurrent surplus target (previously set at 2% surplus) which reduces our 16/17 recurrent CIP from £18.5m to £14.7m.

6. **Note** that the 16/17 recurrent CIP requirement of £14.7m is based on planning assumptions set March 2015 and does not therefore reflect the impact of (i) 16/17 tariff changes and (ii) allocations announcements for 16/17.

165/15 PERFORMANCE REPORT

G Mullins presented the Resilience and Compliance report covering NHS Constitutional Targets for October for statutory duty and compliance. She noted that the 4 hour emergency department target remained challenging and that a recent meeting of the Systems Resilience Group had focussed on managing the issues with a whole economy approach. The impact of reductions in elective capacity had impacted on Referral to Treatment targets and created further pressures within the hospital system. She noted the overall high level of compliance with a large number of the statutory duty and resilience targets.

C Briggs explained how the Systems Resilience Group had been carrying out its work over the winter period and the measures put in place by Stockport Foundation Trust to increase the numbers of acute medical and community beds. A multi-disciplinary discharge event had recently taken place at the hospital and had proved successful. Governing Body was informed that the recent industrial action had placed further pressures on the Foundation Trust but that a systems wide approach had been taken to ensure clinical capacity was maximised with the learning being applied to future scenarios. It was noted that delays in the scheduling of elective activity at the Trust over the Christmas and New Year period until 25 January 2016 would create further system pressures.

A discussion took place regarding care home bed capacity within Stockport and the delays in creation of care packages to enable appropriate and timely discharge of patients from hospital. G Mullins noted that the issue of care home capacity across Greater Manchester had been identified as a priority by the Quality Surveillance Group.

Resolved: That the performance report be noted.

166/15 QUALITY REPORT

M Chidgey provided a brief summary of the recent work of the Quality and Provider Management Committee. He noted that the lack of assurance of Trust CIP plans had been escalated as a risk onto the CCG's Operational Risk Register for monitoring. It was noted that as part of the economy wide work through Stockport Together it was important that partners were able to fully assess the impact of CIP plans to ensure there was no detrimental impact on quality.

Resolved: That the Governing Body note the report.

167/15 LOCALITY CHAIRS UPDATE

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

Heatons and Tame Valley – J Higgins reported that the Neighbourhood meetings were due to start in mid-January. He noted that continued capacity challenges within the District Nursing Service were causing significant issues for Member practices.

Marple and Werneth – A Johnson outlined the approach to the Neighbourhood working within the Locality and explained that meetings had been focussed around public health / prevention matters and understanding the current and future role of district nurses.

Stepping Hill and Victoria - L Hardern explained that the Neighbourhood Meetings were due to commence in late January and that Multi-Disciplinary Team meetings would soon go live. She noted that Viaduct GP Representative for the Hazel Grove Locality had not yet come forward.

Cheadle and Bramhall – P Carne informed Governing Body at the work which had been undertaken within both Neighbourhoods and in particular the recent progress by the Heald Green

The Governing Body discussed the District Nursing Service and the operational issues which existed. M Chidgey provided assurance of the work ongoing with Stockport Foundation Trust regarding the community nursing contract and the related improvement plan. T Ryley noted the importance of ensuring that the Stockport Together work on the new clinical model was based around the right nursing roles across the system with the right skill mix and available workforce capacity both currently and in the future. It was noted that the work of Stockport Together on the clinical model would crystallise in the coming months and general practice leadership of the design would be critical. K Richardson explained that work on a new nursing strategy was being undertaken nationally.

T Ryley noted that the development of the clinical model should drive the related strategy elements and that discussions were ongoing across the partnership about both elements. The Vanguard process was noted as an opportunity through which further resource to help develop the Organisational Development Strategy could be sought, noting the importance of ensuring that the expertise included an in-depth understanding of community and primary care workforce issues.

R Gill highlighted ongoing conversations with Health Education England and the Greater Manchester Devolution Team about clinical workforce issues, including the need to refocus development and clinical capacity from hospital based care to community and primary settings.

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

168/15 REPORT OF THE CHAIR

J Crombleholme reported that there had been no Part 2 meeting in January 2016 and that she had jointly with the Chief Clinical Officer carried out Personal Development Plans with as number of Governing Body Members.

169/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted the key elements included within the report including the recent approval of the CCG's application to be a Level 3 Commissioner. She explained that the CCG would be making arrangements to sign a Memorandum of Understanding with NHS England to utilise the existing centralised team within Greater Manchester and would review local requirements for additional capacity.

She drew the Governing Body's attention to the recent Planning Guidance which had been issued in December 2016 and confirmed that work was underway to comply with the requirements for both an Operational and an economy wide Strategic Plan. She explained that the planning requirements for Greater Manchester Devolution had not yet been confirmed. It was noted that the work on Integrated Commissioning and the Section 75 agreement was ongoing.

Resolved: That the Governing Body:

1. Notes the updates provided.

170/15 REPORT OF THE CHIEF CLINCIAL OFFICER

R Gill informed the Governing Body that the judicial review hearing for the Healthier Together programme had concluded and the judgement reached was that there had been no legal error in the decision reached by the Committees in Common on 15 July 2015. The 7 Day General Practice Model was in operation across Stockport and it would take time before the impact across the healthcare system could be fully understood.

The Governing Body considered the draft terms of reference for the Joint Commissioning Board of the Greater Manchester Governance framework and the approval of the technical change required for the Healthier Together Committee in Common to become a Joint Committee of CCGs.

R Gill responded to a question which had been raised by a member of the public regarding the inclusion of co-design in the Terms of Reference for the Joint Commissioning Board. He explained that co-design of service models and specifications would be undertaken between commissioners and providers up until the point of decision by commissioners with a view to creating consistent high quality healthcare across the region. He confirmed that the Joint Commissioning Board would meet in public.

Councillor Pantall sought confirmation about the boundaries between local and Greater Manchester decision making. In particular the Governing Body considered the importance of maintaining local decision making power on local issues and linking to Devolution on the more strategic region wide discussions.

Resolved: That the Governing Body:

1. Appoint the Chief Clinical Officer at the CCG's appointee to the Joint Commissioning Board and the Chief Operating Officer as the CCG's appointed Deputy.
2. Establish a joint committee with the other GM CCGs to take decisions in relation to Healthier Together, to be known as the Healthier Together Joint Committee.
3. Approve the terms of reference for the Healthier Together Joint Committee in their current form and:
4. Delegate authority to the Chief Clinical Officer to approve any changes to the terms of reference that involve updating the members or deputy members of the Committee or any other minor changes.

171/15 BOARD ASSURANCE FRAMEWORK

The Governing Body considered the revised Board Assurance Framework. T Ryley highlighted the strategic nature of the risks contained within the Register and the inclusion of the management of opportunity. He noted that each themed area included a risk appetite to indicate the level of risk which the organisation was willing to tolerate.

The Audit Committee had been involved in reviewing the Framework and the Governing Body would regularly review as part of future meetings to inform decision making and monitor the organisation's strategic management of risk and opportunity. T Ryley confirmed that the Framework had been refreshed by the CCG's Management Team on the basis of the previous framework and an assessment of new and emerging strategic risk areas.

A discussion took place regarding risk 5 which related to organisational capacity and capability and in particular the mitigating actions shown in the framework. G Mullins noted that capacity had to be

managed within the running cost allowance provided to the CCG which proved challenging alongside the significant programme of change which was currently underway.

J Crombleholme noted that she had a number of detailed comments about the Framework would be discussed outside the meeting and she would report back on as part of a future Chair's Report.

Resolved: That Governing Body:

1. Approves the content of the Board Assurance Framework

172/15 PUBLIC SECTOR EQUALITY DUTY

T Ryley introduced the report and highlighted in particular the legal and statutory duties of the CCG and the changing demographics of the Stockport population.

The Governing Body acknowledged the importance of ensuring service changes were fully impact assessed and that access to services remained high for all elements of the community. A particular question was raised by V Owen Smith regarding the access of individuals with disabilities to mental health services. The underpinning statistics would be provided to clarify the content of the report.

Resolved: That Governing Body:

1. Notes progress on the CCG's Equality Objectives.
2. Approves the content of the CCG's Public Sector Equality Duty report for publication.
3. Approves the topics for 2016-2020 Equality Objectives as follows:

- Adapting services to meet the needs of a changing population and financial pressures on the public sector
- Ensuring that transformation (both workforce and service provision) does not have a disproportionate impact on protected groups
- Supporting providers to deliver the new accessible information standards.

173/15 PUBLIC SECTOR EQUALITY DUTY

- **Clinical Policy Committee**

V Owen Smith provided an update on the work of the Clinical Policy Committee and highlighted in particular the agreement in principle reached by the Committee that rebate schemes from drug companies would be accepted. She highlighted the work which had been undertaken by the Committee to consider and cost the implications of a number of NICE Technology Appraisals.

Resolved: That Governing Body:

1. Notes the update on NICE TA compliance.
2. Notes the update from CPC on rebate schemes.
3. Notes the endorsement of the additions to the Blacklist listed in section 3.2 of the report.
4. Notes the updated costing summary for NICE TA's.

- **QIPP Committee**

J Greenough highlighted the role of the Committee in reviewing QIPP schemes and in particular the renewed focus on the Committee's holding to account and overview roles.

Resolved: That Governing Body:

1. Notes the report of the QIPP Committee

- **Audit Committee**

J Greenough reported that the Committee did not approve a report of the Internal Auditors relating to Standards for Commissioners – Fraud, Bribery & Corruption as they did not feel it reflected fairly on the CCG as a number of red ratings had been incurred as a result of matters beyond the organisation's control. He sought approval of the Governing Body to convene the panel to appoint the CCG's external auditors and it was confirmed that the additional member of the Panel established by the Committee would include the Governing Body Chair.

1. Notes the report of the Audit Committee.
2. Notes the additional appointment of the Chair of the Governing Body to the Audit Committee Panel to appoint the CCG's External Auditor.

174/15 ANY OTHER BUSINESS

Councillor Pantall reported that the Council had recently agreed to commission sexual health services along with several other Local Authorities and that investment of £20m had been agreed to upgrade and rebuild premises utilised by Borough Care to increase capacity across Stockport.

(The meeting ended at 12.27pm)

Public Questions

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

1. What are Neighbourhood Meetings?

   Neighbourhood meetings are the structure within which Member Practices are working together to design local primary care services as part of the Stockport Together Programme.

NHS Stockport Clinical Commissioning Group
9 March 2016

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
12112015	**Safeguarding** That the Stockport Together Programme incorporates safeguarding considerations into the design of new models of care. Impact assessments including safeguarding would be incorporated into the development of the new clinical model to provide assurance. Response: The Stockport Together programme will look to ensure adult safeguarding is considered in the following ways: - The new design entities will be required to show how safeguarding has been addressed/improved within business cases - An adult safeguarding lead and senior nurse will sit on the Practitioner Reference Group who will assure all business cases and other service changes recommending these as clinically appropriate and safe	138/15	February 2016	Tim Ryley

13012016	**Patient Story** Thanks be expressed to the patient for sharing her story with the Governing Body. The opportunity for sharing the film clip on the website of the Stockport Psychological Wellbeing Service be explored to share a real example of the benefits of the service.		January 2016	Laura Latham
13012016	**Locality Chairs** That the Governing Body request that through the Stockport Together Programme, appropriate resource and primary care and community workforce expertise be put in place to ensure the development of the clinical model drives the creation of an enabling Workforce Development Strategy.		March 2016	Tim Ryley
13012016	**Chief Operating Officers Report** A report be provided at the March meeting of the Governing Body be provided to outline how the requirements of Level 3 Delegated Commissioning will be met by the CCG locally and through any regional agreements with NHS England.		March 2016	Gaynor Mullins
13012016	**Board Assurance Framework** A meeting to be arranged with the Chair to discuss in more detail the Board Assurance Framework.		January 2016	Jane Crombleholme / Tim Ryley

13012016	**Public Sector Equality Duty Report** Further detail to be provided on the access to health care services by those with disabilities shown as low on page 10 of the report presented to the Governing Body. Response: The reason the mental health indicator was red was not that there was evidence that there was an inequalities issue, rather that this data was not being collected and from 1st April this will be legal requirement.		January 2016	Tim Ryley

NHS
Stockport
Clinical Commissioning Group

Strategic Impact Report

Performance against key indicators in operational plan

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

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Executive Summary

What decisions do you require of the Governing Body?

The Governing Body are not being asked to make any specific decisions but should note the content of this report when considering the finance report and QIPP.

Please detail the key points of this report

- The previously reported where the CCG is having an impact greater than planned continue to deliver better than plan – *A&E attendance*, *Care Home admissions*, *non-GP referred outpatients*, and admissions where primary cause of admission is a *long-term condition*. Many of these are closely linked to the GP Development scheme aims and changes in admission processes at SFT.

- There have been improvements in plan in both non-elective admissions and prescribing.

- *GP 1st Outpatients* remains above plan but there has not been any further decline in performance.

- Two areas where there continues to be deterioration in performance are *elective activity* and *GP direct admissions* which are now higher than plan rather than better than plan earlier in the year. The latter is due to pathway improvements that we agree.

- There remain a few issues with data quality in Neurology.

- Governing Body members are reminded that this report is a measure against plan. Given plan was close to flat line comparison to actual is broadly similar.

- Variation between practices and localities remains high though some of this is a feature of the planning processes. However, Marple & Werneth have a particularly strong performance across a range of indicators.

Board Assurance Framework

The Board Assurance Framework in providing a strategic perspective on the management of the CCG's Risks closely links to the delivery of targets and performance measures as outlined in the CCG's Operational Plan. The most recent version can be accessed here: Board Assurance Framework

Governing Body Members are therefore asked to reflect on the content of this report in light Board Assurance Framework and consider how the approach to managing risk and opportunity may impact on the achievement of the CCG's performance measures in particular focussing on the robustness of mitigating actions.

What are the likely impacts and/or implications?
The cumulative effect of the gains and under-performance is a contribution to the financial pressure.
How does this link to the Annual Business Plan?
These are the key strategic measures of the effectiveness of the combined work set out in the plan to shift to a more sustainable economy
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors meeting
Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 10th March 2016
Agenda item:7 (a)

General Practice Dashboard

NHS Stockport Clinical Commissioning Group

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

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

Select comparison yr: Plan 2015-16

		2015-15 Plan YTD Apr-Dec	2015-16 YTD Apr-Dec	Variance	<---------- Practice		%Variance Locality	----------> Stkport
Urgent								
A&E Attendances		72547	70569	-1978	-2.7%		**-2.7%**	**-2.7%**
Ambulance Conveyance Rate		81.8%	80.2%					
Non-Elective Admissions								
All Non-Elective Admissions		29032	29293	261	0.9%		**0.9%**	**0.9%**
Occ Bed Days per 100,000 [1]		46128	43520	-2608	-5.7%		**-5.7%**	**-5.7%**
GP Direct Admissions		4773	4960	187	3.9%		**3.9%**	**3.9%**
LTC	**Register**							
CHD Admissions	11741	732	621	-111	-15.2%		**-15.2%**	**-15.2%**
HF Admissions	2728	384	408	24	6.2%		**6.2%**	**6.2%**
COPD Admissions	6711	441	277	-164	-37.2%		**-37.2%**	**-37.2%**
Asthma Admissions	19770	155	164	9	6.0%		**6.0%**	**6.0%**
Diabetes Admissions	14575	98	91	-7	-7.0%		**-7.0%**	**-7.0%**
LTC Admissions	55525	1810	1561	-249	-13.8%		**-13.8%**	**-13.8%**
AF Admissions	5732	431	342	-89	-20.6%		**-20.6%**	**-20.6%**
Care Home Admissions		1560	1393	-167	-10.7%		**-10.7%**	**-10.7%**
Referrals								
GP Referred 1st OPA		41239	43403	2164	5.2%		**5.2%**	**5.2%**
Dermatology		4022	4452	430	10.7%		**10.7%**	**10.7%**
ENT		4599	4968	369	8.0%		**8.0%**	**8.0%**
General Medicine		6528	7148	620	9.5%		**9.5%**	**9.5%**
General Surgery		7675	8102	427	5.6%		**5.6%**	**5.6%**
Obstetrics & Gynaecology		2937	3029	92	3.1%		**3.1%**	**3.1%**
Opthalmology		3137	2704	-433	-13.8%		**-13.8%**	**-13.8%**
Paediatrics		1961	2129	168	8.6%		**8.6%**	**8.6%**
Rheumatology		917	920	3	0.3%		**0.3%**	**0.3%**
Trauma & Orthopaedics		5550	6049	499	9.0%		**9.0%**	**9.0%**
Urology		2309	2274	-35	-1.5%		**-1.5%**	**-1.5%**
Other Specialist Medicine		198	145	-53	-26.8%		**-26.8%**	**-26.8%**
Other Specialties		1406	1483	77	5.5%		**5.5%**	**5.5%**
Other Referred 1st OPA		27432	26509	-923	-3.4%		**-3.4%**	**-3.4%**
GP Referred 1st OPA								
Neurology [2]		1446	2136	690	47.7%		**47.7%**	**47.7%**
Planned								
Elective Admissions		28335	28832	497	1.8%		**1.8%**	**1.8%**
Prescribing [1 3]		4854679	4420324	-434355	-8.9%		**-8.9%**	**-8.9%**

NHS
Stockport
Clinical Commissioning Group

Finance Report January 2016 – Month 10

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

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Executive Summary

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

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

(i) **Year-to-date** - As at 31st January an actual £1,459k surplus as per plan.

(ii) **Forecast Outturn 15-16** – delivery of planned surplus of £1.75m.

II. **Note** the additional net risk totalling £0.28m not reflected within the forecast position (Ref – Table 8).

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

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

Please detail the key points of this report

- Actual surplus reported as at Mth 10 (YTD) of £1,459k as per plan.
- Main areas of cost pressure continue to be within the Acute Sector (Elective and Outpatient) and Prescribing.
- Additional risks with a most likely financial impact of £0.28m have been identified although not factored into the financial position at this stage.

What are the likely impacts and/or implications?

Delivery against statutory financial duties and financial performance targets.

How does this link to the Annual Business Plan?

As per 2015/16 Financial Plan.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

Governing Body only

Clinical Executive Sponsor: Ranjit Gill
Presented by: Mark Chidgey
Meeting Date: 9th March 2016
Agenda item: 7(b)
Reason for being in Part 2 (if applicable)
N/A

Report of the Chief Finance Officer as at 31 January 2016

1. Introduction

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

This report provides an update on:-

1. The financial position both
   (i) Year-to-date as at 31st January 2016 and
   (ii) Forecast outturn 2015/16

2. Key risks not included within the financial position

3. Underlying recurrent financial position

2. Statutory Financial Duties and Performance Targets

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

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty	Performance YTD (Mth 10)	Performance Forecast
Revenue (Dashboard Table 1)	Not to exceed revenue resource allocation		
Running Costs (Dashboard Table 1)	Not to exceed running cost allocation		
Capital – *(Note: The CCG has not received a capital allocation in 2015/16)*	Not to exceed capital resource allocation	**N/A**	**N/A**

Area	Performance Target	Performance YTD	Performance Forecast
Revenue	Deliver a Recurrent Surplus		
Revenue (Appendix 1 Table 1)	Deliver a 0.5% in-year surplus		
Cash (Appendix 1 Table 10)	Operate within the maximum drawdown limit		
Business Conduct (Appendix 1 Table 9)	Comply with Better Payment Practices Code		
QIPP (Appendix 1 Table 11)	Fully deliver planned QIPP saving		

3. Year-to-Date (Mth 10) & Forecast Financial Position (Ref – Appendix 1 Table 1)

3.1 A year-to-date surplus of £1,459k is being reported as per plan. The position includes elective and outpatient over performance within the acute sector, a majority of which relates to Any Qualified Provider (AQP) / Independent Sector providers. Increased prescribing spend as set out in Table 7 is also contributing to the in-year financial pressure. These in-year financial pressures are being offset, in the main, by non-recurrent underspends within other expenditure areas (Ref – Appendix 1 Table 1).

3.2 As reported at the December meeting the CCG is forecasting to deliver its planned surplus of £1.75m.

Acute:

3.3 Key risk areas within Acute continue to be AQP/IS contracts [Appendix 1 Table 2] which are forecast to overspend by £2.690m. The main areas of overspend are:

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

3.4 Acute over performance by Point of Delivery [Appendix 1 Table 3] and specialty is as follows:

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

Mental Health

3.5 Year-to-date underspend of £328k with a forecast underspend of £384k. This is largely due to cessation of the block contract with Calderstones which terminated with effect from 30/09/2015.

Community Health

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

Continuing Care

3.7 The month 10 position continues the trend with a YTD underspend of £368k and a forecast underspend of £495k at year end. This underspend is largely due to the average number of CHC placements being lower than planned levels. It should be noted that the forecast outturn position includes £200k for agreed increase in placement costs.

Primary Care

3.8 Primary Care budgets are forecast to underspend by £453k consistent with previously reported positions.

Prescribing (Ref – Appendix 1 Table 7):

3.10 There has been an increase of c5.7% in prescribing for the period April to November (the latest data available for actual spend) compared to same period 14/15, of which c3.4% is volume related (number of items prescribed). This has resulted in the CCG reporting a YTD overspend of £1.375m and trend continuing with a forecast overspend of £1.5m by year end. Table 7 sets out the main contributors to this overspending by drug type which are summarised below:

- Cardiovascular - Anticoagulants & Protamine (particularly Apixaban) showing increasing spend following NICE TA
- Endocrine - cost increase is being driven by increased prevalence and new drugs being added to current treatment

- Nutrition and Blood - cost increase is being driven by a combination of item growth and cost growth
- Central Nervous System - increase in the number of items prescribed particularly within Analgesics and Antiepileptics

Running Costs

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

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

Table 2: Running Costs

Running Costs	YTD Budget £000s	YTD Actual £000s	Variance (Favourable) / Adverse £000s	Annual Budget £000s	Forecast Outturn £000s	Variance (Favourable) / Adverse £000s
GMCSU - SLA	686	686	0	851	851	0
CCG Admin	4,373	3,929	(444)	5,899	5,101	(798)
Total CCG Running Costs	5,059	4,615	(444)	6,750	5,952	(798)

The month 10 position reflected in the table above includes an 'In Year' allocation of £326k received in relation to 2014-15 Quality Premium.

Reserves (Ref – Appendix 1 Table 4)

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

3.13 Contingency – this reflects the balance of the original £1.9m (0.5%) contingency set aside required for planning purposes. The balance of £313k is being fully utilised to support the CCG's forecast position.

3.14 CIP (Savings & Efficiency) – £3.214m reserve reflects the remaining value of CIP savings not yet embedded within expenditure budgets.

4. Balance Sheet

4.1 **Appendix 2** details the CCG opening balance sheet as at 1st April 2015, closing balance sheet as 30th November 2015 and a forecasted balance sheet as at 31st March 2016.

4.2 Members should note that our projections of cash draw down requirements for 15/16 are forecast to be maintained within the annual cash limit of £382.72m (see Table 10 of Appendix 1.

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

5.1 There are potential risks estimated at c£0.28m which are acknowledged but have not been brought into the financial position at month 10. These reflect risks that could potentially materialise on a 'worst case' basis and as such are identified and recorded but not brought into the financial position. Should any of these risks become more certain then these will be brought in and result in a deterioration in the CCGs financial position.

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

6.1 Recurrent cost pressures have arisen in 2015/16 as a result of :

- Increased activity demand above planned levels for 2015/16
- Unachieved recurrent CIP requirements (see Table 11)

6.2 In addition to the above, the CCG's recurrent position has also been impacted by :-

- Introduction of new tariff option announced during 15/16 planning round which brought about a c£4.5m recurrent pressure
- Primary Care initiatives (GP Development scheme) funded out of BCF in 2015/16 for that year only and therefore will need to be made available through a recurrent investment in 2016/17.

6.3 As a result of these recurrent pressures a £9.7m recurrent deficit will be carried forward into 2016-17 and is a first call against 2016-17 growth funding. Carrying forward a recurrent deficit of £9.7m into 2016-17 will make it extremely challenging to deliver all NHS England business rules in 2016/17. If all NHS England business rules are not met and the CCG has a high level of net risk NHS England will not be assured that the CCG can delivery against its 2016-17 plan and would ask the CCG for a recovery plan.

7. Risk Implications / Mitigation

Risks:

- The key risks remain in the increasing activity / demand growth in acute sector provision.

Mitigation:

- The QiPP Committee is continuing to scope further savings measures to help bridge the 'affordability gap' i.e. recurrent spend less recurrent funding, with the intention that these schemes are aligned to the strategic direction of 'Stockport Together' programme working to the new model of care.

8. Recommendations

The Governing Body is asked to:-

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

(iii) **Year-to-date** - As at 31st January an actual £1,459k surplus as per plan.

(iv) **Forecast Outturn 15-16** – delivery of planned surplus of £1.75m.

II. **Note** the additional net risk totalling £0.28m not reflected within the forecast position (Ref – Table 8).

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

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

Mark Chidgey
Interim Chief Finance Officer
26th February 2016

Appendix 1

MONTH 10 FINANCIAL DASHBOARD

Appendix 1

TABLE 1

RAG Rating Key:

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

Month 10 Financial Position - as at 31st January 2016

	YTD (Mth 10) Plan £000s	YTD (Mth 10) Actual £000s	YTD (Mth 10) Var £000s	YTD (Mth 10) Var %	Forecast 15/16 Plan £000s	Forecast 15/16 Actual £000s	Forecast 15/16 Var £000s	Forecast 15/16 Var %	RAG RATING	Recurrent Budget £000s	Recurrent Commitment £000s	Recurrent Variance (Favourable) / Adverse £000s
Revenue Resource Limit (RRL)												
Confirmed	(317,974)	(317,974)	0	0.0%	(378,328)	(378,328)	0	0.0%	G	(374,047)	(374,047)	0
In Year	0	0	0	0.0%	(5,755)	(5,755)	0	0.0%	G	(1,380)	(1,380)	0
Total RRL	**(317,974)**	**(317,974)**	**0**	**0.0%**	**(384,083)**	**(384,083)**	**0**	**0.0%**	G	**(375,427)**	**(375,427)**	**0**
Net Expenditure												
Acute	185,652	187,958	2,306	1.2%	223,701	226,632	2,931	1.3%	R	221,767	227,256	5,489
Mental Health	26,402	26,074	(328)	(1.2%)	31,683	31,299	(384)	(1.2%)	G	31,103	30,819	(284)
Community Health	29,759	29,672	(87)	(0.3%)	35,786	35,613	(173)	(0.5%)	G	35,711	35,711	0
Continuing Care	14,623	14,255	(368)	(2.5%)	17,126	16,631	(495)	(2.9%)	G	15,009	15,009	0
Primary Care	10,273	9,919	(354)	(3.4%)	12,483	12,030	(453)	(3.6%)	G	10,073	11,473	1,400
Other	3,173	2,094	(1,079)	(34.0%)	5,166	2,436	(2,730)	(52.8%)	G	2,636	3,398	762
Sub Total Healthcare Contracts	**269,882**	**269,972**	**90**	**0.0%**	**325,945**	**324,641**	**(1,304)**	**(0.4%)**	G	**316,299**	**323,666**	**7,367**
Prescribing	40,553	41,928	1,375	3.4%	48,664	50,164	1,500	3.1%	R	48,664	50,164	1,500
Running Costs (Corporate)	5,059	4,615	(444)	(8.8%)	6,750	5,952	(798)	(11.8%)	G	6,424	6,424	0
Reserves (Ref: Reserves Summary)	1,021	0	(1,021)	(100.0%)	974	1,576	602	61.8%	G	2,817	4,876	2,059
Total Net Expenditure and Reserves	**316,515**	**316,515**	**0**	**0.0%**	**382,333**	**382,333**	**0**	**0.0%**	G	**57,905**	**61,464**	**3,559**
Additional Identified CIP	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0.0%**	G	**0**	**0**	**0**
TOTAL (SURPLUS) / DEFICIT	**(1,459)**	**(1,459)**	**0**	**0.0%**	**(1,750)**	**(1,750)**	**0**	**0.0%**	G	**(1,223)**	**9,703**	**10,926**

TABLE 2

Acute Contract Performance		Year to Date			Forecast	
Top 6 Acute Commissioning contracts & AQP/IS	Annual Budget	Budget	Actual	YTD Variance - Overspend / (Underspend)	Forecast Outturn	Forecast Variance - Overspend / (Underspend)
	£'000	£'000	£'000	£'000	£'000	£'000
Stockport FT	144,431	120,359	120,126	(233)	143,957	(474)
University Hospitals of South Manchester FT	25,490	21,241	21,660	419	26,026	536
Central Manchester University Hospitals FT	18,577	15,481	15,288	(193)	18,361	(216)
Salford Royal FT	5,633	4,694	4,981	287	5,972	339
East Cheshire NHS Trust	2,259	1,883	1,881	(2)	2,179	(80)
Tameside Hospital FT	1,084	910	1,047	137	1,248	164
AQPs/IS	11,328	9,440	11,398	1,958	14,018	2,690
Other	14,899	11,644	11,577	(67)	14,871	(28)
Total Acute	**223,701**	**185,652**	**187,958**	**2,306**	**226,632**	**2,931**

ACUTE

PoD

TABLE 3

Forecast variance to plan at Mth 10 based on Mth 9 Activity Data (SLAM) (£000)	Top 6 Acute Commissioning Contracts & AQP/IS								
PoD	SFT (£000)	UHSM (£000)	CMFT (£000)	Salford Royal (£000)	East Cheshire (£000)	Tameside (£000)	AQP / IS (£000)	Other Providers (£000)	Total (£000)
Elective	(83)	13	(38)	(74)	(44)	(5)	2,420	136	2,325
Drugs & Devices	604	0	228	(83)	22	0	0	(3)	768
Outpatients	442	(9)	(61)	627	(45)	(3)	270	15	1,236
Non Elective	670	478	(400)	(38)	(8)	(11)	0	(37)	654
Non Elective (Excess bed days)	(840)	103	13	0	16	(5)	0	(14)	(727)
Macular	0	0	170	0	0	0	0	0	170
Fertility	0	0	54	0	0	0	0	0	54
Maternity	(127)	15	100	0	(3)	0	0	(4)	(19)
A&E	32	64	(11)	24	(4)	1	0	(7)	99
Critical Care	(648)	(202)	223	(100)	(30)	(3)	0	(59)	(819)
Other PoDs	(524)	74	(494)	(17)	16	190	0	(55)	(810)
Total Mth 10 Forecast Variance	(474)	536	(216)	339	(80)	164	2,690	(28)	2,931

PRESCRIBING

TABLE 4

Forecast Reserves Summary

	Reserves Held Mth 10	Commits Mth 10 onwards	Forecast Bals Year End
Amounts Held in CCG Reserves	£000s	£000s	£000s
Investments - National	1,267	350	(917)
Investments - Greater Manchester	1,291	335	(956)
Contingency	313	0	(313)
In-Year Allocations	1,317	891	(426)
CIP - Not embedded in budgets	(3,214)	0	3,214
Total Reserves	**974**	**1,576**	**602**

TABLE 5

Recurrent CIP Requirement 2016-17	£000s
CIP due to recurrent deficit c/fwd from 2015-16	(9,703)
CIP required to deliver 2% in year surplus based on 15/16 planning assumptions	(8,809)
Revised CIP Requirement to deliver 2% Surplus	(18,512)
Change due to notified allocation and planning guidance 16/17	9,213
Revised CIP Requirement to deliver 1% Surplus	(9,299)

TABLE 6

Forecast spend against in year allocation (NHS Eng Requirement)	£000s
2015-16 Allocation	(384,477)
Less: Brought forward 2014-15 Surplus	4,281
Forecast 2015-16 Expenditure	382,727
Forecast (under)/over-spend against in year allocation	2,531

TABLE 7

Top Five Increases in Prescribing Spend by Drug Type	Dec 13 - Nov 14 (£000s)	Dec 14 - Nov 15 (£000s)	Change (£000s)	Change in Spend (%)	Change in No. Items (%)
Endocrine System	6,153	6,780	627	10.2%	5.1%
Cardiovascular System	5,953	6,456	503	8.5%	2.1%
Central Nervous System	10,238	10,730	492	4.8%	4.8%
Nutrition And Blood	2,538	2,939	401	15.8%	4.8%
Respiratory System	6,145	6,299	154	2.5%	3.5%

TABLE 11

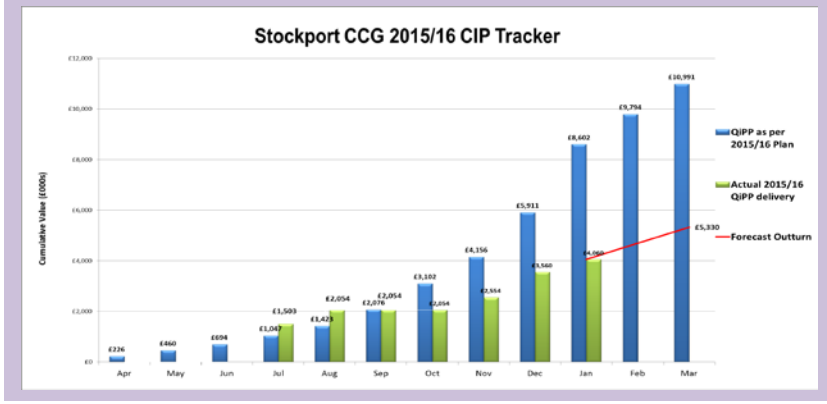

TABLE 8

Risk	Risk Value (£m)	Explanation of risk
Acute SLAs	0.28	Activity / Demand Growth
Total	0.28	

TABLE 10

Cashflow Summary - Month 10	£000s
Cash Limit for the Year	382,723
Cash drawn down YTD	316,611
Remaining cash	130,334
Actual cash drawn down (%)	82.7%
Expected cash drawn down (%)	83.3%

TABLE 9

Public Sector Payment Policy (PSPP) - Measure of Compliance

The Public Sector Payment Policy target requires CCG's to aim to pay **95%** of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.	December YTD Number	December YTD £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	8,513	53,953
Total Non-NHS Trade Invoices Paid Within Target	8,303	52,485
Percentage of Non-NHS Trade Invoices Paid Within Target	97.53	97.28
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,117	216,828
Total NHS Trade Invoices Paid Within Target	2,028	216,359
Percentage of NHS Trade Invoices Paid Within Target	95.80	99.78
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	10,630	270,781
Total NHS Trade Invoices Paid Within Target	10,331	268,844
Percentage of NHS Trade Invoices Paid Within Target	97.19	99.28

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

Appendix 2

NHS STOCKPORT CCG BALANCE SHEET as at 31st January 2016 (Month 10)

	Opening Balances 1.4.15 £000s	Closing Balances 30.11.15 £000s	Movement in Balances £000s	Forecast B/S 31.3.16 £000s
Non-current assets:				
Property, plant and equipment	14	10	(4)	10
Intangible assets	0	0	0	0
Trade and other receivables	0	0	0	0
Total non-current assets	**14**	**10**	**(4)**	**10**
Current assets:				
Cash and cash equivalents	43	11	(32)	50
Trade and other receivables	1,363	1,831	468	1,388
Inventories	0	0	0	0
	1,406	**1,842**	**436**	**1,438**
Non-current assets classified "Held for Sale"	0	0	0	0
Total current assets	**1,406**	**1,842**	**436**	**1,438**
Total assets	**1,420**	**1,852**	**432**	**1,448**
Current liabilities				
Trade and other payables	(20,923)	(21,493)	(570)	(21,000)
Provisions	(883)	(649)	234	(399)
Borrowings	0	0	0	0
Total current liabilities	**(21,806)**	**(22,142)**	**(336)**	**(21,399)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(20,290)**	**96**	**(19,951)**
Non-current liabilities				
Trade and other payables	0	0	0	0
Provisions	0	0	0	0
Borrowings	0	0	0	0
Total non-current liabilities	**0**	**0**	**0**	**0**
Total Assets Employed:	**(20,386)**	**(20,290)**	**96**	**(19,951)**
FINANCED BY:				
TAXPAYERS' EQUITY				
General fund	(20,386)	(20,290)	96	(19,951)
Revaluation reserve	0	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(20,290)**	**96**	**(19,951)**

NHS
Stockport
Clinical Commissioning Group

Resilience and Compliance Report - March 2016

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

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

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Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
Note the report.
Please detail the key points of this report
Performance on NHS Constitutional targets and legal compliance indicators
What are the likely impacts and /or implications?
Continue to monitor measures and compliance, especially ED, RTT, 52 Week Waiters and ambulance response times.
How does this link to the Annual Business Plan?
Updates Governing Body on performance on the measures laid out in our annual business plan.
What are the potential conflicts of interest?
N/A
Where has this report been previously discussed?
Directors Meeting
Clinical Executive Sponsor: Dr Ranjit Gill
Presented by: Gaynor Mullins
Meeting date:
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Chief Operating Officer's Report

Chief Operating Officer's Report

This report covers data to December 2015 for both NHS constitution targets and for statutory duty and compliance indicators.
Additional information is provided below for:-

- Urgent care, including; the 4 Hour ED waiting times standard and 12 hour standard.
- Planned care, including the 18 week and 52 week standards.

Urgent Care

The Governing Body have been kept informed of the significant reduction in performance since the beginning of November. The SRG co-ordinated response is yet to result in improvement flow and performance and therefore a further significant escalation response is required.

Attendances throughout this period have been consistent by month and this has continued into January and February. Whilst it is confirmed that no 12 hour breaches have occurred it is known that patients will have waited for excessive periods of time to access care. The system wide quality review has been rescheduled.

System leaders have been meeting individually and collectively with the respective regulators (NHSE for the CCG and NHS Improvement for Stockport NHS Foundation Trust). In addition the Stockport Health & Scrutiny Committee requested consideration of the linked issue of Delayed Transfers of Care.

A new recovery plan is being formulated in advance of reports from external reviews or visits of the urgent care system that have occurred in recent weeks, this includes CQC, Greater Manchester UM Team and ECIST.

Planned Care

The main target, that 92% of patients should have been waiting no longer than 18 weeks, has been failed in December. The GB will be aware of the increased risk to this target reported in recent months. SFT as our main provider did achieve the standard but reduced performance for Stockport patients at UHSM and Salford were sufficient to move the CCG below the standard. UHSM have developed speciality level recovery plans with trajectories which are monitored weekly. We are awaiting information from SFT on the validation process for the backlog of RTT which will be tracked through the contact meeting. The risk has been compounded by winter pressures resulting in cancellations of elective activity.

The 3 52 week waits originate from UHSM as the external validation work continues. Breaches are clinically reviewed and appointments offered within 3 weeks once identified.

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters									Last Three Months			Details		
NHS Constitutional Compliance Indicator	Q4		Q1		Q2		Q3		Oct 2015	Nov 2015	Dec 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients on incomplete non-emergency pathways (yet to start treatment) should have waited no more than 18 weeks from referral	93.3	★	93.2	★	93.4	★	91.9	▲	92.0 ★	92.1 ★	91.6 ▲	92%	Monthly	Included within COO report.
Number of patients waiting more than 52 weeks	0	★	1	▲	1	▲	3	▲	0 ★	0 ★	3 ▲	0	Monthly	Included within COO report.
Urgent operations cancelled for a second time	0	★	0	★	0	★	0	★	0 ★	0 ★	0 ★	0	Daily during Winter (Nov-Mar)	There is no significant risk identified to threaten future performance.
Number of patients not treated within 28 days of last minute elective cancellation	5	▲	2	▲	2	▲	1	▲				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					Q2		Q3		Oct 2015	Nov 2015	Dec 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	97.2	▲	98.6	▲	98.1	▲	97.6	▲	97.2 ▲	97.5 ▲	98.0 ▲	99%	Monthly	The challenge for this measure still lies with CMFT who predict they will reach target by March 2016.

A&E waits - Last Four Full Quarters								Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4	Q1	Q2	Q3				Oct 2015	Nov 2015	Dec 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients should be admitted, transferred or discharged within 4 hours	86.0 ▲	93.4 ▲	92.1 ▲	82.1 ▲				89.6 ▲	80.1 ▲	76.4 ▲	95%	Weekly	Performance within the ED remains challenging. The SRG are in the process of developing a high impact intervention recovery plan for short and long term whole system performance objectives.
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	Q1	Q2	Q3				Oct 2015	Nov 2015	Dec 2015	Operational Standard	Collection Frequency	Status Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	95.7 ★	96.0 ★	95.8 ★	97.0 ★				96.3 ★	97.0 ★	97.7 ★	93%	Monthly	There is no significant risk identified to threaten future performance.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	98.0 ★	95.5 ★	97.2 ★	94.9 ★				93.2 ★	94.6 ★	96.7 ★	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	Q4		Q1		Q2		Q3		Oct 2015		Nov 2015		Dec 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	97.6	★	98.3	★	98.9	★	98.6	★	100.0	★	99.2	★	96.3	★	96%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is surgery	97.2	★	98.2	★	98.2	★	97.6	★	100.0	★	98.5	★	94.0	★	94%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	100.0	★	100.0	★	100.0	★	100.0	★	100.0	★	100.0	★	100.0	★	98%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	100.0	★	90.0	▲	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	Q4		Q1		Q2		Q3		Oct 2015		Nov 2015		Dec 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85.5	★	88.3	★	88.2	★	87.4	★	78.5	▲	90.5	★	94.4	★	85%	Monthly	There is no significant risk identified to threaten future performance.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	91.9	★	96.9	★	85.2	▲	100.0	★	100.0	★	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)	72.7	n/a	79.5	n/a	72.1	n/a	72.1	n/a	77.8	n/a	64.3	n/a	72.7	n/a	No National Standard	Monthly	There is no National Standard for this measure.

Category A ambulance calls - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4	Q1	Q2	Q3	Oct 2015	Nov 2015	Dec 2015	Operational Standard	Collection Frequency	Status / Commentary
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	67.0 ▲	77.5 ★	78.5 ★	74.7 ▲	75.9 ★	73.4 ▲	74.9 ▲	75%	Monthly	NWAS acknowledged failure to target of category A calls and state that this is in part due to increased demand over winter, an unstable workforce and increased turnaround times at EDs.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	65.8 ▲	76.6 ★	75.4 ★	70.1 ▲	72.5 ▲	68.5 ▲	69.5 ▲	75%	Monthly	There is no significant risk identified to threaten future performance.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	91.1 ▲	95.2 ★	94.8 ▲	92.9 ▲	94.1 ▲	92.0 ▲	92.7 ▲	95%	Monthly	There is no significant risk identified to threaten future performance.

Mixed Sex Accomodation Breaches - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q4	Q1	Q2	Q3	Oct 2015	Nov 2015	Dec 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	Q4	Q1	Q2	Q3	Oct 2015	Nov 2015	Dec 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	100.0 ★	100.0 ★	96.1 ★	96.5 ★	94.4 ▲	96.0 ★	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	Q3		Q2		Q2		Q3		Oct 2015		Nov 2015		Dec 2015		Operational Standard	Collection Frequency	Status / Commentary
Incidence of healthcare associated infection (HCAI) i) MRSA	0	★	0	★	0	★	3	▲	2	▲	0	★	1	▲	0	Monthly	The case in December is a repeat case of one reported in October which was a complex case of an elderly gentleman with multiple wounds and poor compliance to treatment. Full RCA still ongoing.
Incidence of healthcare associated infection (HCAI) ii) C. Difficile	22	★	34	▲	36	▲	30	▲	12	▲	11	▲	7	★	7.4	Monthly	There is no significant risk identified to threaten future performance.

Key

Indicator RAG rating

★ Green - Performance at or above the standard

▲ Red - Performance below the standard

Statutory Duty & Resilience Compliance

Statutory Duty and Resilience - Last Four Full Quarters								Last Three Months						Details		
Statutory Duty or Resilience Measure						Q3		Oct 2015		Nov 2015		Dec 2015		Operational Standard	Collection Frequency	Status / Commentary
Percentage of FoIs handled within the legal timeframe	100.0	★	100.0	★	98.3	★	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	1	▲	0	★	0	★	0 ★	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Number of statutory Governing Body roles vacant	0	★	0	★	0	★	0 ★	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Percentage of complaints responded to within 25 working days	77.8	▲	84.6	★	90.9	★	75.0 ▲	100.0	★	50.0	▲	70.0	▲	80%	Monthly	
Percentage of days lost to sickness in the last 12 months	2.23	★	2.01	★	1.89	★	2.35 ★	2.24	★	2.28	★	2.52	▲	2.5%	Monthly	
Percentage of staff contracts which are substantive.	85.6	★	80.7	★	78.9	▲	81.7 ★	81.8	★	81.3	★	82.1	★	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	100.0	★	100.0	★	100.0	★	100.0 ★							100%	Quarterly	There is no significant risk identified to threaten future performance.

NHS
Stockport
Clinical Commissioning Group

Quality Report

Report of the Quality Committee

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

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Executive Summary

The Governing Body is requested to consider whether any of the issues raised in this report require a higher level of escalation.
Please detail the key points of this report
Summary • This report summarises the key decisions of the Quality & Provider Management October Committee. **Decisions** • None **Attachments** • Quality & Provider Management November Issues Log
How does this link to the Annual Business Plan?
Improving the quality of commissioned services is a key strategic aim within the CCG Annual Operational Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Quality Committee
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Mark Chidgey
Meeting Date: 9 March 2016
Agenda item: 7 (b)
Reason for being in Part 2 (if applicable)
Not applicable

1.0 Decisions of the Quality Committee

1.1 Issues Log:

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- The issue of timeliness of 62 day cancer treatment was removed.
- No new issues were added.

2.0 Issues highlighted to the Governing Body

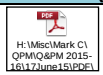
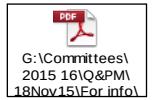
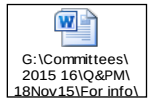
2.1 The following matters were highlighted to the Governing Body for information:-

- Good progress on achievement of TIA standard has been sustained.
- To note that the issue of the quality impact of SFT CIP remains unresolved.
- That failure to achieve performance standards by the NHS111 service is being progressed through contract processes and a performance notice has been issued.
- That the committee are tracking progress on mental health and Learning Disability patients placed out of area.
- That the committee have requested an explanation from the DoF as to how capacity gaps for Looked After Children will be addressed in the context of a GM DoFs agreement on not auctioning cross border funding.
- Assurance had been received on progress on safeguarding compliance within maternity services.
- That both District Nurse capacity and Gastroenetrology follow up will remain on the issues log.

3.0 Decisions for the Governing Body

- None

Quality Committee Issues Log
(Following Quality Committee of 17 February 2016)

Issue	Date added	Description	Action / Progress	Owner	Expected date of removal	Q&PM RAG rating	Last Updated	Context (papers)
1	17/06/2015	There is an issue regarding safeguarding assurance in Maternity at SFT.	Julie Estcourt presented signficant progress against the action plans. To review at next commitee.	SG	Mar-16		Feb-16	
2	20/05/2015	There is an issue with St Ann's Hospice non-compliance with Safeguarding standards which may put patient safety at risk.	Escalated to NHS England. Action Plan received from St Ann's in June. Reviewed and monitored by SG, currently on trajectory, however, voluntary staff are currently not trained to review in March 2016.	SG	Mar-16		Feb-16	St Ann's Action Plan.
3	19/11/2014	There is an issue that the District Nurse service staffing levels are not at a level to meet patient needs. Stockport GPs are reporting a need to provide additional care to patients. This is not sustainable.	SFT trajectory to achieve compliance with staffing establishment is monitored at community contract meeting. However, post acuity review the Trust have supplied a report with a revised shortfall, this is being progressed through seperate meetings and will have further resource implications.	CB	May-16		Feb-16	Trajectory & SFT Risk rating 
4	20/11/2013	There is an issue with patients receiving timely follow-up in gastroenterology.	Number passed due date has risen due to elective capacity over the winter months. The CCG has reviewed the Trusts validation process and did not gain full assurance that all patients were subject to risk assesment. CCG awaiting plan to address backlog and risk review of waiting list.	CB	Mar-16		Feb-16	
5	18/11/2015	There is an issue that front-line staff at SFT have not received PREVENT training and this may not be rectified until 2018.	Compliance with PREVENT training has been tracked through a KPI since April 2015. This has not been met. Trajectory for compliance is by 2018. Stockport CCG communicated that this is not acceptable.	SG	Mar-16		Jan-16	

Locality Chairs report for Governing Body

The Chairs felt that the Primary Care Development Scheme report was extremely positive. At recent Locality meetings members were provided with feedback. This was well received as it was felt it was the first time they had been provided with feedback on something that they are involved in. In view of this Chairs were keen to push the investment in primary care.

Chairs felt that it was important working with hospital as Commissioners that we include primary care capacity in these discussions.

Workforce continues to be a major issue. There are problems recruiting clinicians both GPs and practice nurses. There are less GPs coming into primary care, wanting to work less hours and many aren't interested in partnerships. Many of the practice nurse population are due for retirement in the next 5 years. This all needs to be considered when moving services from the acute sector into primary care.

There continue to be concerns expressed by members about the service provided by NHS 111. Patients are reporting dissatisfaction with the service with long waits for calls to be answered. This in turn is leading to patients abandoning the call and seeking other solutions which may include ED attendance. Clinicians are reporting the forms that they need to complete when they feel inappropriate advice has been provided to patients are lengthy and cumbersome. This in turn is leading to them not bothering to complete these forms so the true scale of the problem cannot be ascertained. It has been agreed that a questionnaire around NHS 111 will be available for GPs to complete at their Start of Year conference in May. Feedback can then be given to Blackpool as lead commissioner.

NHS
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Chief Operating Officer's update

Chief Operating Officer's update to the March 2016 meeting of the Governing Body

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Executive Summary

What *decisions* do you require of the Governing Body?
This report provides an update on a number of issues.
Please detail the key points of this report
Provides an update on: 1. Delegated Commissioning 2. Joint Strategic Needs Assessment 3. CCG Assurance Framework 4. 2016/17 Planning Round 5. Stockport Together 6. Procurement
What are the likely impacts and/or implications?
How does this link to the Annual Business Plan?
Supports delivery.
What are the potential conflicts of interest?
The CCG will need to manage Conflicts associated with delegated commissioning in accordance with national guidance and local policy.
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 9th March 2016
Agenda item: 10

Chief Operating Officer Update

1.0 Purpose

1.1 This is the report of the Chief Operating Officer to the Governing Body for March 2016.

2.0 Delegated Commissioning of Primary Care

2.1 The CCG Accountable Officer has signed the Delegation Agreement with NHS England for the delegation of primary medical care commissioning which will start on 1st April 2016. A Memorandum of Understanding with the GM Primary Care Team for the provision of support for delegated commissioning has been agreed. During 2016/17 the CCG will need to work through any additional capacity requirements associated with this delegated responsibility and develop its approach to the commissioning of primary medical services. It is essential that there are robust arrangements in place to manage the conflicts of interest associated with this. The CCG has previously been assessed as managing conflicts very well (and have been identified as a model of good practice) and we have identified that this is an area that the Governing Body will focus on early in 2016.

3.0 Joint Strategic Needs Assessment

3.1 Every three years Stockport's Health and Wellbeing Board undertakes an in-depth review of health and social care needs in Stockport to inform our strategies and service plans. Key trends emerging from the data focus on the importance of prevention and lifestyles choices to support a sustainable system; the need to integrate health and social care services to meet changing needs and an increase in complex care needs among our ageing population; it highlights the overreliance of the current system on hospital-based services; and identifies cancer, alcohol and liver disease, obesity and diabetes, asthma, mental health, dementia and supporting carers as key priorities going forward. (https://stockport-haveyoursay.citizenspace.com/stockport-council/201516jsnasummaryreport/supporting_documents/201516%20JSNA%20%20Summary%20Report.pdf)

3.2 Data from the JSNA has already been used to shape priorities in the CCG's Operational Plans and the 5 year Stockport Together plans, as well as the Local Authorities.

4. CCG Assurance Framework

4.1 NHS England is currently consulting on a new CCG Assessment Framework (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/CCG-IAF-engagement-document.pdf) as a means for monitoring progress on the Government's Mandate to NHS England. The Framework covers four themes: Better Health; Better Care; Sustainability; and Leadership. Under these headings, it will map CCG performance in 6 clinical areas: Mental Health; Dementia; Learning Disabilities; Diabetes; Cancer; and Maternity. CCG performance will be published on the *my*

NHS website and assess CCGs using Ofsted-style ratings (outstanding; good; requires improvement; inadequate). An initial baseline will be published in June 2016, with formal annual assessments from Summer 2017 onwards.

5. 2016/17 Planning Round

5.1 The CCG and Providers submitted their first draft plans on the 8 February. As previously discussed with Governing Body, the plans are based on Forecast Outturn for 2015/16 and assume a maximum risk of 3% of growth across all services to support delivery of key national Must-Dos - in particular achievement of Referral to Treatment, Mental Health and Cancer targets. Given the progress made across Stockport over the past two years in better managing Long-Term Conditions within Primary Care and reducing variation in referrals, our contract negotiations with Stockport FT are based on 0% growth with this provider. Key investments in the plan include continuation of the successful GP Development Scheme, a significant uplift in Mental Health spending (5.9%) and additional activity around RtT and cancer. The finance report provides an update on the financial challenges which need to be addressed before these plans can be finalized. A final draft operational plan will be brought to the Governing Body at the end of March for approval.

6.0 Stockport Together Update

6.1 The Stockport Together programme continues to develop. In February 2016 we welcomed Paul Plsek a global leader in innovation and improvement in complex organisations, to share how the latest thinking can help transform health and social care for our borough. A wide range of people involved in the Stockport Together team were able to examine the latest thinking and evidence associated with large scale complex change. Paul encouraged the team to understand and explore the factors that influence the development of a culture that drives innovation and to explore the challenges and approaches to leading large scale complex change across organisations.

6.2 The workshop helped the team to understand the complexity of what we're trying to do in Stockport, as well as providing some tangible advice about what we can do to tackle some of the challenges we will face.

4.3 The Vanguard proposal for 2016/17 – 2017/18 was submitted and we are awaiting feedback. This will be assessed and approved in Greater Manchester as part of the Devolution arrangements. The national Vanguard team met with representatives of the Stockport Together Team recently, and were very positive about the Stockport Together programme.

5.0 Procurement

5.1 As required by the CCG procurement policy we are currently prioritising potential procurements against our limited capacity. Currently the following procurements are in progress:

- IV Therapy
- GP Visiting scheme (Pathfinder)
- Care Homes framework agreement for Continuing Healthcare (as below)

5.3 In addition it is confirmed that a procurement which had been in progress for ECG interpretation services has been ceased as the process did not provide a clear outcome. Re-running the procurement is disproportionate to the cost of the service and the CCG is assured on the quality of the existing service. Therefore the existing service will continue with the current provider, Broomwell Healthwatch Ltd.

5.2 The CCG is part of a North West Care Home framework agreement. Review of the proposals has shown that they would not establish the basis of a strong future agreement. We have formed this opinion primarily because of the wide range of responses from care homes; some of these were at a level where they were too low to be sustainable for care home providers and others were not sustainable for the CCG. Consequently, we have made an offer to extend the terms of the existing 2012 agreement until 31st March 2017 with an increase to the current base weekly rate per person. Currently 4 of the 7 providers have agreed to this with 3 responses awaited.

6.0 Action requested of the Governing Body

1. To note the update

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Executive Summary

What *decisions* do you require of the Governing Body?
The Governing Body is required to : 1. Note and approve the Greater Manchester Strategic Plan 2. Endorse the continued approach to the arrangements for the commissioning of specialised services within Greater Manchester 3. Note the establishment of Governance Arrangements for the South East Sector
Please detail the key points of this report
This report provides an update on the following matters: (a) Greater Manchester Strategic Plan (b) Specialised Services Commissioning Update (c) South East Sector Implementation Governance
What are the likely impacts and/or implications?
The implications and impact of each of the reports is outlined within each of the additional appendices.
How does this link to the Annual Business Plan?
Regional and sector based work forms a key part of the delivery of the Stockport Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
The individual reports have been discussed at their development bodies.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Ranjit Gill
Meeting Date: 9 March 2016
Agenda item: 11

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Item [4a]

GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION STRATEGIC PARTNERSHIP BOARD

Date: 18 December 2015

Subject: Strategic Plan – Final Draft Document (v11.1)

Report of: Katy Calvin Thomas

PURPOSE OF REPORT

This paper provides SPB members with a final draft iteration of the GM Strategic Plan, in advance of wider public engagement from January 2016.

RECOMMENDATIONS

The Board is asked to:

- Note the progress made in developing the final draft Plan
- Provide comments/feedback where necessary
- Support and endorse the contents of the Plan, subject to any required refinement/additions from the discussion today and in advance of wider stakeholder consultation from January 2016
- Take through own organisational/locality governance in advance of final signoff of the Plan by April 2016

CONTACT OFFICER:

Katy Calvin Thomas
Katy.calvinthomas@nhs.net

Taking charge of our health and social care in Greater Manchester

FOREWORD

In February 2015 the 37 NHS organisations and local authorities in Greater Manchester signed a landmark devolution agreement with the Government to take charge of health and social care spending and decisions in our city region.

We wanted to do this because we believe having the freedom to radically transform the health of our population and to build a clinically and financially sustainable model of health and social care, is a huge opportunity, as well as a great responsibility.

Greater Manchester has the fastest growing economy in the country and yet people here die younger than people in other parts of England. Cardiovascular and respiratory illnesses mean people become ill at a younger age, and live with their illness longer than in other parts of the country. Our growing number of older people often have many long term health issues to manage.

Thousands of people are treated in hospital when their needs could be better met elsewhere, care is not joined up between teams and not always of a consistent quality. We also spend millions of pounds dealing with illnesses caused by poverty, loneliness, stress, debt, smoking, drinking, unhealthy eating and physical inactivity.

The £6 billion we currently spend on health and social care – and the way we spend it - has not improved this picture across Greater Manchester.

The challenge is significant; if we don't start to act now to radically change the way we do things, by 2021 more people will be suffering from poor health and we will be facing a £2 billion shortfall in funding for health and social care services.

But like the challenge the opportunity is huge. Our goal is to see the greatest and fastest improvement to the health, wealth and wellbeing of the 2.8 million people in the towns and cities of Greater Manchester.

In order to achieve this, we know we need a radical change in how we build resilience in people and communities, as well as providing safe, consistent and affordable health and social care. We need to strike a new deal with people in Greater Manchester.

Our focus must be on our people and our places, not organisations. There will be a responsibility for everyone to work together, from individuals, families and communities as well as the 80,000 staff working in the NHS and social care, to the voluntary sector and the public bodies.

We want our city region to become a place which sits at the heart of the Northern Powerhouse, with the size, economic influence and above all skilled and healthy people to rival any global city.

Put simply, skilled, healthy and independent people are crucial to bring jobs, investment and therefore prosperity to Greater Manchester. We know that people who have jobs, good housing and are connected to families and community feel and stay healthier.

So we need to take action not just in health and social care, but across the whole range of public services so the people here can start well, live well and age well.

We are taking charge of GM through our strategy of growth and reform of public services. All 37 organisations in Greater Manchester are taking responsibility and working with their communities to understand how every person here can play their role.

We hope you will support our bold and ambitious Strategic Plan; the first of its kind in the country.

We welcome the positive contribution of the Healthwatch and other patient groups as well as input from voluntary, social care and 3rd sector organisations. We look forward to continued and stronger partnership working as we implement the Plan.

Lord Peter Smith
Leader Wigan Council
Chair of the Greater Manchester Health and Social Care Strategic Partnership Board

Hamish Stedman
Chair of NHS Salford Clinical Commissioning Group
Chair of the Greater Manchester Association of Clinical Commissioning Groups

Ann Barnes
Chief Executive Stockport NHS Foundation Trust
Chair of the Greater Manchester NHS Provider Trust Federation Board

Tracey Vell
Chair of the Association of Greater Manchester Local Medical Committee
GM Primary Care Representative

Sir Howard Bernstein
Chief Executive Manchester City Council
Head of Paid Service
Greater Manchester Combined Authority

Ian Williamson
Chief Officer
Greater Manchester Health and Social Care Devolution

Chapter 1 – The Greater Manchester context

Across Greater Manchester (GM) we are working together on the radical reform of public services. Our ambition is **to improve outcomes for our people, increasing independence and reducing demand** on public services. The £6 billion we currently spend on health and social care has not improved the long term outcomes for people living in GM.

GM faces an **unprecedented challenge** now, and over the next five years, in health and social care service provision. We know that if we don't act now, not only will **our outcomes remain worse than the rest of the country, but by 2021 we will have a £2 billion gap** in our public service finances.

Our response to this is to place **health and social care reform at the heart of our city region reform and growth** agenda; **healthy and independent people play a key part in enabling us to achieve our ambition for a growing and sustainable GM** in the future.

In order to achieve this, we know we need **radical change at scale** in how we provide health and social care and a new deal with people in GM. Our focus must be on **people and place, not organisations**. This is critical in helping us to achieve our vision 'to deliver the fastest and greatest improvement in the health and wellbeing' of the 2.8 million people living across GM.

We need to **take action across the whole range of care services;** upgrading our approach to prevention, early intervention and self-care; redefining how primary, community and social services become the cornerstone of local care; standardising and building upon our specialist hospital services through the development of shared hospital services; and creating efficient back office support.

This plan explains how, as a system, we are going to approach and achieve this and how our **transformation fund will help us change,** to radically shift the nature of demand and reform service provision.

Our ambition for Greater Manchester

Our ambition is for GM to become a financially self-sustaining city region, sitting at **the heart of the Northern Powerhouse** with the size, assets, skilled and healthy population, and political and economic influence to rival any global city.

In April 2011, GM established the first combined authority in the country (GMCA), providing stable, efficient and effective governance of our strategic agenda through the ten local authorities in GM. In 2014, the **Growth and Reform Plan,** built on our long history of **collaboration**, was underpinned by a common commitment by all of our local authorities to **increase the prosperity** of the people of GM.

The 12 Greater Manchester clinical commissioning groups (CCGs) formed the Greater Manchester Association of CCGs (GMACCG) in 2013, building upon a strong history of collaboration between NHS commissioners in the region. It has been instrumental in planning and delivering a number of significant transformation programmes within GM including: stroke reconfiguration, primary care medical standards and Healthier Together.

GM has a strong track record of collaboration with all of its key stakeholders, particularly business. The GM Local Enterprise Partnership (LEP) works constructively with the GMCA and with the extensive network of business organisations to ensure not only that business plays a full part in helping to shape the strategic direction of GM, but also through its participation in the Manchester Growth Company where it plays an active role in overseeing the delivery of key investment and growth responsibilities.

The **reform of health and social care is vital to improving GM's productivity** by **helping more people to become fit for work, get jobs, get better jobs and stay in work for longer**. It will also help to manage the demand on services created by an ageing population. Addressing together the issues of **complex dependency** will help those further away from the job market to move towards jobs and assist the low paid into better jobs. **Reform of Early Years** provision is key to increasing productivity of parents and, in the future, their children.

Why we need change

The NHS Five Year Forward View acknowledges that some improvements have been made in health and social care over the last 15 years: cancer survival is its highest ever, early deaths from heart disease are down by over 40%, and long waits for operations have reduced from 18 months to 18 weeks.

However, the current fragmented health and social care system has not enabled us to improve the lives of people in GM at a scale and pace to realise our ambitions. The challenge we now face is bigger than ever.

The **health outcomes for GM people are worse than those in other parts of the country** and health inequalities are deep-rooted. Older women in Manchester have the worst life expectancy in England. The high prevalence of long term conditions such as cardiovascular and respiratory disease mean that GM people not only have a shorter life expectancy, but can expect to experience poor health at a younger age than in other parts of the country. Our population has aged and our older population will increase by 25% by 2015. As more people have developed multiple long term conditions the **focus has shifted from curing illnesses to helping individuals live with chronic ill health**.

Many people are treated in hospital when their needs could be better met in primary care or the community. There is too little co-ordination between urgent and emergency services - A&E, Ambulance, GP out of hours, and NHS 111. There are real risks of **significant market failure in domiciliary, residential and nursing care across social care** and this impacts on system resilience and hospital discharge planning. There is a rising burden of illness caused by lifestyle choices like smoking, drinking and obesity. These changes have put the **NHS and social care under increasing pressure** and a growing number of people with multiple problems receive care that is fragmented or leads to wasteful duplication.

On present trends, if we do nothing, the GM health and social care system **will face an estimated financial deficit of £2 billion by 2020/21**. That pattern of rising demand is connected to our current organisation of services and the imbalance between preventive early help services and those which

respond when crisis occurs. The **scale of the challenge demonstrates why radical change is needed**, both in the way services are delivered and in the way the public use them. This is why we must use this opportunity to take charge.

Reforming our services

On 1 April 2016 a new era in GM's history begins when it becomes the first region in the country to have devolved control over integrated health and social care budgets, a combined sum of more than £6 billion. For the first time, **health and social care will become integrated** and local people will be taking charge of decisions on the health and care services for GM.

But GM is not just taking charge of health and social care provision. Fundamental to the success of the ground-breaking agreement between Government and GM will be our ability **to draw together a much wider range of services that contribute to the health and wellbeing** of GM residents.

The impact of **air quality**, **housing, employment, early years, education and skills on health and wellbeing is well understood**. In GM, General Practitioners (GPs) spend around 40 per cent of their time dealing with these non-medical issues. Therefore GM is embarking on a large scale programme of whole-system public service reform, bringing together decision making, budgets and frontline professionals to shape services in ways that better support local residents and communities.

With local services working together, **focussed on people and place**, we want to transform the role of public services and take a more proactive approach rather than responding to crises. We want to transform the way we use information, empowering our frontline workforce to make more informed decisions about how and when they work with individuals and families. Building on the principles of early intervention and prevention, GM aims to deliver the appropriate services at the right time, supporting people to become healthier, resilient and empowered.

This Plan shows that GM has seized the unique opportunity to shape its future, drawing on the assets of world-class public services, a strong business base, and healthy, strong communities. We are taking charge of our future, working together to help GM thrive.

What we think is needed

Our vision is **to deliver the fastest and greatest improvement in the health and wellbeing of the 2.8 million population of GM**, creating a strong, safe and sustainable health and care system that is fit for the future. To do this we have focussed on delivering change in two critical areas:

1. Creating a new health and care system

Our single integrated health and social care plan is a **national first.** The devolution agreement means we can think differently and promote service and system change in ways that build on people's views, **strengthen local decision-making** and accountability to deliver significantly better outcomes.

We want **to see the gap in health inequalities and finances reduced further and faster**, for the first time, by providing joined up care from across the public sector and beyond.

We will take action across the whole range of care services, **upgrading our approach to prevention, early intervention and self-care; redefining how primary, community and social services become the cornerstone of local care; standardising and building upon our specialist hospital services through the development of shared hospital services; and creating efficient back office support.** These proposals are explained in Chapter 4.

By working together, unhindered by artificial and bureaucratic barriers, organisations will provide **integrated care** to support physical, mental and social wellbeing, improving the lives of those who need help most. Our new models of care will build on the NHS England's Five Year Forward View by re-orienting our health and care systems so that we focus on preventing the big health and care problems, like cancer, cardiovascular disease, diabetes and respiratory, but also social isolation and deprivation which undermine our prosperity as a city region, and investment in early years and employment.

We know a critical enabler of the transformation we are pursuing is a fit for purpose health and social care workforce. GM's NHS and social care workforce is currently over 110,000 strong, but we know we need to address some skills and capacity shortages going forward in all parts of the system if we are to improve outcomes for people in GM.

The scale of change will impact significantly on our **workforce** and a key aspect of the Plan will focus on how our workforce becomes an enabler to support the delivery of our ambition. We need a workforce which is fit for purpose, able to adapt to changing demographics and embrace new models of care. We need a more flexible workforce with a breadth of skills and knowledge that enables to us transform, lead and develop new models of care.

2. Reaching a 'new deal' with public

At the heart of our approach to devolution is the brokering of a new relationship with the people of GM.

The long term health and wellbeing of people will only be secured through a new relationship between people and the services they use; striking a new deal which needs both sides to deliver on its promises if we are going to transform the long-term health of GM.

In its simplest form public services will take charge of and responsibility for their localities, for example:

- Ensure there are a wide range of facilities within local communities including parks, open spaces, leisure, safe cycling routes, good quality housing.
- Ensure easy, timely access to good quality seven day a week primary care to screen, diagnose and treat and prevent disease as early as possible.
- Support families to bring up their children to have the best start in life through our Early Years New Delivery Model.
- Support all residents to live well, supporting unemployed people into work or training and

helping residents benefit from the fastest growing economy in the UK.
- Assist people to age well; keeping healthy and connected to their neighbours for as long as possible at home.

At the same time the people of GM must take greater charge of, and responsibility for, their own health and wellbeing. This could include:

- Keeping active and moving at whatever stage of life.
- Registering with a GP and going for regular check-ups, taking charge of their own health and wellbeing.
- Drinking and eating sensibly, not smoking and encouraging their children to do the same.
- Taking time to be supportive parents, bonding with their babies and encouraging their children to be the best they can be.
- Taking advantage of training and job opportunities setting high aspirations for themselves and their families.
- Supporting their older relatives, friends and neighbours to be as independent for as long as possible.
- Getting involved in their local communities.

Devolution of health and social care to GM provides the first opportunity to tackle the historic fragmentation of leadership, planning and service delivery in our health and care services. By **working collaboratively and planning together for change**, we will improve services to increase the wellbeing of our residents and create a strong, safe and sustainable health and social care service that is fit for the 21st century.

Population Health Outcomes

We recognise that we generally have worse health outcomes than England. We will therefore concentrate our efforts closing the gap between GM and England by raising population health outcomes to those projected for England in five years' time, in other words we will go further, faster.

The impact of **housing, employment, air quality, early years services, education and skills on health and wellbeing is well understood** and we have organised our prevention and early intervention work around a life course approach – Start Well, Live Well and Age Well.

Outcome	Measure
START WELL	
More GM Children will reach a good level of development cognitively, socially and emotionally.	Improving levels of school readiness to projected England rates will result in 3250 more children, with a good level of development by 2021.
Fewer GM babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in GM to projected England rates will result in 270 fewer very small babies (under 2500g) by 2021.
LIVE WELL	
More GM families will be economically active and family incomes will increase.	Raising the number of parents in good work to projected England average will result in 16,000 fewer GM children living in poverty by 2021.
Fewer people will die early from Cardio-vascular	Improving premature mortality from CVD to

disease (CVD).	projected England average will result in 600 fewer deaths by 2021.
Fewer people will die early from Cancer.	Improving premature mortality from Cancer to projected England average will result in 1300 fewer deaths by 2021.
Fewer people will die early from Respiratory Disease.	Improving premature mortality from Respiratory Disease to projected England average will result in 580 fewer deaths by 2021.
AGE WELL	
More people will be supported to stay well and live at home for as long as possible,	Reducing the number of people over 65 admitted to hospital due to falls to the projected England average will result in 2,750 fewer serious falls.

We will ensure that we are addressing the health outcomes which are important to the people of Greater Manchester. We will therefore engage with the public to refine our outcomes frame work as we develop our implementation plans - #takingcharge.

Chapter 2 – Our Leadership journey

On 25th February 2015, the **Chancellor George Osborne, the Secretary of State Jeremy Hunt, NHS Chief Executive Simon Stevens** and the **Leaders of Greater Manchester** announced ground-breaking plans for the devolution of health and social care as part of the Northern Powerhouse.

NHS England, 12 NHS Clinical Commissioning Groups, 15 NHS providers and 10 local authorities entered into a landmark agreement - **Memorandum of Understanding** (MOU) – formally agreeing to take control of the £6 billion of public money spent on health and social care to transform the system and deliver radical change over the next five years.

We have committed to work together 'to deliver the fastest and greatest improvement in the health and wellbeing' of people across GM.'

We have already achieved significant progress together, through eight **early implementation work streams**, which have demonstrated our ambition, determination and capability to make rapid, system-wide service change.

Our journey

The Greater Manchester Devolution Agreement was settled with the Government in November 2014. It describes how decisions around a range of public services (transport, planning and housing) would be devolved to GMCA, giving people and their local representatives control over decisions which have previously been taken at national.

The reform of health and social care is a key part of this and following the wider agreement, NHS England, the 10 GM councils, 12 clinical commissioning groups and NHS and foundation trusts agreed to work together to transform health and social care.

In February 2015, the Memorandum of Understanding (**MoU)** between the Government, the GM health bodies and local authorities and NHS England, gave **local control** over an estimated budget of **£6 billion each year from April 2016**. The MoU covered all services including acute care, primary care, community services, mental health services, social care and public health.

Leadership challenge

In February 2015, we signed a historic agreement with the Government called a Memorandum of Understanding (MOU) which gave a commitment to GM having devolved powers for health and social care. We committed to the production, during 2015/16, of a comprehensive GM Strategic Sustainability Plan for health and social care. This, aligned with NHS England's Five Year Forward View, will describe how a clinically and financially sustainable landscape of commissioning and provision could be achieved over the subsequent five years, subject to the resource expectations set out in the Five Year Forward View, appropriate transition funding being available and the full involvement and support of national and other partners.

The 37 statutory organisations involved in health and social care across GM (listed at the back of the document) have formally agreed to work together by taking control of the £6 billion of public money spent on health and social care in GM. Working within the NHS Mandate, associated national policy and quality assurance parameters, we will aim to deliver rapid and radical improvements over the next five years.

Following the formal agreement to work together, the leadership and governance arrangements in GM had to be developed at pace and scale to ensure the system could reach decisions together in a robust, fair and equitable way. These governance arrangements were designed and agreed with the full involvement of senior leaders across the health and social care system.

Following the signing in February, A **Programme Board** met for the first time on 20th March 2015 to oversee the transition to full health and social care devolution. Co-chaired by Sir Howard Bernstein, Chief Executive of Manchester City Council and Simon Stevens, Chief Executive of NHS England it includes representatives from the NHS and local authorities in GM, and NHS England.

Early implementation priorities

We agreed a set of early implementation priorities as a GM system to help us to test our devolved arrangements and deliver change at pace and at scale.

In July 2015, we agreed and created a unified public health leadership for GM.

This is the first agreement of its kind in England and is between GM, NHS England and Public Health England to place a greater leadership emphasis and focus on prevention and early intervention to stop people in GM becoming ill, so that they can remain independent and have the best family, work and lifestyle opportunities to contribute to a transformational and sustainable shift in the health and wellbeing of the population.

By the end of 2015, everyone living in GM who needs medical help will have same day access to primary care services, supported by diagnostic tests, seven days a week.

In February 2014, we published our GM Strategy for Primary Care, which outlined our primary care commitments. As part of the delivery of this strategy, we developed the GM Primary Care Medical Standards, which will be implemented in the ten GM localities by December 2017.

In January 2016, we will extend our Working Well pilot to an additional 15,000 out of work GM residents.

In March 2014, GM established a Working Well pilot through a unique agreement with Government, which supports residents who have been unemployed for a long time back into sustainable employment.
Due to the success of the GM pilot, in January 2016, we will launch the expansion of the programme to improve support for a further 15,000 out-of-work residents who face barriers to work. This approach across health, employment and skills is the first example of its kind in England.

We have started the implementation of four shared, single site services as a result of the Healthier Together programme. This will save up to 1,500 lives across GM over the next five years.

In 2012, the CCGs in GM embarked on a programme to develop single shared services (care will be provided by a team of clinical staff working together across a network of linked hospitals) for urgent and emergency care, acute medicine and general surgery across the acute trusts in GM because there was variation in outcomes for patients undergoing abdominal general surgery at different hospitals.

In July 2015, the 12 GM CCGs, through the decision making body the Committee in Common, agreed to have four shared, single site services. As a result, hospitals will work in partnership to form shared single services. One of the hospitals within each of the single services will specialise in emergency medicine and abdominal surgery for patients with life-threatening conditions to ensure quality and safety standards are met and all hospitals can continue to provide care to their local population.

In September 2015, we launched Health Innovation Manchester – a partnership between leading healthcare research, academia and industry organisations across GM.

Health Innovation Manchester has been established to accelerate the discovery, development and implementation of new treatments and approaches, with a focus on improving health outcomes and generating economic growth. The combination of our research strengths, business base and eco-system and devolution makes this a unique opportunity within the UK and globally. We aim to be one of the best regions in the world for partnerships with innovative lifescience companies, driving economic growth and improving health outcomes.

Getting new ideas tested, adopted and widely used takes too long in the NHS – sometimes up to 20 years. To overcome this, GM has taken this unique step to accelerate health innovation into the local health and social care system. It is already in a strong position with three teaching hospitals, a research-led university base, a critical mass of life science firms and skilled workers, and a large and diverse population.

We will identify and spread the interventions that will have the biggest impact on the greatest number of people in GM. We will work to source the rapid take up of innovations on a large scale and to achieve this, we will also work to create industry partnerships, to speed development and attract inward investment.

There are a number of key enabling platforms that GM has that will be further developed to support health innovation. The priorities are our informatics and clinical trial capability, which provide essential underpinning for discovering, developing and delivering new therapies. Work is already underway to identify those treatments or approaches that could be delivered at scale in the short term and bring short term benefits while also testing the innovation system. These will be chosen within the context of place-based priorities that focus on the particularly health needs of the population.

We will set caps on locum and agency expenditure and develop a skills and employment passport by April 2016 to enable more flexible movement of our workforce.

An agreement is being negotiated to cap locum and agency expenditure across GM by April 2016.

In November 2015, we launched the GM three year vision for Learning Disabilities to improve independence for people living with learning disabilities and their families across GM.

Following the Winterbourne View scandal, a national strategy was announced to close long term institutions for people with learning disabilities and care for them in their communities closer to home.

There are currently 150 people with learning disabilities from GM in hospital who could more appropriately live in the community. In addition some people are in hospitals far from GM and are therefore unable to maintain good contact with their families and friends. There is a wide variation between the localities in GM in how people access services such as health checks and day care. We also have a higher number of children with learning disabilities in hospitals, compared to the average for England and Wales.

Our vision sets out how we will provide each person with a learning disability with a supported place to live, as close to their homes and families as possible. This should help people with complex needs to live in local neighbourhoods, encourage the development of skills and of social relationships, support them at times of crisis, and foster choice and independence.

This GM programme will align to the work taking place at a locality level to improve services for people living with learning disabilities.

In March 2016, we will launch a five year GM programme – Dementia United, to improve the lived experience of people with dementia and their families.

Dementia causes immense suffering to the individuals and families affected. To provide effective support, integrated services are vital - across NHS and social care, hospital and community services and physical and mental health services. Without good access, good co-ordination and good support, suffering is increased and costs rise.

By 2021, it is estimated there will be nearly 35,000 people living with dementia in GM.
Nearly a third (30%) will have severe symptoms, requiring 24 hour care. By 2021 the cost of caring for them is estimated to be around £375 million annually.

We will create a dementia service for GM that supports the delivery of the Prime Minister's dementia challenge and serves as a beacon for the UK.

It will:

- identify patients early
- slow down deterioration through monitoring
- provide consistently high quality community care to prevent hospital admission
- provide consistently high quality hospital care to avoid increases in length of stay

Central to our five year programme is the theme of 'connectedness' within which we have identified three key areas - Monitor my Health, Enrich my World, Connect me to my Support System.

To deliver this, we will **create a single commissioning framework to support the following**:

- Preventing well – reducing the risk of dementia, for example through health checks for vascular dementia
- Diagnosing well – developing a "seek and treat" system offering early assessment
- Living well – establishing dementia friendly communities
- Supporting well – providing access to health and social care as necessary, to reduce emergency admissions and care home placements
- Dying well – ensuring people die in the place of their choosing

We will support people newly diagnosed with dementia, with a **case worker** who will provide increasing levels of support to them and their carers as the condition progresses.

A great example of how working together across GM can create improved services is the work we are doing on cancer. Our goal is to push GM's outcomes and survival rates to at least the national average and to ensure, through prevention, that fewer people have cancer.

GM has some of the **very best cancer services and clinical outcomes in the country**. One year survival rates have increased faster than elsewhere over the last 15 years and have now surpassed the average for England. But it also has some of the **worst rates of premature death from cancer because of lifestyle factors for example smoking and delays in patients seeking help.** More than a quarter (28 per cent) of cases of cancer are diagnosed in A&E, when it is often too late for treatment to be effective. We also know that how people access services varies across different places.

As part of a GM Cancer Strategy by 2021, our vision is that we will have:

- a single GM cancer commissioning organisation to manage and monitor cancer services across GM
- a system leader that will be accountable for integrating all elements of cancer prevention and care
- a strategy for partner engagement to drive improvement
- innovative models of care such as delivering services closer to home
- reduced delays in referrals for treatment
- improved outcomes and survival comparable with top European countries
- reduced inequity across the conurbation by tackling unacceptable variations in access and quality of care
- a clear focus on prevention and rapid access to diagnostics
- support for education and research
- consistent quality standards
- a financially sustainable service

We will run a 3 year pilot (2015 – 2018) spanning the entire spectrum of cancer care from public health and primary care through to diagnostics, treatment, long term support and end of life care.

We are leading the way in GM, with cancer services working with the Royal Marsden and University College London Hospitals within a single National Cancer Vanguard established to test out new models of care delivery across the entire cancer patient pathway. The aim of this is to bring significant improvements in outcomes and patient experience through a strengthened focus on early referral and rapid access to diagnostic services.

We have developed and agreed a GM Strategy for integrated mental health services across public service provision. Implementation of this strategy will commence from April 2016.

Mental illness can seriously affect the lives of individuals and their families. People with mental health problems are far more likely to suffer physical ill health. For example they are approximately three times more likely to use emergency care, often for reasons not connected with their mental state.
Health costs for people with long term conditions are at least 45 per cent higher if they also have a mental health problem. Up to 18 per cent of all NHS spending on long term conditions is linked to poor mental health – equivalent to £1.08 billion in GM. Employment rates are below the national average (at 4.77 per cent of those on the Care Programme Approach) and sickness absence is high.

Life expectancy for those with severe mental illness is 10-15 per cent shorter than the general population.

There are many examples of good practice in mental health across GM but quality, access and support vary.

We will explore the integration of mental health service across the ten GM localities, and across the wider GM conurbation, with a single point of contact making it easier for service users and professionals to navigate.

Stronger links will be forged with the following programmes: Troubled Families, Working Well and Complex Dependency.

We are committed to achieving parity of esteem for people with mental health issues in GM through the development and agreement of a GM Mental Health Strategy. Through this we will focus on four priority areas:

- *Prevention and early intervention* through strengthened community services and public health campaigns
- *Improved access* through increased collaboration among services with 24/7 crisis support and shorter waits for psychological therapies
- *Creating a sustainable system* with common standards and payments for outcomes
- *Integrating care* across the life course and with a focus on delivering the right care at the right time in the right place

Chapter 3 – Building and governing the Plan

Following the signing of the MOU in February 2015, harnessing the strong leadership across the GM system, we agreed that to **transform our services** we need to work across the pathway of intervention and support.

This means we are working together to agree and define how we:

- **Change our relationship with people**, helping them to stay well, care for themselves and prevent illness and intervene early
- **Transform care in localities** by integrating primary, community, acute, social and third sector care through the development of new locally accountable platforms with single integrated commissioning hubs to facilitate clinical co-ordination
- Standardise and create consistent **evidence based hospital services**
- **Redesign our back office** support to create the most efficient services we can
- Create systems once at GM level which **incentivise our new models of care** and support

This Plan has been **built from ten locality plans**, **provider reform plans** and a range of **GM strategies**; it is complementary to and driven by what's happening in each local area. It has been developed with the input and support of national bodies and regulators, including NHS England, NHS Improvement (Monitor and the Trust Development Authority) and the Care Quality Commission.

Principles of the Plan

All of our **plans are focussed on people and places** rather than the different organisations that deliver services. This means we are thinking more innovatively about **pulling services together and integrating them** around people's homes, neighbourhoods and towns.

Our plans are developed on the principles of **co-design and collaboration**, all 37 statutory GM organisations have been working together to agree how we do things once, collectively, to make our current and future services work better.

We aim to secure **financial sustainability** through our plans and service reform.

Each locality is putting the money we have for health and social care into **pooled budgets**, so we can buy health, care and support services once for a place in a joined up way.

We develop plans based on the **principle of fairness** to ensure that all the people of GM can have timely access to the support they require.

We are **innovative in our approach**, using **international evidence and proven best practice** to shape our services to achieve the best outcomes for people in the most cost effective way.

We aim to deliver the best quality, outcome based services within the resource available.

We have used this early work to begin to create a plan between commissioners and providers at a GM level and submitted a bid as part of the government's Comprehensive Spending Review (CSR). This was our first piece of whole system modelling and financial planning and was submitted as part of the overarching Devolution CSR bid.

Building the plan

Our Plan for health and social care in GM is built on a history of collaboration between health and Local Authority partners, and we are used to working together.

We are working to ensure that we agree and take decisions in GM about GM at the right level – at neighbourhood, locality (there are ten localities in GM see below), cluster (more than one locaility) or GM wide.

We are working to agree the most appropriate levels of service delivery at which to plan, take decisions and deliver.

This Plan marks a significant change in the approach to planning that has been in place in previous years, where each statutory organisation developed its plans separately. This Plan describes how the GM health, care and support system and its 37 statutory organisations will work together. They will still have their own plans, as statutory bodies, but these individual plans will be shaped by the strategic context of the locality plans as well as the overall GM Strategic Plan.

Following the signing of the MoU, we have worked with all of the national and regulatory bodies to develop our plans at locality and GM level across commissioners and providers. This includes NHS England, NHS Improvement (Monitor and Trust Development Authority) , Public Health England (PHE), the Care Quality Commission CQC), National Institute for Health and Care Excellence (NICE), Health Education England (HEE), the Department of Health (DH), Her Majesty's Treasury (HMT) and the Department for Communities and Local Government (DCLG). Their strong support and commitment has been vital in achieving rapid progress and we will continue to work with them to implement our plans. We have signed an agreement for how we will work with PHE as a devolved system and will sign agreements with the remaining national bodies before the end of March 2016.

The Plan is built from locality plans, NHS provider plans and GM work stream plans.

Locality Plans

We have based this Plan on the ten localities - Bolton, Bury, Rochdale (including Heywood and Middleton) Manchester, Oldham, Salford, Stockport, Tameside (including Glossop), Trafford and Wigan.

Each of our ten localities has a **place-based plan** which will be signed off by their Health and Wellbeing Board.

The **Locality Plans form the bedrock** of what will be delivered in their area and set out how the savings from the integrated better care models and prevention will be delivered. The plans have been developed from work already underway to develop Better Care Fund (the integration of health and social care funding) plans, but have been radically extended across public sector services to integrate social care, mental health and Learning Disability services.

Each locality will start to align the CCG and Local Authority commissioning functions from April 2016 to develop **a single commissioning plan, pool budgets, integrate governance, decision-making and commissioning skills**. Across GM we have **committed to pool £2.7 billion**. This will ensure the outcomes that health and wider public services aim to achieve are aligned.

The plans also outline the intention to create single service models in each locality delivered through integrated neighbourhood teams to remove the fragmentation between services.

Work will focus on aligning primary and community care to ensure high quality re-ablement, rehabilitation, discharges and referral management.

Sharing these plans has enabled us to see where there is best practice in our localities, identify opportunities to scale up and roll out changes and determine the key priorities for delivery in the next five years and beyond to integrate our public service offer.

Each locality plan includes a **place-based ambition to contribute towards the delivery of the wider GM ambition**. They capture the full range of initiatives to improve health and wellbeing and many go beyond traditional health services to include work on housing, employment, Early Years, Troubled Families and community development.

NHS provider plans

All of the NHS providers in GM agree plans each year to run their services, including hospitals. These have always been agreed in individual organisations and with the people who regulate trusts (Monitor or the Trust Development Authority). For the first time, the 15 individual provider plans have been shared across GM between providers and with commissioners. The providers are working together with their commissioners to deliver local requirements, but are also working on some key work streams together where this makes sense.

GM work stream plans

Work in our localities alone will not fully address our financial sustainability challenge and in some cases there can be a greater benefit to plan and commission services at a cluster or GM level. We are always striving to integrate and provide services at the level closest to where people receive them, but how we change some services and connect people to the growth and economic reform opportunities is better done once at a GM level. This approach enables us to understand when we need to propose bold ideas that can only be planned and commissioned at a cluster or GM level, but will need to be delivered in the context of our neighbourhoods and localities.

We have developed and agreed plans which are aiming to address some of the specific challenges that exist across all localities in GM, like mental health, cancer, high levels of unemployment and deprivation. We have focussed these on areas where it makes sense to do the thinking once and agree how we can improve health care and support for people. The GM strategies include:

- Primary Care Strategy
- Specialised services
- Mental Health Strategy
- Public Service Reform programmes
- Cancer Strategy
- Learning Disability services
- Dementia services
- GM information sharing strategy: GM Connect

Agreeing how we work and take decisions

To successfully deliver our Plan and deliver the change that is required, the 37 statutory organisations involved in health and social care across GM have formally agreed to a new governance system – the first time this has been accomplished at this scale in England. This will enable GM to establish integrated leadership founded upon collaboration and evidence-based decisions about services delivered to GM residents. Commissioning will be undertaken in accordance with statutory responsibilities at locality level or when it is most appropriate, by commissioners collaborating at GM level.

Our governance system is based on the principles agreed in the MOU:

- GM NHS will remain within the NHS and subject to the NHS Constitution and Mandate
- Decisions will be taken at the most appropriate level
- GM will take decisions that are relevant to GM
- CCGs and local authorities will retain their statutory functions and their existing accountabilities for current funding flows
- Clear agreements will be in place between CCGs and local authorities to underpin the governance arrangements
- GM commissioners, providers, patients and public will shape the future of GM health and social care together
- All decisions about GM health and social care to be taken with GM as soon as possible

The new governance structure has:

- A Strategic Partnership Board (SPB) which sets the vision, direction and strategy for GM health and social care economy.
- A Strategic Partnership Board Executive (SPB Executive) which supports the SPB and will develop policy and make recommendations to the Board. It will be the engine that drives delivery of the Strategic Plan and ensures business at the Board is transacted efficiently.
- A Joint Commissioning Board (JCB) which commissions services at the GM level to deliver the vision set out by the SPB. It will be the largest single commissioning vehicle in GM and will produce a commissioning strategy in line with the Strategic Plan. The decisions it takes will be joint and binding.
- An NHS Provider Trust Federation Board where the 15 Trusts in GM have joined together to allow Trusts to work more effectively and efficiently.
- An overarching Provider Forum which will bring together NHS and non-NHS providers (domiciliary providers, private sector health providers, voluntary and hospices) to be part of the development of new models of care.
- Primary Care is represented at the SPB and SPB Executive and has also formed a Primary Care Advisory Group made up of representatives from Dentistry, General Practice, Pharmacy and Optometry

The members of these groups come from all 37 statutory GM health and social care organisations plus national bodies as appropriate (NHS England, NHS Improvement and others), as well as other providers, representatives from primary care, the voluntary sector and patients, including Healthwatch.

A key principle of the governance arrangements is that local commissioning will remain a local responsibility. The JCB will intervene in local decisions only where it agrees that it would be more efficient and effective for decisions to be made at a GM level.

Some national services (for example highly specialised services) will remain within the remit of NHS England, for practical and cost effectiveness reasons, and will be co-commissioned in many circumstances.

These arrangements will enable us to be clear about responsibility, accountability and assurance around the decisions that we take together.

Chapter 4 – Health and Social Care Reform

Our health and social care reform is built on the need to **reimagine services across our whole care system**.

By **upgrading prevention and self-care** we are proposing to change the way GM people view and use public services, creating a new relationship between people and the care system. This means more **people managing their health**, looking after themselves and each other. This means increasing early intervention at scale and finding the missing thousands who have conditions, but don't know it yet. We want to work across GM to have standardised support that helps people to **start well, live well and age well**.

Through the **transformation of community based care and support** we are proposing to enhance our **primary care services**, with local GPs driving new models of care and Local Care Organisations (LCO) forming to include **community, social care, acute, mental health services**, the full range of **third sector providers and other local providers such schools**. We want LCOs to be the place where most people use and access services, in their communities, close to home.

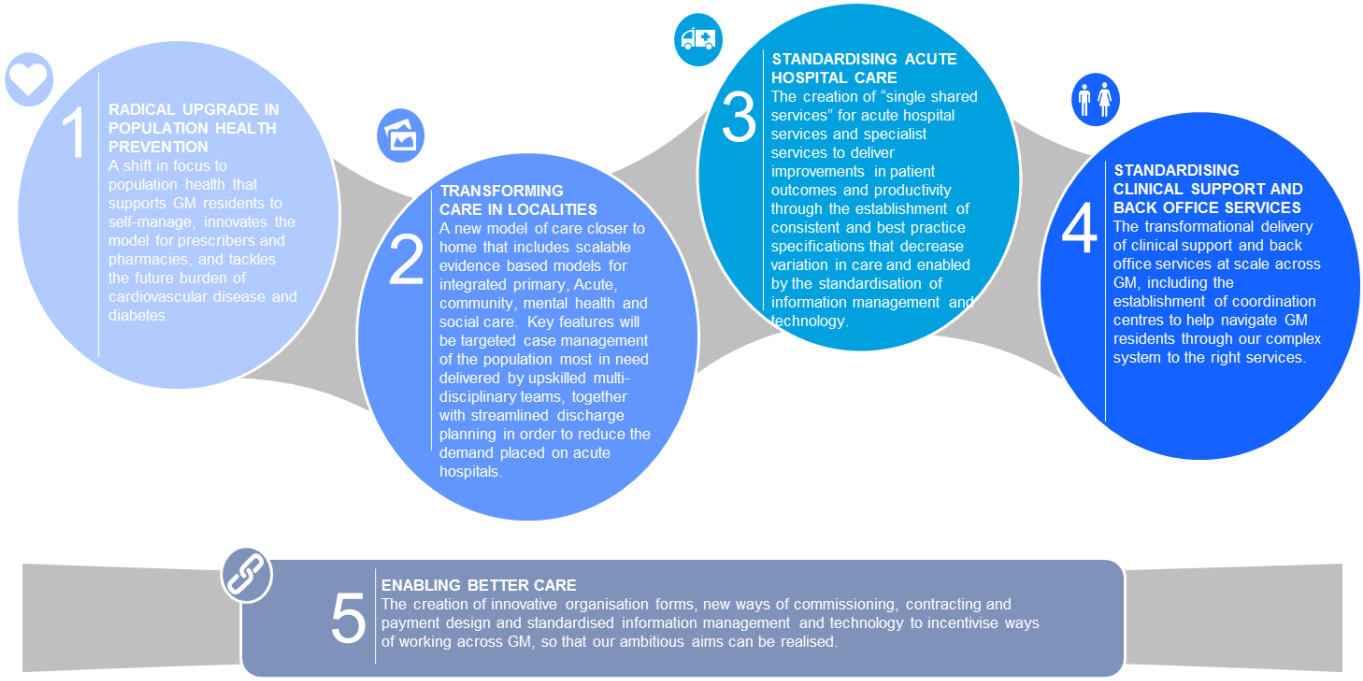
Through the **standardisation of acute and specialist care** we are proposing that NHS providers across GM increasingly work together and collaborate across a range of clinical services. We want a hospital sector which is functioning to the **best clinical pathways** and the **highest level of productivity** so people get the high quality care when they need it.

Through the **standardisation of clinical support and back office functions** we are proposing to redesign our services to meet the delivery and efficiency challenges of a redesigned care system. We want clinical support services which deliver at locality level and back office functions which drive the **best possible service models** for procurement, pharmacy and estate management.

In **enabling better care** we are proposing to work together to look at the most effective way to deliver our new care models and deliver standardised offers. We want a radically redesigned **payment system** to drive care in localities, we want **technology** to support this, we want an innovative and real time approach to **research and development** and we want one integrated approach to managing our public sector **buildings**.

It is widely accepted that GM will not meet the challenges it faces over the next five years through incremental change. Additionally, no single locality can deliver the scale of reform proposed here acting alone. Our transformation must be comprehensive, covering all aspects of care and support and all parts of Greater Manchester.

Engagement with NHS commissioners, providers and local authorities, alongside best practice from national and international experts has identified five key areas for transformational change, as indicated in the diagram below:



By **upgrading prevention and self-care** we are proposing to change the way GM people view and use public services, creating a new relationship between people and the care system. This means more people managing their health, people looking after themselves and each other. This means increasing early intervention at scale and finding the 'missing thousands' who have diseases, but don't know it yet. We want to work across GM to have standardised support that helps people to start well, live well and age well.

Through the **transformation of community based care and support** we are proposing to transform our primary care services, with local GPs driving new models of care and Local Care Organisations (LCO) forming to include community, social care, acute, mental health services and the full range of third sector providers. We want LCOs to be the place where most people use and access services, in their communities, close to home.

Each locality will have a joined up commissioning approach between the local authority and health partners, using pooled funds for a substantive proportion of the health and social care spend. Joint spending plans will be agreed to deliver shared improved outcomes for their local people.

These services will be delivered through the range of models described in the NHS England Five Year Forward View. The choice of model will be relevant to the local circumstances (multi-specialty community provider (MSCP), primary and acute care system (PACS), integrated care organisations (ICO), accountable care organisations (ACO) and accountable healthcare management organisations (AHMO)) but will hold a range of common features to ensure scale of impact. Across all the GM localities, we will refer to these as **Local Care Organisations**.

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The future health of our children, the sustainability of the NHS and the economic prosperity of GM all now depend on a radical upgrade in prevention and public health, as the NHS England Five Year Forward View made clear.

Our progress in achieving wider public service integration is key to securing the health benefit of non-medical support and helping our health and care system function better. This can span from early help to crisis response across the whole public service, alongside the voluntary and community sector, to ensure our blend of support is as effective and appropriate as it can be.

For example, connecting health and care to housing providers will extend their established role in building communities and improving individual wellbeing by working in partnership across the region to support health services, particularly around prevention, early intervention and re-ablement. Additionally, GM is clear on the health benefit brought by the fire service as an expert in prevention and community engagement. Greater Manchester Fire and Rescue Service now acts as a prevention agent on behalf of all health and care partners whilst continuing to reduce demand relating to fire.

Our aim is to boost independence, improve health and reduce demand on services, through five key themes:

1: More people managing health: people looking after themselves and each other

The influence of people's behaviour on health outcomes can be seen in everything from preventing illness through to the management of long term conditions. 60-70% of premature deaths are caused by behaviours that could be changed and around 70-80% of all people with long term conditions can be supported to manage their own condition.

Our ambition is to develop a whole systems approach to self-care, which can be adopted across localities. This will entail driving changes in commissioning, organisational and clinical processes, workforce development and the support provided to individuals and communities.

Key elements of our programme are:

- Working with Health Innovation Manchester to develop new digital technologies to allow people to track and analyse their own health data and to share this with others to aid prevention and management of long term illnesses.

- Large scale social marketing programmes, using behavioural insights, to support lifestyle change and engage the population to be more active in promoting their own and others' health.
- Developing a GM framework for 'patient activation', motivating people to take control and supporting work to tackle health inequalities.
- Increasing the range and profile of self-care support programmes and train our workforce to deliver them.
- Working with Health Education England to upskill up our public sector workforce in key areas of practice such as self-management education, shared decision making, health coaching and patient activation.
- Working to embed social responsibility across our public sector

2. Increasing early intervention at scale – finding the missing 1000s:

Late diagnosis causes unnecessary suffering and means diseases are harder and more expensive to treat. We only know about half of the preventable disease that exists in our population. The people with illnesses we – and often they - do not yet know about are called 'the missing thousands'.

Finding people who already have, or who are at risk of developing, disease and successfully managing their condition/s is crucial to prevent illnesses across GM and to reduce mortality, morbidity and inequalities in health.

Key elements of our programme are:
- Bringing together our screening and immunisation commissioning and our public health people to form an integrated commissioning team.
- Implementing the evidence base for early detection of disease through screening and case finding to find the missing 1000's who have a condition but have not yet been diagnosed. This will be supported by better information on a range of conditions including online advice, discussion forums and self-management programmes to empower people to look after themselves.
- Proactively reaching out to people registered on a GP list who do not attend GP practices, to engage with the community and create a cultural movement for health awareness and improvement.

3. Starting Well – supporting parents to give their children the best possible start in life

GM has consistently recognised the importance of a child's early years in achieving our long term ambition for growth and reform. Enabling parents to give their children the best possible start in life is essential in helping children reach a good level of development as measured by school readiness. Children who do not achieve a good level of development at age five will struggle in later years with social skills, reading, maths, physical skills, overall educational outcomes. They are more likely to experience difficulties with the criminal justice system, have poorer health and ultimately die younger.

Across GM the percentage of children achieving a Good Level of Development (GLD) is 62.4% compared with 66% nationally. Within this there is significant variation across GM itself with some localities achieving 73.4% whilst others only achieve 57.2%. Creating consistency of achievement without stifling innovation and further progress in other areas is a key challenge to our GM programme.

Our Early Years New Delivery Model is based on consistent age appropriate assessment measures promoting early intervention and prevention, implemented through improved engagement with families with young children from pre-birth to school. This is supported by a series of evidence based interventions supporting short and long term benefits.

We will make sure children are ready to start school by:

- Prioritising delivery and effectiveness of universal and targeted services in the antenatal period and to children age 0-5 and their families
- Early identification of risks and developmental delays supported by evidence based assessments and interventions
- A GM wide approach to further improving high quality early education and child care and increasing the skills and qualifications of the early years and child care workforce
- Helping parents who are out of work to access education and training to help them towards work
- Focussing on prevention and early intervention through consistently high quality universal/early help services through maternity services, health visiting, Children's Centres and early education providers
- Addressing health and social inequalities by improving the physical and emotional health and wellbeing of the 0-5 population and their families
- Delivering integrated commissioning and provision across all Early Years services focussed on: Parent and infant mental health; maternity/health visiting communication; speech, communication and language; social, emotional and behavioural pathway including parenting; High needs pathway for vulnerable children and complex families.
- Further improving the quality of early education for 2, 3 and 4 year olds including effective support to providers to increase the accuracy and use of assessment tools and information to improve outcomes for the most vulnerable children, making best use of the Early Years Pupil Premium and supporting effective transition to primary school.
- In July, the Government and local authorities agreed to undertake a fundamental review of the way that all our services to children are delivered. As a trailblazer, the Government will support the GMCA to develop and implement an integrated approach to preventative services for children and young people by April 2017.

4. Living well in Greater Manchester 'Good work – good health'

A healthy workforce can reduce sickness absence, lower staff turnover and boost productivity - this is good for employers, workers and the wider economy. We know that people in work tend to enjoy healthier lives than those out of work, and people with health conditions such as back pain, stress, depression and high blood pressure, find that getting back to work is often the best way to recover – often it isn't always necessary to be 100% fit before returning.

Approximately 683,000 adults in Greater Manchester have a mental health or wellbeing issue which can affect everything from health, to employment, to parenting and housing.

Key elements of our programme are:

- In partnership with employers, we will establish a Workplace Wellbeing Charter which will provide employers, of all sizes and from all sectors, with a way of driving improvements in workplace health and wellbeing.
- We will roll out the Work for Health programme which helps patients to better manage their health conditions and to stay in work by training front line health staff to consider work as part of the therapeutic intervention, encouraging self-management and problem solving.

- We will launch a programme in a number of neighbourhoods to help older people into work.
- Expanding our Working Well programme will support up to 50,000 Greater Manchester residents who are claiming a range of out of work benefits and experiencing barriers to employment. The programme will fundamentally change how skills, health and employment services function together.
- Establishing the Working Well Talking Therapies service, as part of our participation in the national Mental Health Trailblazer programme. This aims to improve employment and health outcomes for out-of-work claimants who face barriers to work due to common mental health conditions.
- Improving mental wellbeing and providing high quality mental *health services as* part of the overarching GM Mental Health Strategy.
- Supporting 'Healthier Lifestyles' will explore the potential of a devolved and flexible approach to licensing, regulatory compliance and enforcement, particularly in support of the proposal to introduce 'Promoting Public Health' as a fifth licensing objective across GM. This would enable localities to consider the impact of alcohol consumption on communities, proactively encourage licensed premises to promote responsible drinking and to play a key role in identifying and supporting those for whom alcohol is a problem.
- 'GM Moving' our physical activity strategy outlines a series of ten pledges that will add value locally and at a GM level. Already this has seen a significant increase in the number of opportunities to participate in recreational cycling, with 4,000 ride opportunities being delivered across GM by March 2016 through investment from the Department for Transport and British Cycling.

5. Helping people age well:

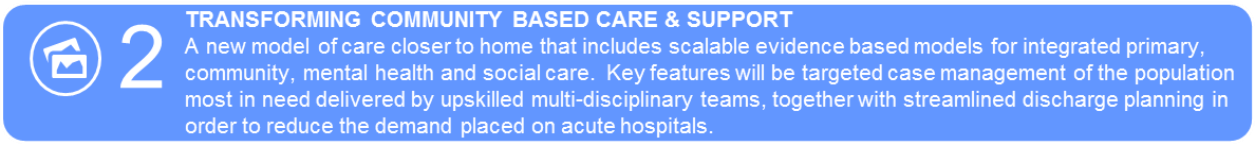
GM has an ageing population and we know we need to focus on helping older people stay well longer and supporting them to cope better if they have a long term illness, especially dementia.

More than a fifth of GM's 50-64 age group are out of work and on benefits, many because of ill health. The employment rate is 5.3 per cent below the England average and the gap has not narrowed for ten years. Unemployment imposes a significant burden on health and care services and the numbers in this age group are set to grow by 20 per cent in the next decade. Bringing the employment rate for 50-64 year olds up to the UK average would boost GM's earnings by £813.6 million.

By 2021, it is estimated there will be nearly 35,000 people living with dementia in GM, a quarter (25%) with mild symptoms, almost half (45%) with moderate symptoms and nearly a third (30%) with severe symptoms, requiring 24 hour care. The current cost of caring for them is estimated at £270 million annually, rising to £375million in 2021. Integrated services are vital, without early diagnosis, good access, good co-ordination, and good support, suffering is increased and costs rise.

From April 2016, we will:

- Launch a programme in a number of neighbourhoods to help older people into work. The programme will be expanded as funds become available. We aim to increase the number of long term workless adults in employment by eight percent over five years.
- Establish the GM Ageing Well Hub to make GM an age-friendly city region. It will provide links to social movements, social isolation, loneliness and have a focus on dementia.
- The Dementia United programme for GM that serves as a beacon for the UK, supporting people newly diagnosed with dementia with a case worker (further details are in Chapter 2).



GM has one of the highest rates of emergency hospital admission for conditions that would be better treated in the community. At any one time an estimated 2500 patients are in an acute hospital bed in GM, who could be treated more cost-effectively at home or in a community setting.

Fragmentation in services is seen most clearly in the referral into acute services and on discharge from them; between primary, community and social care, between those services and wider public services which can enhance health outcomes or prevent poor health emerging, such as housing, fire and rescue and employment services.

A key aim of combining the health and social care budgets is to enable care to be moved out of hospitals (where appropriate) into the community, closer to where patients want to be – at home. Even more significant however, will be our ability to radically reduce the demand for acute services through population level, integrated, community care and support which slows, or prevents altogether, the development of poor health.

Bringing GPs, community pharmacists, social workers, hospital doctors and community nursing teams together with a population focus, will help to make the connections between social and medical support, tackle loneliness and strengthen communities.

The sustainability of our hospital system will increasingly depend upon our ability to secure the right level of investment and capacity in community models to reduce demand on crisis and emergency services and facilitate reliable discharge home. The contribution to mainstream savings in this and the next CSR period are increasingly significant.

A focus on early intervention and prevention is a cornerstone of our approach to health and social care reform, ensuring we identify and treat early, reducing escalation of need. But this approach will only be successful if delivered alongside broader integration across local services. Across GM, we are seeking to tackle the complex issues that lead to escalating public service pressure in an integrated way. We will therefore not only bring together health and social care provision but a much wider range of organisations and services, tackling broader forms of complex public service demand.

Our ten localities and the neighbourhoods within them, will develop and design delivery models that fit the needs of their people and at a GM level. We will agree the core characteristics, common standards and key outcomes that those models will aim to deliver. A reformed system must recognise the limits of what formal care provision can offer and the important role of the 'informal' voluntary and community sector. The model of care needs to be built around the resident first and foremost, bridging some of the unnecessary splits between 'health' services and 'social care' services.

Primary Care, Social Care and Community services

Primary care is the driving force behind our prevention-focussed approach within localities and across GM. Primary care is working to integrate and lead a wider public service community-based model, through the agreement of standards, which will be delivered within each locality of GM and the testing of new models of contracts for GPs, which promote prevention and self-management. This will be at the heart of a new model of care to predict and prevent ill health utilising the power of the registered list.

Social care, both publicly and privately provided, will be an integral part of the community service model working to reduce demand for acute services. Our new models will look to expand the role of services like leisure and libraries and further develop alternative and preventative community-based approaches from the voluntary and community sector. Assessment processes will concentrate on the individual and their aspirations, maximising what they can do, not what they cannot do.

GM needs a system of community care that enables people to step up / step down their support flexibly and easily, ensuring people receive the right type of care at the right time. Currently too many people are going into residential and nursing care, particularly from hospital, in part because of a lack of clear and planned alternatives.

- We will make every contact with public services count by ensuring our staff are able to understand the needs of the people they come into contact with and signpost them to the most appropriate service(s) for their needs.
- We will train our staff in recognising prevention, identifying risks, supporting discharge from hospital and transfer between services.
- The development of our current and future workforce is core to the development of our community services to enable our staff to work with communities and support people to have the knowledge, skills and confidence to take an active role in managing their own health.

The establishment of fully integrated Local Care Organisations (LCOs).

The community service models chosen within each of our localities varies depending on the objectives they are trying to achieve, but the essential characteristics of the models are the same. Health and social care providers will work collaboratively to provide care to a defined population (predominantly led by Primary Care). Local Care Organisations is a term developed at a GM level to describe how across GM, we will secure, in all parts of the conurbation, the principal features of a proactive, preventative, population health model, which delivers consistently high outcomes. It takes the best of local, national and international learning from Accountable Care Organisations and applies them to the GM context.

Primary Care standards agreed at a GM level will be delivered within each locality to ensure that primary care drives our prevention-focussed approach within localities and across GM.

The LCO and its member organisations will be collectively accountable for delivery. The key elements of our programme from April 2016 are:

1. Enable conditions to be managed at home and in the community

People will only need to tell their story once and self-care will be encouraged and enabled.
We will introduce multi-disciplinary neighbourhood integrated care teams, built from clustered general practice, coordinating the care for a defined group of people (children and adults) using evidence-based pathways.

The locality approach will facilitate strengthened links with community groups and the voluntary sector and connect people to their local networks to promote independence and self-care.
The new models of provision in our localities will bring specialist acute-based consultants and nurses into the neighbourhood model via technology or face to face visits where necessary.

Technology has a critical role to play. Assistive technology like telecare can reduce the number of bed days and the level of home care needed. There is more detail later in this chapter.

2. ***Provide alternatives to A&E when crises occur***

LCOs will develop models of care and support, which provide alternatives to hospital when crisis occurs. It is acknowledged that no community model could keep us all well all of the time, but it can provide safe, responsive and effective urgent care services that keep people out of hospital (unless it is appropriate for them to be there) and at home. Our community services in our localities will use different rapid response models, but they will all aim to achieve the same outcome to manage people as close to home as possible.

These local models will ensure that the estimated 2500 patients in an acute hospital bed in any given day in GM are treated more effectively and appropriately closer to home. The concept of 'virtual beds' is already an established model, a model of care that manages both step-up and step-down pathways for people with urgent care, rehabilitation and/or re-ablement needs.

We will ensure our system works to a common set of objectives, with an emphasis on improving outcomes and the principles of re-ablement. It will meet the aspirations of people with care and support needs, support people to live well in the community, prevent people with significant health or care needs from having to use residential or nursing care and hospital; and help people with care needs maintain themselves in the community.

3. Support effective discharge from hospital

Our staff in our hospitals and in our community services work hard on a daily basis to ensure that patients are discharged in a safe and timely manner back to their chosen setting, but there are challenges due to different processes and requirements for the agencies concerned.

Our hospitals will work with the patient, their family/support networks and their GP to a planned date of discharge upon admission, they will ensure the patient is medically fit for transfer and then work with community services to ensure that the support services are in place when they transfer to their chosen next care setting.

We will build on work in our localities to introduce a standardised, streamlined discharge service and aim to develop an agreed GM discharge framework, which is focussed on the standards that the people of GM expect to be delivered when patients are discharged and help them return home safely with a co-ordinated discharge plan.

4. Help people return home and stay well

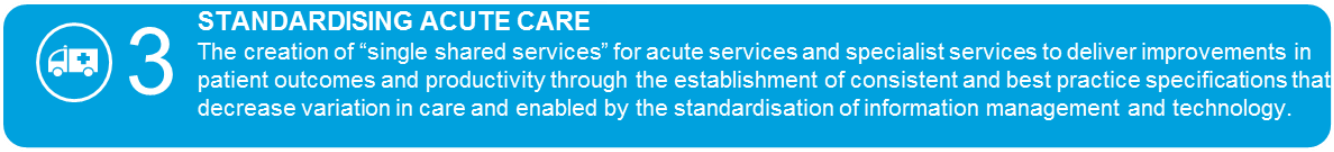
It is important that patients leave hospital with a clear discharge plan that is communicated to their GP, families, relevant agencies and support networks within their community, with a clear understanding of who they need to contact if they are concerned.

This will require integrated working between integrated neighbourhood teams, GPs and hospital teams to agree care or support programmes.

Vanguards
In GM, NHS England has announced four Vanguards which are testing the implementation of new models of care to improve and integrate services as described in NHS England's Five Year Forward View:

- Salford Together (Integrated primary and acute care system – PACS).
- Stockport Together (Multi-specialty Community Provider - MSCP).
- Salford and Wigan Foundation Chain (Multispecialty chain).
- Accountable Clinical Network for Cancer (ACNC).

In GM, we recognise that new models of care need to be implemented in all our localities to address our system challenges. This will require an open and transparent approach which supports innovation and the testing of new ideas. The Vanguards have enabled work within 3 localities and across GM to take forward the design and implementation of a variety of new models of care as described in the NHS Five year Forward View, and share their learning and the input from the national support team with the rest of the GM localities and our acute provider sectors.



There are 15 NHS Trusts and Foundation Trusts providing acute, mental health and community care across GM. Their dedicated staff deliver high quality care to the population of the region in the face of growing demand and tight budgets.

The present system is, however, not financially sustainable and it does not deliver the consistently high standards our population deserve. The total forecast deficit for these provider organisations is forecast to be £1.4 billion by 2020/21 before taking account of cost improvements. NHS Trusts in Greater Manchester must change and evolve to meet today's demands and the changing demands of the future.

Plans for our acute services will be developed with the public, patients and carers. They will be generated through the GM governance arrangements and by the Provider Federation Board to enable greater collaboration between Trusts.

The focus of work for Trusts will cover:

- Improving the safety and quality of services
- Improving productivity: Hospitals are drawing up plans to achieve efficiency savings of 2.5 per cent in 2016/17, and 2 per cent per annum in subsequent years.
- Improving delivery: Hospitals are working to introduce new care models to avoid emergency admissions and cut very long lengths of acute hospital stays. Trusts are working to deliver the four priority clinical standards for seven day working as part of the first phase of implementation by 2017.
- Increasing collaboration: trusts have agreed to a programme of collaborative efficiency and to joint working between trusts to achieve significant savings targets.

Whilst a large part of the improvement in GM will come from investment in and expansion of prevention and integrated primary and community services, we want to improve the quality, consistency and efficiency of services across the region and make sure there are adequate specialist staff present at the time of high risk procedures. Providers in GM are already working together to a greater extent, in order to spread good clinical practice. This focuses on maintaining local access to clinical services which might otherwise not be sustainable due to workforce shortages as well as achieving economies of scale through sharing services across GM. This ensures that the vast majority of acute care remains accessible in local hospitals whilst only the more complex treatments are provided in specialist centres.

The GM programme Healthier Together first initiated this concept with identification of urgent and emergency care, acute medicine and general surgery as a single service; taking the first step towards greater transformations that will be extended to other specialties.

GM will quickly establish the most appropriate governance form to secure provider collaboration through the development of groups, multi-site providers, lead provider arrangements and specialty service chains building on our learning from national Vanguards. This will be essential to allow the benefits of standardisation to be achieved at scale. This reform can identify the best evidenced-based practices for patients and provide decision support systems for clinicians. This means that key scaled up functions can be delivered across organisations and operational delivery can continue to be taken forward within organisations and at neighbourhood level. This will provide better outcomes and implementing standardised processes across a chain or group of providers will deliver better care at lower cost.

Organisations with a strong track record of high performance, able to support their staff to assist in local improvement and with the capability to develop standardised operating procedures, will share their skills and knowledge with organisations to support standardisation across the acute sector.

GM will develop a framework to determine which services will be delivered at which level; neighbourhoods, localities, clusters and across GM. In summary:

- Care that does not require a hospital stay will be provided locally
- In-patient emergency care and all in-patient surgery would be organised at a cluster or group level.
- Highly specialised services requiring specialist skills and infrastructure will be organised at a GM level.

We know that basing clinical care protocols on evidence can help reduce variations in the delivery of care, increase the quality of our services and reduce cost. GM will proactively enhance and standardise care models and operating procedures across services beyond those which are included within the shared service model so that procedures of the same type will follow an agreed protocol.

GM Trusts will develop a culture for improving standards. Clinicians will have to justify deviations from the agreed evidence pathway and these deviations and the associated reasons will be continuously monitored and reviewed (by shared clinical governance arrangements) to determine if the pathways need to be improved, updated or amended. Clinical care protocols will provide a clear audit trail, which can be used to quickly spot anything unusual and any decline in performance, as well as providing real time insight into where improvements are needed. This data will be shared with commissioners and regulators. This approach relies on improved methods to collect data, which

will be developed as part of this work. The adoption of evidence based protocols will be supported by the role of Health Innovation Manchester.

From April 2016, we will:

- **Deliver most services locally**, in conjunction with each LCO.
- **Build on Healthier Together to share acute services at scale.** Providers will find new ways of partnering and collaborating to improve acute and specialist services delivered to patients. This will be achieved through consolidating services at a cluster and Greater Manchester level.
- **Agree cluster level services.** Trusts will work collaboratively to form cluster or group-level services, and clinical staff will work together across a network of hospitals within the shared single service. Based on clinical evidence, this will drive improvement in standards of care across all hospitals as they follow a consistent approach for care delivery.
- **Agree Greater Manchester level services.** These services will be provided in one network across Greater Manchester, potentially across multiple sites, but with a lead service provider responsible and accountable for service delivery. We already have some services like this including adult major trauma, paediatric services, secure mental health and most recently the Cancer Vanguard.
- **Develop standardised treatment and care pathways.** Protocol based care will enable staff to put evidence into practice by addressing the key questions of what should be done, when, where and by whom. This standardisation of practice reduces variation in pathways and will improve the quality of care uniformly across Greater Manchester.

The development of standardised clinical support and back office services across Greater Manchester is a critical part of our transformation work.

Back Office

Shared services are no longer a radical new idea; they are an accepted part of business strategy that has repeatedly demonstrated its value. All public sector organisations in Greater Manchester have a common business platform including: finance; technology; business intelligence; HR; procurement; transformation and property services. As such there is an opportunity to generate significant efficiencies through organisational collaboration. Greater Manchester will pursue the potential outlined in Lord Carter's report and be an early, large scale delivery site for that work.

Developing a shared service model across GM level will drive greater efficiency while delivering world class business solutions. A shared service centre will not only deliver consistency in back office functions across Greater Manchester, but will deliver significant financial savings.

Care Co-ordination

Greater Manchester is clear that the integration of health and social care commissioning, whether at a locality, cluster or GM level is key to delivering agreed and shared improvement outcomes for residents. This joined up commissioning approach will deliver significant changes in commissioning activity, with a greater emphasis and investment in prevention and early intervention. This will

allow GM commissioners to shift activity and expenditure from high cost parts of the system to (where appropriate) care and services delivered closer to people's homes.

This will need to be underpinned by an effective means of care co-ordination to consistently track risk, activity, resources and outcomes across population segments. This will require the adoption of a whole system approach and the establishment of a multi-agency care co-ordination centre, encompassing primary, secondary and social care provision.

This would be able to:

- Track and co-ordinate patient care in a locality or cluster of localities.
- Utilise real time demand data to support more proactive care planning
- Reduce the variability in patient or cohort costs by limiting or avoiding high cost episodes.
- Generate total patient costing information to support lower average patient costs as more efficient and preventative care is incentivised.
- A central clinical team would work to reduce variations in care, ensure that care pathways are adopted consistently and refine pathways in line with the most effective interventions.

Shared Clinical Services

NHS Providers are already working together on radically reviewing how shared clinical services could be provided at a pan GM level to enhance individual organisational efficiency. These are focussed on:

- Procurement of goods and services through improvement in economies of scale and reductions in product variation.
- Review of Private Finance Initiative arrangements across GM in order to gain greater value from these contracts.
- Revised pharmacy arrangements through the improvement of drug procurement, logistics and medicines optimisation.
- Centralisation of back office functions by coordinating and providing these services at the appropriate geographical level
- Making better use of the public sector estate to ensure that estate owned and managed by NHS and local authorities is utilised efficiently and effectively, or disposed where it is not needed.
- Appropriate centralisation of pathology and radiology services in line with the recommendations set out in Lord Carter's 'Review of Operational Productivity in Hospitals.

From April 2016, we will be developing:

- A single Greater Manchester level Shared Service; bringing together a common platform for all of the public sector in GM
- A care co-ordination system for GM
- Implementing shared clinical support services across GM.

5

ENABLING BETTER CARE

The creation of innovative organisation forms, new ways of commissioning, contracting and payment design and standardised information management and technology to incentivise ways of working across GM, so that our ambitious aims can be realised.

The tolerance of variation across health and social care service provision is one of our biggest challenges. In Greater Manchester, our approach will see us no longer accept this wide variation of outcomes and service standards within and between organisations. Greater Manchester will need to deliver a significant programme of standardisation.

New care organisations

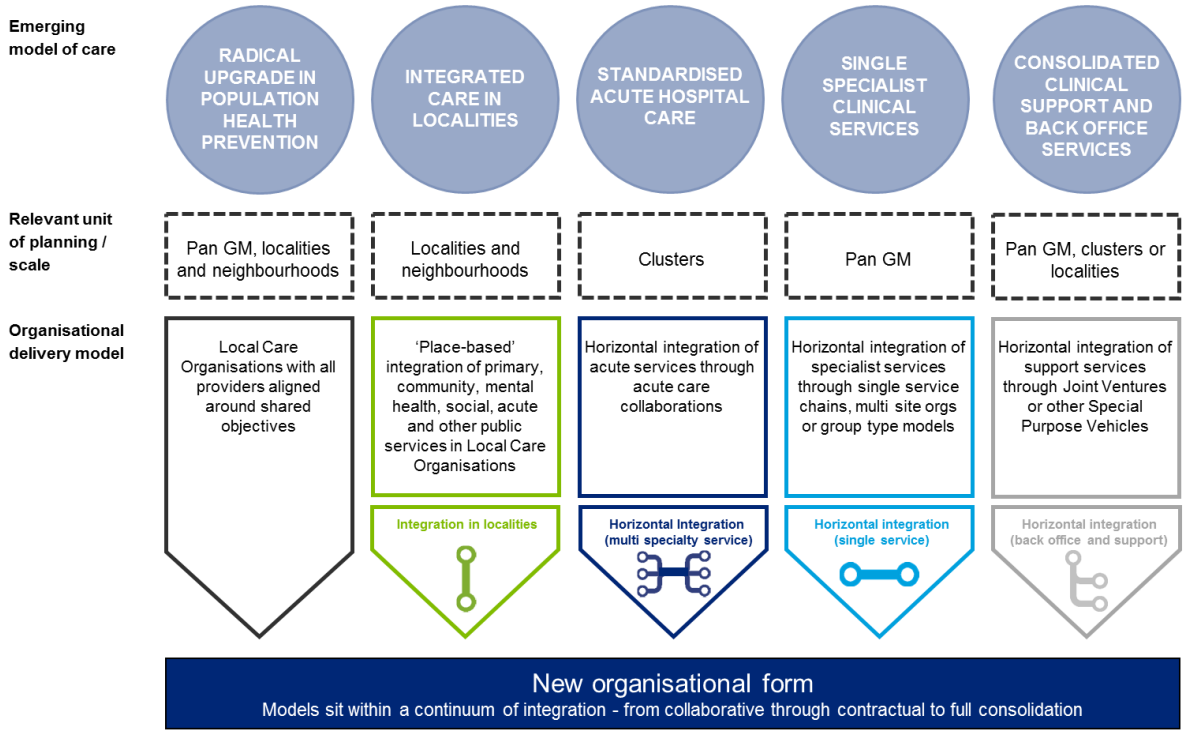
Health and social care providers in Greater Manchester need to become more adept at standardisation and reliable implementation of best practice. Through our revised working arrangements, supported by our new governance arrangements, we will ensure that our new models of care remove tolerance to variation both in service delivery and standards.

There is growing consensus in Greater Manchester that new organisational forms or delivery models will be required to enable integration and standardisation. To ensure that such integration and standardisation can occur, existing boundaries between organisations need to be removed. It is by removing these boundaries that efficiencies can be delivered and standardisation is service achieved.

We will develop any changes with full discussion and, where appropriate, consultation.

It is clear that integration is required across different levels; horizontally across similar services and organisations, and vertically through different care settings.

There are a number of different options for organisational form, ranging from loose collaboration to full consolidation. Analysis of the potential options for the different types of integration has been undertaken and the table below represents the suggested models across each type of integration.



Contracts, payments and innovation

The successful delivery of new models of health and social care at locality, cluster and GM level will need to be driven through new, innovative, evidence-based contracting models and pricing

mechanisms. The scope of these will need to be broad ranging covering all sectors and a wide range of providers.

The current Payment by Results system, agreed at a national level, albeit with local variation where appropriate, has created a system that incentivises different outcomes in different localities or providers. As a result it has failed to deliver whole system outcomes.

Whilst there will not be a one-size fits all approach, there will be a set of common principles across the whole of Greater Manchester, and a defined list of options around contracting and payment choices. This will include primary care and specialised services as well as all the services currently commissioned by CCGs and Local Authorities. All models should:

- Incentivise cost reductions from efficiency improvements and effective demand management
- Incentivise integration within and across the health social and care system
- Facilitate a transparent and accountable pathway for patient outcomes
- Incentivise prevention to counter rising acute hospital care activity

It is recognised that the design of any such payment system will be complex and require specialist input through our partnerships established with national bodies including NHS Improvement, NHS England and DH.

Technology

In Greater Manchester, many organisations still rely on inefficient paper based systems. Significant investment will be required to enable digital operation, without this investment it will not be possible to deliver a high quality efficient health and social care system.

Our new models of care will require technology enabled change. We will use technology to understand patient needs, and develop services more efficiently and effectively as a result. We want residents to have greater access, ownership and responsibility over their own data, generating multiple ways to interact with the health and social care system and putting people at the heart of how their information is collected, stored and used. More effective use of information across organisations, driven by patient ownership, will reduce duplication and ensure more speedy access to the right services.

We want technology to support self-management, from staying well to living well with long term conditions. We need to share data and information across organisations on a day to day basis to support assessment, triage and integrated multi-agency case management.

The Health and Social Care system in Greater Manchester will work with the wider public sector on the implementation of GM-Connect. As part of the wider GM reform activity, GM-Connect will establish a new data commission for GM that will own the data sharing mandate and will deliver GM wide solutions for employees and residents to access, update and analyse data. Implementation on GM-Connect will start in January 2016.

Accelerating discovery

Developing, testing and implementing new ideas takes too long. Fragmentation in funding, organisation approach and regulatory systems all slow up the process. This needs to change.

Greater Manchester, supported by its three large teaching hospitals, a research-led university base, a critical mass of life science firms and skilled workers, and a large and diverse population, is putting innovation at the heart of its health and social care system.

Our academic, research and industrial assets have been brought together under the umbrella of Health Innovation Manchester, launched in September 2015, to accelerate innovation into the local health and social care system.

Health Innovation Manchester will draw on the collective expertise of all partners from health and social care providers, academia and industry collaborators to address the health needs of the local population.
At the same time it will deliver economic benefits through manufacture and commercialisation. We aim to create one of the best regions in the world for innovative life science companies to be involved as partners. Additional detail on this is in Chapter 2.

Buildings

The estate varies significantly in terms of quality, condition and suitability. Some of the estate is in excellent condition providing state of the art facilities, whilst at the other end of the scale there are a lot of properties that are in very poor condition and no-longer fit for purpose.

Estates is a critical enabler of the GM health and social care transformation programme which must continue to be fully informed and led by frontline service strategy. Collaborative working across GM agencies is well established and effective however it is recognised that a lot more is required to improve health outcomes for the residents of Greater Manchester and to increase efficiency.

The public sector estate in Greater Manchester is under-used. Making the best use of the property and space available is a key part of Greater Manchester's health and social care transformation plans. It is also key to supporting our economic growth. The GM One Public Estate initiative is aimed at using public sector property assets as a single resource across organisations.

Integrating health and social care services across the region will mean changes are required to the buildings from which the services are delivered. A focus on prevention and care provided nearer to the home will mean that more facilities will be required in the community. This may result in the way that land is used at hospital sites changing as we need to ensure that our estate is able to respond to changing needs and demands of our residents.

A rationalisation of our public sector estate will inevitably free up much needed space that is required to support our economic growth both through new housing and employment sites.

Current ownership and management of the public sector estate is complex. In the NHS, buildings are owned and managed by NHS Trusts, Foundation Trusts, GPs, Community Health Partnerships, private landlords, NHS England and NHS Property Services. To ensure we make best use of this estate we will develop a NHS estates GM Delivery Team who will work closely with colleagues from across the Public Sector to deliver a One Public Estate approach to property management.

A GM Strategic Estates Planning Board will be formed, which will be responsible for translating strategic requirements into a set of GM Estates Targets, ensuring it meets local health and social care needs. It will develop a clear framework to enable GM to make better investment decisions, for example in primary care, and to ensure that the buildings required to deliver new models of care can be realised.

To ensure we are able to reconfigure the GM public sector estate in a way that supports our transformed services we have requested that any receipts received from disposing of capital assets is be retained within Greater Manchester for re-investment.

From April 2016, we will:

- Develop one public estate for GM and agreement of a framework to make estate investment decisions
- Develop the GM Estates Framework focussing on the following key elements:
    - Control - Public bodies in GM have control over all estate policies, procedure, decision making and allocation of resources
    - Ability to incentivise - Ability to retain and share savings and value released to fund change and align objectives across public bodies and departmental silos; Introduction of locally aligned incentives
    - Funding – Public bodies in GM have control over spending , Receipts and associated revenue costs; Pump prime funding e.g. to support asset rationalisation and improvements to the retained estate; Ability to recycle savings & receipts for estates transformation.
- Each locality will have a draft Strategic Estates Plan by the end of December 2015, which will be aligned to the locality and GM plan. In accordance with DH guidance with target savings/utilisations applied to each to deliver over a period of time and these will be further developed and implemented.

Chapter 5 - Financial Plan

In order to achieve our ambitions, we need the £6 billion invested in health and care to flow differently round our system. We have produced a detailed GM financial plan which shows how we see the £2 billion gap emerging over the next five years.

This integrated plan, the first of its kind, enables us to drive change within the transformation areas described above and the actions we will take to close the gap over the next five years.

Central to the delivery of the Strategic Plan is the ability to access the Transformation Fund across our GM system. This will enable us to develop new models of care to change the nature of demand and keep services safe and sustainable, while we make this radical shift.

The Financial Challenge

The integration of health and social care is a fundamental part of the growth and reform strategy essential to GM's priority of reducing unemployment, supporting people back into work, and providing growth through innovation. It is a key driver to ensure that the health and social care system becomes financially sustainable over time.

The population of Greater Manchester is 2.8 million with forecast spend of £7.7 billion on health and social care services. This includes £6.2 billion on health services including mental health, GP services, specialist services and prescribed drugs and £1.5 billion on local authority public health and social care services.

After taking into account the resources that are likely to be available and the pressures that the health and social care system will face over the next five years it is estimated that there will be a financial deficit of £2 billion by 2020/21. The scale of the challenge demonstrates why radical change is needed, both in the way services are delivered and in the way people use them.

Comprehensive Spending Review assumptions

As described in Chapter 2, the MoU outlined a 'road map' leading to full devolution on 1st April 2016. A key element of the MOU was the development of a Plan, including access to a transformation fund to enable us to deliver clinical and financial sustainability over the five years. In order to support us to achieve this, the recent CSR Settlement proposed the following for GM:

- A fair share of the additional funding of £8 billion that had been identified for health care
- Funding to enable social care activity to continue at the current level in line with the NHSE assumptions in the Five Year Forward View
- Additional one off transformation funding of £500m to support the delivery of the savings opportunities
- Access to capital funding to support areas such as the development of a single patient record and for the reconfiguration of the health and social care estate required.

GM submitted a high level Strategic Financial Plan in August 2015 to Government and NHS England as part of the CSR. This set out how it intended to meet the clinical and financial challenges over the CSR period and what was specifically required to significantly close the £2 billion financial gap.

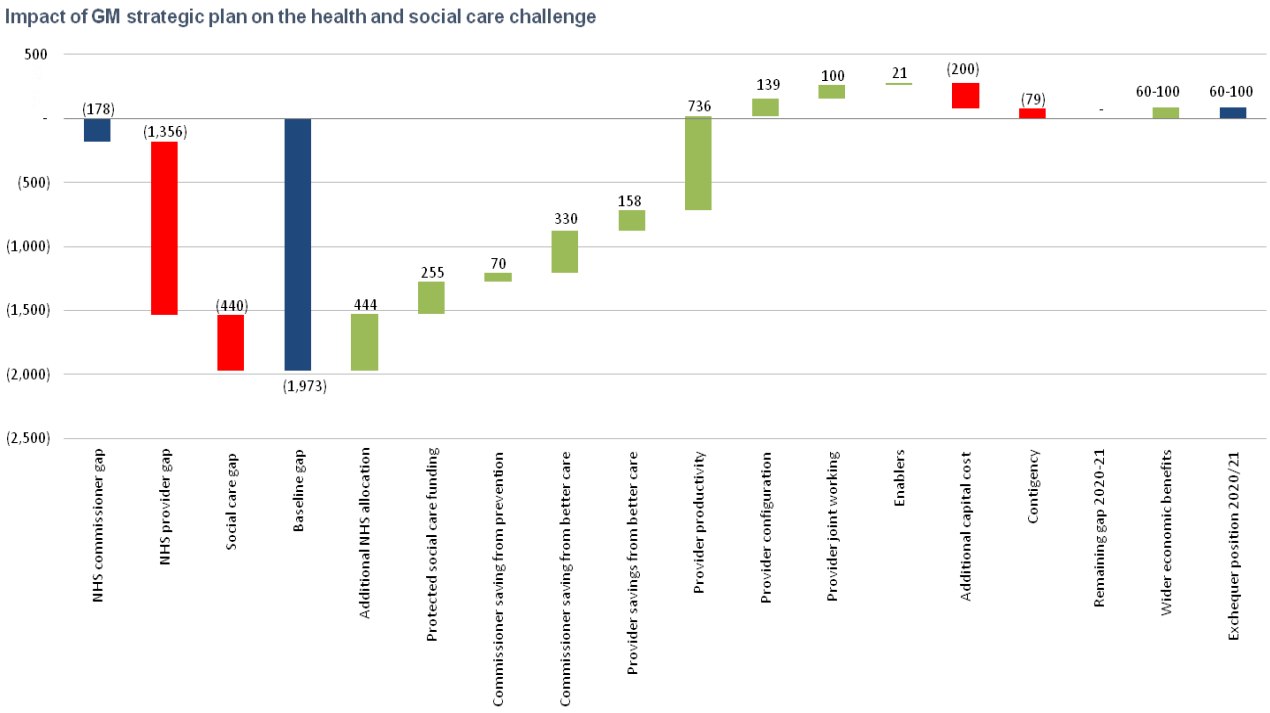
Alongside GM's fair share of on-going funding in line with Five Year Forward View (which would close the gap by £700m) proposals were shown to deliver a further £1.5 billion of savings, after reprovision costs, from the following areas:

- £70 million from prevention
- £488 million from better care models delivered across NHS and local authority commissioners and providers
- £139 million from reform of NHS Trusts
- £21 million from commissioner collaboration
- £836 million from NHS provider productivity savings and joint working

Delivering these changes is estimated to cost £200 million in capital charges leaving a net saving of £1.3 billion.

In addition to the above, benefits to the wider economy are expected through increased employment and productivity in the workplace, estimated at £160 million to £315 million.

The bridge diagram below summarises the Strategic Financial Framework that was submitted as part of the CSR.



The Plan describes how these savings will be achieved. Key to this is the implementation of the new models of care in line with the transformation themes outlined in Chapter 4 of this document. These provide the framework for a radical transformation of health and social care and will significantly impact upon patterns of demand. These are grouped into five main themes:

- Radical Upgrade in Population Health and Prevention
- Transforming Community Based Care and Support
- Standardising Acute and Specialist Care
- Standardising clinical support and back office services

- Enabling better care

The Transformation Fund described in the CSR is required to support the delivery of the significant change that GM will start to deliver from 1 April 2016. Achieving transformation of this nature requires critical enablers to be put in place, including an investment in the non-recurrent cost of putting new delivery models in place (including funding costs of staff development and new payment models), information and technology, community-based facilities and the renewal and adjustment to hospital capacity.

The Transformation Fund will consist of £77m one off costs to enable delivery of change and £423m double running costs to support the implementation the new service models and change to existing models. In return for access to this funding, GM will deliver the £1.5bn cumulative savings, use of the fund will be fiscally neutral and GM would be clinically and financially sustainable by 2020/21.

Fundamental to the delivery of transformation is the work set out in the Locality and Provider Plans which is underpinned by the pooling of budgets at scale at locality level, access to transformation funding for delivering the enablers and the dual running costs for moving to new models of care.

Financial assumptions to be agreed

The Strategic Financial Framework contains assumptions on:

- The future levels of funding available across health and social care
- Treatment of provider deficits
- Tariff deflator assumptions
- Level of transformation funding available

The expected changes to the above assumptions will have a significant impact on whether clinical and financial sustainability can be achieved during the five year period and on the development of detailed operational financial plans. The following key issues need to be resolved:

1. The level of the Transformation Fund

The amount of one off transformation funding (£500 million) was based on what was thought to be the minimum amount required to deliver the change to achieve clinical and financial sustainability over the five year period. If the amount or phasing changes then financial sustainability will not be achieved over the five years and will be reflected in commissioning and NHS provider organisations operating with financial deficits for a longer period.

The SPB Executive will propose allocation of the Transformation fund in accordance with criteria agreed and will secure independent assurance on each of these investments.

The use of the Transformation Fund (TF) should be underpinned by the following principles:

- The total for the TF currently proposed by NHS England is £450m. This is lower than the amount in the CSR submission and the TF is still the subject of discussion.

- The governance of the TF will be the responsibility of the SPB. The TF will be focussed on the delivery of the transformation programmes described in the Plan; all proposals will be independently verified to demonstrate value for money, strategic fit and robustness.

- The TF will be separate from the conventional funding allocation to CCGs etc, but at the appropriate time CCGs will be expected to agree with NHS England how their budgets are supporting the transformation programmes.

- NHS England has the right to determine the financing of the TF. However there must be the necessary degree of flexibility to enable the TF deliver the transformation programmes set out in the Plan. To the extent that any national programmes are used to support the financing of the TF, then the TF will only fund those aspects of proposals which are wholly consistent with the transformation programmes in the Plan. To the extent that any proposals from these national programmes do not correspond to these programmes then these will fall for consideration by NHS England separately.

- Deficit management will be the responsibility of the NHS and will be outside the funding scope of the TF. GM will play a full part to ensure that detailed deficit arrangements are aligned to the Plan.

- The TF will be subject to a performance management framework. Once the detailed profile has been agreed, GM will produce a full range of outcomes across health and social care to be delivered by the TF which will form part of the performance management framework, for agreement by HMT, NHS England and DH.

The amount and phasing of the TF continues to be negotiated with NHS England.

2. Estates

The CSR proposals assumed access to capital funding to support both the enablers such as development of a single patient record and for the reconfiguration of the estate required. The work included funding for the recurring cost of capital, although the amount will vary depending on the phasing of the transformation funding and implementation of change. The proposal is based around the ability to bring together the estates function across GM into a single property management function and the ability to retain any capital receipts. How this is implemented, alongside the detailed work underway, will inform the exact nature of the investment required.

A key component of the work will be securing access to the national funding 'pots' which are available with a proposal that GM requirements are 'earmarked' subject to the production of a detailed business case to be agreed by NHS England, DH and HMT before the end of this financial year.

A high level strategy will be developed by the 31 December 2015 and from this a business plan and financial proposal will be developed by 31 March 2016 for discussion with HMT, DH and NHS England.

3. Social Care

The underlying principle in the CSR is that the funding should enable the current level of activity, as per the logic in the Five Year Forward View, to be delivered and for social care budgets to be maintained at their current level. For adult social care this represented additional funding of £180m for GM across the CSR period. This did not include funding for additional demographic pressures and the cost of implementing the changes to the Minimum Wage. The scale of the funding gap is linked to the overall outcome of the financial settlement so the numbers are subject to change.

There has always been some concern about how a national social care settlement could be responsive to the particular circumstances in GM, given the status on devolution. Discussions are ongoing as to the impact of the changes set out in the CSR. The early assessment is that the proposals leave GM with a shortfall of funding for 2016/17 and 2017/18.

The CSR announcement included two additional areas for social care:

- The ability to raise an additional 2% in council tax over and above the referendum limit
- Additional £1.5bn BCF monies that will go direct to local authorities

Council Leaders are considering a further radical step to pool funding for the five years for the SR period to use the income generated from the 'social care precept', or equivalent income, to establish a platform for commissioning certain social care services on a GM wide basis. This is linked to there being a comprehensive settlement.

The additional BCF funding for local authorities will start to come on stream from 1 April 2017, with it being predominately back-loaded to the last two years of the CSR settlement. The phasing of the BCF nationally will not deliver what GM requires given that our transformation journey will start on 1 April 2016.

GM, after it has evaluated the impacts of the local government finance settlement on social care, will want to discuss with HMT, DH and DCLG the impact of the settlement on social care spend in the early years of the transformation programme and whether the funding is sufficient to enable the transformation objectives to be delivered.

Achieving transformation of this scale is a significant ambition, which will require leaders at all levels across GM to promote the need for change and the development of detailed implementation plans over the coming months.

Chapter 6 – Implementation

We have already started implementing some of the changes we need across the system. A critical part of our work between January and March 2016 will be to **engage with people across GM** and staff working in the health and care system, about the direction of travel and the changes we are proposing. We have shared our thinking early so that people have a chance to be **part of building our plans for the future**.

We are developing a **draft high level implementation plan** which describes what we think will need to happen across the five years to create a **clinically and financially sustainable GM** health and social care system. There will be a detailed work programme for each of the transformation themes described in Chapter 3, outlining specific deliverables in years 1 and 2 and higher level deliverables for years 3-5. This will ensure we can continue to **review, refine and if necessary refresh** our work programme to reflect our system needs.

To find out more or get in touch with us please go to:
Website: www.gmhealthandsocialcaredevo.org.uk
Email: gm.devo@nhs.net
Twitter: @GMHSC_Devo

We have a bold, clear and ambitious plan for GM. All partners are working together to understand how we can begin to deliver this plan.

Engaging people

Between January and March 2016, the partners across the ten localities of GM will be talking to their staff and local people about these plans. At the same time we plan to run events and talk to people about what would help them take charge of their own health and wellbeing – and get views on how we might support people to do this.

We will be doing this under our Taking Charge theme, which sets out the idea that GM is taking charge of a significant opportunity, as well as a significant challenge, and that as well as taking charge the people of GM must also take responsibility – at an individual, community and wider level.

Thousands of conversations about health and social care, preventing ill health and integration of services have been held in GM over recent years. They have included roadshows, citizen's panels, workshops, online forums and many other outlets and events, organised by public bodies and the voluntary and community sector. The ideas set out in this plan are the culmination of those conversations – and we will continue to build on them.

Examples include:

- In Bolton, the CCG launched "Let's make it" with 120 events to give a voice to those who find it hard to get heard
- In Manchester, the voluntary sector has led 22 workshops on improving mental health services
- In Rochdale 225 people have helped shape the locality plan, covering children's services and end of life care
- In Trafford, local people have been involved in creating a one-stop Care Co-ordination Centre for booking appointments, patient transport and learning about services

The people of GM recognise the challenges facing the health and social care services from an ageing population, advances in medicine and growing financial pressures. They accept that the rising demand for services must be slowed, and say the way to achieve this is for people to take more responsibility for their health.

Their priorities for the future, in relation to health and care services, include to:

- get appointments promptly and be seen within a reasonable time
- tell their story once and receive co-ordinated multidisciplinary care – with a single key worker
- have their families and carers involved
- have things explained, their questions answered and given choices about their care
- be supported to manage their own care
- have emotional and practical support recognised as important as medical treatment
- not to be blamed when costs and competing priorities interfere with their ability to look after their health
- have everything in place when they are discharged from hospital
- be treated with dignity and respect

We will build on this engagement with people – at a local and GM level - to continue to better understand what people need to take charge of their health and wider wellbeing in different places across GM.

As well as using traditional engagement approaches we are also exploring a web-based, crowdsourcing platform, and will link with national and potentially commercial partners, to ensure our engagement is as broad and deep as possible.

Engaging with Staff

There are around 80,000 staff working in health and social care services in GM and they are a critical group who are crucial to the success of our ambitions. Staff engagement will be led by their own organisations so they are able to put the wider GM work in the context of what's happening in their own organisations and are able to understand what this means for them, their families and the people they help care for.

Starting the work

Alongside the work we will be doing with residents, we will also be working across public sector services in GM to begin to work through how we implement the changes described in this Plan.

Changes will happen across all parts of our health, care and support services. We are already starting to make some of these a reality as we begin to deliver different service models which are described in Locality Plans and to make better use of the resources we have to save across health and social care.

We know that we need to begin work now on some areas that will take months or even years to change and deliver.

Our approach to implementation will align to the 5 key areas for transformational change (as described in chapter 4), delivered through reform across all parts of the care and treatment pathway:

- Upgrading prevention and self-care

    - **Population Health and Prevention**: High impact approaches and programmes to lift life expectancy
- Transformation of community based care and support
    - **Place Based Commissioning**: Place based commissioning in localities and a consistent approach to GM population health
    - **Primary Care at Scale:** The deployment of primary care at scale acting as the foundation of integrated care in localities, organised with other Local Care Organisations (LCO)
    - **Mental Health:** Implementation of our GM Mental Health Strategy
- Standardising acute hospital care
    - **Acute & Specialist**: Single shared acute services coming together under Acute Care Collaborations
- Standardising clinical support and back office services
    - **Shared Services**: A unified and evidence based approach to Lord Carter's findings
- Enabling better care
    - **Health Innovation**: Confirmation of priority programmes within the HInM pipeline
    - **Enablers:** Pricing and contract approach that aligns incentives; common approach to information to enable standardisation as scale. A single Estate Plan
- Programme implementation
    - **Engagement and Communications Plan**
    - **Establishing the GM health and social care team**
    - **Governance**

It will describe the key deliverables for each part of the work that we are aiming to deliver by April 2016 and then years 1 and 2, with an outline for years 3-5.

Work to deliver this plan is happening now across our GM services. As we progress through the next three months of this work, we expect our plans to be built on, expanded and improved based on the views of residents who use services across health, social care and support services.

A significant proportion of delivery activity will take place within our localities, working with our staff and our people to implement the reform in the context of local needs. Each locality will develop a Locality Implementation Plan by April 2016. Each locality will be responsible for ensuring it has the capacity and capability to implement its reform plan, drawing on local and national expertise as appropriate.

We recognise the value in collaboration across GM, so in partnership with NHS England, we will create the GM health and social care team. This team will be small in number and flexible, with ability to source expertise from within and out with Greater Manchester to support delivery in the localities and at a GM level. It will be responsible for driving the devolution, reform and transformation agenda for the integration of health and social care services between 2016 – 2020.

From April 2016, the team will:
- Ensure delivery of the GM Financial Plan.
- Oversee and drive governance across GM.
- Enable the implementation of Locality Plans and ensure they support the direction of GM health and social care.
- Assure the operational delivery of health and social care, in line with the devolved functions from NHSE, such as Clinical Commissioning Group assurance, plus specialised and primary care commissioning.

- Lead GM commissioning where agreed and endorsed by the Partnership Board and Joint Commissioning Board.
- Sponsor, drive and facilitate GM transformational projects.
- Facilitate GM population and cross sector involvement in health and wellbeing improvements.
- Understand the overall performance and delivery of services across the whole system within GM and therefore, identifying and managing risk.
- Establish effective working arrangements with health and social care regulators.
- Lead on the development and delivery of public and political engagement.

We will produce a refreshed version of this plan in March that includes more details of how we propose to change our services over the next five years.

Assurance, accountability and implementation

Greater Manchester is our 'Unit of Planning' and we are working to the principle that GM is assured once by national bodies as a place.

This approach does not compromise the statutory responsibilities of the 37 health and care organisations in GM to the national bodies. However, as all of our 10 localities are moving towards the establishment of pooled commissioning budgets, management arrangements, governance structures and the development of Local Care Organisations, they will operate in a different ways and the assurance and accountability processes will need to support these developments.

It is recognised that further work is required to understand and agree what this means for each of the national bodies and how the individual processes could be brought together to achieve assurance of GM as a place. This will be worked through as part of the implementation planning and listening phase from January to March 2016.

Staying in touch and getting involved

We already have a range of ways to stay in touch with this work. These are:

Website: www.gmhealthandsocialcaredevo.org.uk
Email: gm.devo@nhs.net
Twitter: @GMHSC_Devo

Opportunities to engage in the work will be widely advertised following the publication of this Plan.

This 5 year strategic plan for the reform of health and social care in Greater Manchester has been developed in consultation with and approved by the Greater Manchester Strategic Partnership Board. This Board is chaired by Lord Peter Smith, the leader of Wigan Council and through the membership of that Board; it has support of the 37 statutory organisations in Greater Manchester, listed below:

Bolton Clinical Commissioning Group

Bolton Hospital NHS Foundation Trust

Bolton Metropolitan Borough Council

Bridgewater Community Healthcare NHS Trust

Bury Clinical Commissioning Group

Bury Metropolitan Borough Council

Central Manchester Clinical Commissioning Group

Central Manchester NHS Foundation Trust

Greater Manchester West Mental Health Foundation Trust

Heywood, Middleton and Rochdale Clinical Commissioning Group

Manchester City Council

Manchester Mental Health and Social Care NHS Trust

North Manchester Clinical Commissioning Group

North West Ambulance Service NHS Foundation Trust

Oldham Clinical Commissioning Group

Oldham Metropolitan Borough Council

Pennine Acute NHS Hospitals Trust

Pennine Care NHS Foundation Trust

Rochdale Metropolitan Borough Council

Salford City Council

Salford Clinical Commissioning Group

Salford Royal NHS Foundation Trust

South Manchester Clinical Commissioning Group

Stockport Clinical Commissioning Group

Stockport Metropolitan Borough Council

Stockport NHS Foundation Trust

Tameside and Glossop Clinical Commissioning Group

Tameside Hospital Foundation Trust

Tameside Metropolitan Borough Council

The Christie NHS Foundation Trust

Trafford Clinical Commissioning Group

Trafford Metropolitan Borough Council

University Hospitals of South Manchester NHS Foundation Trust

Wigan Clinical Commissioning Group

Wigan Borough Metropolitan Borough Council

Wrightington, Wigan and Leigh NHS Foundation Trust

5 Boroughs Partnership NHS Foundation Trust

Wider partners in the GM Plan:

Greater Manchester Police

Greater Manchester Local Medical Committee

Greater Manchester Fire and Rescue Service

Healthwatch

Patient Groups

Social Care and Residential Providers

Voluntary Groups

3rd Sector Providers

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4B

GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION STRATEGIC PARTNERSHIP BOARD

Date: 18 December 2015

Subject: Implementing the GM Health and Social Care Strategic Plan

Report of: Katy Calvin Thomas

PURPOSE OF REPORT

This paper updates the Strategic Partnership Board (SPB) on the work that is underway to develop the implementation plan for the GM Health and Social Care Strategic Plan.

The aim of this paper is to outline the critical work streams we need to begin and complete across the GM system in the December to March period, to enable us to begin implementing the agreed and prioritised work streams from April 2016.

RECOMMENDATIONS

The Board is asked to:

- Note the progress made to establish a framework for the implementation of the GM Health and Social Care Strategic Plan.
- Approve the proposed framework for the implementation plan as attached in appendix A.
- Recommend that this framework is used by the each of the GM localities for their Locality implementation plan
- Note the key tasks identified that need to be undertaken before April 2016 to enable implementation of the GM Health and Social Care Strategic Plan, as listed in the draft implementation plan (Appendix A).
- Note that a fully drafted implementation plan will be presented to Partnership Board Executive and then Partnership Board in January.

CONTACT OFFICER:

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1. Introduction

1.1 This paper updates the Strategic Partnership Board (SPB) on the work that is underway to develop the implementation plan for the GM Health and Social Care Strategic Plan.

1.2 The aim of this paper is to outline the critical work streams we need to begin and complete across the GM system in the December to March period to enable us to begin implementing the agreed and prioritised work streams from April 2016.

1.3 It acknowledges that work during this period will be also part of a listening exercise with local people and staff across GM who work in services across the public sector.

2. Engaging people

2.1 Between January and March 2016, we will work with local residents to support them to think about, add to, influence and drive some of our thinking further. We will be doing this as part of our #taking charge campaign and expect that the plans we have today will be shaped and changed through this work.

2.2 Key to the success of plan is that it meets the needs of residents, patients, carers and people who work in public services. To achieve that, we need to know what people want, and what they value.

2.3 We will build on this engagement with people, encouraging feedback and monitoring responses as we get them. We will swiftly gather and analyse residents' views from all our communities and begin to better understand what people need in different places across GM.

2.4 As well as using newspapers, roadshows and newsletters, we will launch a web-based, crowdsourcing platform, linked with national and commercial partners, to ensure our engagement is as broad and deep as possible.

3. Engaging our health and social care system

<u>Localities</u>

3.1 A significant proportion of delivery activity will take place within our localities, working with our staff and our people to implement the reform in the context of local needs.

3.2 Each locality will develop a Locality Implementation Plan by April 2016.

3.3 Each locality will be responsible for ensuring it has the capacity and capability to implement its reform plan, drawing on local and national expertise as appropriate.

<u>GM</u>

3.4 Whilst it is acknowledged that a significant proportion of work will take place within localities, there is the recognition of the need to do appropriate work at a GM level.

3.5 It is therefore proposed that from April 2016, we will need in place a GM Portfolio Management Plan and a team to deliver the following critical work streams:

- Oversee and ensure delivery of the GM Financial plan.
- Oversee and drive governance across GM.
- Enable the implementation of locality plans and ensure they support the direction of GM health and social care.
- Assure the operational delivery of health and social care, in line with the devolved functions from NHSE, such as Clinical Commissioning Group assurance, plus specialised and primary care commissioning.
- Lead GM commissioning where agreed and endorsed by the Partnership Board and Joint Commissioning Board.
- Sponsor, drive and facilitate GM transformational projects.
- Facilitate GM population and cross sector involvement in health and wellbeing improvements.
- Understand the overall performance and delivery of services across the whole system within GM and therefore, identifying and managing risk.
- Establish effective working arrangements with health and social care regulators.
- Lead on the development and delivery of public and political engagement.

3.6 We are constructing an overarching GM implementation plan, which is attached at Appendix A. It is proposed that this framework is used by each of the GM localities to formulate their locality implementation plan.

3.7 We recognise the value in collaboration across GM, so in partnership with NHS England, we will create the GM health and social care team.

3.8 This team will be small in number and flexible, with ability to source expertise from within and out with Greater Manchester to support and compliment delivery in the localities and at a GM level. It will be responsible for driving the devolution, reform and transformation agenda for the integration of health and social care services between 2016 – 2020.

3.9 We will produce a refreshed version of this implementation plan in March that includes more details of how we propose to change our services over the next five years.

4. Recommendations

4.1 The Strategic Partnership Board is asked to:

1) Note the progress made to establish a framework for the implementation of the GM Health and Social Care Strategic Plan.
2) Approve the proposed framework for the implementation plan as attached in appendix A.

3) Recommend that this framework is used by the each of the GM localities for their Locality implementation plan
4) Note the key tasks identified that need to be undertaken before April 2016 to enable implementation of the GM Health and Social Care Strategic Plan, as listed in the draft implementation plan (Appendix A).
5) Note that a fully drafted implementation plan will be presented to Partnership Board Executive and Partnership Board in January.

Appendix A – Draft implementation plan

GM Transformation Proposals		By April 2017	January – March 2016 Designing	April – September 2016 Mobilising	October 2016 – March 2017 Implementing
Upgrading prevention and self-care	**Population Health and Prevention**: High impact approaches and programmes to lift life expectancy	• Agreed range of GM work streams on population health and prevention, implementation plan and key work streams agreed. • Key work streams commenced.	• Agreeing format, content and implementation of programmes (programme and implementation plan). • Agreeing the GM programme priorities and outcomes for years 1-5 based on locality priorities. • Agree a programme and outcomes for developing self- care training for certain clinical cohorts. • Agree overarching training across the public sector to support health and wellbeing. • Develop investment and cost benefit analysis. • Agree at a GM level the principles of a risk stratification approach for local implementation. • Conduct a gap analysis at a locality level. • Develop and agree a set of KPIs to track progress and success. • Roll out routine health checks.	• Implement GM prevention work	
Transformation of community based care and support	**Primary Care at Scale**: The deployment of primary care at scale acting as the foundation of integrated care in localities, organised with other Local Care Organisations (LCO)	• Primary Care – new contract models tested and plan to roll out in Jan – March. • Full implementation of Primary Care standards.	• Primary Care pilot EOI received. • Engagement with stakeholders re Primary Care Strategy. • Implementation plan agreed.	• Implement revised primary care strategy • Commence go live of 'new models of care'	Full implementation of GM Primary Care Standards
		LCO - new out of hospital system implementation	• Agree features of a LCO including Integrated Care (linked to TF criteria).	• Implement standardised	Duplicate care models in place (prevention

		commenced	• Assess payment and contract options for LCOs. • Agree governance for agreeing sign off of LCO plans submitted. • Design independent assurance process for LCOs. • 10 Locality plans submitted and assessed. • Completion of GM transformation initiative analysis. • Agree standardised models for Primary / integrated care including Access Targets. • Deliver plans for agreed prevention work streams (from MOU).	models for Primary/ integrated care	and integrated care)
	Place Based Commissioning: Place based commissioning in localities and a consistent approach to GM population health	Locality commissioning platforms established and implementation commenced in some localities	• Completion of locality plans and implementation plans. • Agree place based commissioning strategy – incl. budgets, governance and management arrangements. • Agree prevention programmes.	• Implement PB	
Standardising acute hospital care	**Mental Health**: Implementation of our GM Mental Health Strategy		• Implementation of GM Mental Health Strategy agreed and in place.		
	Acute & Specialist: Single shared acute services coming together under Acute Care Collaborations	The foundation for transformation of hospital services is agreed and ready for implementation	• Initial discussions on new provider models. • Further work on provider collaborative opportunities. • Agree mental health provider collaboration (linked to TDA). • Agree response to Carter review and provider plans. • Agree next steps for Healthier Together implementation. • Agree process for approving acute care collaboration. • Agree next steps for Vanguards (Salford,	• Implement Carter Review and provider plans • Agree plans for provider reconfiguration • Agree acute collaboration	

			Stockport, Christie). • Engage clinicians in defining clinical models and options. • Provider proposals for Year 1 CPs – based in guidance. • Earlier than usual plans for Provider CPs. • Agree the acute IM&T strategy.		
Standardising clinical support and back office services	**Shared Services**: A unified and evidence based approach to Lord Carter's findings		• Review efficiency and effectiveness of current operations. • Pilot Trafford Care Co-Ordination Centre. • Start to collaborate amongst acute providers. • Communicate to back office staff, engaging staff in the process.		
Enabling better care	**Health Innovation**: Confirmation of priority programmes within the Health Innovation Manchester (HinM) pipeline	Confirm priority programmes within the HInM pipeline and implementation plans	• Agree priority of programmes. • Agree plan to implement the priority programmes.		
	Enablers: Pricing and contract approach that aligns incentives	• Work stream plan established • Quick wins identified for 16/17 contracting round • Key priorities for 16/17 and 17/18 agreed and commenced	• Contract options identified and evaluated. • Scope new payment mechanism options for GM. • Payment model options assessed and preferred option agreed. • Agree plan to implement payment and contracts system. • Agree for phased introduction of payment, performance etc. • Deploy revised set of contract negotiation principles for 16/17 annual planning guidance/round.	Design and test new payment models	Implement new payment and contract models
	Common approach to information to enable standardisation as	The key implementation enablers are in place and GM approach to planning for 17/18 agreed	• **Estates** requirement analysed, context and implementation plan agreed. • **Workforce** impact modelled and high level strategy defined.	Matched patient level dataset to enable co-ordination of care	Matched patient level dataset to enable co-ordination of care

	scale. A single Estate Plan		• Agree additional resourced required to enable 'double running' • Define spec for match patient level dataset and agree strategy to deliver patient level costings. • **IM&T** key priorities decided and implementation/ procurement commenced • Further develop existing 'Data well' health information exchange.		
Programme implementation	**Communication Plan**	Sophisticated stakeholder engagement and communications planning underway	• Agree and initiate public engagement work. • Develop crisp and compelling case for change. • Rapid post spending review messages. • Gather input from representatives across clinicians, patients and leadership to develop the 6 -10 key messages and outcomes of devolution in GM. • Initiate staff communications.		
	Establishing the GM health and social care team	Full team in place working across GM and within the localities	• Chief Officer advertised and recruited. Recruitment to other critical roles. • Agreement of resources to project manage the transformation programme. • Establish overarching clinical governance function and agree strategy and immediate priorities. • Create the implementation plan. • PMO established. • Transfer of NHSE role to GM H&SC team – create checklist of key areas and transfer plan, including winter resilience, CCG planning and assurance and Primary Care • Agree and issue GM specific annual planning guidance.		
	Governance	Agree implementation enablers	• Agree Governance of Transformation Fund (QA, Criteria).		

			• Agree Programme Management capacity and capability. • Mobilise programme for configuration in key areas. • Establish a GM design authority. • Agree commissioning functions at a GM and locality level. • Agree joint commissioning arrangements between CCGs and local authorities.		

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GREATER MANCHESTER HEALTH AND SOCIAL CARE JOINT COMMISSIONING BOARD

Date: 19th January 2016

Subject: Specialised Services Update

Report of: Gina Lawrence, Chief Operating Officer, Trafford CCG and Steve Dixon Chief Finance Officer, Salford CCG

PURPOSE OF REPORT:

To provide recommendations on issues surrounding the arrangements for commissioning of specialised services in GM in 2016/17 and the associated financial delegations.

RECOMMENDATIONS

1. The shadow GMJCB is asked to support the Chief Clinical Officer and Chief Operating Officer of Trafford CCG being nominated to continue with their existing role as CCG leads for the commissioning of specialised services in GM, with appropriate linkages established through the Devolution Management Team to ensure appropriate support is in place to facilitate the effective discharge of these responsibilities.

   This recommendation is made in the context that the ultimate accountability for the discharge of Specialised Commissioning responsibilities in GM, will lie with the Chief Officer for Health and Social Care Devolution.

2. The shadow GMJCB is asked to support the proposal that the Commissioning of "group one" specialised services in GM in 2016/17 will take place via Model 1 delegation, (see appendix 2 for definition).

   In making this resolution, the Board is referred to the Accountability, Budgeting and Reporting paper contained elsewhere on this agenda, which describes the relevant arrangements.

3. The shadow GMJCB is asked to confirm the resolution made at its inaugural meeting of its view that "group 2 and 3" services should continue to be commissioned on a regional/ national basis working with the North West specialised commissioning team and other relevant partners. The Accountability, Budgeting and Reporting paper referred to above, is also relevant to this recommendation in terms of its detailed description of the financial arrangements.

4. The shadow GMJCB is asked to support GM pursuing a devolved commissioning arrangement, (model 4), in the future, (targeted for 2017/18), using the powers contained in the Cities and Local Government Devolution Bill, following its passage into law.

CONTACT OFFICERS:

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1. INTRODUCTION

1.1 This paper provides an update to the report presented at the inaugural meeting of the Joint Commissioning Board on 15 December. Specifically, the paper provides recommendations on the two resolutions made at this first meeting with regard to:

- The commissioning arrangements for specialised services
- Recommendations on the delegation of specialised services to Greater Manchester in the context of the related financial risks and issues

2. CONFIRMING THE CONTEXT

2.1 To recap, specialised services are a specific group of services that have been designated as such by NHS England. They are services that are highly specialised, usually low in volume and complex to deliver.

2.2 The services are currently commissioned by NHS England, either on a North West basis or a national basis. There are in the region of 180 services that are categorised as specialised. Greater Manchester's main providers of specialised services are University Hospital South Manchester Foundation Trust, Central Manchester Foundation Trust, Salford Royal Foundation Trust and the Christie, with most other Trusts also being providers of some specialised services.

2.3 As described at the previous meeting, a process has been undertaken to categorise each of the 180 services into three groups, as follows:

- Group 1 (Greater Manchester)
  - These services are considered discrete
  - Inter-dependencies are not significant
  - Work on a GM footprint
  - Population base of 3 million people
  - Services can sit within a GM construct
  - Services within this group will be considered for early review and opportunity for redesign/ transformation

- Group 2 (Regional)
  - More appropriate to be commissioned on a wider than GM footprint
  - Profile means difficult to split service
  - Large net importer from other areas
  - To be managed jointly by Devolution Manchester with other NW CCG's under the guidance of the NW Spec Commissioning Team
  - AGG under Devolution Manchester would offer high level input
  - These services have an opportunity in future to move into full commissioning within Devolution Manchester

- Group 3 (National)
  - Highly specialised services
  - Small number of patients
  - One/two centres in the Country
  - Input from National Team

2.4 The GM element, (group 1), constitutes approximately £457m, being circa 55% of the total spend. A breakdown of the financial value of specialised services, split into the 3 groups of commissioning, is shown in Appendix 1.

3. COMMISSIONING ARRANGEMENTS FOR 2016/17 AND BEYOND

3.1 An update, together with a series of options was provided at the last meeting, describing potential models to secure appropriate arrangements for the "business as

usual" commissioning of specialised services and the related process of transformation. Business as usual in this context involves contract negotiation, monitoring of performance and quality, together with minor service model changes.

Business as Usual Commissioning

3.2 At the last meeting, three potential options were considered. One of the options, for each CCG to take a number of services and embed them into their existing local structures, was discounted at the meeting. This left two options for further review as described below.

3.3 Both remaining options, in the first instance, would see the relationship with the existing NHS England North West specialised commissioning team remaining in place and being managed via a service level agreement.

3.4 The current model sees the Chief Clinical Officer and Chief Operating Officer of Trafford CCG nominated as leads for this agenda on behalf of the 12 GM CCGs, reporting through to the Association of GM CCGs. This arrangement has been developed over a considerable period of time and has the support of the CCGs. Clearly, the work to date also has seen a high degree of knowledge built up within Trafford, as well as a series of effective working relationships with both commissioners and providers.

3.5 The alternative to retaining the current arrangement with Trafford leading is to remove the concept of CCG leads and transfer responsibility in full to the central Devolution Management Team, effectively rebuilding the arrangement currently in place. At this stage, this is not seen as a preferred option, with limited benefit over the current arrangement and a number of risks relating to mobilisation, implementation and delivery.

3.6 In proposing that the current lead arrangements should remain in place, it is recognised that strong levels of connectivity between the lead CCG and the Devolution Management Team will need to be in place. This will ensure that the leads have appropriate support to fulfil their responsibilities and also that the Chief Officer, through which the delegation of specialised services commissioning will be channelled, can be appropriately assured of the effective discharge of these key strategic responsibilities. Formation of these arrangements will be an important part of the mobilisation process as we move towards implementation from 1 April 2016.

3.7 It is recognised that further capacity will be required to support the Clinical Accountable Officer and Chief Operating Officer of Trafford CCG in the delivery of these arrangements. This will be quantified and specified as an immediate priority.

3.8 Group 1 services will be directly managed and led from Greater Manchester using the model 1 delegation described at appendix 2 with supporting capacity from the North West Commissioning team being secured via an SLA. Group 2 and 3 services, will continue to be commissioned at regional or national level, also with the support of the North West Team. The GM input to this process will be co-ordinated by the lead CCG.

Transformation

3.9 As discussed at the first meeting of the Joint Commissioning Board, capacity to support the process of transformation for specialised services will be secured from the GM Service Transformation Team. This process was described in more detail in the papers presented at the first meeting.

4. FINANCIAL IMPLICATIONS AND TECHNICAL OPTIONS

4.1 Since the first meeting of the Joint Commissioning Board, considerable work has taken place between GM commissioners and NHS England to develop a proposal relating to the financial aspects of the transition, including the management of risk. This work is described in detail in the Accountability, Budgeting and Reporting item on today's agenda.

4.2 As part of the development of these arrangements, consideration has been given to the commissioning model to be adopted in the first instance. The table at appendix 1 provides an overview of the identified options.

4.3 The proposal for year one is that the commissioning of the "Group 1" services should be managed through the Model 1 Delegation arrangement. This will facilitate a smooth transition to the new arrangements and provide a balanced and mutually acceptable model for the handling and management of risk during year one.

4.4 In proposing the arrangement described in 4.3 above, it is further proposed that the longer term preferred option should be for Greater Manchester to pursue full devolution for the commissioning of the relevant specialised services, using the powers contained in the Cities and Local Government Devolution Bill, following its passage into law. This would be targeted for 2017/18, subject to appropriate arrangements for the ongoing management and handling of risk being achieved.

4.5 Any such move to full devolution/delegation of commissioning responsibility will need to be cognisant of the relevant NHS England assurance process and this will need to be factored into the workplan for 2016/17 to be ready for any transfer in 2017/18.

4.6 For Group 2 and 3 services, the proposal remains as described at the inaugural meeting of the shadow GMJCB, ie that they should continue to be commissioned on a regional/ national basis, with GM Health and Social Care working closely with the North West specialised commissioning team and other relevant partners to ensure an appropriate level of input and influence to this process.

4.7 To confirm, in relation to specific risks on the financial implications of co-commissioning specialised services, separate discussions have been held with NHS England colleagues and concluded:

- Co-commissioning at GM level will be limited to GM providers
- Co commissioning at GM level will be limited to Group 1 services
- Any under or overspends on specialised services in 2016/17 will be managed as part of the NHS England's budgets (North of England's control total)

5.0 RECOMMENDATIONS

5.1 The shadow GMJCB is asked to support the Chief Clinical Officer and Chief Operating Officer of Trafford CCG being nominated to continue with their existing role as CCG leads for the commissioning of specialised services in GM, with appropriate linkages established through the Devolution Management Team to ensure appropriate support is in place to facilitate the effective discharge of these responsibilities.

This recommendation is made in the context that the ultimate accountability for the discharge of Specialised Commissioning responsibilities in GM, will lie with the Chief Officer for Health and Social Care Devolution.

5.2 The shadow GMJCB is asked to support the proposal that the Commissioning of "group one" specialised services in GM in 2016/17 will take place via Model 1 delegation, (see appendix 2 for definition).

In making this resolution, the Board is referred to the Accountability, Budgeting and Reporting paper contained elsewhere on this agenda, which describes the relevant arrangements in detail.

5.3 The shadow GMJCB is asked to confirm the resolution made at its inaugural meeting of its view that "group 2 and 3" services should continue to be commissioned on a regional/ national basis working with the North West specialised commissioning team and other relevant partners. The Accountability, Budgeting and Reporting paper referred to above, is also relevant to this recommendation in terms of its detailed description of the financial arrangements.

5.4 The shadow GMJCB is asked to support GM pursuing a devolved commissioning arrangement, (model 4), in the future, (targeted for 2017/18), using the powers contained in the Cities and Local Government Devolution Bill, following its passage into law.

Appendix 1: Financial Value of Specialised Services Split by Service Line and Commissioning Group

	Services in Group 1: Greater Manchester	Services in Groups 2 and 3: Regional or National	Total	Notes
	£m	£m	£m	
A01 - Cystic Fibrosis	£0.0	£12.8	£12.8	
A02 - Hepatobiliary	£0.0	£4.4	£4.4	
A03a - Endocrinology	£2.0	£0.0	£2.0	
A03b - Dermatology	£11.5	£0.0	£11.5	
A03c - Rheumatology	£0.0	£0.9	£0.9	
A03d - Respiratory	£10.4	£3.5	£13.9	4
A04 - Vascular	£6.4	£0.0	£6.4	
A05 - Morbid Obesity	£1.3	£0.0	£1.3	
A08 - Colorectal	£1.5	£2.0	£3.5	
A09 - Complex Invasive Cardiology	£15.7	£1.7	£17.4	
A10 - Cardiac Surgery	£36.3	£0.0	£36.3	
A11 - Pulmonary Hypertension	£0.0	£0.8	£0.8	
A12 - Thoracic Surgery	£9.6	£0.0	£9.6	
A13 - Adult Congenital Heart Disease	£0.9	£0.3	£1.1	4
B01 - Radiotherapy	£0.0	£0.5	£0.5	
B02 - PET-CT	£1.0	£0.0	£1.0	
B03 - Cancer	£87.9	£43.9	£131.8	4
B04 - BMT	£0.0	£13.5	£13.5	
B06 - HIV	£58.6	£1.2	£59.8	
B07 - Infectious Diseases	£0.0	£2.7	£2.7	
B08 - Haemoglobinopathies	£2.0	£0.0	£2.0	
B09 - Immunology and Allergy	£5.0	£0.0	£5.0	
C02 - Forensic and Secure	£0.0	£3.7	£3.7	
C05 - Perinatal	£0.0	£1.3	£1.3	
C06 - Tier 4 CAMHS	£0.0	£9.0	£9.0	
D01 - Complex Physical Disabilities	£0.5	£5.5	£6.0	
D02 - Rehab for Brain Injury and Complex Disability	£7.1	£0.0	£7.1	
D03 - Adult Neurosurgery	£32.5	£0.0	£32.5	
D04 - Neuroscience	£30.1	£0.0	£30.1	
D05 - Stereotactic Radiosurgery	£0.0	£0.7	£0.7	
D06 - Burns	£0.0	£11.9	£11.9	
D08 - Pain Management	£2.8	£0.0	£2.8	
D09 - Ear Surgery	£0.9	£2.6	£3.5	
D10 - Orthopaedics	£6.6	£0.0	£6.6	
D12 - Ophthalmology	£1.1	£0.0	£1.1	
D13 - Spinal Cord Injury	£0.0	£0.0	£0.0	
D14 - Spinal Surgery	£11.5	£0.0	£11.5	
E01 - Medical Genetics	£0.0	£7.2	£7.2	
E02 - Paeds Surgery	£0.0	£15.8	£15.8	
E03 - Paeds Medicine	£20.3	£6.8	£27.1	4
E04 - Paeds Cancer	£0.0	£5.8	£5.8	
E05 - Paeds Cardiac	£0.0	£2.0	£2.0	
E06 - Metabolic Disorders	£0.0	£1.2	£1.2	
E07 - PICU Inpatients	£0.0	£26.7	£26.7	
E08 - NICU Inpatients	£45.1	£0.0	£45.1	

	Services in Group 1: Greater Manchester	Services in Groups 2 and 3: Regional or National	Total	Notes
	£m	£m	£m	
E09 - Paeds Neuroscience	£0.0	£2.4	£2.4	
E10 - Complex Gynae	£0.3	£0.2	£0.5	
E11 - Specialised Maternity	£0.0	£0.4	£0.4	
Other	£15.2	£5.1	£20.3	4
Other Devices	£0.1	£0.0	£0.1	4
Other Drugs	£0.3	£0.1	£0.4	4
Transplant Drugs	£0.0	£0.1	£0.1	
E12 - Fetal Medicine	£0.0	£0.0	£0.0	
A07 - Renal Transplantation	£0.0	£9.7	£9.7	
Antifungal Drugs	£1.7	£0.0	£1.7	
B05 - Haemophilia	£0.0	£10.2	£10.2	
A06 - Renal Dialysis (Child)	£0.0	£0.0	£0.0	
A06 - Renal Dialysis (Adult)	£30.6	£0.0	£30.6	
C02 - Forensic and Secure	£0.0	£41.7	£41.7	
C01 - Eating Disorders	£0.0	£0.0	£0.0	
C03 - Deaf Mental Health	£0.0	£1.7	£1.7	
Grand Total GM Providers/GM CCGs	**£456.7**	**£259.9**	**£716.6**	**2, 3**
Non GM Providers (within North West)	£0.0	£83.5	£83.5	
Non GM providers (outside North West)	£0.0	£30.8	£30.8	
Grand Total GM CCGs	**£456.7**	**£374.2**	**£830.9**	**1**
	55%	**45%**	**100%**	

Notes:

Scope:

1	Above analysis relates to GM CCG activity at all providers, totalling £831m across all providers
2	Scope of services to be managed at GM level relates to GM CCGs' activity at GM providers (£717m)
3	Scope then reviewed based on most appropriate footprint for commissioning decisions (Levels1 ,2,3)- with only level 1 services being appropriate to be commissioned on a GM footprint (£457m). These splits are estimate at this stage (see note 4)

Data quality:

4	Some areas cannot be split easily between level 1 (GM) and level 2 (regional) as activity is not routinely captured in that way. A dedicated Information analyst ahs been employed to work unpick these areas and ensure information can be routinely captured and monitored.
5	Further work in on-going with providers to improve data quality to ensure accuracy of data at source.

Appendix 2: Options for delegation/ devolution

Approach	Broad Definition	Definition for GM
Not Delegated	No change from current arrangements	No change
Model 1 Delegation	• No legal change, or organisational restructuring • Decisions about a function are taken by the function holder but with input from another body • Accountability and responsibility for function remains with original function holder	• Local CCGs involved in discussions with NHSE budget holders but accountability and responsibility remains within NHSE • This option could be pursued in conjunction with delegation to a GM footprint and/or GMCA • The GMCO will act upon recommendation made by the JCB
Model 2: Co-/Joint Commissioning	• Two or more bodies with separate functions come together to make decisions together on each other's functions • Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)	• Decisions made by joint commissioning body established for GM including CCGs, NHSE, GMCA and LA's. • This option could be pursued in conjunction with delegation to a GM footprint
Model 3: Delegated Commissioning	• Function is delegated to another body • Decision-making and budget rest with the delegate • Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends to be exercised through the GMCO)	• Function and budget will be delegated to GM CCGs and in some cases GMCA.
Model 4: Fully Devolved Commissioning (Transfer of Function)	• Function is taken away and given to another legal body on a permanent basis (meaning responsibility, liability, decision-making, budgets and everything else to do with that function) e.g. under a s.105A order • Accountability and responsibility for those functions transfers to the new 'owner' (including budgetary responsibility and funding for overspends)	• Function and funding could be devolved to a Combined Authority.

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Date	Version	Author	Details
14/12/2015	V0.1	Jen Parsons	First Draft
	V0.2	Jen Parsons	Updated with comments from Ann Schenk
Approved by:			

Governance route:

Group	Date	Version	Purpose
South East Sector Programme Board	14/01/2015		Agreement

Purpose

This document describes the revised governance arrangements for the South East Sector in preparation for the implementation of Healthier Together.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

South East Sector Implementation Governance

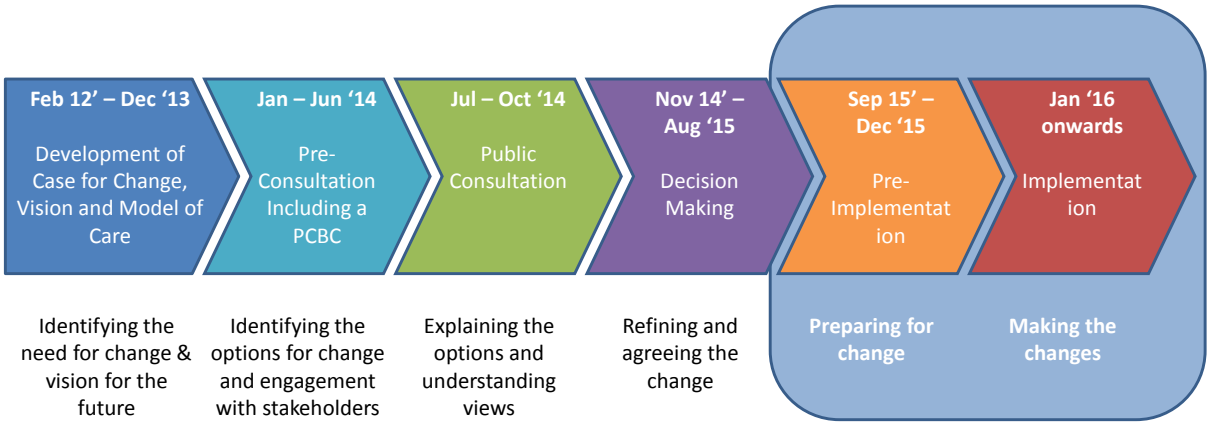
1. Purpose of this document

This document describes the governance and reporting arrangements to be established for the South East Sector, to successfully manage the implementation of the Healthier Together service standards and single service model of care.

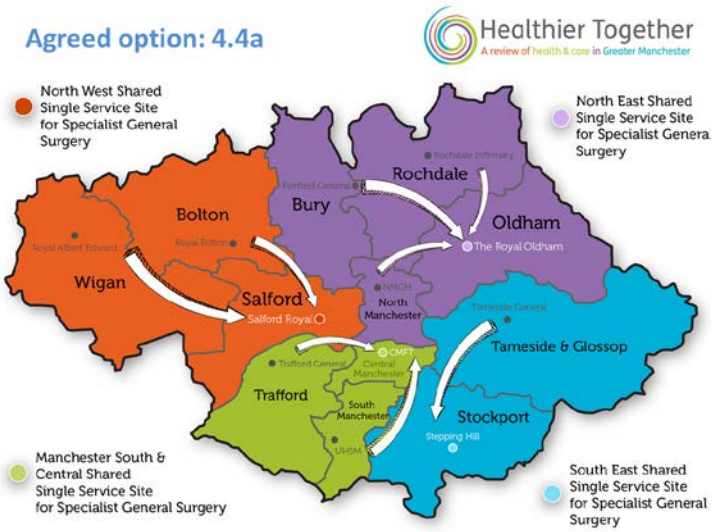
2. Context

The South East Sector brings together the following organisations: Stockport NHS Foundation Trust, Tameside NHS Foundation Trust; East Cheshire NHS Trust; NHS Stockport CCG; NHS Tameside & Glossop CCG; Eastern Cheshire CCG and North Derbyshire CCG.

The Healthier Together Programme is entering the Implementation Phase. This follows a period of pre-implementation planning and the completion of decision making on the 15th July with the decision of the Committees in Common to implement Option 4.4a. This named Stepping Hill Hospital in Stockport as the fourth hospital in Greater Manchester to provide emergency abdominal surgery as part of a single service.



Option 4.4a is illustrated below, and describes a single service in the South East Sector that involves two sites: Stepping Hill Hospital and Tameside General Hospital, with the potential for involving Macclesfield District General Hospital. The South East Sector Single Service Mandate is outlined in section 3.



[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

The Healthier Together Committees in Common agreed that the focus and drive of implementation should be driven by Single Service Implementation teams, in each of the four sectors, with the following proposed functions:

- To manage the implementation of single service teams for General Surgery, A&E, Acute Medicine and associated specialities Anaesthetics, Critical Care and Support Services
- To manage the implementation of changes required to achieve the standards in A&E, Acute Medicine and General Surgery.

When the option for implementation was selected, commissioners also set a number of implementation conditions that must be met by the programme (and therefore sectors) prior to implementation. These are summarised below and outlined in detail in Appendix 71 to the Decision Making Business Case[1]:

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

Condition 2 – Structured process of peer review across GM

Condition 3 - Establishment of a Greater Manchester Clinical Alliance

Condition 4 – Joint appointments to Single Services

Condition 5 – Appointment of GM clinical leadership for implementation

Condition 6 – Formation of Single Service Research Hubs

Condition 7 – Development of a GM governance framework

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

3. South East Sector Single Service Mandate

NHS Stockport CCG, NHS Tameside & Glossop CCG and NHS North Derbyshire will formally amend their commissioning intentions in line with the Healthier Together decision. NHS Eastern Cheshire CCG have agreed to collaborate with the South East Single Service to fully understand the impact of the proposed changes; with an initial focus on General Surgery.

The scope and focus of the Healthier Together hospital programme is:

- Urgent, Emergency & Acute Medicine;
- General Surgery.

In addition, it is recognised that there are key services that are interdependent with the above services which will be included *to the extent of their dependency*, within the final Model of Care (Hospital Services):

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

- Anaesthetic Services;
- Critical Care;
- Clinical Support Services (e.g. Diagnostics).

Furthermore, programme documentation will also describe the enabling changes in local "Out of Hospital" services that will need to take place before changes to hospital services are made.

(Scope and focus of HT hospital programme taken from Terms of Reference for Greater Manchester Healthier Together Joint Committee V1.4)

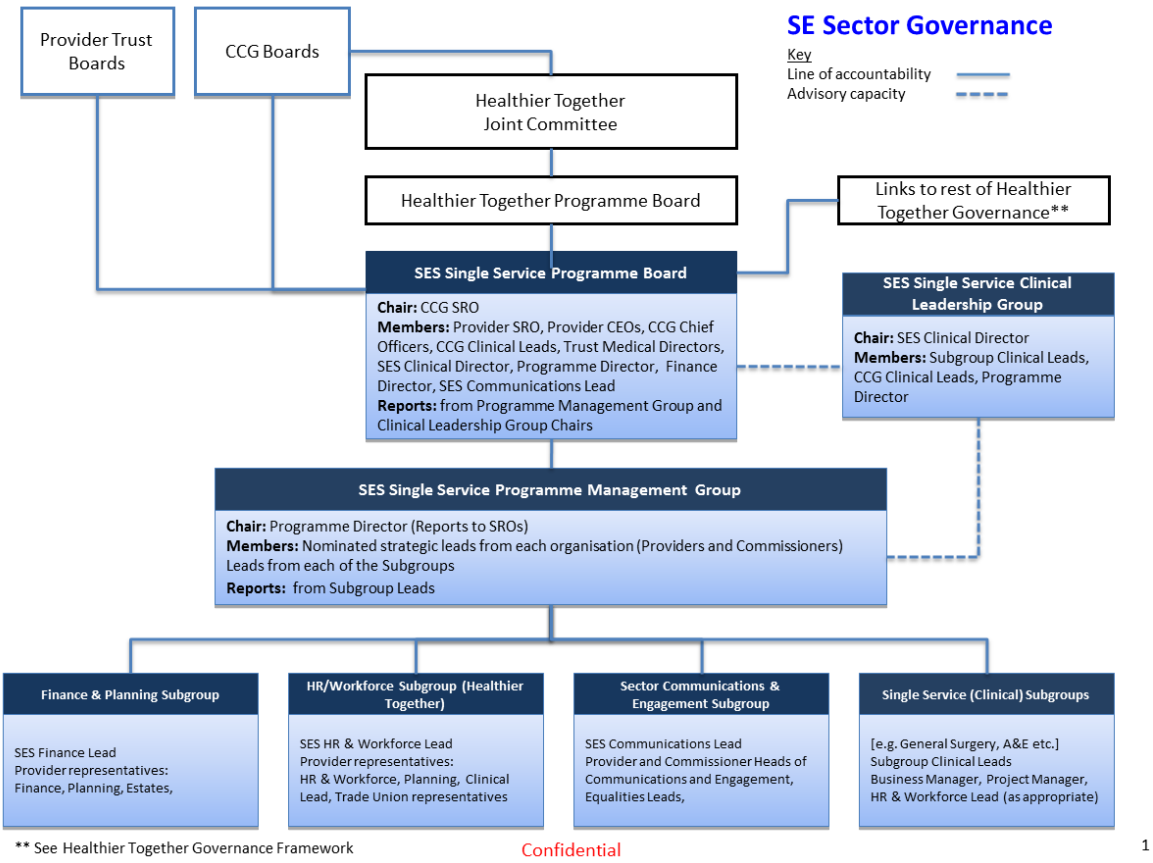
4. South East Sector Principles

The governance arrangements have been designed to build on the work of the sector to date, and include the following key principles:

- To act in the best interests of service users and an engaged public
- To demonstrably improve the quality and clinical outcomes of the clinical services which the Parties provide to their patients
- To work as a partnership of equals
- To adopt an open and constructive relationship with each other in relation to the collaboration
- At all times to act in good faith towards one another
- To be cognisant of the sustainability of the system
- To manage all information supplied by other parties in a confidential manner (Until a Memorandum of Understanding agreed)

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

5. South East Sector Governance Structure



6. Purpose of groups

Full terms of reference for each group is provided as an appendix to this document, however, the purpose of each of the groups within the governance structure above is summarised below.

Group	Membership	Frequency	Summary purpose
SES Programme Board	CCG SRO (Chair), Provider SRO, Provider CEOs, CCG Chief Officers, Trust Medical Directors, Programme Clinical Lead, Programme Director, Finance Director (Lead for the sector), SES Communications Lead	Monthly reporting to the Healthier Together GM Programme Board	• Bring together executive and clinical leaders from providers and commissioners in the South East Sector to form an accountable body for the implementation of Healthier Together • Oversee the design of the local model of care in the South East Sector, and safe delivery of the changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015 • Provide information and assurance to the Healthier Together Programme Board, member provider trust boards, and member clinical commissioning group boards

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

Group	Membership	Frequency	Summary purpose
SES Clinical Leadership Group	SES Clinical Lead (Chair), Subgroup Clinical Leads, CCG Clinical Leads, HT Chief Medical Advisor or GM Clinical Champion, SES Programme Director	Monthly in advance of the SES Programme Board and SES Programme Management Group	• Lead the work to develop and agree the local model of care and clinical changes required to implement the single service and achieve the Healthier Together quality and safety standards in the South East Sector • Provide clinical advice to the SES Programme Board and SES Programme Management Group as required • Lead clinical implementation planning and advise the SES Programme Board on the safe sequencing of changes, and clinical readiness for implementation
SES Programme Management Group	Nominated strategic leads from each organisation (Providers and Commissioners) Leads from each of the Subgroups	Monthly in advance of the SES Programme Board	• Manage the overall implementation programme for the South East Sector Single Service including the design of the local model of care in the South East Sector, and safe delivery of the changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015 • Provide assurance to the South East Sector Programme Board on progress against the programme plan
Finance & Planning Sub Group	SES Finance Lead Provider representatives: Finance, Planning, Estates, Programme Director	Task and Finish Group – to be decided as required	• To be defined as required by the programme
HR/Workforce Subgroup	SES HR & Workforce Lead Provider representatives: HR & Workforce, Planning, Clinical Lead, Trade Union representatives, Programme Director	Task and Finish Group – to be decided as required	• To be defined as required by the programme

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

Group	Membership	Frequency	Summary purpose
Sector Communications & Engagement Subgroup	SES Communications Lead Provider and Commissioner Heads of Communications and Engagement, Equalities Leads, Programme Director	Task and Finish Group – to be decided as required	• To be defined as required by the programme
Single Service (Clinical) Subgroups	Single Service Clinical Lead Business Manager Project manager HR & Workforce Lead (as appropriate)	Task and Finish Group – to be decided as required	• To be defined as required by the programme

South East Sector Governance

While the quality and safety of services of services has been the principal driver behind the Healthier Together programme, this does not replace the current responsibilities that trust boards and CCG governing bodies have for the safe delivery of services. It is expected that Trusts and CCGs will make the programme aware of any concerns or issues arising concerning clinical safety that may have an impact on the implementation, and that these are escalated as appropriate within the South East Sector governance.

Each sector will also be expected to report monthly, in writing, to the Healthier Together Programme Board. A standard status reporting template will be created for this purpose. This status report will include sections on the clinical, estate / capital, workforce, financial and communication / engagement activities required to implement Healthier Together. This status report will be in place from January 2016.

It is proposed that the SES Single Service Programme Board and Programme Management Group meet monthly to align with this, while the SES Subgroups are established as task and finish groups to complete the work as required to implement the changes.

Horizontal relationships

In addition to the vertical reporting structure, there are identified horizontal relationships between:

- The SES Single Service Programme Board and SES Programme Clinical Leadership Group, and the Healthier Together Greater Manchester Clinical Alliance – the Clinical Alliance will be responsible for assuring clinical go-live readiness of single services. It will also be a forum to share learning about development of the model of care in each single service, therefore the clinical section of the Single Service status report will be reported to this meeting.
- South East Sector SROs, the Healthier Together Programme Sponsor and the Healthier Together Programme Director who will provide collective leadership of the programme

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

- Each of the South East Sector task and finish groups, and in particular the HR and Workforce Sub Groups and the Single Service Sub Groups - the workforce should be recruited to meet the clinical quality and safety standards and model of care; this will therefore require joint working between the two groups to ensure the workforce design is in line with the clinical model.

SES Programme roles

Two Senior Responsible Officers (SROs) for the South East Sector Programme have been agreed: Ann Barnes CEO, Stockport NHS Foundation Trust, and Ranjit Gill, Chair, NHS Stockport Clinical Commissioning Group.

In addition, on the 15th July when the option for implementation was selected, commissioners also set a number of implementation conditions, which included the following in relation to single service governance:

Condition 4 – Joint appointments to Single Services

- Each single service to appoint a Clinical Director to work across all sites within the Single Service - recruitment to be a joint process between Trusts and agreed lead CCG
- Clinical Director to lead the formation of single service teams, oversee design of single service model of care and pathways, and be responsible for clinical performance of the single service

It is also proposed that clinical champions for each speciality are identified to lead the clinical work in their respective Trusts. Nominations have been invited from each hospital site for the following:

- A&E
- General Surgery
- Acute Medicine
- Anaesthetics
- Critical Care
- Diagnostics

Timescales of the governance framework

The South East Sector Governance will be effective from January 2016 and will be in place through the implementation and evaluation phase of the Programme. The governance may be revised if required as directed by the SROs / SES Programme Board.

Recommendation

Programme Board members are requested to:

- Note the contents of this paper agree any required amendments
- Approve the governance framework (subject to above amendments)
- Review and approve the Terms of Reference of the Programme Board
- Note the draft Terms of Reference of the Programme Management Group and Clinical Leadership Group.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

Appendix – Terms of Reference

South East Sector Single Service Programme Board Terms of Reference

1. Introduction

The South East Sector established itself in response to the need for a co-ordinated response to the Healthier Together Programme during the decision making phase. The sector has evolved from the Southern Sector Partnership, a well-established collaboration between East Cheshire NHS Trust, Stockport NHS Foundation Trust, Tameside NHS Foundation Trust, and University Hospital of South Manchester NHS Foundation Trust.

Since the decision of the Healthier Together Committees in Common on the 15th July to name Stepping Hill Hospital in Stockport as the fourth hospital in Greater Manchester to provide emergency abdominal surgery, the sector has evolved to reflect the single service as described in Option 4.4a between Stepping Hill Hospital in Stockport and Tameside General Hospital, with the option to include Macclesfield District General Hospital as appropriate.

The South East Sector therefore brings together providers and commissioners in Tameside & Glossop, Stockport, East Cheshire and North Derbyshire to implement the Healthier Together changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015. The South East Sector Programme Board is the Executive Group responsible for the implementation.

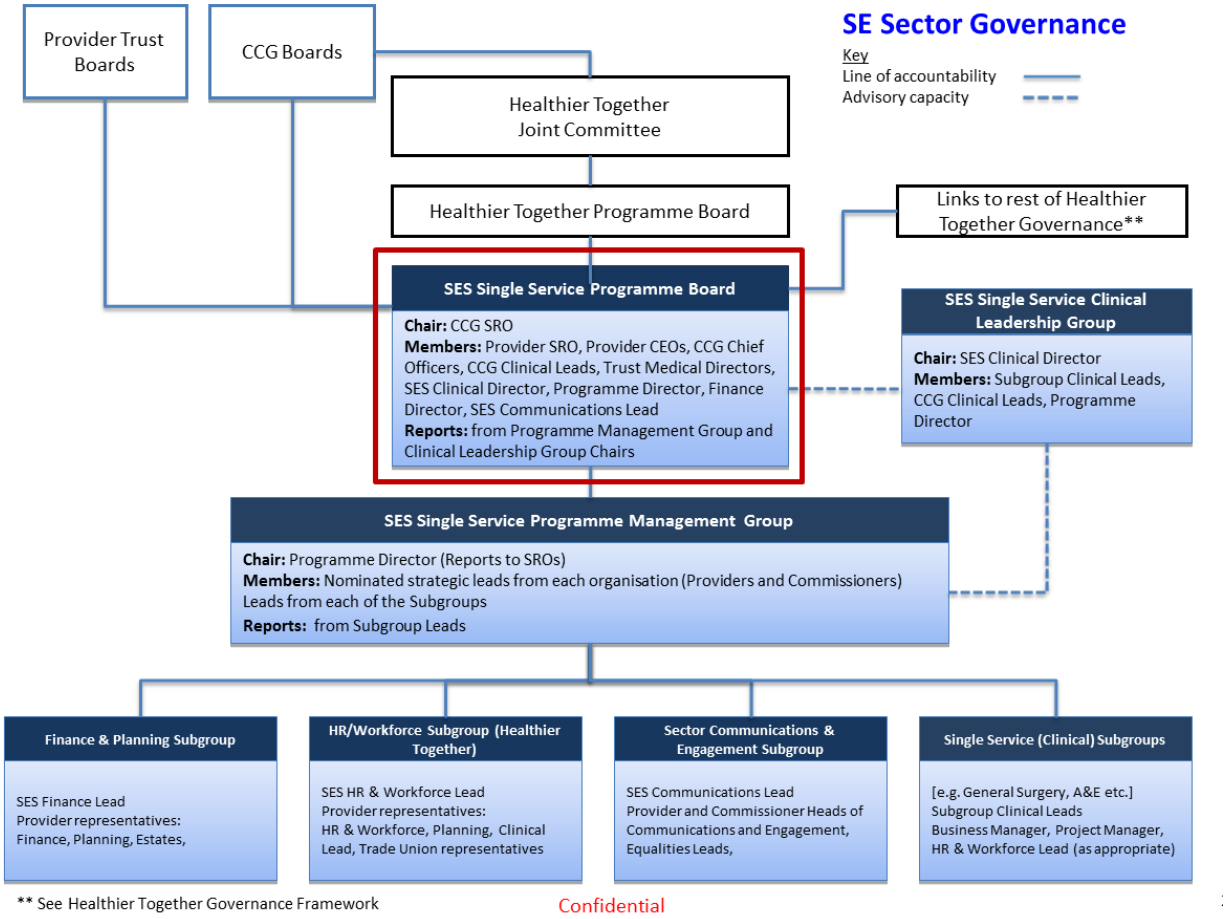
2. Establishment

The South East Sector Programme Board has agreed to renew the programme governance, including these terms of reference as the programme moves into implementation following the decision of the Healthier Together Committees in Common on the 15th July 2015, and the conclusion of the Healthier Together decision making phase.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

3. South East Sector Governance Structure

The South East Sector Programme Board is highlighted below in the governance for the sector.



4. Purpose

The purpose of the South East Sector Programme Board is to:

- Bring together executive and clinical leaders from providers and commissioners in the South East Sector to form an accountable body for the implementation of Healthier Together
- Oversee the design of the local model of care in the South East Sector, and safe delivery of the changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015
- Provide information and assurance to the Healthier Together Programme Board, member provider trust boards, and member clinical commissioning group boards; including a monthly written status report to the Healthier Together Programme Board
- Act as a forum to jointly manage progress, programme level risks and issues, and interdependencies
- Collectively approve key deliverables (e.g. Implementation Plan, Business Case etc.) prior to submission

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

- Ensure that the agreed-upon South East Sector principles are incorporated throughout the sector's work.

5. Accountability and authority

The South East Sector Programme Board is accountable to the boards of its member clinical commissioning groups and provider trusts, and the Healthier Together Programme Board. The Healthier Together Programme Board is accountable to the Healthier Together Joint Committee which is in turn accountable to clinical commissioning group boards.

The South East Sector Programme Board is reported into by the South East Sector Single Service Programme Management Group, which in turn is reported into by the single service subgroups.

The South East Sector Programme Board may be advised by the South East Sector Programme Clinical Leadership Group, and vice versa.

The South East Sector Programme Board may act within the powers delegated to it by the Healthier Together Programme Board.

6. Membership

The South East Sector Programme Board is formed from the member organisations of the South East Sector:

- East Cheshire NHS Trust
- NHS Eastern Cheshire Clinical Commissioning Group
- Stockport NHS Foundation Trust
- NHS Stockport Clinical Commissioning Group
- Tameside Hospital NHS Foundation Trust
- NHS Tameside and Glossop Clinical Commissioning Group
- NHS North Derbyshire Clinical Commissioning Group

Membership of the Board is described below:

Name	Organisation	Role
Ranjit Gill (Chair)	NHS Stockport CCG	Chief Medical Officer
John Wilbraham	East Cheshire NHS Trust	Chief Executive
Jerry Hawker	NHS Eastern Cheshire CCG	Chief Officer
Ann Barnes	Stockport NHS Foundation Trust	Chief Executive
Ann Schenk	Stockport NHS Foundation Trust	Director of Strategic Partnerships
James Sumner	Stockport NHS Foundation Trust	Chief Operating Officer
Gaynor Mullins	NHS Stockport CCG	Chief Operating Officer
Karen James	Tameside Hospital NHS Foundation Trust	Chief Executive

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

Steve Allinson	NHS Tameside & Glossop CCG	Chief Operating Officer
Jayne Stringfellow	NHS North Derbyshire CCG	Chief Nurse
Debbie Austin	NHS North Derbyshire CCG	Clinical Lead
To be discussed		SES Clinical Director
To be discussed		SES Programme Director
To be discussed		Finance Director
To be discussed		SES Communications Lead

7. Meetings

Meetings of the South East Sector Programme Board will take place once a month, in advance of the Healthier Together Programme Board which it reports into.

8. Modus Operandi and Quorum

Where the Chair has determined – and has given two weeks' notice to Programme Board members – that a key decision will be made then the quorum shall include members (or their deputies) of all organisations that the Chair determines should be present unless that organisation has instead chosen to make a written submission.

For other meetings, to constitute a quorum, a minimum of half the core members must be present.

9. Attendees

The Chair of the SES Programme Board may at his or her discretion permit other persons to attend its meetings but, for the avoidance of doubt, any persons in attendance at any meeting shall not count towards the quorum.

10.Support

Support and advice to the SES Programme Board will be provided by the Programme Director and by the Programme Team. This support shall include:

- Agreement of the agenda with the SES Programme Board Chair
- The proper and timely preparation and circulation of papers a week prior to the meeting
- Preparing and circulating minutes of meetings in draft form for members' approval at the following meeting.

11.Review

These Terms of Reference will be reviewed as deemed necessary by the SROs / SES Programme Boar

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

South East Sector Single Service Programme Management Group Terms of Reference

1. Introduction

The South East Sector established itself in response to the need for a co-ordinated response to the Healthier Together Programme during the decision making phase. The sector has evolved from the Southern Sector Partnership, a well-established collaboration between East Cheshire NHS Trust, Stockport NHS Foundation Trust, Tameside NHS Foundation Trust, and University Hospital of South Manchester NHS Foundation Trust.

Since the decision of the Healthier Together Committees in Common on the 15th July to name Stepping Hill Hospital in Stockport as the fourth hospital in Greater Manchester to provide emergency abdominal surgery, the sector has evolved to reflect the single service as described in Option 4.4a between Stepping Hill Hospital in Stockport and Tameside General Hospital, with the option to include Macclesfield District General Hospital as appropriate.

The South East Sector therefore brings together providers and commissioners in Tameside & Glossop, Stockport, East Cheshire and North Derbyshire to implement the Healthier Together changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015.

2. Establishment

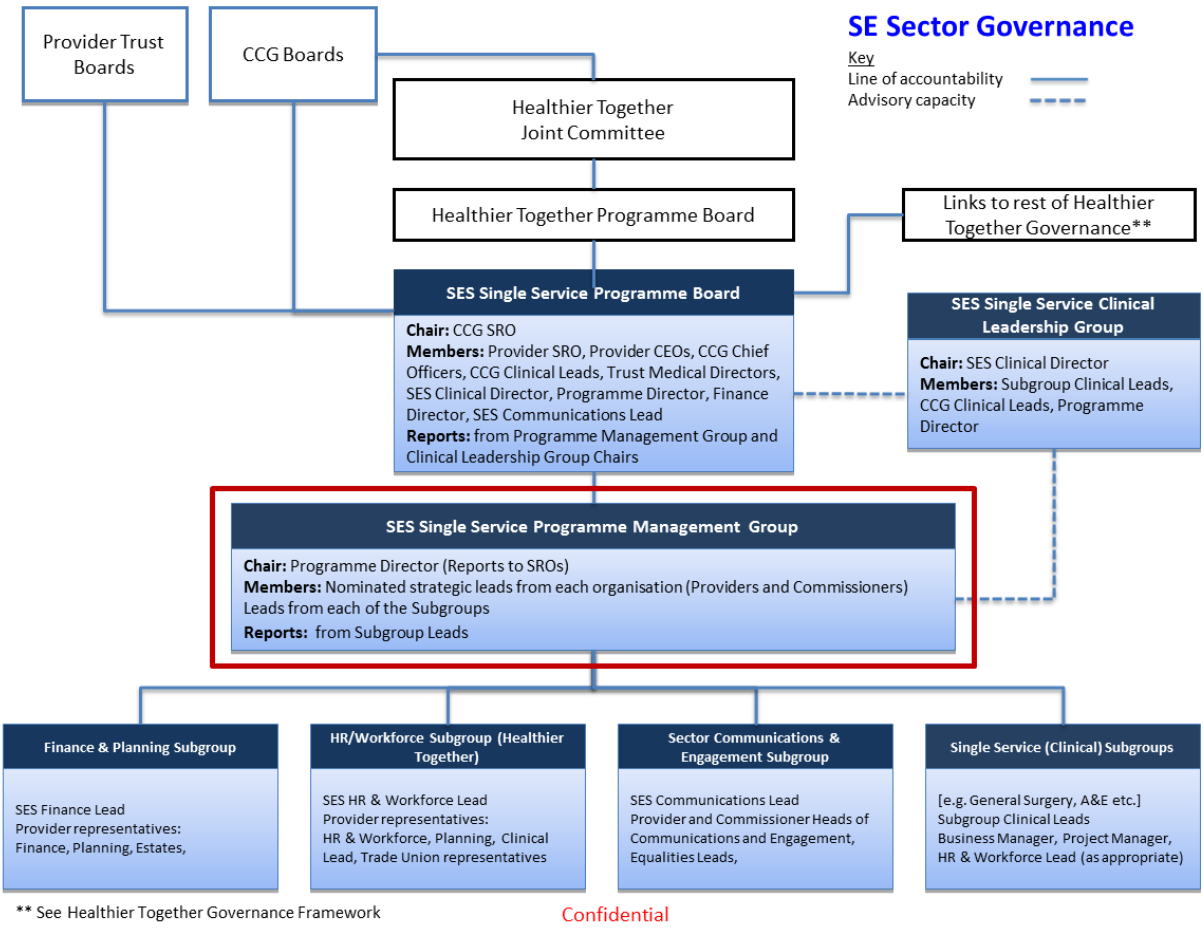
The South East Sector Single Service Programme Management Group (SES Programme Management Group) is a cross-organisational group between the following organisations:

- East Cheshire NHS Trust
- NHS Eastern Cheshire Clinical Commissioning Group
- Stockport NHS Foundation Trust
- NHS Stockport Clinical Commissioning Group
- Tameside Hospital NHS Foundation Trust
- NHS Tameside and Glossop Clinical Commissioning Group
- NHS North Derbyshire Clinical Commissioning Group

3. South East Sector Governance Structure

The South East Sector Programme Management Group is highlighted below in the governance for the sector.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf



4. Purpose

The purpose of the South East Sector Programme Management Group is to:

- Manage the overall implementation programme for the South East Sector Single Service including the design of the local model of care in the South East Sector, and safe delivery of the changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015
- Provide assurance to the South East Sector Programme Board on progress against the programme plan
- Act as a forum to jointly manage progress, risks and issues, and interdependencies, agreeing any that require escalation to the SES Programme Board
- Collectively review and make recommendations to the SES Programme Board on key deliverables (e.g. Implementation Plan, Business Case etc.)
- Commission and oversee the work of the task and finish subgroups

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

5. Accountability and authority

The SES Programme Management Group is accountable to the South East Sector Programme Board, which in turn is accountable to the Healthier Together Programme Board and the sector's provider trust and clinical commissioning group boards.

The SES Programme Management Group may be advised by the South East Sector Clinical Leadership Group.

The sector's subgroups are accountable to the SES Programme Management Group, although the Clinical Leadership Group will provide the clinical leadership and direction for the Single Service (Clinical) Subgroups.

6. Membership

The South East Sector Programme Management Group is formed from the nominated strategic leads from each of the member organisations of the South East Sector (below) as well as the Subgroup Leads:

- East Cheshire NHS Trust
- NHS Eastern Cheshire Clinical Commissioning Group
- Stockport NHS Foundation Trust
- NHS Stockport Clinical Commissioning Group
- Tameside Hospital NHS Foundation Trust
- NHS Tameside and Glossop Clinical Commissioning Group
- NHS North Derbyshire Clinical Commissioning Group

Membership of the Programme Management Group is described below:

Name	Organisation	Role
Ann Schenk (Chair)	Stockport NHS Foundation Trust	Director of Strategic Partnerships
Jess Williams	Tameside and Glossop locality	Programme Director - ICO, Tameside & Glossop
Tim Ryley	NHS Stockport CCG	Programme Director, Stockport Together
Neil Evans	NHS Eastern Cheshire CCG	Commissioning Director
Giles Wilmore	Tameside NHS Foundation Trust	Director of Strategy and Partnerships
Mark Ogden	East Cheshire NHS Trust	Director of Finance
Gillian Bird	East Cheshire NHS Trust	Head of Surgical Services
To be discussed		SES Finance Lead
To be discussed		SES HR Lead
To be discussed		SES Communications and Engagement Lead
To be discussed		Single Service (Clinical) Subgroup Leads
To be discussed		SES Programme Director

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

7. Meetings

Meetings of the South East Sector Programme Management Group will take place once a month, in advance of the SES Programme Board which it reports into.

8. Modus Operandi and Quorum

In order to constitute a quorum for any meeting, half of the identified members must be present. Whilst the presence of a quorum is also sufficient to mandate any decision made at a meeting, every effort will be made to enable all members' opinions to be taken in to account and delegates will be accepted when necessary. The responsibility for deciding as to whether to refer a proposal to the full membership rests with the Chair of the meeting.

9. Attendees

The Chair of the SES Programme Management Group may at his or her discretion permit other persons to attend its meetings but, for the avoidance of doubt, any persons in attendance at any meeting shall not count towards the quorum.

10.Support

Support and advice to the SES Programme Management Group will be provided by the programme team (support provided currently through the Transformation Unit). This support shall include:

- Agreement of the agenda in advance with the Chair
- The proper and timely preparation and circulation of papers a week prior to the meeting
- Preparing and circulating minutes of meetings in draft form for members' approval at the following meeting.

11.Review

These Terms of Reference will be reviewed as deemed necessary by the SROs / SES Programme Board / SES Programme Management Group.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

South East Sector Single Service Clinical Leadership Group Terms of Reference

1. Introduction

The South East Sector established itself in response to the need for a co-ordinated response to the Healthier Together Programme during the decision making phase. The sector has evolved from the Southern Sector Partnership, a well-established collaboration between East Cheshire NHS Trust, Stockport NHS Foundation Trust, Tameside NHS Foundation Trust, and University Hospital of South Manchester NHS Foundation Trust.

Since the decision of the Healthier Together Committees in Common on the 15th July to name Stepping Hill Hospital in Stockport as the fourth hospital in Greater Manchester to provide emergency abdominal surgery, the sector has evolved to reflect the single service described in Option 4.4a between Stepping Hill Hospital in Stockport and Tameside General Hospital, with the option to include Macclesfield District General Hospital as set out in the South East Sector Single Service Mandate.

The South East Sector therefore brings together providers and commissioners in Tameside & Glossop, Stockport, East Cheshire and North Derbyshire to implement the Healthier Together changes in line with the decisions taken by the Healthier Together Committees in Common on 15 July 2015. To date, the clinical work has primarily focused on General Surgery, but will need to widen to include all in-scope and affected specialties. In common with the other three single services, a Clinical Leadership Group will need to be established to lead the clinical work required to implement the changes in the South East Sector.

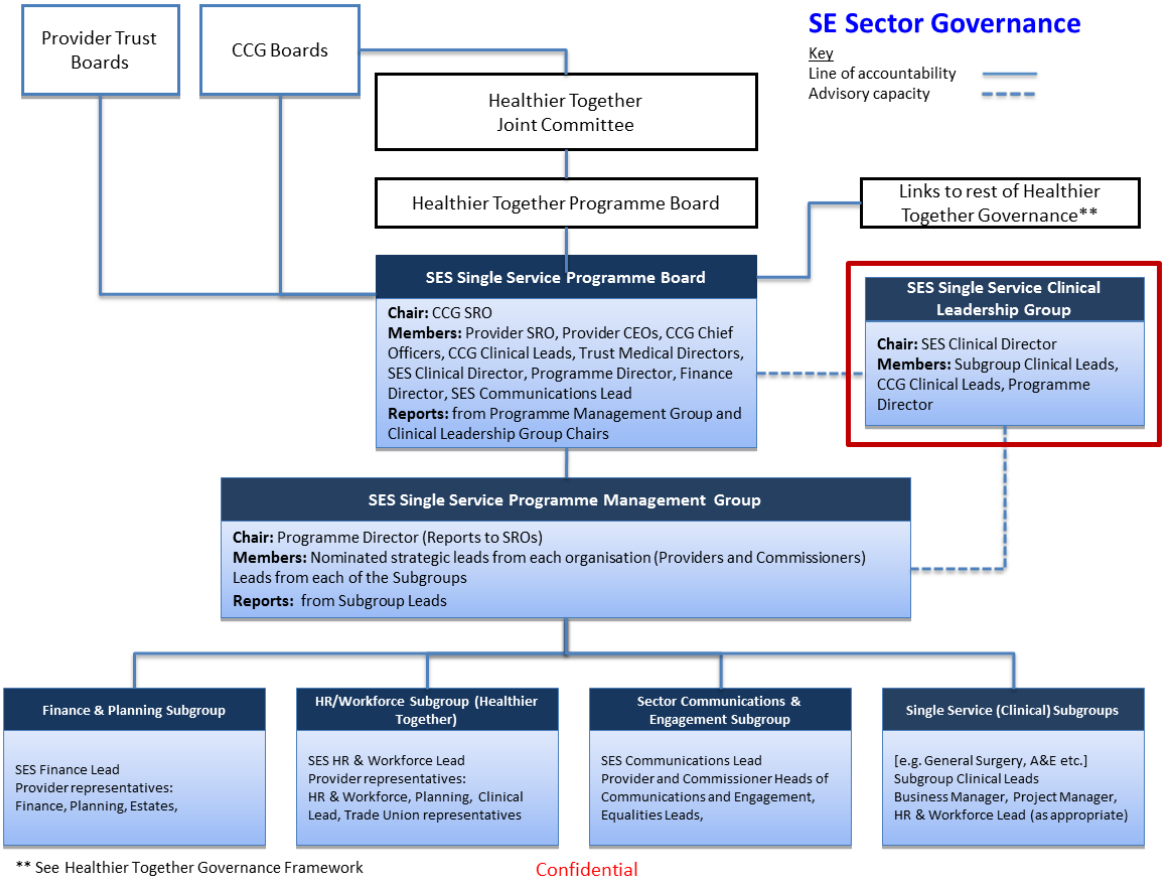
2. Establishment

The SES Programme Board has agreed to renew the South East Sector programme governance for the implementation of Healthier Together including the establishment of a Clinical Leadership Group as described above.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

3. South East Sector Governance Structure

The SES Clinical Leadership Group is highlighted below in the governance for the sector.



4. Purpose

The purpose of the SES Clinical Leadership Group is for local commissioners and the three trusts within the South East Sector "single service" to discuss design and oversee implementation of the detailed clinical model and pathways that are appropriate for the South East Sector according to the Healthier Together model and standards. As such, it is anticipated that the SES Clinical Leadership Group would:

- Lead the work to develop and agree the local model of care and clinical changes required to implement the single service and achieve the Healthier Together quality and safety standards in the South East Sector
- Provide clinical advice to the SES Programme Board and SES Programme Management Group as required
- Lead clinical implementation planning and advise the SES Programme Board on the safe sequencing of changes, and clinical readiness for implementation
- Work collaboratively with partner organisations to manage clinical interdependencies and ensure that the local model of care is coherent and co-ordinated across the sector

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

- Act as a forum to task, manage progress, and resolve risks and issues arising from the work of the Single Service (Clinical) Subgroups
- Monitor and manage clinical risk across the sector during planning and implementation, escalating risks and issues to the SES Programme Board as necessary
- Provide a monthly written clinical report as part of the status update to the Healthier Together Programme Board by the SES Programme Board.

5. Accountability and authority

The work of the SES Clinical Leadership Group is advisory and as such has it no executive powers. The Group may act within the authority delegated to it by the SES Programme Board to deliver the outputs of the clinical work. It is expected that the group will make recommendations and report into the GM Clinical Alliance via the SES Programme Board.

6. Membership

The membership of the SES Clinical Leadership Group is as follows:

Name	Organisation	Role
For discussion (Chair)	TBA	SES Clinical Director
TBA	TBA	Subgroup Clinical Leads x6
TBA	TBA	CCG Clinical Leads x 4
TBA	TBA	SES Programme Director

7. Meetings

Meetings of the SES Clinical Leadership Group will take place once a month, in advance of the SES Programme Board and SES Programme Management Group which it provides advice to.

8. Modus Operandi and Quorum

In order to constitute a quorum for any meeting, half of the identified members must be present. Whilst the presence of a quorum is also sufficient to mandate any decision made at a meeting, every effort will be made to enable all members' opinions to be taken in to account and delegates will be accepted when necessary. The responsibility for deciding as to whether to refer a proposal to the full membership rests with the Chair of the meeting.

9. Attendees

The Chair of the SES Clinical Leadership Group may at his or her discretion permit other persons to attend its meetings but, for the avoidance of doubt, any persons in attendance at any meeting shall not count towards the quorum.

10.Support

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

Support and advice to the SES Clinical Leadership Group will be provided by the programme team (support provided currently through the Transformation Unit). This support shall include:

- Agreement of the agenda in advance with the Chair
- The proper and timely preparation and circulation of papers a week prior to the meeting
- Preparing and circulating minutes of meetings in draft form for members' approval at the following meeting.

11.Review

These Terms of Reference will be reviewed as deemed necessary by the SROs / SES Programme Board / SES Clinical Leadership Group.

[1]https://healthiertogethergm.nhs.uk/files/5614/4535/6666/Appendix_71_Implementation_Considerations.pdf

NHS
Stockport
Clinical Commissioning Group

Committee Terms of Reference

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

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

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

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
The Governing Body is asked to approve the Terms of Reference for the following Committees: 1. Finance and Performance Committee 2. Quality Committee 3. Remuneration Committee 4. STAMP **5.** Primary Care Commissioning Committee (to be in place from 1 April 2016)
Please detail the key points of this report
The Governing Body approved the recommendations of a review of the CCG's Governance Structure in September 2016 arising from which a number of Constitutional Changes were approved by the Annual General Meeting and NHS England. The Constitution includes as appendices the Terms of Reference for the Committees and Sub-Committees of the Governing Body. All have been subject to review by the relevant Committee and recommended for approval to the Governing Body. Those which remain outstanding are the Audit Committee Terms of Reference which are being reviewed in light of a review of the Committee's effectiveness in mid-February and will be brought to a future meeting of the Governing Body for approval.
What are the likely impacts and/or implications?
Effective operation of the CCG's Committees is integral to the effectiveness of the organisation's overall decision making and assurance processes. Non-compliance with the requirements of the CCG's Constitution.
How does this link to the Annual Business Plan?
The CCG's Governance Structure and Committees form an integral part of the delivery of the organisations activity and plans.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
CCG's Management Team Meeting Relevant Committees for each Terms of Reference

Clinical Executive Sponsor: Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 9 March 2016
Agenda item:

NHS
Stockport
Clinical Commissioning Group

Terms of Reference

Terms of Reference for the Finance and Performance 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

1. Introduction

Purpose

The Finance and Performance Committee (the Committee) has evolved from the Quality Innovation Prevention and Productivity (QIPP) and is established in accordance with NHS Stockport Clinical Commissioning Group's (CCG's) constitution, standing orders and scheme of delegation. The purpose of the Committee is to focus on the development and monitoring of the CCG's Operational Plan and priority areas as linked to the CCG's delivery of financial and performance targets and make recommendations to the CCG's Governing Body.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Clinical Commissioning Group's constitution and standing orders.

2. Membership

The Committee shall be appointed by NHS Stockport Clinical Commissioning Group.

It is only the members of the Committee who have the right to attend the meetings of the committee. Other individuals may be invited to attend for all or part of any meeting as and when appropriate.

The Chair of the Committee will be a clinical member of the committee

In the event of the Chair of the Committee being unable to attend all or part of the meeting, the Vice-Chair will assume the role. In the event of the Chair or Vice-Chair being unavailable, the Chair will nominate a replacement from among the members to deputise for that meeting.

- Locality Chairs (x1) (clinical) (Chair)
- Governing Body Lay Member (x1) (non clinical)
- Clinical Director of Public Health (x1) (clinical) (Vice-Chair)
- Clinical Director of General Practice Development (x1)
- Chief Clinical Officer (x1) (clinical)
- Chief Operating Officer (x1) (non clinical)

The Chief Finance Officer will support the Committee but they will not be a member of the Committee. The Chief Finance Officer will proactively, through the Committee hold the organisation to account for its delivery of finance and performance targets.

Where the SRO for a particular QIPP scheme is a member of the Finance and Performance Committee, they should declare a conflict of interest and withdraw

from membership of the Committee to be held accountable for their work as an SRO.

3. Minutes / Preparation of papers

A member the Committee Support team will take the minutes of the meetings. The relevant Officer will liaise with the Chair of the Committee to set the agenda, follow up actions from the previous meeting, collate papers for the meeting and distribute papers no later than seven days before the date of the meeting. Members of the Committee should declare any interests as they arise. The minutes shall be signed by the Chair as a true record at the end of the meeting. The approved minutes will be uploaded on to the CCG website.

4. Reporting responsibilities

The recommendations of the Committee shall be presented as soon as practicable to the Governing Body. Any recommendation agreed by the Committee will require ratification by the Governing Body as it is the Governing Body which remains ultimately responsible for taking decisions on the investments. The minutes from the relevant meeting of the Governing Body will record the decisions made.

5. Quorum

The Quorum for the Committee meeting shall be one third of the Committee membership (two of the six members) as outlined in section 2, and shall have at least one clinical member in attendance.

If the meeting is not quorate within thirty minutes of its planned start, the Chair of the meeting must decide to adjourn the meeting or to proceed and ensure all decisions are ratified at the next meeting.

6. Frequency and notice of meetings

The Committee shall meet no less than eight times a year. A meeting of the Committee can be called by any member in liaison with the Chair, with seven days' notice given. Papers will be distributed to members no later than seven days before the meeting.

7. Remit and responsibilities of the Committee

The Committee should focus its time on proactively holding those senior clinical or managerial officers across the organisation to account for the delivery of the CCG's financial and performance targets in addition to its monitoring and overview role.

The Committee shall:

7.1 Ensure effective monitoring arrangements are in place for the delivery of the Operational and Strategic Plans of the CCG.

7.2 Routinely review the delivery and effectiveness CCG QIPP plans and associated business cases and hold those responsible for their delivery.

7.3 Make recommendations to the Governing Body and executive team in line with standing financial instructions on required adjustments to ensure continual delivery of financial position.

7.4 Develop and recommend to the Governing Body formal recovery plans should the need arise.

7.5 Review Outline Business Cases prior to Governing Body approval and approve Full Business Cases greater than £250,000.

7.6 Oversee and determine variances from and variations to contracted activity levels.

In addition to the formal delegations from the CCG Governing Body, the Committee will:

- Provide assurance on the development of plans throughout the NHS Planning Cycle.

- The Committee will prioritise QIPP schemes into a review schedule to guide the committees work in year

- Receive updates on performance against financial statutory duties and performance targets.

NHS
Stockport
Clinical Commissioning Group

Terms of Reference

Terms of Reference for the Quality Committee

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1. Introduction

Purpose

The Quality Committee (the Committee) is accountable to the CCG's Governing Body for providing assurance of patient safety, patient experience and clinical effectiveness of commissioned services in line with the CCG's Quality Strategy. It will provide leadership for the quality agenda in Stockport and ensure commissioned services are continuously improving, achieving and exceeding national and local standards. The Governing Body has approved and keeps under review the Terms of Reference for the Quality Committee.

2. Membership

Membership of the Quality Committee

The Committee shall be appointed by the CCG Governing Body as set out in the CCG's constitution and may include individuals who are not on the Governing Body.

The membership of the Committee will be as follows:

- The Executive Nurse member of the Governing Body (clinical)
- The Clinical Director for Quality & Provider Management (clinical)
- A Locality Council Committee Chair (clinical)
- The Lay Member with a remit for Public and Patient Involvement (non clinical)
- The Safeguarding Lead Nurse (clinical)
- Senior Commissioning Quality and Performance Lead (clinical)
- A Nurse or Allied Healthcare Professional who is not an employee of NHS Stockport CCG nor a member of the Governing Body (clinical)
- A Healthwatch committee representative (non clinical)
- The Clinical Director, Public Health (clinical)

The Chair of the Committee will be the Executive Nurse member of the Governing Body. In the event of the Chair of the Committee being unable to attend all or part of the meeting, the Chair will nominate a member from among the members to deputise for that meeting.

Each member of the Committee should attend five of the possible number of meetings held each year. A register of attendance will be published in the CCG's annual report. Members and those present should state any declarations of interest and the minute taker should minute them accordingly.

Other individuals may be invited to attend the Committee as required in order to inform decision making and discharge of duties. Any such individual may speak and participate in debate but may not vote.

3. Minutes / Preparation of papers

A member the Committee Support team will take the minutes of the meetings.

The Committee Support Officer will liaise with the Chair of the Committee to set the agenda, follow up actions from the previous meeting, collate papers for the meeting and distribute papers no later than seven days before the date of the meeting. Members of the Committee should declare any interests as they arise. The minutes shall be signed by the Chair as a true record at the end of the meeting. The Committee Support Officer will send approved minutes to the CCG Communication Team to upload on to the CCG website.

4. Reporting responsibilities

The Chair of the Committee shall draw to the attention of the Governing Body any issues that require full disclosure or require executive action.

5. Quorum

The Quorum for the Committee meeting shall be one third of the Committee membership as outlined in section 2, and shall have a clinical majority in attendance with at least one GP in attendance.

If the meeting is not quorate within thirty minutes of its planned start, the Chair of the meeting must decide to adjourn the meeting or to proceed and make recommendations to be ratified at the next meeting of the Committee.

6. Frequency and notice of meetings

The Committee shall meet bi-monthly and will alternate its formal meetings with a Quality Review meeting according to the priorities included within the work plan. A meeting of the Committee can be called by any member in liaison with the Chair, with seven days' notice given. Papers will be distributed to members no later than seven days before the meeting.

7. Remit and responsibilities of the Committee

The Committee will provide assurance on the quality of services commissioned and the promotion of a culture of continuous improvement and innovation with respect to the safety of services, clinical effectiveness and patient experience. The Committee will operate a work plan that is flexible to new and emerging priorities and to threats to optimum service delivery and quality \ services

The Governing Body has delegated the following functions to its Quality Committee:

- To focus on quality and risk issues including the clinical agenda to ensure that appropriate governance structures, systems and processes are in place across its commissioned providers (including jointly commissioned services)
- To seek assurance that all elements of quality (patient safety, patient experience and clinical effectiveness) are reflected in the duties of the CCG
- To monitor any Safeguarding risks for children and vulnerable adults and

be advised on any changes to safeguarding policies

- To approve the Safeguarding Annual Report to be presented to Governing Body
- To monitor the improvement / action plans following third-party inspections and own service reviews and identify major quality improvement requirements
- To escalate any issues of concern/risk to the Governing Body in a timely manner
- To note any risk or compliance issues against NICE guidance that would need reporting to the CCG Governing Body

Appendix 1

Quality Review meetings

Membership of Quality Review meetings

The Quality Review meetings shall consist of relevant members of the Committee and any other nominated professional as deemed relevant to the discussion at that particular meeting. The Chair will be selected prior to each meeting.

Quorum

It is recommended that one third of the Committee membership is invited to participate in the Quality Review meetings.

Reporting responsibilities

A representative from the Quality Review meeting will report back to the Quality Committee with any recommendations.

Approved: 9 March 2016
Review date: March 2017

NHS
Stockport
Clinical Commissioning Group

Terms of Reference

Terms of Reference for the STAMP Committee

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7th Floor
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1. Introduction

Purpose
STAMP is a sub-group of and accountable to the Finance and Performance Committee for NHS Stockport Clinical Commissioning Group (CCG).

Its purpose is to ensure safe, effective and affordable use of medicines, technologies and treatments which reflects the needs of the local population.

2. Membership

The membership of the sub-group will be as follows:

- A Pharmacist from the CCG Medicines Optimisation Team
- A representative from CCG General Practice Directorate
- A Locality Chair or Vice chair (GP)
- The CCG GP Prescribing Lead (GP)
- A Healthwatch representative
- A lay member of the governing body (also representing Quality Committee)
- The Clinical Director for Public Health (also representing Quality Committee)

The sub-group will be supported by a number of nominated observers who do not have voting rights including

- A Committee Support Officer
- Clinical/Pharmaceutical representation from NHS Stockport Foundation Trust
- Representation from Pennine Mental Health Trust
- A representative from the Local Pharmacy Committee by nomination for a three year term of office
- A representative from North Derbyshire CCG MO team
- A member of the Finance Team

The Chair of the sub-group will be the Locality Chair and the deputy chair will be the CCG GP Prescribing Lead.

Each member of the sub-group should attend no less than eight of the meetings held each year. A register of attendance will be published in the CCG's annual report. Members and those present should state any declarations of interest and the minute taker should minute them accordingly.

Other individuals may be invited to attend the STAMP sub-group as required in order to assist in its decision making and discharge of duties. Any such individual may speak and participate in debate but may not vote.

3. Administrative Support

A member of the Committee Support team will take the minutes of the meetings. The Committee Support Officer will liaise with the Chair of the sub-group to set the agenda, follow up actions from the previous meeting, collate papers for the meeting and distribute papers no later than five days before the date of the meeting. Minutes of a meeting will be approved as a true record at the following meeting. The Committee Support Officer will send approved minutes to the CCG Communication Team to upload on to the CCG website.

4. Quorum

The Quorum for the STAMP sub-group meeting shall be 1/3 of members as outlined in section 2, and shall have a clinical majority in attendance with at least one GP in attendance, one CCG Pharmacist and one lay member.

If the meeting is not quorate within thirty minutes of its planned start, the Chair of the meeting must decide whether to adjourn the meeting or to proceed and ensure all decisions are subsequently ratified by a quorum of members.

5. Frequency and notice of meetings

The STAMP sub-group will meet monthly. Urgent decisions may be taken by four members' agreement, at Chairs discretion and later ratified by the next full sub-group.

6. Remit and responsibilities of the Sub-Group

The STAMP sub-group will be accountable to the Finance and Performance Committee. The remit of STAMP is as specified above. The Finance and Performance Committee has delegated the following functions to its STAMP sub-group:

- To review and approve GM Effective Use of Resources (EUR) policies and GMMMG policies, formulary and guidance.
- To review NICE guidance in relation to GP and secondary care practice, technologies, treatments and medicines in association with the relevant costing tools as supplied by CCG finance
- To assess impact on existing pathways and any GP development requirements
- To report any identified gaps or clinical risks to the Quality Committee.
- To disseminate relevant information and decisions made at STAMP to providers and GP Practices.
- To agree practice prescribing budgets and assist in management of budget and available resource through the CCG Medicines Optimisation Team
- To develop guidance and policy in response to local needs where no GM or national guidance is available
- To develop and manage the local lists to support good practice in prescribing, included delegated authority to sign off and implement the local RAG/Black & Grey list ensuring consideration of GMMMG guidance and formulary

- To ensure that there are appropriate shared care protocols in place for relevant drugs in line with NHS England and the GMMMG Red/Amber/Green status of drugs
- To support local management of medicines related to MHRA or other safety alerts
- Other duties may be delegated at the discretion of the Finance and Performance Committee or Governing Body.

Date approved by the Finance and Performance Committee:
Review date:

Draft terms of reference – NHS Stockport CCG Primary Care Commissioning Committee

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Stockport CCG. The delegation is set out in Schedule 1.

3. The CCG has established the NHS Stockport CCG Primary Care Commissioning Committee ("Committee"). The Committee will function as a corporate decision- making body for the management of the delegated functions and the exercise of the delegated powers.

4. It is a committee comprising representatives of the following organisations:
   - NHS Stockport Clinical Commissioning Group
   - Stockport Healthwatch -non-voting
   - Stockport Metropolitan Borough Council (via Health and Wellbeing Board) – non voting
   - NHS England – non voting

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

   a) Management of conflicts of interest (section 14O);

   b) Duty to promote the NHS Constitution (section 14P);

   c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

   d) Duty as to improvement in quality of services (section 14R);

   e) Duty in relation to quality of primary medical services (section 14S);

   f) Duties as to reducing inequalities (section 14T);

   g) Duty to promote the involvement of each patient (section 14U);

   h) Duty as to patient choice (section 14V);

   i) Duty as to promoting integration (section 14Z1);

   j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act

   - Duty to have regard to impact on services in certain areas (Section 13O)
   - Duty as respects variation in provision of health services (Section 13P)

9. The Committee is established as a committee of the Governing Body of NHS Stockport CCG in accordance with Schedule 1A of the “NHS Act”.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Stockport, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Stockport CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities:

a) To plan, including needs assessment, primary [medical] care services in Stockport

b) To undertake reviews of primary [medical] care services in Stockport

c) To co-ordinate a common approach to the commissioning of primary care services generally;

d) To manage the budget for commissioning of primary [medical] care services in Stockport

e) To coordinate and oversee a common approach to the management of primary care estates

Geographical Coverage

17. The Committee will comprise the area covered by NHS Stockport CCG as defined within its Constitution.

Membership

18. The Committee shall consist of:

- The Lay Member with responsibility for Patient and Public Participation
- A Lay member specifically recruited to the Committee
- The Nurse Member of the Governing Body
- The Chief Operating Officer
- The Chief Finance Officer
- A Locality Council Committee Chair or Vice-chair
- Clinical Director for Public Health
- Chief Clinical Officer
- Clinical Director General Practice Development

19. The Chair of the Committee shall be the Lay Member with responsibility for Patient and Public Participation

20. The Vice Chair of the Committee shall be the Lay Member specifically recruited to the Committee.

21. **The following will have a standing invitation to attend the meetings of this Committee in a non-voting capacity:**

- A Representative of the Stockport HealthWatch
- A Representative of the Stockport Health and Wellbeing Board on behalf the Local Authority
- A representative of NHS England

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Board Secretary and Head of Governance to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

23. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and casting vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

24.The quorum for the Committee shall be one third of the Committee Membership and must include one Lay Member and one Clinical Member of the Committee.

25. If the meeting is not quorate within thirty minutes of its planned start, the Chair of the meeting must decide to adjourn the meeting or to proceed and ensure all decisions are ratified at the next meeting.

Frequency of meetings

26. The Committee shall meet no less than four times a year. A meeting of the Committee can be called by any member in liaison with the Chair, with seven days' notice given. Papers will be distributed to members no later than seven days before the meeting.

27.Meetings of the Committee shall:

a) be held in public, subject to the application of 23(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

28.Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

29. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest..

30. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

31. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

32. The Committee will present its minutes to the Greater Manchester Area Team of NHS England and report to the governing body of NHS Stockport CCG each month quarterly for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

33. The CCG will also comply with any reporting requirements set out in its constitution.

34. It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions. NHS England may also issue revised model terms of reference from time to time.

Accountability of the Committee

35. The membership of the CCG has established a Governing Body in order to discharge its statutory functions. The Committee is accountable to the Governing Body. Membership of the Governing Body is representative of the membership through the elected Locality Chairs and through the appointment of Clinical Executive Directors and the Accountable Officer.

36. Appropriate consultation with patients and the general public is undertaken through the CCG's Patient Panel and in line with the national and locally adopted guidance

Procurement of Agreed Services

37. The CCG will make procurement decisions as relevant to the exercise of its delegated authority and in accordance with the detailed arrangements regarding procurement set out in the delegation agreement.

Decisions

38. The Committee will make decisions within the bounds of its remit.

39. The decisions of the Committee shall be binding on NHS England and NHS Stockport CCG.

40. The Committee will produce an executive summary report which will be presented to the Greater Manchester Team of NHS England and the governing body of NHS Stockport CCG quarterly for information.

Schedule 1 – Delegation as listed within the Body of the Terms of Reference

Schedule 2 - List of Members as included in the Body of the Terms of Reference.

NHS
Stockport
Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group

Governing Body

Remuneration Committee

Terms of Reference

Version 2.0

1. Introduction

The Remuneration Committee (the committee) is established in accordance with NHS Stockport Clinical Commissioning Group's constitution, standing orders and scheme of delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the clinical commissioning group's constitution and standing orders.

2. Membership

The committee shall be appointed by NHS Stockport Clinical Commissioning Group.

It is only the members of the Remuneration Committee who have the right to attend the meetings of the committee. Other individuals such as the Accountable Officer, any Human Resource lead, Staff Side or LMC representatives and external advisers may be invited to attend for all or part of any meeting as and when appropriate.

No individual should be in attendance for discussions or decisions concerning their own remuneration and terms of service. If this means that the meeting becomes inquorate then the Chair will adjourn the meeting until a date and time when the meeting will be quorate.

The Chair of the Remuneration Committee will be the Lay Member who leads on audit, remuneration and conflict of interest issues.

The other members of the Remuneration Committee will be:

- a Locality Council Chair approved by the Governing Body (Vice-chair of Remuneration Committee)
- the Lay Member for Patient and Public Participation
- a Clinical Director
- the Secondary Care Consultant.

The Chief Operating Officer will provide advisory support to the Committee and will withdraw from the meeting when matters relating to their remuneration and terms of service are being considered.

3. Secretary

The Secretary to the Governing Body will provide secretarial support to the committee.

The Secretary will be responsible for supporting the Chair in the management of remuneration business, for the taking of formal

minutes, and for drawing the committee's attention to best practice, national guidance and other relevant documents, as appropriate.

4. Quorum

The quorum for the meeting shall be one third of the Committee Membership as outlined in section 2 and must include either the Chair or Vice-chair.

If the meeting does not have a quorum within thirty minutes of its planned start the chair of the meeting must adjourn it.

5. Frequency and notice of meetings

The Remuneration Committee shall meet a minimum of once a year.

A meeting of the Remuneration Committee can be called with a minimum of seven days' notice. The agenda and papers will be made available to the committee's members one week before the time of the meeting.

6. Remit and responsibilities of the committee

The committee shall make recommendations to the governing body on determinations about pay and remuneration for employees of the NHS Stockport Clinical Commissioning Group, for people who provide services to the NHS Stockport Clinical Commissioning Group, and for allowances under any pension scheme it might establish as an alternative to the NHS Pension Scheme.

The Remuneration Committee will:

- Review the performance of the Accountable Officer and other senior team members and determine annual salary awards (if appropriate)
- Consider the severance payments of the senior staff (including the Accountable Officer), seeking HM Treasury approval as appropriate in accordance with the guidance Managing Public Money
- Provide for the Governing Body an opinion on any salary and benefits framework which may be introduced to replace Agenda for Change.

7. Relationship with the Governing Body

The recommendations of the Remuneration Committee shall be presented as soon as practicable to the Governing Body. Any recommendation agreed by the Remuneration Committee will require ratification by the Governing Body as it is the Governing Body which remains ultimately responsible for taking decisions on the

remuneration, allowances, and terms of service of the senior team members.

The minutes from the relevant meeting of the Governing Body will record the remuneration decisions made.

The Remuneration Committee shall ensure that Governing Body members' emoluments are accurately reported in the required format within the annual report of the NHS Stockport Clinical Commissioning Group, and that the composition of the committee is correctly disclosed in the annual report.

8. Policy and best practice

The Remuneration Committee will endeavour to apply best practice in its decision-making at all times. For example the committee will:

- Comply with current disclosure requirements for remuneration
- On occasion seek independent advice about remuneration for individuals
- Ensure that decisions are based on clear and transparent criteria.

The committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

9. Conduct of the committee

The Remuneration Committee will, at all times, conduct its business in accordance with the NHS Stockport Clinical Commissioning Group's Code of Conduct. This Code of Conduct has at its foundation the Nolan Principles which are:

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

The Remuneration Committee will review its own performance, membership and these Terms of Reference no less frequently than annually. Any changes resulting from such a review will be reported to the Governing Body for approval.

Reviewed 23 February 2016

NHS
Stockport
Clinical Commissioning Group

Governing Body Forward Plan 2016/2017

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

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Executive Summary

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

The Governing Body is asked to consider and approve the approach to the operation of its meetings and development time within the 2016/17 year.

Please detail the key points of this report

The Governing Body is operating in an increasingly complex environment as both the leaders of the CCG as an individual organisation and within a wider economy partnership.

It is crucial therefore that the time available for meetings and development time is utilised with maximum effect with the right balance being achieved between formal meetings and informal opportunities for strategy formulation, internal board challenge and discussion, reflection on direction of travel and in year progress against the achievement of strategic priorities.

The report proposes a Forward Plan for 2016/17 to guide the work of the Governing Body and also to suggest ways in which the Governing Body can maximise the activities carried out across the whole governance structure.

The approach focuses on a Plan guided by a number of key factors:

- CCG's Operational Plan 2016 / 17
- The aligned Strategic Plans of the wider Partnership including Stockport Together and at a regional level Greater Manchester Devolution
- The Governing Body's assurance role as a key body working in a complex partnership
- Board Assurance Framework as the strategic view of the CCG's risks
- Forward Planning at CCG Committee Level and opportunities that exist to align and coordinate activities
- The embedded learning culture of the Board supported by a programme focussed on individual and collective learning objectives with time to reflect, challenge, develop and consider strategy development.

What are the likely impacts and/or implications?

Effective operation of the CCG's Governing Body is key to ensuring the organisation is well governed, led and achieves its strategic objectives. Failure to do this will result in non-compliance with legal and statutory requirements and impact significantly on the functioning of the CCG.

The governance structure provides the framework in which the formal functions are carried out.

This is supplemented by a governing body development plan which is currently in its second year and serves to develop the individual members and the Governing Body to lead the organisation in the best way possible.

How does this link to the Annual Business Plan?
Linked to planning and annual business cycle and key pieces of work described in the CCG's operational plan and the aligned strategic plans of the wider partnership both within Stockport and at a regional level.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
CCG's Management Team Meeting Chair of the Governing Body
Clinical Executive Sponsor: Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 9 March 2016
Agenda item:

1. Introduction and Purpose

1.1 The activities of the Governing Body in the 2015 / 16 year were guided by a Forward Plan approved by its Members. It is proposed that a similar approach be implemented for the 2016 / 17 year, building on the work undertaken in the current year and reflecting the complex partnership environment in which the CCG is currently operating.

1.2 The purpose of a Forward Plan is to align the activity of a Governing Body or Board to their annual business cycle and delivery of organisational priorities and projects. It also seeks to maximise the use of meeting time available to plan ahead for the discharge of business and to horizon scan for opportunities for the development and review of strategy and seek assurance.

1.3 It is increasingly important that in the partnership working environment that the CCG is able to align its decision making approach with those of partners where required to enable for consideration of matters at an economy wide level, in particular in advance of the point of decision making.

1.4 The Forward Plan has been written in light of the review of the CCG's Governance Structures which was approved by the CCG's Governing Body in September 2015 and was implemented from 1 January 2016 onwards.

1.5 The Governing Body is asked to:

- Discuss the guiding principles on which the Forward Plan has been drafted
- Consider the frequency of reporting on key standing issues and time required for discussion of other strategy related matters
- Note the balance between formal meetings and board development time and suggest any amendments
- Suggest any changes to the content of the plan

1.6 Once approved the Plan will form the basis of the agenda and meetings for the 2016 / 17 and be adapted based on continued review of organisational and partnership wide priorities for planning and delivery.

1.7 The detail of the Board Development time included in the plan will be developed by the Chair of the Governing Body with support from the existing organisation supporting the Board's continued leadership development. This will be supplemented by the Personal Development Plan work undertaken by the Chair of the Governing Body and Accountable Officer to focus on the continued personal skills development of individual members.

2. Role of the Governing Body and its Committees

2.1 Governing Bodies have responsibilities to set strategic direction and hold the executive to account for delivery and organisational performance. This is no different for the CCG. Setting strategic direction requires a good understanding of the strategic context, the

options and opportunities, its risk appetite and available resources as well as the national mandates. In holding the executive to account it scrutinises delivery of its plans, its compliance with the NHS Constitution and other statutory and legal duties. A good governing body ensures there is a good balance of time given to these two twin functions.

2.2 At the current time the Governing Body also has a key role to play along with the equivalent strategic decision making bodies of its partners in assuring and ensuring the delivery of the vision for the future of health and care services in Stockport through the Stockport Together Programme. It is important that the Governing Body observes the parameters of the Programme governance and does not look to duplicate the work undertaken therein but that it can maintain strategic oversight on the strategy development and delivery of the Programme and receive assurance as required.

2.3 The Governing Body reporting to it a range of formal Committees who play an integral role in enabling the CCG to fulfil its governance duties and focus resource and attention on reviewing local priorities. In order to maximise the overall effectiveness of the Governance framework it is important that as well as Committee Chairs reporting to Governing Body for the performance of their Committees that the Governing Body delegates work to them where specialist input is required or the Governing Body is unable to undertake the work directly. Likewise Committees should escalate matters for Governing Body's attention to ensure progress where it is required and discussion where matters require more strategic focus.

2.4 A recent review of Audit Committee Effectiveness identified the importance of coordinating work across the whole governance model so that the Audit Committee, with its relevant independence can undertake its role effectively and seek to identify areas within its remit where assurance and challenge can be provided. It is therefore proposed that the Chair of the Governing Body meets annually with the Chair of Committees to align Work Programmes to maximise the use of available meetings resource and ensure the strategic priorities of the organisation are being considered across the whole model. The Governing Body meeting cycle has also been changed to ensure that all Committees as appropriate can report into the Governing Body within the same month – thereby ensuring information flow is maintained and issues can be escalated and delegated appropriately at pace.

2.5 Similarly, work has been undertaken to align the activities of the Governing Body and the Locality Committee structure to better enable two way communication and to horizon scan for strategic issues on which the Locality input is vital as a way of developing and testing strategic thinking and considering practical implication. This approach will be developed over the coming months in line with the changes agreed as part of the Governing Body to maximise the effective use of Members time within the Locality Meetings structure.

3. Developing a Forward Plan

3.1 As well as the balance between its strategy and governance responsibilities a governing body plan should reflect the organisational priorities it has set. This becomes increasingly important when the focus of an organisation's priorities includes both those internal to its own operations and a significant percentage to be delivered through wider partnerships and

collaboration. The setting and strategic planning of the wider partnership needs to remain in focus for the Governing Body and constantly be revisited as part of its work to ensure continued commitment, tracking and assurance of delivery and a clear understanding of the CCG's role within the partnership and delivery of wider priorities.

3.2 To enable the Governing Body to continue to carry out its strategic role effectively and to confidently influence and lead across the economy both locally within Stockport and across Greater Manchester it remains as important in the coming year as at the current time that space is made within the overall time available for Governing Body members to meet to think through strategy, discuss ideas and options for the vision and design of strategic changes programmes and to reach consensus on the Body's view on key matters. This is why the Forward Plan at its highest level will continue to be supplemented by a range of Development sessions and pre-meeting information and strategy sessions to allow for developmental thought and working issues through.

3.3 The CCG Constitution requests that that the Governing Body meets in public 8 times a year and also to meet with members at the Annual General Meeting which will in 2016 / 17 take place in July rather than September as has been the case in previous years. This will allow for consideration of the end of year position and review including the Annual Report and Accounts closer in a more timely way.

3.4 The Forward Plan has been developed on the basis of the following key elements:

- CCG's Operational Plan 2016 / 17
- The aligned Strategic Plans of the wider Partnership including Stockport Together and at a regional level Greater Manchester Devolution
- The Governing Body's assurance role as a key body working in a complex partnership
- Board Assurance Framework as the strategic view of the CCG's risks
- Forward Planning at CCG Committee Level and opportunities that exist to align and coordinate activities
- The embedded learning culture of the Board supported by a programme focussed on individual and collective learning objectives with time to reflect, challenge, develop and consider strategy development.

3.5 Given the scale and pace of change in which the CCG is a key part, the Forward Plan will need to remain flexible and to be able to adapt to consider new and emerging issues. In particular it is important that the Governing Body on behalf of the GP Membership is able to respond quickly with a consistent message where views on policy and strategy are required in particular as part of the Stockport Together Programme and Greater Manchester Devolution. Governing Body agreed policy positions can then be enacted and voiced as required by Governing Body Members and the CCG's Senior Management Team with confidence.

4. Proposal Summary

4.1 The detailed plan described below includes the following features:

a) Meeting formally in public 8 times per year and 3 times for study, development and discussion together.
b) An annual meeting between Chair of Governing Body and Committee Chairs to align Forward Plans across the whole Governance model to maximise the time available in particular valuable clinical expertise and input into key issues.
c) Greater use of the Board Assurance Framework as a guiding document in setting and prioritising issues within the Forward Plan across the year to respond to high risk areas balanced against potential reward in delivery.
d) Continued focus on the delivery and assurance of strategic plans governing the CCG as an individual organisation, on an economy wide basis through the Stockport Together Programme and within the Greater Manchester Devolution Framework
e) Balance between setting the CCG strategic direction and influencing the strategic direction and seeking assurance of external bodies and partners, principally through the Stockport Together Programme.
f) Use of pre-board information sessions to develop strategy, thinking and policy positions on a continual basis outside of the 3 main development sessions
g) Continuation of the Board Bitesize learning sessions themed alongside the key matters to be considered by the Governing Body at each meeting

5. Forward Plan

5.1 Meetings Outline

Month	Meeting	Date and Time
April 2016	**Formal Meeting**	**27 April 9.00am – 13.00pm**
May 2016	**Formal Meeting**	**25 May 9.00am – 13.00pm**
June 2016	**Development Day**	**29 June 9.00am – 4.00pm**
July 2016	**Annual General Meeting**	**6 July 12 noon – 5.00pm**
July 2016	**Formal Meeting**	**27 July 9.00am – 4.00pm**
August 2016	**No meeting**	
September 2016	**Formal Meeting**	**28 September 9.00am – 13.00pm**
October 2016	**Development Day**	**26 October 9.00am – 4.00pm**
November 2016	**Formal Meeting**	**30 November 9.00am – 13.00pm**
December 2016	**Formal Meeting**	**21 December 9.00am – 13.00pm**
January 2017	**Formal Meeting**	**25 January 9.00am – 13.00pm**
February 2017	**Development Day**	**22 February 9.00am – 4.00pm**
March 2017	**Formal Meeting**	**29 March 9.00am – 4.00pm**

5.2 Standing Items

5.2.1 There are a number of items which the Governing Body in its strategic role focusing on its assurance role and that of performance should receive at each meeting. Reporting format is at a high level and continually reviewed to ensure that Members are able to interpret and interrogate data provided and provide clear steer to the CCG's Management, across the Stockport Together Partners and Greater Manchester Devolution.

5.2.2 The standing items to be considered at each Governing Body Meeting are as follows:

- Procedural Governance Items – eg Apologies, Declarations of Interest Minutes etc
- Patient Story
- Reports from the Chair, Chief Clinical Officer and Chief Operating Officer
- Performance Reports – Strategic Impact Report, Finance Report, Resilience and Compliance Report and Quality Report
- Reports of Committees – Audit Committee, Finance and Performance Committee, Primary Care Commissioning Committee and Locality Committees

5.2.3 In addition to the Standing Items there are a number of routine strategic items and formal matters which require Governing Body approval and consideration throughout the year which have been incorporated into the outline Forward Plan overleaf.

5.2.4 The Governing Body should, in its strategic and guiding role utilise all the tools available to it to operate as effectively as possible. A key document which it considers multiple times each year is the Board Assurance Framework which provides a structure and process which enables the CCG to focus on the principal risks to achieving its strategic objectives and receive assurance about controls that are in place to manage risks as far as possible. Outside the times it is considered as a full document, the content of the Board Assurance Framework and where relevant Operational Risk Registers will be aligned to the Strategic Impact Report as the regular report which monitors performance against the achievement of organisational objectives to prompt wider consideration from Governing Body Members of associated risks and mitigations. This approach will be reviewed in-year to test effectiveness and impact.

5.2.5 In addition to the items outlined above, the Forward Plan will need to include as they emerge a number of strategic areas in which decisions are required. They could be related to CCG business, delivery of the economy wide changes to health and care through the Stockport Together Programme and Greater Manchester Devolution. Any good Forward Plan remains under continued review as a ‘living document’ so it will be adapted as new items emerge and timescales change. It is important that the ask of Governing Body related to these special focus items is clear in advance to give time for prior thought and reflection and the discussion of a consensus policy position by the CCG’s Management Team as key advisors to the Governing Body, the wider CCG GP Membership and the Governing Body itself.

5.2.6 A skeleton Forward Plan is proposed below for comment and discussion.

5.2.7 The Plan will be refined following the approval of the CCG’s Operational Plan and the Strategic Plans of local and regional partners which inform significant elements of the CCG’s business and activity. It will then remain under continued review throughout the year.

5.2.8 In addition to the meetings in the Plan the Governing Body will continue to meet at least twice a year in a Board to Board meeting with the Governing Body of NHS Stockport Foundation Trust to work collaboratively and enable cross organisational working.

Meeting Date	Item Description	Link to Priority or Plan	Decision / Steer or Action
April 2016	1.Primary Care Estates Strategy?		Approval
May 2016	1. Annual Report and Accounts 2.Board Assurance Framework	Statutory Requirement Underpinning Framework document	Approval Discussion, review and approval
July 2016 – Annual General Meeting	1.Annual Report and Accounts	Statutory Requirement	Review by Members and Members of the Public
July 2016	1.Sustainability and Transformation Plan 2.Winter Pressures – Lessons Learned and Planning 3. Stockport Together Business Case	NHSE Requirement / Greater Manchester Devolution Delivery Assurance of Systems Resilience Group Activity Whole System Transformation	Approval Review and discussion Approval
September 2016	1.Board Assurance Framework 2. Statement of Involvement 3. Organisational Capacity	Underpinning Framework document Activity review framework Integral to ensure capacity to	Discussion, review and approval Discussion, review and approval Comment and approval

	Review and Development Plan	deliver priorities and develop	
November 2016	1.Primary Care Commissioning – 6 month review and assurance 2.Winter Planning and Resilience	Organisational Plan Priority Assurance of Systems Resilience Group Plans	Assurance review Assurance and discussion
December 2016	1.Safeguarding Reports	Statutory Requirement	Consideration and review.
January 2016	1.Board Assurance Framework 2.Public Sector Equality Duty	Underpinning Framework document Legal Requirement	Discussion, review and approval Consideration and Approval
March 2016	1.Operational Plan 2017/18 2.Annual Compliance report of the SIRO 3.Governing Body Forward Plan 2017/18	CCG's Plan as required by NHS England Information Governance underpinning element Delivery of Governing Body's Strategic Role	Approval Scrutiny and approval Approval

NHS
Stockport
Clinical Commissioning Group

Compliance Report 2015/2016

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

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Executive Summary

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

The Governing Body is required to consider and review the CCG's Information Governance and compliance work during the 2015/16 and approve an action plan identifying priorities for the forthcoming 2016/17 year.

Please detail the key points of this report

The CCG's Information Governance Framework captures Stockport Clinical Commissioning Group's approach to Information Governance and compliance. Robust information governance requires clear and effective management and accountability structures, governance processes, document policies, trained staff and adequate resources.

This report provides an update on compliance in the following key areas:

1. Information Governance Framework and Accountability
2. Compliance with mandatory training
3. Information Governance Incidents and related learning
4. Management of the CCG's Information Assets
5. Information Governance Toolkit Submission 2015/16
6. Information Governance Improvement Plan 2016/17

What are the likely impacts and/or implications?

None adherence to Information Governance requirements would expose the CCG to unnecessary levels of risk regarding the management of information assets held by the organisation.

Meeting the legal requirements and seeking to implement best practice in the area of Information Governance will improve organisational efficiency and minimise risk exposure linked to the Compliance Theme of the Board Assurance Framework and Operational Risk Registers.

How does this link to the Annual Business Plan?

The governance processes which underpin the CCG's operations are central to the delivery of the organisation's strategic aims and objectives.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

Information Governance Group – Internal and Management Team Meeting

Clinical Executive Sponsor: Ranjit Gill

Presented by: Tim Ryley

Meeting Date: 9 March 2016

Agenda item: 14

Reason for being in Part 2 (if applicable)

Detail

1. Information Governance Framework and Accountability

1.1 In the NHS, information is a vital yet potentially vulnerable asset, both in terms of the clinical management of individual patients and the efficient commissioning and management of services and resources.

1.2 It is important that information is managed efficiently and securely within a framework of clear policies, procedures and accountability structures.

1.3 The framework sets out the approach taken within NHS Stockport CCG to ensure that the necessary people, resources and processes are in place to support the core principles of Information Governance in the caring of individuals, improvement of public health, and commissioning of local health services. The document serves as the CCG's IG assurance framework and the detailed IG policy for CCG staff.

1.4 The framework will be the subject of a full review in 2016.

2. Compliance with mandatory training

2.1 The CCG will have 100% mandatory training compliance by 31 March 2016 covering the 2015 – 2016 year. An interim deadline of 29 February was agreed by the CCG's Management Team to encourage early completion.

2.2 All CCG employees, including Governing Body Members are required to complete modules covering the following topics:

- Information Governance Awareness
- Equality and Diversity
- Fire Safety and Evacuation
- Health and Safety
- Safeguarding Adults
- Safeguarding Children
- Display Screen Equipment

2.3 As at 2 March 2016, the completion rate was 88% across the organisation.

2.4 The CCG's designed Senior Information Risk Officer (SIRO) who was in post until 29 February 2016 had completed all the mandatory training aligned to the duties of the role and arrangements have been made for the new SIRO to undertake the relevant training.

2.5 The CCG's designed Caldicott Guardian and Deputy Caldicott Guardians have also met all the mandatory training requirements linked to their roles.

3. Information Governance Incidents and related learning

3.1 The CCG has an electronic system for reporting and managing information governance incidents and a number of activities have been undertaken throughout the year to raise awareness amongst staff of reporting incidents promptly.

3.2 Logged incidents are reviewed on a monthly basis and where appropriate fully investigated and actions plans created to prevent recurrence.

3.3 The number of incidents logged during the 2015 – 2016 year relating to information governance was 23. In addition a further 57 issues were logged relating to the Acute Trust / Community Contracts and 7 relating to Safeguarding.

3.4 Of the total number, two incidents were escalated in line with the requirements of the Information Commissioner's Office (ICO) as a Tier 2 incidents. Both had been previously investigated by the

CCG and the ICO is now undertaking a further investigation of one matter to review the actions of the CCG in managing the data breach.

3.5 Greater Manchester Shared Services provides the CCG's IM&T infrastructure services of which a key part is the management of electronic information. The CCG works closely with the Shared Services as part of its compliance work and can confirm that the following activity has been undertaken:

- The GMSS has implemented new processes for Cyber Security incidents.
- The GMSS has updated its IT Information Asset Register in year.
- The current Starter and Leaver processes have been reviewed and are documented. Work is continuing to update processes. This has been prioritised in the IT Service Improvement Plan in agreement with the CCGs.
- The GMSS has an IT Service Business Continuity Plan, this has been reviewed and updated in year. The updated document has been approved by the GMSS Senior Management Team.
- A regular IT Security Audit Programme is currently being developed

4. Management of the CCG's Information Assets

4.1 In January 2016 a full review of the CCG's Information Asset Register was undertaken with relevant Information Asset Owners and Administrators. This included a review of the information assets held by the organisation, the form in which they are stored and for which purpose and the Risk Rating associated potential loss or damage.

4.2 An overview copy of the Information Asset Register is published on the CCG's website and updated accordingly.

5. Information Governance Toolkit Submission 2015/16

5.1 Annually prior to 31 March the CCG is required to submit an evidence based self- assessment against the criteria as outlined in the Health and Social Care Information Centre's Information Governance Toolkit. There are 28 standards against which evidence of compliance must be submitted.

5.2 It was agreed that the CCG would aim to self-assess at Level 2. Level 2 requires a minimum score of 68% across all indicators and demonstrates that the CCG meets the satisfactory requirement for the

5.3 A two stage internal audit review of the self-assessment document was undertaken which concluded in early February 2016. This provided a judgement of 'significant assurance' against the 10 criteria assessed and identified two areas where sufficiency of evidence to demonstrate the Level sought had not been observed. The evidence would be in place by the time of submission.

5.4 In line with the requirements of the Toolkit, the Governing Body is asked to note the Level 2 submission.

6. Information Governance Improvement Plan 2016/17

6.1 Arising from compliance work during the 2015/16 year and linked to the management of risk within the CCG, an Information Governance Action Plan has been devised for the forthcoming 2016/17 year. The action plan covers the key areas of compliance within the area of Information Governance and links to the self-assessment criteria utilised as part of the Information Governance Toolkit.

6.2 In addition to the ongoing systems and processes embedded within the organisation as outlined in the Information Governance Framework, the following actions were proposed and agreed by the Information Governance Group to focus activity on key areas within the forth coming year which will provide greater controls in areas of information risk management and security, records management and increase staff awareness and access to resources regarding information governance.

6.3 The Improvement Plan Actions and timescales are listed overleaf.

Governing Body is requested to:

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

Information Governance Improvement Plan 2016/17

Action no.	Sub-section	Completion Date
	Caldicott	
1	Develop a strategy and audit schedule for internal spot checks and audit. - Identifying scope i.e. CHC, Safeguarding, IG and IT system/drives/software access audits, leavers removal of access rights	Apr-16
	Information Security	
2	Develop and sign off for GP data sharing agreement	Mar-16
3	Review NHS Numbers Procedure in line with patient safety requirements.	Apr-16
4	Finalise a Business Continuity Plan (Clarity on CSU provision)	Nov-15
	Information Risk	
5	Complete the annual review of the Information Asset Register, including correct ownership, accuracy of information and if still current	Dec-15
6	Review the complaints, FOI and SARs processes and investigate improved mechanisms for working in a more joined up way	Jun-16
7	Produce Risk strategy and register, identifying controls and measures.	Nov-15
8	Risk strategy and register focus on aligning Operational Risk Register to projects and programme risks.	Jul-16
	Data Quality	
	N /A	N/A
	Records Management	
9	Review care home data controls regarding the secure sharing of documents with partners.	Apr-16
10	Review how the CCG manages it records across the business.	May-16
11	Create Records Management strategy.	Nov-16
12	Implement new system to control Personnel files, strategy and file management and controls	May-16
	Staff Awareness	
13	Refresh and re-launch staff induction program. Staff learning i.e. brown bag lunchtime awareness sessions for staff	Apr-16
	Develop staff learning and awareness sessions by creating a learning program for staff annually.	Apr-16
	Public Awareness	
	N/A	N/A
	Contracting	
	N/A	N/A
	IG Toolkit	
14	Review and update all IG Policies and Procedures	Nov-16

NHS
Stockport
Clinical Commissioning Group

Primary

Care Development

End of Year Report

2014-2015

This paper describes the first year's summary of findings of the GP development scheme and future points to consider for the continual success of this scheme.

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

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Introduction

Executive Summary

What *decisions* do you require of the Governing Body?
Governing Body is required to note the impact of the scheme after its first full year of operation and confirm that the funding source will become recurrent from the 2016/17 onwards.
Please detail the key points of this report The GP development scheme commenced in November 2014 to improve care for the people of Stockport by identifying conditions and illnesses early and managing them optimally at all stages of disease. The goal was to support and develop the existing core service in primary care in such a way as to reduce unplanned hospital attendance and admission, thereby improving the financial sustainability of the health system compared to the current model of care. This report presents and discusses the findings of the financial and business intelligence data available and a qualitative report submitted by each practice at the end of the first year of the scheme from November 2014 to October 2015.
What are the likely impacts and/or implications?
The report outlines the impact of the additional financial investment in general practice and highlights a number of best practice examples which can be used to improve quality and drive innovation across Stockport.
How does this link to the Annual Business Plan?
At the end of year one the GP Scheme shows clear signs that the additional financial investment of approximately £1million of new funding in general practice is starting to address CCG strategic objectives and is achieving positive outcomes.
What are the potential conflicts of interest?
All Practices in Stockport were able to propose schemes and projects to be funded as part of the Scheme.
Where has this report been previously discussed?
Finance and Performance Committee
Clinical Executive Sponsor: Viren Mehta
Presented by: Roger Roberts
Meeting Date: 9 March 2016
Agenda item:

Introduction

The GP development scheme commenced in November 2014 to improve care for the people of Stockport by identifying conditions and illnesses early and managing them optimally at all stages of disease. The goal was to support and develop the existing core service in primary care in such a way as to reduce unplanned hospital attendance and admission, thereby improving the financial sustainability of the health system compared to the current model of care.

From the original Business case this GP Development scheme was the favoured option because it aligns with the Stockport Together Vision and CCG strategic objectives. It provides an opportunity to deliver the support for the Healthier Together programme which relies heavily on general practice expanding and being at the centre of the reforms needed.

The total resource made available across all Stockport practices was £3m. £1.6m of this was to continue to provide services already commissioned from General Practice but in a more effective way leaving £1.4m of new investment available. Practices submitted a proposal and funding plan for their allocation, approximately £10 per head of the population. Each practice plan was required to demonstrate how the funding would contribute reducing the numbers of avoidable admissions, attendances and the cost of prescribing. £0.4m was not claimed in the first year leaving a total of £1m actual investment against which to assess benefits.

This report presents and discusses the findings of the financial and business intelligence data available and a qualitative report submitted by each practice at the end of the first year of the scheme from November 2014 to October 2015.

Summary of Findings

At the end of year one the GP Scheme shows clear signs that the additional financial investment of approximately £1million of new funding in general practice is starting to address CCG strategic objectives and is achieving positive outcomes. In relation with the desired outcomes highlights include:

A reduction in avoidable urgent hospital admissions:

- 277 less people admitted to hospital with a Long Term Condition (LTC) resulting in a saving of £187k

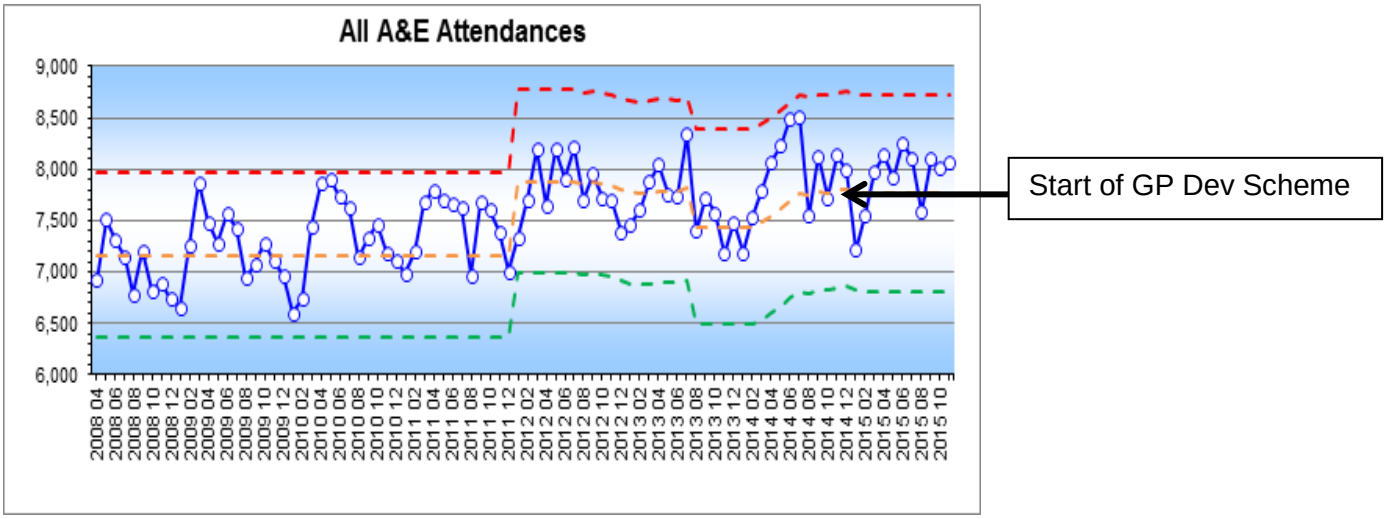
- 202 less people admitted to hospital from a care home setting resulting in a saving of £375k

- 6 practices have employed care coordinators - data suggest a reduction in readmissions within 30 days.

A reduction in avoidable ED attendances:

- ED attendances have flat lined in Stockport compared to an increase of 2.2% nationally, providing a potential saving of 250k

- No significant change in out of hours data (except since 111 –Nov 2015)



Prescribing cost to be kept within England average:

- Improved engagement in working on prescribing by GP practices this year
- Employment of 7 pharmacists by practices suggests a positive contribution to reduce spending and continued improvement in management of patients
- Challenges remain within prescribing in working towards all practices achieving the England average

Increased capacity for LTC Patients:

- Over 50% of practices have increased LTC capacity through extended hours under the scheme
- Most common use of funding suggest COPD and HF
- Many practices are being more proactive in improving the management of chronic disease

Double the extended hours DES –core hours guaranteed – hours of patient demand specific:

- 145 hours a week (7545pa) of Extended Hours just through GP development scheme
- Successful uptake of appointments (75% +)
- No half day closures and increased appointment times for the working population.

Increase in patient satisfaction:

- Recent survey by Mori, focussed on ten areas of patient experience including questions around making appointments, waiting times, opening hours and the level of care received
- In every area, Stockport's GP surgeries overall performed better than the previous year and better than the national average - on some topics by as much as 6%

Financial Analysis

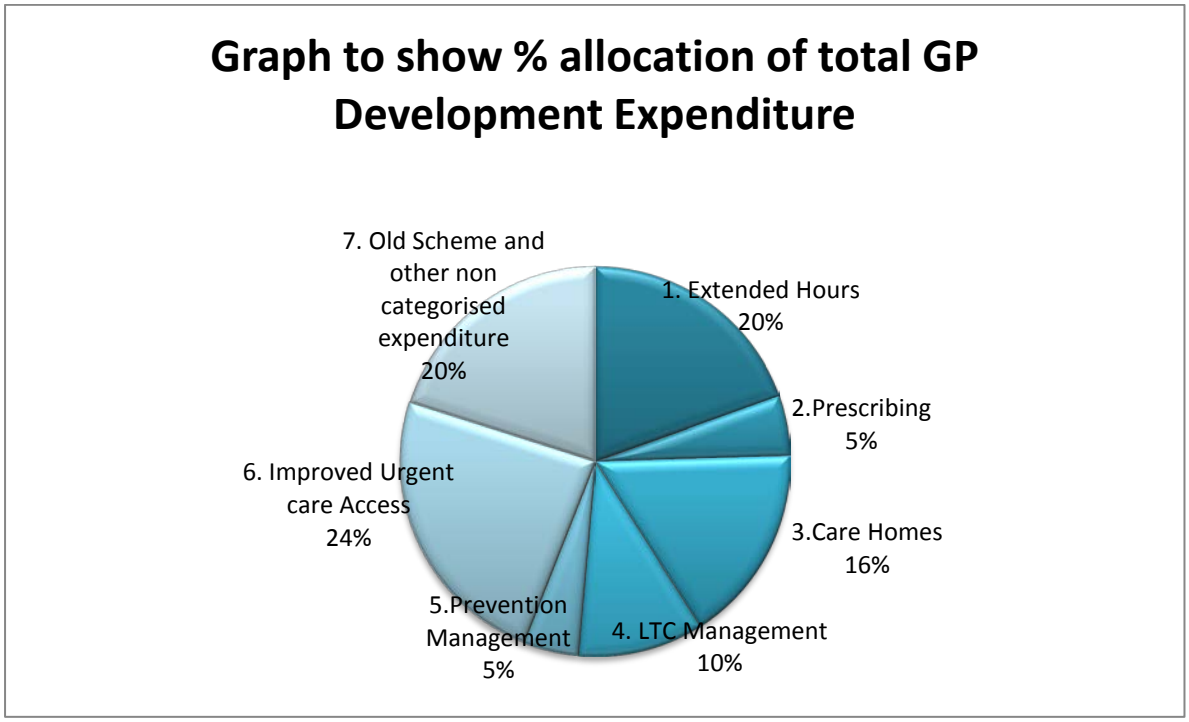
The total Value of GP development bid submissions for 2014 / 15 was **£3,095,832.**

The total actual spend for the period under review was **£2,666,037**

The previous year (2013/14) investment from the Enhanced Primary Care Scheme and other local enhanced schemes is now included in GP development scheme and has a value of **£1.6m**

Actual spend is less than the full allocated budget due to the following reasons:

- The period under review is Nov 2014 to Oct 2015 and therefore there will be a continued spend up to 31st March 2016 totalling approximately £2.9m
- Some practices had difficulties in recruiting or setting up the scheme received no payments until they were operational
- Two practices are funded £2.50 per the raw list as they are not part of the new scheme



Summary of GPDF Expenditure November 2014- October 2015	**2014/15 Expenditure**
Extended Hours	£521,160
Prescribing	£132,613
Care Homes	£438,627
LTC Management	£277,844
Prevention Management	£122,204
Urgent Care Access	£638,579
Previous scheme and other non-categorised expenditure	£535,010
Total	**£2,666,037**

The above table is an estimate based on an analysis of the bid documents and the reports detailing year one activity. It is true that categories overlap and money will move as services become established. They are therefore indicative for the purposes of analysis.

Taking into account the actual spend and factoring in the previous year's £1.6m investment the amount of 'new money' as an increased investment for 2014 / 15 is in the region of £1m only for the period under review.

National trends suggest an increase in ED attendances of 2.2%. Stockport shows no significant growth in this area for the period under review. This shows that for the initial investment of the GP scheme has achieved an avoidance of growth in ED attendance. This equates to a cost saving of almost £250k.

Overall, the financial outcome of this investment shows that in the first year for every £ invested a saving of £0.81 was achieved. This is a return of circa £810k based on £1m of the new monies invested. This is less than the targeted return of £1: £1.17 (based on a return of investment of 117%) but given the immediate impact despite for example challenges in recruitment it is highly likely that some of the developments will further realise their potential as they become embedded within primary care services.

Component Findings

1. Extended Hours

   A successful outcome of this scheme is that all practices no longer close for half a day each week. This allows patients to have greater access to their own GP instead of an out-of-hours service. In addition, practices were required to extend their opening hours under the scheme in order to target specific patient cohorts and report on the uptake of these extra hours. Across all practices 50% increased appointments for the management of LTC. The remaining amount was shared between urgent access and some prevention work.

   Those practices which in their reports recorded uptake of these appointments reported that they were almost fully booked (greater than 75% uptake).

   The extended hours has created an additional capacity for the management of patients with chronic illness. Within general practice by having these extra appointments it is highly possible it is one of the reasons that there has been a reduction in LTC admissions of 277 for the year of the GP Development Scheme (November 2014- October 2015). The total real reduction in admissions equates to a cost saving of the reduction is approximately £187k.

   Going forward we will need to consider:

   - Ensure practices advertise the additional hours on practice websites
   - Consider how data can be used to better ascertain that patient demand and new working arrangements provide sufficient increased hours
   - Gain a better understanding of what specific patient cohort these extended hours are reaching so that we can better target resource

2. Prescribing

   The investment of £133k has seen18 practices make progress towards the England Average. In total 7 pharmacists have been appointed under the scheme and are starting to show benefits in cost improvement but also improvement in patient access for medication review and the freeing up of GP appointments. Where practices can focus they can make a significant impact in this area. For

example, in the month of November (2015) a saving of £100k off the forecasted overspend was achieved.

Best Practice Example

Gatley Medical group recruited a practice pharmacist and the outcome to date has resulted in financial reductions in prescribing spends and reduced GP time on prescription duties. This workforce change is seen as a significant benefit to the practice and the patients. Examples of the work now been done by the pharmacist include:

- Medication review clinics held three times per week;
- Hospital discharge medicines
- New patient medicines
- Advising prescribers on medication supply issues, new medication/ branded generics
- Medication queries, repeat prescription queries, requests to prescribe blacklisted items

3. Care Homes

There are circa 2380 care home beds in Stockport. The overall admissions rate from care homes reduced by 202 throughout the year. This equates to a potential saving for the year of approximately £375k .

It could be indicative that there has been an improvement in the management of care homes following the reallocation of patients to GP practices giving them their 'fair share' across the borough. 36 of the practices report an enhancement in the service they provide to care homes but the reduction and cost savings mentioned above are also due to weekly ward rounds, care plans and more engagement with care home staffing and GP practices.

It should be noted that the reallocation started from July 2015 and upon analysing the monthly dashboard data it is clear there is a trend of month on month reductions since the care home reallocation began. These reductions are greater than those from the previous years, for example, from November 2014 the care home variance was -202 and based on the most recent dashboard data the number is moving towards 300 reduced admissions for the forthcoming year. Therefore, there is a strong likelihood of further benefits accruing.

Best Practice Example

Under the care home reallocation The Guywood Practice had a large increase in their patient numbers and has still managed to significantly reduce admissions.

Going forward we will need to consider:

- Further refinement at a practice level to ensure equality of workloads
- Develop ward rounds into MDT's in line with neighbourhood developments to offer support for management of care home patients

- Training and skill mix within care home setting to be more effective
- Look to better understand non-financial benefits of service in improved care of residents in line with new standards being developed

4. Long Term Conditions

Of the total investment for this scheme around 10% has been allocated to the management of long term conditions (£278K). Most practices reported having a proactive LTC management system with 42 practices having care plans in place.

As previously cited there has been a reduction of 277 admissions for the year. It was difficult to ascertain the specific LTC that has seen the most significant change since the scheme began. However, the dashboard suggests that COPD is the condition with the most significant reduction of 102 admissions compared to the previous year.

Stockport practices are within the top performing quartile nationally for management of LTC (GP 2020 Plan)

Points to consider:

- STAIRS2 project developed skills. We are now continually seeing the benefit in the treatment being given.
- Ensure we develop the neighbourhood working model to improve the management of chronic illnesses

Best Practice Example

Marple Cottage is currently piloting a new system called Vidyo which is a video consultation system that links in with the EMIS system.

Real time test with Asthma patients have shown promising results, with the quality of video able to show poor inhaler technique. They are planning to roll this out as in the next few months.

5. Prevention Management

An investment of £122k, approximately 5% of the total, has been made towards prevention management. Few practices have dedicated any significant budget to this area of work.

All practices have effective recall and review systems in place and conduct work on the early causes of disease. Diabetes and Heart Failure are a focus of prevention management through health checks but engagement with patients groups appears challenging.

In terms of un-diagnosed patients there is no real evidence suggesting practices audit and identify who should be screened.

Preventative work is unlikely to result in any cost savings over the short term of this scheme.

Best Practice Example

Marple Cottage developed patient education sessions which have generated a lot of interest. For example, working alongside the patient forum a pain management presentation was arranged to educate patients on how to manage their own conditions and lifestyle improvements to avoid hospital admissions and / or surgical intervention.

Points to consider:

- Utilising Public Health 'Health Trainers' employed at a neighbourhood level
- More work on Patient Education
- Neighbourhood working- A joint approach at MDT's to target prevention
- GP Dev Scheme to be reviewed in line with the five year forward view in relation to prevention driving a reduction in emergency and elective care

6. Patient Communication & Satisfaction

All practices reported making improvements to communication access for patients. Mainly consisting of improved websites where there is continuing work to support practices in developing clear and accurate information. The use of email, text messaging and better telephone access has also been implemented.

Best Practice Example

Cheadle Medical Practice- Following the patient survey, in order to improve telephone access, introduced a telephone access protocol with reception staff which is reviewed periodically. They also offer online access to patients enabling them to book appointments, request repeat prescriptions and view a summary of their medical record online.

An admin email account has been introduced which allows them to communicate with patients via email. They have also set up a text cancellation facility to make cancelling appointments easier which is helping to reduce DNA rates. This is audited monthly.

7. Improved Urgent Care Access

Urgent care access has seen the largest investment from the original budget of £639k (24%). The expected outcome was to maximise capacity within general practice so that avoidable ED attendances could reduce by patients having easier access to primary care services in and out of core hours. Nationally, ED attendance has increased on average by 2.2% and although Stockport ED attendance has shown no significant change this is a positive outcome when compared to the national average. It is thought continual investment in this area allowing General Practice to increase capacity for urgent access will in time result in a downward trend of ED attendance.

The majority of practices who allocated funding to this area have increased capacity mainly by recruiting salaried GP's and other clinicians. From the reports submitted, 24 practices state that they offer same day appointments for patients who believe their conditions are important. 5 practices have implemented a triage service to effectively manage the use of appointments more appropriately. In addition, all children are offered appointments on the same day in line with the specification with some practices offering appointment times to fit in with after school pick-ups. This is a positive outcome.

Points to consider:

- Further work on patient education is necessary to reduce urgent care attendance
- Understand and address, if required, the use of locums who lack familiarity with practice systems and affinity to the local population
- Further analysis is required to understand the correlation between increased capacity in primary care and use of ED services

Best Practice Example

Manor Medical Practice- Patients attending ED during practice hours are reviewed by clinician and may be contacted by the Practice; this revealed that a number of parents were being told to go straight to ED by either nursery or school. In other cases a letter is sent re-affirming Practice hours and services available encouraging contact with surgery first. Patients attending A&E outside of practice hours are reviewed and if appropriate are sent a letter urging them to call Out of Hours first rather than directly attending ED.

All patients with a care plan who request urgent access are put on triage with a priority note CARE PLAN in place so Clinician can prioritise. Any patients who have with suspected or confirmed cancer diagnosis has an alert on patient record to ensure *prompt access if requested.*

The most common highlights identified about the scheme included:

- Recruitment of additional GPs and other clinicians including Pharmacists
- Increased access for LTC management patients
- The role of the care co-ordinator

The most common issues about the scheme included:

- Estates and the lack of space such as consulting rooms to deliver improved services
- Care Homes was a common concern for practices including management and the additional work it involved with care home staff

Practices were asked what improvements they would make in the short, medium and long term. A The most common were:

- Short Term: Installation of a new improved centralised telephone system
- Medium Term: Improved Long Term Management and Prevention Management
- Long Term: Include the Referral Management Scheme in this scheme

9. Overall Status

All practices were asked to rate the scheme either green, amber or red. The results of which show that there is overwhelming support for the scheme whereby 89% have rated the scheme green (26 practices) or amber (16 practices).

Conclusion

For approximately £1m of additional funding the outcomes of the GP Development scheme have been positive in the first year. In-particular there has been successful savings and increased quality of care specifically in the areas of long term condition management and care home management, as a direct result of the GP reallocation. The flat-lining of ED attendances in Stockport is a result of the overall scheme and

has bucked the national trend. This represents a considerable step forward to achieve the long term aspirations for what is a relatively modest investment.

Going forward there remain challenges in order to continue to see the benefits of this investment. For instance, a greater understanding and focus is required in the areas of urgent care and prevention to compliment the success of the scheme to date. The work around patient education within the scheme must be strengthened to align with the five year forward plan around obesity, smoking, alcohol and other major health risks.

This means that much closer and stronger joint working arrangements and pooled resources is necessary between partner services. This can certainly be achieved through the commitment to neighbourhood working and the planned integrated care models across the borough presently underway.

As a final point it is important to emphasise that the GP Development scheme is still in the early stages of delivery and with further investment will see greater improvement and results in the long term. For example, from this evaluation such improvement is likely to be seen in Urgent Care because there will be shift to more care delivered in a community setting in alignment with neighbourhood working plans. In addition, patient knowledge of what services are offered by their practice will increase.

It is therefore a recommendation of this report that this scheme is continued to realise the benefits that can be achieved.

Next Steps

1. Ensure that the report is distributed to practices and that best practice is shared across the locality
2. Further work to be carried out with prioritised practices to review outcomes of their specific scheme
3. Continue to assess the outcomes of the improved urgent access element in relation to ED attendances
4. Encourage an increase in prevention management and patient education by identifying what initiatives can be trialled and put in place e.g. creating the role of Health Trainers with Public Health across neighbourhoods.
5. Review the business intelligence data currently sent to practices.

NHS
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Report from Finance and Performance Committee

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

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Executive Summary

What *decisions* do you require of the Governing Body?
This report provides an overview of the discussions at the Finance and Performance Committee meetings which took place on 27 January 2016 and 23 February 2016. It is important that Governing Body is aware of the progress in delivering the CCG's QIPP Schemes in year and able to identify schemes which are off track and actions to mitigate / support delivery.
Please detail the key points of this report
A key role of the CCG's Finance and Performance Committee is to maintain a strategic overview of the delivery of QIPP schemes and track progress and implementation. The Committee transitioned from the QIPP Committee on 1 January 2016. The report provides an overview of the discussions which took place at the meeting relating to the following matters: • 2016/17 Planning Guidance • QIPP Project Review – Intermediate Tier Review and Community Assertive In Reach (CAIR) Team • QIPP Project Review – GP Development Scheme • Terms of Reference Review
What are the likely impacts and/or implications?
Non delivery of QIPP impacts significantly on the CCG's financial plans and the delivery of required efficiencies (both non-financial and financial.)
How does this link to the Annual Business Plan?
QIPP is an integral part of the CCG's Operational Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
The issues covered by this report were considered at the Finance and Performance Committee meetings on 27 January 2016 and 23 February 2016.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Peter Carne
Meeting Date: 9 March 2016
Agenda item: TBC

Finance and Performance Committee Update for Governing Body

Terms of Reference Review

The Committee considered its Terms of Reference in light of the refocussing of the Committee across a broader finance and performance portfolio at the meeting held in January 2016. The Terms of Reference were agreed subject to the requirement for a Clinical Chair, meeting frequency to be no less than 8 times a year and a change in membership to include the Clinical Director for General Practice Development as a member in place of a second Lay Member. The Terms of Reference were recommended to the Governing Body for approval.

2016/17 Planning Guidance

At both the January and February meetings of the Committee, a discussion took place regarding the NHS Planning Requirements for CCGs and the activity being undertaken to ensure compliance with the number of 'must dos' and prioritise investments and activity within Stockport. In January the Committee considered the detailed understanding of the CCG's financial allocations as aligned to the national 'must dos' and the link to the Stockport Together Programme in seeking financial sustainability across the whole economy. A discussion took place regarding the Rightcare Programme and its future impact on the delivery of QIPP savings.

The Committee considered the ongoing contract negotiation work based on the proposed block contract with NHS Stockport Foundation Trust and the potential benefits and risks of this approach were discussed in detail. Members made recommendations relating to the prioritisation of resource and investment in line with the national 'must dos' to the CCG's Governing Body for consideration at its Away Day held on 10 February 2016.

At its meeting in February the Committee considered the draft narrative for the CCG's Operational Plan 2016/17 submission. In particular Members focussed on the financial and activity planning work which had been undertaken and the importance of framing the plan within the 5 Year Strategic Plan already agreed by the CCG and within the Stockport and Greater Manchester contexts. A discussion took place regarding the national 'must do' relating to primary care investment and the importance of telling the narrative of investment in general practice in Stockport clearly.

The Committee endorsed the continuing approach to completion of the Plan.

QIPP Project Review – Intermediate Tier Review and Community Assertive In Reach (CAIR) Team

As part of its role in holding to account those responsible for the delivery of QIPP Schemes the Committee received an update from the Senior Responsible Officer for The Intermediate Tier Review and Community Assertive In Reach Team Reviews. In reviewing the progress and delivery of the Scheme the Committee considered the following:

- The importance of a coherent, cost efficient intermediate tier system, based on a neighbourhood approach with coordinated overall management arrangements.
- The need to ensure efficient discharge processes and re-ablement for those in hospital to develop packages of care focussed on independence at home where appropropriate and if not, effective placements in care beds.
- The impact of the existing system fragmentation on bed utilisation and overall cost efficiency.
- The importance of integrating the health and social practitioner workforce to enable the provision of effective and holistic care for patients.

- The importance of ensuring potential savings from the Intermediate Tier redesign were counted only once across the wider system.

Members of the Committee highlighted the importance of the development of the new clinical model nd the potential to manage people differently within the system.

QIPP Project Review – GP Development Scheme

As part of its role in considering the outcome of CCG priority Projects, the Committee received a report on the first year outcomes and financial return on the investments in primary care delivered through the GP Development Scheme. Members discussed the best practice examples of schemes within particular practices and focussed on where positive benefits had been delivered.

In considering the item the Committee focussed in particular on:

- Innovative work undertaken in General Practice as a result of the funding made available.
- The positive engagement in the scheme from GPs across Stockport
- Emerging areas where it was thought investments had impacted positively on particular schemes and admission / referral figures
- The challenges for some practices in expanding the staff team where there was not additional suitable space to carry out treatments and consultations
- How the next steps in taking the scheme forward could be considered and the importance of sharing the learning and best practice widely

The Committee agreed that the report be escalated to Governing Body for further discussion.

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Audit Committee Report to Governing Body

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

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What *decisions* do you require of the Governing Body?
To note the recent activity undertaken by the Audit Committee including a review of its effectiveness.
Please detail the key points of this report
This report provides an update on the recent activity undertaken by the Audit Committee at its meeting held on 17 February 2016.
What are the likely impacts and/or implications?
The CCG's Audit Committee is a key mechanism for control and review of the CCG's activity and operates within the statutory functions and delegations provided by Governing Body. Failure to operate an effective Audit Committee would lead to significant risks for the CCG.
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?
Audit Committee
Clinical Executive Sponsor: Ranjit Gill
Presented by: John Greenough
Meeting Date: 9 March 2016
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

1.0 Audit Committee Effectiveness Review

1.1 Prior to the Committee meeting on 17 February 2016 Members of the Audit Committee met to carry out a Committee Effectiveness Review facilitated by the CCG's Internal Auditors.

1.2 The purpose of the session was to:

- Set the Audit Committee within the context of the CCG and more widely within the NHS Framework and consider some of the 'hot topic's being considered nationally.
- Consider the current operation and impact of the Committee's work as compared to its Terms of Reference and the best practice publication 'Knowing the Ropes' by Grant Thornton
- Agree some principles for the delivery of Audit Committee duties and consider the wider aspects of interaction within the organisation
- Build a development plan aligned with the aspirations of the Committee

1.3 The outcome of the discussion will be reflected in an action plan which will be considered by the Committee at its next meeting.

2.0 Audit Committee Activity

2.1 The most recent meeting of the CCG's Audit Committee was held on 17 February 2016 to consider a range of matters as detailed in its comprehensive annual Work Programme.

2.2 The Committee discussed a range of matters which included the following:

- Month 10 Financial Position

- Risk Management Framework Updates – The Committee reviewed and discussed the content of the Board Assurance Framework and the Operational Risk Register. It was agreed that timescales for completion of mitigating actions and aligned to the management of individual risks should be included. Members considered how both documents should drive both organisational activity and in particular the Audit Committee's work plan in reviewing and assuring systems and processes.

- External Audit Plan and Progress Update – Members considered the activity being undertaken by the CCG's External Auditors and the identification of challenges and opportunities being experienced by the organisation at the current time. A discussion took place regarding the overall audit approach, progress against the Audit Plan plan, materiality levels and identification of risks and in particular on the results of the interim work concluded so far.

- Internal Audit Progress Report - The Committee received and considered 3 reports of the Internal Auditor relating to Co-Commissioning and Conflicts of Interest, Statement of Involvement and Information Governance Toolkit. All of the areas had received significant assurance. Updates on audit activity underway were noted and the

Committee approved a change to the Internal Audit Plan to take forward the proposed Committee Effectiveness Review planning for 2015/16 into Quarter 3 of the Plan for 2016/17.

- The Committee deferred consideration of its Terms of Reference to allow for discussion in light of the Committee Effectiveness discussion.

2.3 The Committee will next meet in May 2016.

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Report from Remuneration Committee

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

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Executive Summary

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

This report provides an overview of the discussions from Remuneration Committee which took place on 24 February 2016 and recommends approval to the Governing Body of the remuneration for the role of Interim Chief Finance Officer.

Please detail the key points of this report

The role of the Remuneration Committee includes considering the remuneration of Senior Officer roles of the Clinical Commissioning Group and making recommendations to the Governing Body for approval.

The Committee met on 24 February 2016 to consider the remuneration for the post of Interim Chief Finance Officer.

The recommendations of the Committee are outlined as below:

1. That the Governing Body notes the arrangements being proposed to ensure the CCG meets the requirements for the appointment of a Chief Finance Officer for an interim period.

2. That the Interim Chief Finance Officer role be remunerated at Agenda for Change Band 9 based on the duties as outlined in the revised Job Description considered by the Remuneration Committee.

3. That the interim arrangements be put in place for 6 months whilst arrangements to recruit to the position permanently are explored.

What are the likely impacts and/or implications?

The CCG is statutorily required to appoint an individual to undertake the role of the Chief Finance Officer.

How does this link to the Annual Business Plan?

The remuneration of Chief Officers of the CCG is integral to ensuring that the organisation meets its statutory requirements and ensures sufficient capacity to deliver organisational plans and priorities.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

The issues covered by this report were considered at the Remuneration Committee held on 24 February 2016

Clinical Executive Sponsor: Jane Crombleholme

Presented by: John Greenough

Meeting Date: 9 March 2016
Agenda item: