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 13 January 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 9 December 2015.	Attached	To receive and approve		J Crombleholme
4	Actions Arising	Attached	To comment and note		J Crombleholme
5	Notification of Items for Any Other Business	Verbal	To note and consider		J Crombleholme
6	Patient Story	Video		10.15	J Crombleholme
7.	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	 Tim Ryley Gary Jones Gaynor Mullins Mark Chidgey
8.	Locality Chairs' Update	Verbal Report	To receive and note	11.10	Locality Chairs
9.	Report of the Chair	Verbal Report	To receive and note	11.20	J Crombleholme
10.	Report of the Chief Operating Officer to include the following: • Planning Guidance and allocations • Level 3 Delegated	Written Report	To discuss and approve	11.30	G Mullins

	Commissioning				
11.	Report of the Chief Clinical Officer • Joint Commissioning Board • Healthier Together Committee	Verbal Report	To approve specific recommendations	11.45	R Gill
12.	Board Assurance Framework	Written Report	To approve	12.00	T Ryley
13.	Public Sector Equality Duty	Written Report	To approve	12.10	T Ryley
14.	Reports from Committees • Clinical Policy Committee • QIPP Committee • Audit Committee	Written reports	To note	12:20	 Vicci Owen Smith J Greenough J Greenough
15.	Any Other Business	Verbal		12:35	J Crombleholme
	Date, Time and Venue of Next meeting The next NHS Stockport Clinical Commissioning Group Governing Body meeting will be held on 9 March 2016 at Regent House, Stockport. Potential agenda items should be notified to stoccg.gb@nhs.net by 1 February 2016.				

NHS
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NHS STOCKPORT CLINICAL COMMISSIONING GROUP
DRAFT
MINUTES OF THE GOVERNING BODY MEETING
HELD AT REGENT HOUSE, STOCKPORT
ON WEDNESDAY 9 DECEMBER 2015
PART 1

PRESENT

Ms J Crombleholme	Lay Member (Chair)
Mrs G Mullins	Chief Operating Officer
Dr D Kendall	Consultant member
Dr J Higgins	Locality Chair: Heatons and Tame Valley
Mr J Greenough	Lay Member
Dr V Mehta	Clinical Director for General Practice Development
Dr P Carne	Locality Chair: Cheadle and Bramhall
Dr C Briggs	Clinical Director for Quality and Provider Management
Mr G Jones	Chief Finance Officer
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

IN ATTENDANCE

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

APOLOGIES

Mr T Ryley	Director of Strategic Planning and Performance
Dr D Jones	Director of Service Reform
Dr V Owen Smith	Clinical Director for Public Health
Mrs K Richardson	Nurse Member

*Prior to the start of the meeting the Chair re-arranged the business to allow for the presentation of a petition by members of the public relating to the proposed closure of the Sir Joseph Whitworth Community Centre and for a number of questions submitted in advance to be answered. Further detail can be found under the Public Questions section of the minutes.

142/15 APOLOGIES

Apologies were received from T Ryley, D Jones, V Owen Smith and K Richardson

143/15 DECLARATIONS OF INTEREST

A Johnson 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 Marple Neighbourhood under the Viaduct Health locality arrangements.

144/15 APPROVAL OF THE DRAFT MINUTES OF THE GOVERNING BODY MEETING HELD ON 11 NOVEMBER 2015

The minutes of the meeting held on 11 November 2015 were agreed as a correct record of the meeting.

145/15 ACTIONS ARISING

The following updates on actions were provided:

- 12112015 Proactive Care – This action was being progressed through the Stockport Together work and could be removed from the Plan.
- 12112015 Report of the Chair – Winter Resilience would be picked up part of an upcoming Board to Board meeting between the CCG and NHS Stockport Foundation Trust. It was noted that separate letters in response to the letter of the Systems Resilience Group would be sent.
- 12112015 Chief Operating Officers Report – The information arising from the Quarter 1 assurance meeting with NHS England had not yet been received by the CCG. The timescale of the action should be amended to read January 2016.

146/15 NOTIFICATION OF ITEMS OF ANY OTHER BUSINESS

There were none.

147/15 PATIENT STORY

The Governing Body watched a clip which formed part of the 'Stop before the Op' campaign being run in Stockport to encourage patients to stop smoking before clinical procedures to improve overall health and fitness for surgery and aid recovery.

In responding to the patient story, the Governing Body acknowledged the importance of ensuring that smoking cessation messages were promoted across the year in addition to specific campaigns including Stoptober. R Gill noted the importance of health monies being invested in preventative work which contributed to reductions in people requiring stays in hospital.

It was noted that the work of Stockport Together focussed on models of care which required individuals to take control of their lifestyles and live in a healthier way.

C Briggs requested that the information about Healthy Stockport be displayed more prominently on the CCG website. A discussion took place regarding figures relating to smoking within Stockport and the number of vulnerable people whose smoking contributed to exacerbation of other health conditions, including mental health.

Resolved: That the Governing Body:

1. Notes the content of the video and the importance of continuing to share smoking cessation and health messages across the year.

148/15 STRATEGIC IMPACT REPORT

The Governing Body considered a report which outlined the activity against the CCG's strategic and operational plans. M Chidgey explained that at a headline level the data demonstrated a reduction in emergency department attendances and it was anticipated that work on long term condition management in primary care may be having a positive impact. He explained that urgent care admissions had gone up 1% in year and that GP referrals had grown overall by 4%. He highlighted that variation existed across localities with a 9% increase in referrals in Cheadle and Bramhall and a 1% reduction in Marple.

J Crombleholme sought clarification about work being undertaken within speciality areas to review referrals. Dermatology was highlighted as an area under review and the Governing Body was informed that work would be undertaken with a number of pilot practices to provide education and medical tools to try and manage more complex cases appropriately in-house and reduce referrals.

A Johnson noted that some referrals from areas such as Optometry were routed through GPs and work would be undertaken more widely across Primary Care through Stockport Together to encourage peer review.

The Governing Body concluded the discussion by acknowledging the importance of ensuring that data was analysed to take into account time lags across the system arising from various factors and noted the difficulty in linking cause and effect with complex projects. It was noted that the data being provided to Locality Chairs had proved useful.

Resolved: That Governing Body:

1. Notes the content of the Strategic Impact Report.

149/15 FINANCE REPORT

The Governing Body considered the current financial and forecast positions of the CCG as a month 7 of the 2015/16 financial year. G Jones noted that the CCG was currently forecasting achievement of a £1.1m financial surplus which whilst remaining £649k off plan, represented an improving financial trend. He confirmed that the assumed £1m return of CHC monies from the national risk pool would not be returned to the CCG. He highlighted lower spend than planned around electives and other areas including non-elective work and CHC placements. He noted that the recurrent position of £9.6m impacting in 2016/17 took the financial challenge overall to approximately £20m in that year. The CCG should receive confirmation of its settlement announcement for 16/17 on 24 December 2015.

G Jones explained that the CCG remained in a financial turnaround position and was awaiting confirmation in writing from NHS England. In considering the content of the report, the Governing Body reviewed the basis of the improving financial position presented within the report and sought assurance about the robust nature of the forecasting. G Jones explained that costs arising from the impact of winter may create further financial challenges for the CCG.

The importance of the work being undertaken by the CCG's QIPP Committee was noted, in particular the focus on monitoring the delivery of QIPP Scheme milestones.

A Johnson sought confirmation about whether any of the additional funding for the NHS which had been announced by the Government would benefit the CCG. G Jones explained that the CCG had been funded under the target level for a number of years which totalled approximately £10m. The pace

of change for bring the CCG up to the appropriate level had not yet been communicated by NHS England. Greater Manchester Devolution may also impact on NHS financing across the region.

Resolved: That Governing Body:
1. Notes the financial position for 15/16 which is reporting:-
(i) Year to date - As at 31st October an actual £598k surplus compared to plan surplus of £1,021k - shortfall of £423k
(ii) Forecast 15-16 - a forecast surplus of £1,101k compared to planned surplus for 15-16 of £1.75m – shortfall £649k
2. Acknowledges that the forecast surplus of £1,101k assumes achievement of £756k additional CIP measures.
3. Acknowledges that the additional £649k savings requirement to deliver the £1.75m planned surplus is being taken forward by the QiPP Committee.
4. Notes the additional net risk totalling £1.67m not reflected within the forecast position (Ref – Table 8).
5. Notes that the forecast position reflects the retention of £0.9m performance Fund held in BCF to offset over performance in NEL activity.
6. Notes that the anticipated return of £1m from underspending national CHC legacy risk pool has now been removed from our forecast as it is highly unlikely that this underspend will be returned to CCGs in 15-16.
7. Notes the additional recurrent cost pressures of £9.6m arising in 15/16 are treated as carry forward commitments and as such increase the total savings requirement in 16/17 to c£19.1m.

150/15 PERFORMANCE REPORT

G Mullins presented the Resilience and Compliance report covering NHS Constitutional Targets for September for statutory duty and compliance. She explained that the Quarter One assurance meeting had taken place in early November and the notes of the meeting had not yet been provided. She explained that the Systems Resilience Group had been monitoring closely the urgent care system,the early impact of the winter period and a significant reduction in performance, the SRG would be using an upcoming meeting as a summit on urgent care to review immediate actions which could be implemented. Matters around Referral to Treatment Time and delayed hospital discharges were also being closely monitored.

In response to a question it was noted that the impact of NHS 111 on those attending accident and emergency was being monitored but that there was no evidence at this stage of any material impact.

The role of the Systems Resilience Group in working across and reviewing the whole system was noted including reviewing the impact of the Medical Assessment Unit at Stepping Hill Hospital. The Governing Body acknowledged that whilst issues relating to urgent care resulted in visible pressure at NHS Stockport Foundation Trust, there were system wide responsibilities which were being managed collaboratively.

Resolved: That the performance report be noted.

151/15 QUALITY REPORT

M Chidgey provided a brief summary of the recent work of the Quality and Provider Management Committee including the assurance on the CIP Plans for NHS Stockport Foundation Trust. He noted that work was underway to transition the existing Committee as part of the Governance Review to the refocused Quality Committee.

Resolved: That the Governing Body note the report.

152/15 LOCALITY CHAIRS UPDATE

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

Cheadle and Bramhall – P Carne noted that both neighbourhoods within the Locality had developed differently and Cheadle in particular had progressed well.

Marple and Werneth – A Johnson provided an update on the series of neighbourhood meetings which had taken place within the Locality and highlighted the focus on putting the patient at the centre of the work.

Stepping Hill and Victoria – L Hardern reported that the Integrated Neighbourhood Team would go live in February 2016 and that it was anticipated that the newly appointed Neighbourhood Viaduct Leads would be instrumental in taking that work forward.

Heatons and Tame Valley – J Higgins explained that the appetite for neighbourhood working within the Locality remained positive and the process was underway to nominate representatives to the Viaduct Locality Structure.

Councillor Pantall raised a question about the link between CCG Neighbourhood work and that of the Council's Area Committees in terms of engaging with the local community.

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

153/15 REPORT OF THE CHAIR

J Crombleholme reported that the Governing Body had a Part 2 meeting in November to consider a commercially sensitive procurement decision and a second prior to the December meeting to consider the outcome of a Greater Manchester wide service investigation.

The Governing Body was informed that the CCG's Director of Finance Gary Jones had announced retirement and departure from the CCG at the end of February 2016. J Crombleholme noted his departure would be formally marked by the organisation in due course but noted the significant commitment throughout his career to the NHS and public service.

154/15 REPORT OF THE CHIEF OPERATING OFFICER

G Mullins highlighted the key elements included within the report in particular the work underway relating to integrated commissioning and the re-negotiation of the Section 75 agreement and progress of the Stockport Together Programme. She highlighted the approval of the Constitutional Changes arising from the Governance Review undertaken and the implementation of the changes from 1 January 2016 onwards.

The Governing Body considered the preparations underway for the CGG's annual planning cycle which would commence in January 2016. It was noted that there was a strong link between CCG planning and the developing plans of Stockport Together and capacity would be in place within the CCG to ensure the requirements were met.

Resolved: That the Governing Body:

1. Notes the updates provided.

155/15 REPORT OF THE CHIEF CLINCIAL OFFICER

R Gill informed the Governing Body that the judicial review hearing for the Healthier Together programme was underway and anticipated to conclude before Christmas.

The Governing Body was provided with an update on the continued development of the governance arrangements underpinning Greater Manchester Devolution and noted that he had been elected to serve on the Greater Manchester Strategic Partnership Board Executive. The Executive was currently operating in shadow form.

Discussions were underway regarding the structure of and appointments to the Joint Commissioning Board and how it would relate to the existing Association of Greater Manchester CCGs. The CCG would be required to confirm its nominee and deputy to the Board in due course. This meeting would commence operation in shadow form from January 2016.

R Gill explained that discussions were taking place at regional level to discuss how the planning and contracting round should be managed for 2016/17 in light of the emerging Devolution arrangements.

Resolved: That the Governing Body:

1. Notes the updates provided.

156/15 REPORTS FROM COMMITTEES

- **Clinical Policy Committee**

L Hardern provided an update on the work of the Clinical Policy Committee and highlighted a number of key areas including changes to the EUR treatment list and the costing summary for NICE TA's.

Resolved: That Governing Body:

1. To note the update on the changes to the EUR treatment list.
2. To note the cost implications of new national NICE guidance: TA358 Tolvaptan for treating autosomal dominant polycystic kidney disease.
3. To note CPC have endorsed the GMMMG NTS recommendations in section 3.2.
4. To note the updated costing summary for NICE TA's.

- **QIPP Committee**

G Mullins provided an overview of the first report of the QIPP Committee to the Governing Body which outlined key activity undertaken. She noted that the first QIPP schemes reviewed as part of the Committee's deep dive work had been Maximising EUR and GP referrals. She noted the

enhanced focus on the delivery of scheme milestones and overall performance had provided for a constructive conversation between project managers and the Committee.

G Jones explained that additional capacity had been put in place to ensure robust performance management of the delivery of QIPP schemes and associated financial support.

It was noted that as part of the Governance Review, the focus of the Committee had been widened to include Finance and Performance and greater clinical representation on the Committee.

Resolved: That Governing Body:

1. Notes the report of the QIPP Committee

156/15 ANY OTHER BUSINESS

R Gill noted that the petition submitted relating to the proposed closure of the Sir Joseph Whitworth Centre had been received into his inbox on 1 October 2015. He apologised for the lack of response and noted that it would be responded to at the earliest opportunity.

(The meeting ended at 12.16pm)

Public Questions

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

1. Why has the CCG not responded to the petition for saving from closure the Sir Joseph Whitworth Community Centre?

   G Mullins responded to explain that to the best of her knowledge the CCG had not received the petition although were aware one had been submitted to the Health and Wellbeing Board.

2. Can we now have the CCG's response to the petition?

   G Mullins noted that if the petition was handed to the Board Secretary it would be formally logged by the CCG and responded to as soon as possible.

3. Why has the CCG given notice to quit on 31 December 2015 to the tenants of the Sir Joseph Whitworth Community Centre instead of working with Stockport MBC to retain this important mental health support facility in its current accessible location for the people of Stockport?

   G Mullins explained that when the Primary Care Trust was dissolved and became a Clinical Commissioning Group in March 2013, the responsibility for all existing property leases was transferred to NHS Property Services. The CCG would therefore need to work with NHS Property Services to further understand what has happened in this particular case.

4. Will the CCG now share the recognition expressed by Stockport MBC of the valuable role of the Sir Joseph Whitworth Community Centre in providing support for the health and wellbeing of persons with mental health problems as well as the population of Stockport generally and overturn forthwith the notice to quit the centre?

G Mullins reconfirmed that the CCG would need to work with NHS Property Services to further understand the details of the lease arrangements and to discuss the commissioning of the service by the Council at the Centre. Once the full picture was understand, the CCG would be in a position to formally respond.

5. Will the CCG and the Council be publishing a full list of activities which will form part of the integrated commissioning arrangements?

   It was noted that the CCG had published the list of activities which would be included and for the Council it comprised the entirety of spend on Adult Social Care, Learning Disability and elements of public health spend. A report on the Council's contribution had been considered by the Health and Well Being Board.

6. Will the implementation of the Stockport Together Programme include timescales for changes to case including Zone 1, 2 and 3?

   G Mullins confirmed that this issue was being included as part of the ongoing design stage and no decisions had yet been made. Timescales would be confirmed as part of the wider programme in due course.

7. When will the Strategic Partnership Board Executive and Joint Commissioning Board commence operation?

   R Gill confirmed that all existing Devolution Governance arrangements were operating in shadow and it was anticipated that both groups would commence operation in January 2016.

NHS Stockport Clinical Commissioning Group
9 December 2015.

NHS Stockport Clinical Commissioning Group

Actions arising from Governing Body Part 1 Meetings

NUMBER	ACTION	MINUTE	DUE DATE	OWNER AND UPDATE
08072015	**Strategic Impact Report** That work be undertaken through the CCG's Business Intelligence Team to ensure Locality Chairs were provided with overview data to support work within their areas and as part of the development of Neighbourhoods.	126/15	January 2016	Mark Chidgey
12112015	**Report of the Chair** That a joint response be provided by the CCG and NHS Stockport Foundation Trust to the letter of the System's Resilience Group Chair and shared with the Governing Body Members after submission. This matter would be considered at the upcoming Board to Board meeting between the CCG and Stockport Foundation Trust. Single responses would be sent to the letter by both organisations.	135/15	December 2015	Jane Crombleholme

12112015	**Chief Operating Officer's Report** Information arising from the Quarter 1 assurance meeting be shared with Governing Body Members as soon as it became available.	136/15	January 2016	Gaynor Mullins
12112015	**Safeguarding** That the Stockport Together Programme incorporates safeguarding considerations into the design of new models of care.	138/15	February 2016	Tim Ryley
09122015	**Questions from the Public** The CCG provide a formal written response to the petition sent to the CCG on 1 October 2015 and the questions raised by members of the public relating to Sir Joseph Whitworth Community Centre		December 2015	Ranjit Gill
09122015	**Patient Story – Stop Before the Op** The link to the information regarding the Stop Before the Op be placed more prominently on the CCG website to improve the accessibility of the information.		December 2015	Laura Latham

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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

- There are a number of areas where the CCG is having an impact greater than planned – *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.

- Total *non-elective admissions*, *GP 1st Outpatients* and *Prescribing* cost all remain above plan but there has not been any further decline in performance.

- Two areas where there has been a slight worsening of performance are *elective activity* and *GP direct admissions* which are now in line with plan rather than better than plan.

- There remain a few issues with data quality.

- 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.

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: 13 January 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

	Register	2015-15 Plan YTD Apr-Oct	2015-16 YTD Apr-Oct	Variance	<---------- %Variance ----------> Practice		Locality	Stkport
Urgent								
A&E Attendances		56522	54940	-1582	-2.8%		**-2.8%**	**-2.8%**
Ambulance Conveyance Rate		81.8%	80.5%					
Non-Elective Admissions								
All Non-Elective Admissions		22472	22757	285	1.3%		**1.3%**	**1.3%**
Occ Bed Days per 100,000 [1]		35422	34320	-1102	-3.1%		**-3.1%**	**-3.1%**
GP Direct Admissions		3746	3749	3	0.1%		**0.1%**	**0.1%**
LTC	**Register**							
CHD Admissions	11741	571	482	-89	-15.6%		**-15.6%**	**-15.6%**
HF Admissions	2728	305	290	-15	-5.0%		**-5.0%**	**-5.0%**
COPD Admissions	6711	308	199	-109	-35.4%		**-35.4%**	**-35.4%**
Asthma Admissions	19770	109	111	2	1.9%		**1.9%**	**1.9%**
Diabetes Admissions	14575	78	74	-4	-5.0%		**-5.0%**	**-5.0%**
LTC Admissions	55525	1372	1156	-216	-15.7%		**-15.7%**	**-15.7%**
AF Admissions	5732	343	259	-84	-24.6%		**-24.6%**	**-24.6%**
Care Home Admissions		1229	1087	-142	-11.6%		**-11.6%**	**-11.6%**
Referrals								
GP Referred 1st OPA		32617	33894	1277	3.9%		**3.9%**	**3.9%**
Dermatology		3242	3577	335	10.3%		**10.3%**	**10.3%**
ENT		3647	3911	264	7.3%		**7.3%**	**7.3%**
General Medicine		5156	5657	501	9.7%		**9.7%**	**9.7%**
General Surgery		6106	6294	188	3.1%		**3.1%**	**3.1%**
Obstetrics & Gynaecology		2336	2306	-30	-1.3%		**-1.3%**	**-1.3%**
Opthalmology		2482	2122	-360	-14.5%		**-14.5%**	**-14.5%**
Paediatrics		1507	1570	63	4.2%		**4.2%**	**4.2%**
Rheumatology		768	679	-89	-11.6%		**-11.6%**	**-11.6%**
Trauma & Orthopaedics		4303	4729	426	9.9%		**9.9%**	**9.9%**
Urology		1780	1763	-17	-0.9%		**-0.9%**	**-0.9%**
Other Specialist Medicine		157	117	-40	-25.4%		**-25.4%**	**-25.4%**
Other Specialties		1133	1169	36	3.2%		**3.2%**	**3.2%**
Other Referred 1st OPA		21604	20874	-730	-3.4%		**-3.4%**	**-3.4%**
GP Referred 1st OPA								
Neurology [2]		938	1679	741	78.9%		**78.9%**	**78.9%**
Planned								
Elective Admissions		22381	22420	39	0.2%		**0.2%**	**0.2%**
Prescribing [1]		3752678	3874382	121704	3.2%		**3.2%**	**3.2%**

1 - For Occ Bed Days per 100,000 and prescribing items there is no plan data so it is always compared with 2014/15 actual
2 - There is a data excess for Neurology which is being investigated with Salford Royal FT

NHS
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Finance Report November 2015 – Month 8

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

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Executive Summary

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

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

   (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.

Please detail the key points of this report

- Actual surplus reported as at Mth 8 (YTD) of £1,172k which is £6k above 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 £1.35m have been identified although not factored into the financial position at this stage.

What are the likely impacts and/or implications?

Delivery against statutory financial duties and financial performance targets.

How does this link to the Annual Business Plan?

As per 2015/16 Financial Plan.

What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Governing Body only
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gary Jones
Meeting Date: 13th January 2016
Agenda item: 7 (b)
Reason for being in Part 2 (if applicable)
N/A

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

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 30th November 2015 and
   (ii) Forecast outturn 15/16

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 15/16 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

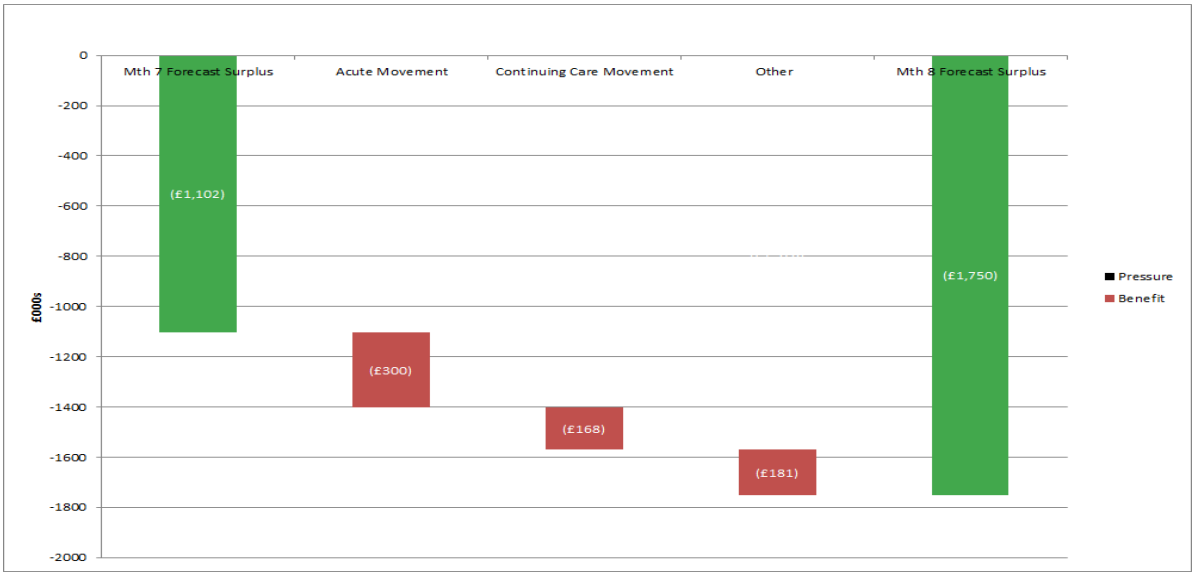
Area	Statutory Duty	Performance YTD (Mth 8)	Performance Forecast
Revenue (Dashboard Table 1)	Not to exceed revenue resource allocation		
Running Costs (Dashboard Table 1)	Not to exceed running cost allocation		
Capital – *(Note: The CCG has not received a capital allocation in 2015/16)*	Not to exceed 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 8) & Forecast Financial Position (Ref – Appendix 1 Table 1)

3.1 The CCG financial position has improved in month 8 to the extent that the CCG's planned surplus of £1.75m in now being forecast to be delivered. The improvement is mainly due to a reduction in the acute forecast overspend and forecasting additional Continuing Care underspend due a decrease in the average number of placements during the financial year. The month on month improvement in the CCG's financial position is represented in Chart 1.

Chart 1: Forecast Financial Position Movement month 7 to 8



A year-to-date surplus of £1,172k which is £6k above plan set for Mth 8 (£1,166k

planned). 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 as previously reported. Increased prescribing spend as set out in Table 7 is also contributing to the in-year financial pressure which is being offset by in the main by non-recurrent underspends within other expenditure areas (Ref – Appendix 1 Table 1).

3.2 The CCG is now forecasting to deliver its planned surplus of £1.75m. Forecast variances are set out by Provider [Appendix 1 Table 2] and by Point of Delivery [Appendix 1 Table 3].

Acute:

3.3 Key risk areas within Acute continue to be AQP/IS contracts which are forecast to overspend by £2.87m. 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 The latest activity data received from SLAM monitoring data (to September) shows Elective in line with plan, Non Elective activity and outpatient activity are both above plan but broadly at same level as mth 7.

3.5 Acute over performance by Point of Delivery 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

3.6 Year-to-date underspend of £248k with a forecast underspend of £289k. This is largely due to cessation of the block contract with Calderstones which terminated with effect from 30/09/2015.

Community Health

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

Continuing Care

3.8 The month 8 position continues the trend with a YTD underspend of £246k and a forecast underspend of £678k 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 anticipated costs £200k for additional placements in year for children with complex needs.

Primary Care

3.9 Primary Care budgets are forecast to underspend by £374k consistent with position reported at month 7.

Prescribing (Ref – Appendix 1 Table 7):

3.10 There has been an increase of c4.1% in prescribing for the period April to October (the latest data available for actual spend) compared to same period 14/15, of which c3.3% is volume related (number of items prescribed). This has resulted in the CCG reporting a YTD overspend of £1.3m 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	567	567	0	851	851	0
CCG Admin	3,476	3,121	(252)	5,573	4,975	(444)
Total CCG Running Costs	**4,043**	**3,791**	**(252)**	**6,424**	**5,979**	**(444)**

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

CIP schemes not yet embedded

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

In addition to the above CIP, the forecast assumes that additional identified CIP of £38k recovery plan measures will be delivered in full (Ref – Table 1).

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 £382.16m (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£1.35m which are acknowledged but have not been brought into the financial position at month 8. 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 15/16 borne by a mixture of :

- Increased activity demand above planned levels for 15/16
- 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 funded out of BCF in 15/16 for that year only and which in 16/17 will revert to funding from CCG core allocation.

6.3 The impact of recurrent pressures in 2015-16 are carried forward in 2016-17. As a result the CCG will be required to deliver a recurrent CIP of **£18.5m (**before any investments are made in 2016-17) in order to deliver a 2% (£7.6m) recurrent surplus. In planning for a 1% recurrent surplus then the recurrent CIP challenge reduces to £14.7m. The £14.7m CIP challenge do not yet reflect the planning allocations 16/17 as these have not been announced at the time of writing this report.

6.4 As mentioned in the finance report for month 7, the CCG is in the process of being placed into formal turnaround given the significant challenge faced by a £14.7m savings target in delivering a 1% surplus in 16/17. This is in line with the CCG Assurance Framework which NHSE follow in carrying out their role as a Regulator of

CCGs. The CCG is liaising with NHSE GM & Lancs Area team and will be providing updates on 16/17 planning intentions once the CCG allocations for 16/17 are announced .

7. Risk Implications / Mitigation

Risks:

- The key risks remain in the increasing activity / demand growth in acute sector provision and also increased cost pressures in prescribing driven by both price and volume growth.

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 year-to-date surplus of £1,172k which is £6k above plan and that NHS Stockport CCG is now forecasting **to deliver the planned surplus of £1.75m** for 2015/16.

II. **Acknowledge** the additional net risk totalling £1.35m not within the forecast position

III. **Acknowledge** that the CCG position reflects the retention of £0.9m BCF performance fund to offset the additional NEL costs above BCF planned levels.

IV. **Note** that given the scale of the CIP challenge the CCG faces in 16/17, based on current financial assumptions pre 16/17 announcements, the CCG is being placed into 'Turnaround' in accordance with NHSE Assurance Framework for CCGs.

Gary Jones
Chief Finance Officer
29th December 2015

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

Appendix 1

MONTH 8 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 8 Financial Position - as at 30th November 2015

	YTD (Mth 8) Plan £000s	YTD (Mth 8) Actual £000s	YTD (Mth 8) Var £000s	YTD (Mth 8) 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	(254,503)	(254,503)	0	0.0%	(378,328)	(378,328)	0	0.0%	G	(374,047)	(374,047)	0
In Year	0	0	0	0.0%	(4,598)	(4,598)	0	0.0%	G	(1,362)	(1,362)	0
Total RRL	(254,503)	(254,503)	0	0.0%	(382,926)	(382,926)	0	0.0%	G	(375,409)	(375,409)	0
Net Expenditure												
Acute	147,893	148,850	957	0.6%	223,701	226,399	2,698	1.2%	R	221,767	226,716	4,949
Mental Health	21,122	20,874	(248)	(1.2%)	31,683	31,394	(289)	(0.9%)	G	31,103	30,890	(213)
Community Health	23,731	23,609	(122)	(0.5%)	35,671	35,518	(153)	(0.4%)	G	35,596	35,596	0
Continuing Care	12,120	11,874	(246)	(2.0%)	17,126	16,448	(678)	(4.0%)	G	14,957	14,957	0
Primary Care	8,226	7,841	(385)	(4.7%)	12,483	12,109	(374)	(3.0%)	G	10,073	11,473	1,400
Other	2,864	2,755	(109)	(3.8%)	5,525	3,424	(2,101)	(38.0%)	G	4,406	5,100	694
Sub Total Healthcare Contracts	215,956	215,803	(153)	(0.1%)	326,189	325,292	(897)	(0.3%)	G	317,902	324,732	6,830
Prescribing	32,443	33,737	1,294	4.0%	48,664	50,164	1,500	3.1%	R	48,664	50,164	1,500
Running Costs (Corporate)	4,043	3,791	(252)	(6.2%)	6,424	5,980	(444)	(6.9%)	G	6,424	6,424	0
Reserves (Ref: Reserves Summary)	895	0	(895)	(100.0%)	(101)	(222)	(121)	119.8%	G	1,196	3,132	1,936
Total Net Expenditure and Reserves	253,337	253,331	(6)	(0.0%)	381,176	381,214	38	0.0%	R	56,284	59,720	3,436
Additional Identified CIP	0	0	0	0.0%	0	(38)	(38)	0.0%	G	0	0	0
TOTAL (SURPLUS) / DEFICIT	(1,166)	(1,172)	(6)	0.5%	(1,750)	(1,750)	0	0.0%	G	(1,223)	9,043	10,266

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	145,348	96,287	95,906	(381)	145,086	(262)
University Hospitals of South Manchester FT	25,490	16,993	17,038	45	25,647	157
Central Manchester University Hospitals FT	18,577	12,385	12,190	(195)	18,343	(234)
Salford Royal FT	5,633	3,755	3,852	97	5,778	145
East Cheshire NHS Trust	2,259	1,506	1,411	(95)	2,123	(136)
Tameside Hospital FT	1,084	736	879	143	1,299	215
AQPs/IS	11,328	7,552	9,178	1,626	14,196	2,868
Other	14,899	8,679	8,396	(13)	14,843	(55)
Total Acute	224,618	147,893	148,850	1,227	227,315	2,698

ACUTE

TABLE 3

POD

Forecast variance to plan based on Mth 7 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	(340)	(272)	(89)	(73)	(32)	33	2,868		2,095
Drugs & Devices	505	0	329	(153)	31	0			712
Outpatients	433	(16)	30	523	(31)	(7)			932
Non Elective	625	342	(591)	9	5	67			457
Non Elective (Excess bed days)	(1,002)	25	41	13	0	36			(887)
Macular	0	0	240	0	0	0			240
Fertility	0	0	108	0	0	0			108
Maternity	(143)	57	178	0	(4)	1			89
A&E	24	71	(8)	23	(9)	9			110
Critical Care	(598)	(163)	238	(176)	(28)	74			(653)
Other PoDs	(173)	294	(594)	(21)	(65)	3		51	(505)
Total Mth 8 Forecast Variance	(669)	338	(118)	145	(133)	216	2,868	51	2,698

PRESCRIBING

TABLE 4

Forecast Reserves Summary

	Reserves Held Mth 8 £000s	Commits Mth 8 onwards £000s	Forecast Bals Year End £000s
Amounts Held in CCG Reserves			
Investments - National	1,232	315	(917)
Investments - Greater Manchester	1,502	1,247	(255)
Contingency	313	0	(313)
In-Year Allocations	66	66	0
CIP - Not embedded in budgets	(3,214)	(1,850)	1,364
Total Reserves	(101)	(222)	(121)

TABLE 5

Recurrent CIP Requirement 2016-17	£000s
Additional CIP c/fwd from 2015-16	(9,043)
CIP required to deliver 2% in year surplus	(9,469)
Revised CIP Requirement to deliver 2% Surplus	(18,512)
Adjust to delivery 1% recurrent surplus	3,829
Revised CIP Requirement to deliver 1% Surplus	(14,683)

TABLE 6

Forecast spend against in year allocation (NHS Eng Requirement)	£000s
2015-16 Allocation	(382,926)
Less: Brought forward 2014-15 Surplus	4,281
Forecast 2015-16 Expenditure	381,176
Forecast (under)/over-spend against in year allocation	2,531

TABLE 7

Top Five Increases in Prescribing Spend by Drug Type	Nov 13 - Oct 14 (£000s)	Nov 14 - Oct 15 (£000s)	Change (£000s)	Change in Spend (%)	Change in No. Items (%)
Central Nervous System	10,246	10,686	440	4.3%	4.4%
Respiratory System	6,140	6,276	136	2.2%	3.3%
Endocrine System	6,128	6,708	580	9.5%	4.7%
Cardiovascular System	5,937	6,388	451	7.6%	1.7%
Nutrition And Blood	2,525	2,912	387	15%	4.8%

TABLE 11

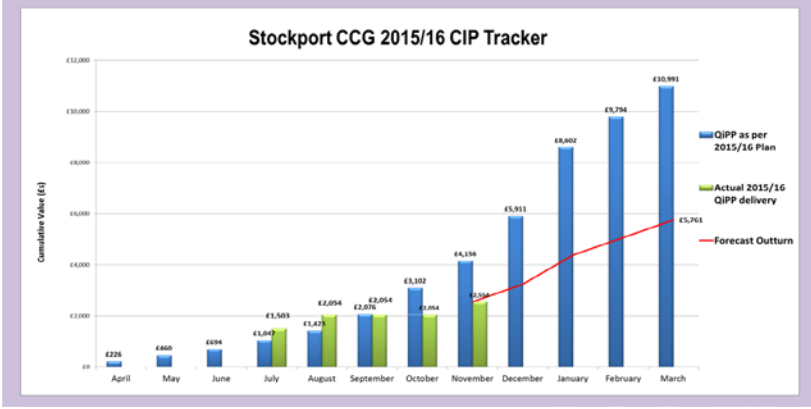


TABLE 8

Risk	Risk Value (£m)	Explanation of risk
Acute SLAs	1.00	Case mix / price pressures
Prescribing	0.25	NICE TAs, volume & price increases
Mental Health SLAs	0.10	Potential cost pressures within Mental Health contracts
Total	1.35	

TABLE 10

Cashflow Summary - Month 8	£000s
Cash Limit for the Year	382,156
Cash drawn down YTD	251,822
Remaining cash	130,334
Actual cash drawn down (%)	65.9%
Expected cash drawn down (%)	66.7%

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.	November YTD Number	November YTD £000s
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	6,723	42,646
Total Non-NHS Trade Invoices Paid Within Target	6,569	41,769
Percentage of Non-NHS Trade Invoices Paid Within Target	97.71	97.94
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,634	172,149
Total NHS Trade Invoices Paid Within Target	1,571	172,082
Percentage of NHS Trade Invoices Paid Within Target	96.14	99.96
Total NHS and Non NHS Payables		
Total NHS Trade Invoices Paid in the Year	8,357	214,795
Total NHS Trade Invoices Paid Within Target	8,140	213,851
Percentage of NHS Trade Invoices Paid Within Target	97.40	99.56

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 30th November 2015 (Month 8)

	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	11	(3)	10
Intangible assets	0	0	0	0
Trade and other receivables	0	0	0	0
Total non-current assets	**14**	**11**	**(3)**	**10**
Current assets:				
Cash and cash equivalents	43	3	(40)	50
Trade and other receivables	1,363	341	(1,022)	500
Inventories	0	0	0	0
	1,406	**344**	**(1,062)**	**550**
Non-current assets classified "Held for Sale"	0	0	0	0
Total current assets	**1,406**	**344**	**(1,062)**	**550**
Total assets	**1,420**	**355**	**(1,065)**	**560**
Current liabilities				
Trade and other payables	(20,923)	(21,549)	(626)	(21,000)
Provisions	(883)	(701)	182	0
Borrowings	0	0	0	0
Total current liabilities	**(21,806)**	**(22,250)**	**(444)**	**(21,000)**
Non-current assets plus/less net current assets/liabilities	**(20,386)**	**(21,895)**	**(1,509)**	**(20,440)**
Non-current liabilities				
Trade and other payables	0	0	0	0
Provisions	0	0	0	0
Borrowings	0	0	0	0
Total non-current liabilities	**0**	**0**	**0**	**0**
Total Assets Employed:	**(20,386)**	**(21,895)**	**(1,509)**	**(20,440)**
FINANCED BY:				
TAXPAYERS' EQUITY				
General fund	(20,386)	(21,895)	(1,509)	(20,440)
Revaluation reserve	0	0	0	0
Total Taxpayers' Equity:	**(20,386)**	**(21,895)**	**(1,509)**	**(20,440)**

NHS
Stockport
Clinical Commissioning Group

Resilience and Compliance Report - January 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

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

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

Website: www.stockportccg.org

Executive Summary

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

Chief Operating Officer's Report

Chief Operating Officer's Report

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

Additional information is provided below for:-

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

Urgent Care
Last month the Governing Body were informed of a significant reduction in ED performance from the beginning of November and continuing into December. It is confirmed that performance in both of these months will be below 80%.

An urgent SRG meeting was called to determine the factors driving the reduced performance and to agree urgent actions. The key actions were:-
- Increasing the ring fenced care home capacity into which patients can be discharged directly from SFT.
- Focusing a daily meeting, with senior decision maker support, on matching patients in the hospital with the community capacity.
- Increasing the medical bed capacity across the Christmas and New Year period by significantly reducing the elective programme.
- Ensuring that minors / primary care patients are deflected appropriately from ED to primary care / out of hours.

All of the above were actioned and both performance and available bed capacity improved, for a period, during the Christmas break. This has not been sustained and an RCA has been requested.

ED performance at this level will impact and be impacted by ambulance performance and will also increase the risk of 12 hour breaches. It is confirmed that no 12 hour breaches have occurred as at the 5th January. Whilst the SRG has reviewed from a performance perspective, the Quality committee will be asked to review in January the current position and mitigating actions from a quality of care perspective.

Planned Care
The main target is that 92% of patients should have been waiting no longer than 18 weeks. Whilst this continues to be achieved pressure has been increasing but will be further impacted by the reduction in elective capacity at SFT referenced above. The plan is to return to normal elective capacity from the 15th January with contingency options currently being reviewed.

There were no 52 week waiters in October with the main risk continuing to be from UHSM.

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

NHS Constitution Compliance

Referral To Treatment - Last Four Full Quarters					Last Three Months			Details		
NHS Constitutional Compliance Indicator	Q3	Q4	Q1	Q2	Aug 2015	Sep 2015	Oct 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients on incomplete non-emergency pathways (yet to start treatment) should have waited no more than 18 weeks from referral	93.1	93.3	93.2	93.4	93.3	93.1	92.0	92%	Monthly	See commentary.
Number of patients waiting more than 52 weeks	0	0	1	1	1	1	0	0	Monthly	See commentary.
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	7	5	2	2				0	Quarterly	This measure is specific to Stockport Acute FT. The Trust have made reductions since last year and progress continues to be tracked at performance meetings.

Diagnostics - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Aug 2015	Sep 2015	Oct 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	97.9	97.2	98.6	98.1	98.0	97.6	97.2	99%	Monthly	SFT have achieved the target however this has been a consistent challenge for CMFT who continue to fail to meet the target and this results in a CCG failure. CMFT have developed a recovery plan, focused on those specialties which were significantly under-performing. However, the projected date for completion is Q4-2016. Whilst improvement work is on-going the Trust are reviewing the wait times from a clinical urgency and risk stratification, governance view. This review and prioritisation is happening weekly.

A&E waits - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Aug 2015	Sep 2015	Oct 2015	Operational Standard	Collection Frequency	Status / Commentary
Patients should be admitted, transferred or discharged within 4 hours	90.2 ▲	86.0 ▲	93.4 ▲	92.1 ▲	92.9 ▲	91.4 ▲	89.6 ▲	95%	Weekly	See commentary.
12 Hour waits from decision to admit until being admitted	0.0 ★	0.0 ★	0.0 ★	0.0 ★	0 ★	0 ★	0 ★	0	Quarterly	See commentary.

Cancer waits - 2 week wait - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Aug 2015	Sep 2015	Oct 2015	Operational Standard	Collection Frequency	Status Commentary
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	95.5 ★	95.7 ★	96.0 ★	95.8 ★	95.8 ★	95.1 ★	96.3 ★	93%	Monthly	There is no significant risk identified to threaten future performance.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	98.4 ★	98.0 ★	95.5 ★	97.2 ★	96.8 ★	96.8 ★	93.2 ★	93%	Monthly	There is no significant risk identified to threaten future performance.

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

Cancer waits - 62 days wait - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q3		Q4		Q1		Q2		Aug 2015		Sep 2015		Oct 2015		Operational Standard	Collection Frequency	Status / Commentary
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	75.5	▲	85.5	★	88.3	★	88.2	★	98.2	★	84.4	▲	78.5	▲	85%	Monthly	There were 4 more breaches than allowable to achieve target in October, as a result of this the cancer board will be asked to review any long waiter data across the system, link to and identify potential issues, such as complex pathways for example Cancer of Unknown Primary.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	97.2	★	91.9	★	96.9	★	85.2	▲	100.0	★	75.0	▲	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)	80.4	n/a	72.7	n/a	79.5	n/a	72.1	n/a	83.3	n/a	75.0	n/a	77.8	n/a	No National Standard	Monthly	There is no National Standard for this indicator.

Category A ambulance calls - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Aug 2015	Sep 2015	Oct 2015	Operational Standard	Collection Frequency	Status / Commentary
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	65.3 ▲	67.0 ▲	77.5 ★	78.5 ★	77.7 ★	78.4 ★	75.9 ★	75%	Monthly	There is no significant risk identified to threaten future performance.
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	66.7 ▲	65.8 ▲	76.6 ★	75.4 ★	75.4 ★	74.9 ▲	72.5 ▲	75%	Monthly	See commentary.
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	91.2 ▲	91.1 ▲	95.2 ★	94.8 ▲	95.1 ★	94.6 ▲	94.1 ▲	95%	Monthly	See commentary.

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

Mental Health - Last Four Full Quarters					Last Three Months			Details		
Name of NHS Constitutional Indicator	Q3	Q4	Q1	Q2	Aug 2015	Sep 2015	Oct 2015	Operational Standard	Collection Frequency	Status / Commentary
Care Programme Approach (CPA) : the proportion of people under adult mental illness specialities on CPA who were followed up within seven days of discharge from psychiatric inpatient care during the period	98.3 ★	100.0 ★	100.0 ★	96.1 ★	93.3 ▲	100.0 ★	94.4 ▲	95%	Monthly	Performance in October was based on 18 discharges where 17 were followed up within 7 days, the 1 patient who was not followed up was contacted. For Q3 overall to date there is a predicted achievement of target.

Healthcare associated infection (HCAI) - Last Four Full Quarters									Last Three Months						Details		
Name of NHS Constitutional Indicator	Q3		Q4		Q1		Q2		Aug 2015		Sep 2015		Oct 2015		Operational Standard	Collection Frequency	Status / Commentary
Incidence of healthcare associated infection (HCAI) i) MRSA	2	▲	0	★	0	★	0	★	0	★	0	★	2	▲	0	Monthly	There have been 2 reported cases, one was a patient from UHSM, we are awaiting the outcome of the investigation. The other case is a complex patient who resides in a Care Home and has had previous MRSA in complex wounds, this patient received District Nurse input from Stockport and lessons learned from the investigation will be disseminated. We have been informed that this patient has been re-tested in December and as such a repeat case will show in the figures for December.
Incidence of healthcare associated infection (HCAI) ii) C. Difficile	24	▲	22	★	34	▲	36	▲	11	▲	12	▲	12	▲	7.4	Monthly	he health economy is over trajectory, however, to date there have only been 2 associated with lapses in care in the Acute Trust and 16 in the community. Of the Community cases 10 are repeat samples, which would take numbers under year end trajectory by 13 cases with 5 months to go, but still over YTD trajectory by 23 cases. The rise in cases has been a consistent and stable picture over the last 9 months. Lessons in care from all cases are discussed, disseminated and action planned within a robust and collaborative process.

Key

Indicator RAG rating

★ Green - Performance at or above the standard

▲ Red - Performance below the standard

Statutory Duty & Resilience Compliance

Statutory Duty and Resilience - Last Four Full Quarters									Last Three Months						Details		
Statutory Duty or Resilience Measure	Q3		Q4		Q1		Q2		Aug 2015		Sep 2015		Oct 2015		Operational Standard	Collection Frequency	Status / Commentary
Percentage of FoIs handled within the legal timeframe	98.0	★	100.0	★	100.0	★	98.3	★	100.0	★	93.8	★	100.0	★	90%	Monthly	There is no significant risk identified to threaten future performance.
Number of limited assurance reports received from auditors	1	▲	1	▲	0	★	0	★	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Number of statutory Governing Body roles vacant	0	★	0	★	0	★	0	★	0	★	0	★	0	★	0	Monthly	There is no significant risk identified to threaten future performance.
Percentage of complaints responded to within 25 working days	93.8	★	77.8	▲	84.6	★	90.9	★	85.7	★	N/A		100.0	★	80%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of days lost to sickness in the last 12 months	2.25	★	2.23	★	2.01	★	1.89	★	1.89	★	1.94	★	2.24	★	2.5%	Monthly	There is no significant risk identified to threaten future performance.
Percentage of staff contracts which are substantive.	83.8	★	85.6	★	80.7	★	78.9	▲	79.1	▲	82.5	★	81.8	★	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 & Provider Management Committee

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

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

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Text Relay: 18001 + 0161 426 9900

Website: www.stockportccg.org

Executive Summary

The Governing Body is requested to consider whether any of the issues raised in this report require a higher level of escalation.
Please detail the key points of this report
Summary • This report summarises the key decisions of the Quality & Provider Management October Committee. **Decisions** • None **Attachments** • Quality & Provider Management November Issues Log
How does this link to the Annual Business Plan?
Improving the quality of commissioned services is a key strategic aim within the CCG Annual Operational Plan.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Quality & Provider Management Committee
Clinical Executive Sponsor: Dr Cath Briggs
Presented by: Mark Chidgey
Meeting Date: 13th January 2016
Agenda item: 8
Reason for being in Part 2 (if applicable)
Not applicable

1.0 Decisions of the Quality & Provider Management Committee

1.1 Issues Log:

- The committee requested that the issue of assurance of SFT CIP plans be moved to the corporate risk register.
- The issue of timely follow up of glaucoma patients at CMFT was removed and would be reviewed in 6 months time.
- No new issues were added.

2.0 Issues highlighted to the Governing Body

2.1 It was agreed that the January meeting would focus on the urgent care system, the key messages from this will be reported to the next Governing Body. This links to the update provided within the statutory compliance report.

3.0 Decisions for the Governing Body

- None

Compliance Checklist:

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

		Any form of change: Risk Assessment Completed and included	N/A
		Any impact on staff: Consultation and EIA undertaken and demonstrable in document	N/A

Locality Chairs update for Governing Body-January 2015

Locality Chairs would like to make the Governing Body aware of the pressures that General practice are experiencing across Stockport.

There are high levels of staff sickness across all staff groups.

This is being compounded by the recruitment difficulties for salaried GPs and Practice Nurses.

There are also problems getting GP locums to cover sessions.

These are all impacting on the capacity of practices to provide training for potential future GPs.

NHS
Stockport
Clinical Commissioning Group

Chief Operating Officer's update

Chief Operating Officer's update to the January 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 which the Governing Body are requested to note.
Please detail the key points of this report
Provides an update on: 1. Level 3 Co-Commissioning 2. 2016/17 Planning Guidance
What are the likely impacts and/or implications?
How does this link to the Annual Business Plan?
Supports delivery.
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
Directors
Clinical Executive Sponsor: Ranjit Gill
Presented by: Gaynor Mullins
Meeting Date: 13th January 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 January 2016.

2.0 Level 3 Co-Commissioning

2.1 The CCG has been approved as a level 3 co-commissioner of primary medical services. We will be reviewing the committee and other support arrangements to ensure that we can carry out these delegated functions effectively, and a further update will be provided to the Governing Body prior to the new arrangements commencing on 1st April 2016.

3.0 2016/17 Planning Guidance

3.1 Planning guidance was published on 22 December 2015. This sets out the national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. The guidance sets out the requirement for two separate but connected plans:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View;
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

3.2 The requirement for the STP is consistent with the approach taken as part of the Stockport Together plan and we will review these plans in line with the guidance, together with any emerging guidance from the Greater Manchester devolution planning process.

3.3 A first draft operational plan will need to be submitted by 8 February, with final plans signed off by 31st March 2016 and submitted by 11 April 2016. STPs will need to be submitted by end of June.

4.0 Action requested of the Governing Body

1. To note the updates provided

NHS
Stockport
Clinical Commissioning Group

Chief Clinical Officer's update

Chief Clinical Officer's update to the January 2016 meeting of the Governing Body

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Executive Summary

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

This report requires decisions on two elements of Greater Manchester Wide Governance: the Joint Commissioning Board and the Healthier Together Joint Committee.

The Governing Body is requested to:

(a) 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.
(b) 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.
(c) Approve the terms of reference for the Healthier Together Joint Committee in their current form and:
(d) 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.

Please detail the key points of this report

Joint Commissioning Board

Attached as an appendix to the report is a discussion paper which outlines the proposed approach to the shadow and then formal operation of the Joint Commissioning Board which will form an integral part of the Greater Manchester Devolution Governance Arrangements. The report outlines the proposed responsibilities of the Board.

The CCG is entitled to one seat on the Joint Commissioning Board.

Governing Body approval is sought to appoint the Chief Clinical Officer as NHS Stockport CCG's appointee to the Board and the Chief Operating Officer as the CCG's appointed Deputy.

Healthier Together Joint Committee

When the Greater Manchester CCGs (GM CCGs) began the Healthier Together programme, CCGs did not have the power to establish joint committees and so the GM CCGs established the Healthier Together committees-in-common (HTCiCs) to take decisions in relation to the programme. In preparation for the implementation phase of Healthier Together, it is now proposed that the GM CCGs establish a joint committee which will take over decision-making responsibility from the HTCiCs.

The CCG's Constitution provides for the establishment of a Joint Committee.

A new set of terms of reference has been drawn up for the HTJC. The CCG's Governing Body will need to resolve to establish the HTJC and approve the terms of reference which have been attached as an Appendix to this report.
What are the likely impacts and/or implications?
The CCG's ability to participate actively on behalf of the patients in Stockport in both sets of governance arrangements requires the approvals outlined within the covering report. It is anticipated that engaging fully in both the Joint Commissioning Board and Healthier Together Programme will support the continued development of the health and social care outcomes I Stockport and continue to reduce health inequalities.
How does this link to the Annual Business Plan?
The establishment of Greater Manchester Wide Governance arrangements relating to both the Healthier Together Programme and Greater Manchester Devolution are consistent with local plans and support delivery.
What are the potential conflicts of interest?
There may be occasions where conflicts of interest arise for appointees to Greater Manchester Bodies. These will be
Where has this report been previously discussed?
Both elements have been discussed in their respective meetings and previously through CCG Governing Body meetings.
Clinical Executive Sponsor: Ranjit Gill
Presented by: Ranjit Gill
Meeting Date: 13 January 2016
Agenda item: 11

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Item 2

GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION
SHADOW JOINT COMMISSIONING BOARD

Date: 15 December 2015

Subject: GM Joint Commissioning Board – discussion paper

Report of: Liz Treacy and Rob Bellingham

PURPOSE OF REPORT

Greater Manchester has agreed to formalise joint commissioning arrangements through the creation of a Joint Commissioning Board. This discussion paper sets out the role of the Board, and identifies key next steps.

RECOMMENDATIONS

The Shadow Joint Commissioning Board is invited to note and comment on the contents of the paper, and agree the next steps.

CONTACT OFFICER:
Tim Griffiths
Tim.griffiths@agma.gov.uk

1. INTRODUCTION

1.1 Greater Manchester has agreed to formalise joint commissioning arrangements through the creation of a Joint Commissioning Board. This discussion paper sets out the role of the Board, and identify key next steps.

1.2 It will provide an overview of:

- Functions of the GM Joint Commissioning Board (GMJCB)
- Membership of the GMJCB
- How decisions will be taken at the GMJCB
- Advisory Groups
- In scope services
- The GMJCB Executive
- GM Commissioning Strategy

1.3 The shadow Joint Commissioning Board will meet in shadow form until April 2016.

2. JOINT COMMISSIONING BOARD

2.1 The GMJCB will be a Joint Committee where each participant makes joint decisions which are binding on each other. It is likely that the GMJCB will be two (or more) separate meetings; one for Specialised Services, and one (or more) for other commissioning.

2.2 The GMJCB will have significant commissioning decision making responsibility as the largest single commissioning vehicle in GM.

2.3 Greater Manchester has agreed that in order to comply with regulatory requirements the GMJCB will function independently of providers. However, it has been agreed that one of the key principles of GM commissioning will be that of co-design.

2.4 The key functions of the GMJCB are as follows:

- To develop a commissioning strategy based upon the agreed Strategic Plan.
- Be responsible for the commissioning of health and social care services on GM footprint
- Have strategic responsibility for commissioning across GM
- Be responsible for the delivery of the pan GM strategy via its commissioning decisions (local commissioning will remain a local responsibility).
- To operate within existing commissioning guidelines following key principles of co-design, transparency, and broad engagement.

2.5 The GMJCB will only take GM wide commissioning decisions; any decision that currently sits with the commissioning responsibilities of LAs

and CCGS will stay with these organisations (or at a locality level where new commissioning arrangements are being developed).

2.6 However, any existing decision taken on a GM footprint collectively by GM CCGs or AGMA will transfer to the GMJCB, where it is agreed that it would be beneficial to do so.

2.7 GM has agreed that the GMJCB will need to develop a clear mechanism and protocol to determine what can be commissioned at a GM level.

2.8 It is accepted that there are certain specialised services that would be impractical and inappropriate to commission on a Greater Manchester footprint. However, NHSE are committed to working collaboratively with the GMJCB to ensure that these services are not commissioned in isolation of Greater Manchester i.e. to ensure that Greater Manchester is able to exert a proportionate influence over the decision making process. Work has already been undertaken to analyse the 240+ plus specialised service currently commissioned, and put them into three broad categories: to be commissioned on a GM footprint; to be commissioned on North/North West footprint; and, to be commissioned nationally.

2.9 The GMJCB will be required to produce a clear Commissioning Strategy that is aligned with the aims and objectives of the Strategic Plan. The Commissioning Strategy will be reviewed periodically, or at times when the priorities for the Greater Manchester health and social care economy change; thus necessitating a shift in commissioning priorities.

2.10 The GMJCB will also have a responsibility to ensure that there is alignment between the GM Commissioning Strategy and the commissioning strategies that will be developed at a locality level.

2.11 The Strategic Partnership Board and GMJCB are connected via the GM Strategic Plan. The GMJCB will be responsible for the delivery of the pan GM elements of the Plan, and will have ongoing responsibility for the delivery of the GM vision for health and social care at a GM level.

2.12 The GMJCB is not subservient to the Strategic Partnership Board, it has no formal accountability to it. The Strategic Partnership Board endorses the Commissioning Strategy, and ensures that there is alignment between the Commissioning Strategy and Strategic Plan.

2.13 The GMJCB is accountable to its constituent bodies, however there will be clear reporting on the outcomes of activity overseen by the GMJCB at the Strategic Partnership Board.

3. JOINT COMMISSIONING BOARD: MEMBERSHIP AND VOTING

3.1 The membership of the GMJCB will be comprised of the 23 commissioning organisations in Greater Manchester, and the Greater Manchester Combined Authority:

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

Total 24 representatives

3.2 NHSE will be represented on the GMJCB by the GM H&SC Chief Officer.

3.3 It is anticipated that CCGs will be represented on the GMJCB by their accountable officer, NHSE will be represented by the GM H&SC Chief Officer, the Greater Manchester Combined Authority will be represented by the lead Chief Executive for Health and Wellbeing, and local authorities will be represented by their Chief Executive.

3.4 However, GM has agreed that it is for each organisation or stakeholder group to decide who best represents their organisations. The seniority of the membership of the GMJCB will need to reflect both the size of the budget and the significance of the decisions taken, and each member will be expected to attend with authority (delegated where necessary) to take decisions in a joint committee.

3.5 The GMJCB will be co-chaired by GMACGG and AGMA. AGMA have nominated Steven Pleasant, Chief Executive of Tameside Council as their co-chair. Hamish Stedman will act as the GMACGG co-chair.

3.6 GM has agreed that the GMJCB will be supported by specialised officer groups such as the Cancer Board, Specialised Service Commissioning Oversight Group, and in recognition of the need for innovation a health research and innovation group will be formed to support the commissioning process. This is covered in more detail below.

3.7 The GMJCB will meet in public from April 2016.

4. DECISION MAKING

4.1 The GMJCB will be the decision making body for all those commissioning decision that fall within its remit; this will include those elements of the Strategic Plan that will be delivered (and commissioned) on a GM footprint, and devolved functions such as Specialised Service Commissioning.

4.2 Work is required to establish a clear and agreed baseline for the GMJCB. However, it has been agreed that the GMJCB will have no decision making power over those services that are currently commissioned at a local level, or those that are commissioned on broader footprint than GM, unless it is agreed that there would be a clear benefit for commissioning those services at a GM level. As identified above, a clear mechanism will be developed by the JCB that will enable its remit to broaden by agreement of the ten localities. This mechanism will need to make provision that affords the GMJCB the ability to consider requests from non GMJCB members, for example through a research and innovation group, or through service providers.

4.3 There will be four voting parties at the GMJCB: GMCA; NHSE; CCG's; and, AGMA. The GMCA, NHSE, CCGs and LAs will each have one vote (i.e. four votes in total). Decisions will require a 75% majority of the participant organisations.

4.4 As set out above NHSE will be represented on the GMJCB by the GM H&SC Chief Officer, however there may be circumstances where NHSE has no present interest in a particular matter e.g. where the matter relates to a function that NHSE has delegated to GMCA and/or CCGs. In such circumstances the Chief Officer, who would cast the vote on behalf of NHSE, will pass the NHSE vote to CCGs or align their vote to that of CCGs. This will ensure parity across GM commissioning agencies.

4.5 Due to the fact that NHSE commissions many services on a national basis, notably some very specialised services, there will be a proportionate ability for NHSE to notify the GMJCB where an item due for consideration could have significant ramifications for NHSE, eg proposed spending beyond existing budget(s); or potential and significant adverse implications for communities beyond GM.

4.6 The exact circumstances, in which these arrangements apply, have yet to be determined and further is required to develop such criteria. This will be taken forward by the Governance Sub Group. In these instances, any decision will need to be taken with the consent of NHSE.

4.7 NHSE also reserve a right of veto over certain commissioning decisions relating to specialised services. However this right of veto is not absolute, for it to be exercised it would need to satisfy clear and agreed criteria e.g. where the commissioning of services would give rise to a significant financial risk for NHSE. Again, the exact circumstances, in which this would apply, have yet to be determined and further is required to develop such criteria.

4.8 The GMJCB will not have the ability to take decisions on those services that are commissioned on a local level, nor will it be able to take decisions on services commissioned on a broader than GM footprint. However, it is expected that GM via the GMJCB is able to participate in, and exert an appropriate level of influence over the commissioning and decision making process for the latter.

4.9 Greater Manchester has agreed the GMJCB will have a clear dispute resolution process. Where disputes relates to the potential commissioning of services on a GM footprint, the GMJCB will reserve the right to proceed and commission on a smaller footprint should it be beneficial (and agreed) to do so.

4.10 The dispute resolution procedure will be clearly set out in the written agreement that will be required to support the proposed joint commissioning arrangements; this will either be in the form of a s.75 agreement or follow the structure of such an agreement.

5. ADVISORY GROUPS

5.1 GM has agreed that the GMJCB will be supported by subject specialist advisory groups, such as the Cancer Board, Learning Disabilities Programme Delivery Board, and the emerging structures that are supporting the transfer of Specialised Service Commissioning. There will be a clear role for clinical support through both the Strategic Clinical networks, and NHS Clinical Senates.

5.2 GM has also agreed that the GMJCB will be supported by a research and innovation group. This will ensure that the GM commissioning process is innovative underpinned by robust evidence bases, and its commissioning decisions are outcomes focused. Work is required to establish this group and clearly define the key role it will need to play to ensure that GM does not do more of the same.

5.3 The role of these groups (sub boards) will not be commission services, that will be the domain of the GMJCB. However, the GMJCB will take commissioning decisions based upon recommendations made to it by the specialist sub groups.

5.4 Whilst a number of these groups are already established, work will be required to ensure that current terms of reference for the groups that are already established are revised to ensure they align with the emerging GM governance arrangements, and in particular to clarify their role with regards to commissioning decisions. Likewise, the GMJCB scheme of delegation will need to clarify how recommendations received by the GMJCB are implemented.

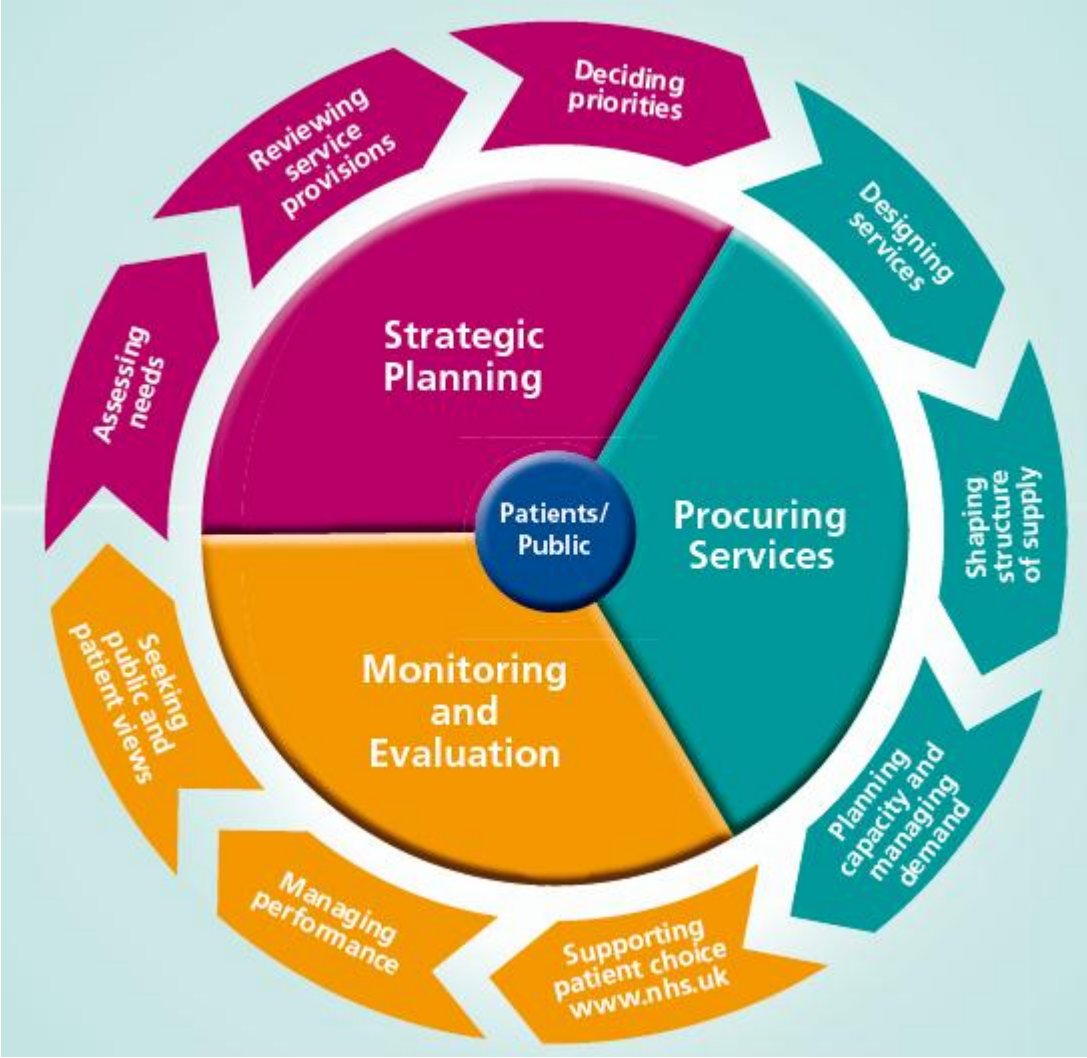
5.5 In order to ensure that the GMJCB is supported in an efficient and effective way work is required to clearly understand and define what the supporting architecture will look like, and how the GMJCB will interact with what is likely to be a large, complex sub structure.

6. 2016-17 COMMISSIONING CYCLE

6.1 The GMJCB will need to have oversight of those services that are currently in the process of being commissioned that will impact on GM and its residents. Whilst the GMJCB will be unable to be the decision making body, it will need to be appraised as to progress in these areas and form part of the decision making process.

6.2 The diagram below provides a visual depiction of the NHS Commissioning Cycle (in providing this, it is acknowledged that the work of the Board will not be confined to NHS provision and the Board will always need to take a wider, whole system view of the commissioning process). As the Joint Commissioning Board develops over the coming months, this may provide a helpful aide memoire to members in defining the role, function and workplan of the Board.

6.3 Operationally, the NHS currently works to an annual contracting round where contracts with service providers are agreed for a financial year. NHSE and CCgsWe are currently embarking on the 2016/17 contracting process. For the immediate future, the Board will be appropriately briefed on relevant operational matters relating to the securing of appropriate contractual agreements for 2016/17.



7. IN SCOPE SERVICES

7.1 It has already been acknowledged that the GMJCB will be the single largest commissioning body in Greater Manchester. Its scope only extends to those services that have been agreed to be commissioned at a GM level; commissioning decisions currently taken at a locality level will continue to be taken at a locality level unless it is agreed (by localities) that such activity would be best served by commissioning at a GM level.

7.2 GM has agreed that the GMJCB (via its executive) will develop a clear mechanism by which the commissioning of services can move from a locality to the GMJCB.

7.3 Significant work has been undertaken to identify which Specialised Services should be commissioned on a GM footprint.

7.4 There are a series of items currently commissioned by NHS England, that form part of the Health and Social Care devolution agreement and therefore will be within the scope of the GMJCB. These include:

- Specialist Commissioning (see paper elsewhere on today's agenda)
- Primary Care (Community Pharmacy, Dental Services, Optometry)
- Public Health "Section 7a" services – these include Screening and Immunisation Programmes, (including cancer screening), Child Health Information Systems

7.5 Within Greater Manchester, it is anticipated that all 12 CCGs will be "level 3" commissioners of General Practice from 1 April 2016. This means that they will have delegated responsibility for this work, including a delegated budget. However, it is anticipated that GM level working will continue in this area, for example in developing quality standards or agreeing high level strategy. This GM level work would be within scope for the GMJCB.

7.6 Health and Justice Commissioning is in scope for the overall devolution programme but is not part of the transfer taking place on 1 April. When such a transfer does occur, this would be in scope for the GMJCB.

7.7 In addition to these core responsibilities, it is expected that the GMJCB will be asked to take a lead in other areas of commissioning, relating to both health and social care. Formalising these areas will be subject to the processes described elsewhere in this paper but, for example, may include aspects of:

- Learning Disability services
- Mental health services
- Public Health Services, (eg Health Visiting)

8. ROLE OF A JCB EXEC

8.1 GM has agreed that the GMJCB will be supported by a smaller executive. The executive will act as a representative working group, and be comprised of a smaller number of GMJCB members.

8.2 In order for the GMJCB to function effectively it maybe that the executive is comprised of a different membership; for example where the GMJCB member is a local authority's Chief Executive then it might be considered beneficial for the organisation lead commissioner to form part of the executive.

8.3 The precise function and form of the executive need to be defined and agreed. However, its responsibilities will include:

- To develop the GM Commissioning Strategy, ensuring it able to deliver the Strategic Plan; the GM Commissioning Strategy will need to be approved by the wider GMJCB.
- To work with the specialist advisory groups to ensure that recommendations made by them are aligned to both the Commissioning Strategy, and deliver the relevant parts of the Strategic Plan
- The executive will be responsible for developing the assurance mechanisms for those activities that are commissioned by the GMJCB. This will need to form part of the broader assurance framework, and be linked to the delivery of outcomes.
- The executive will have performance management responsibility for those activities commissioned by the GMJCB – providing regular and/or exception reporting to the GMJCB.
- The GMJCB will agree the framework within which the executive will operate.

8.4 The executive will not be able to take commissioning decisions; it will however have the ability to make clear recommendations to the GMJCB.

8.5 The membership of the GMJCB Executive will need to be agreed, however it is proposed that it follows a similar structure to that of the Strategic Partnership Board Executive and it be a representative body of four members each from CCGs and AGMA, along with NHSE (and other members as deemed and agreed appropriate).

9. COMMISSIONING STRATEGY

9.1 GM has agreed that the GMJCB will produce a Commissioning Strategy. This strategy will have a clear focus on the commissioning of the pan GM elements of the Strategic Plan, and will therefore need to be clearly aligned with the same.

9.2 The GMJCB will need to embed that principle of co-design into the strategy.

9.3 The GM Commissioning Strategy will need to be constructed in a way that complements and is aligned to local commissioning strategies. It is proposed that the GMJCB Executive will be responsible for production of this plan.

10. NEXT STEPS

10.1 In order for the GMJCB to transition from shadow to full status by April 2016, the Governance Sub Group have begun to identify the work that will

be required. The development of the next steps and supporting work is an iterative process, and should therefore not be considered exhaustive:

i. Agree the membership of the GMJCB
ii. Agree a cycle of meetings
iii. Agree a clear forward plan for the GMJCB
iv. Agree the membership of the GMJCB Executive
v. Agree how the GMJCB work programme will be resourced and structured
vi. Agree the baseline of the GMJCB – ie what business will be transacted there. Refer to Section 7.
vii. Undertake due diligence against those services agreed to be in scope of the GMJCB
viii. GMJCB has to agree the process by which it will accept responsibility for commissioning specialised services (and other services where appropriate).
ix. The mechanism by which the remit of the GMCJB can be broadened needs developing and agreeing; this will need to include the development and agreement of criteria including financial and clinical benefit of doing so.
x. The allocation of funding including pooled funds needs to be agreed.
xi. The performance management and assurance role of the GMCJB (and executive) needs to be defined and agreed.
xii. The supporting architecture for the GMJCB needs to be clearly understood, agreed and mapped. As do the required responsibilities and reporting mechanisms.
xiii. The fragmentation of commissioning in Greater Manchester will need to be addressed via the development of a place based commissioning workforce strategy.
xiv. The process by which a commissioning strategy for GM needs to be developed, and associated commissioning strategy produced.
xv. A clear GMJCB implementation plan will need to be developed and agreed.
xvi. Reach collective agreement on the definition and understanding of what co-design means in Greater Manchester.
xvii. Due to unique nature of the GMJCB it is proposed to develop a series of member development sessions.

10.2 The next steps identified will need to be turned into a clear GMJCB work programme.

11. RECOMMENDATIONS

11.1 The shadow GMJCB are invited to note and comment on the contents of the paper, and agree the next steps.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

3

GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION SHADOW JOINT COMMISSIONING BOARD

Date: 15 December 2015

Subject: GM Joint Commissioning Board – draft Terms of Reference

Report of: Liz Treacy and Rob Bellingham

PURPOSE OF REPORT

Greater Manchester has agreed to formalise joint commissioning arrangements through the creation of a Joint Commissioning Board. This paper sets out proposed draft terms of reference.

RECOMMENDATIONS

The Shadow Joint Commissioning Board is invited to note and comment on the contents of the paper, and agree the next steps.

CONTACT OFFICER:

Tim Griffiths
Tim.griffiths@agma.gov.uk

The Greater Manchester Health and Social Care Shadow Joint Commissioning Board

AUTHORITY

In February 2015 the Association of Greater Manchester Authorities (AGMA) and the Association of Greater Manchester Clinical Commissioning Groups (CCGs) signed a Memorandum of Understanding (MoU) with NHS England to create a framework for achieving the delegation and ultimate devolution of health and social care responsibilities to accountable and statutory bodies in Greater Manchester (GM).

The MoU outlined a process for collaborative working across health and social care making provision for arrangements to be in place (in shadow form) from November 2015 It also made provision for a programme of work to be undertaken during 2015/16 to move to fully devolved system from April 2016. This includes work to develop and agree the supporting governance including the creation of a Joint Commissioning Board.

PURPOSE AND OBJECTIVES

The shadow Joint Commissioning Board will be responsible for:

- Developing a commissioning strategy based upon the agreed Strategic Plan.
- The commissioning of health and social care services on GM footprint
- The delivery of the pan GM strategy via its commissioning decisions (local commissioning will remain a local responsibility).
- To operate within existing commissioning guidelines following key principles of co-design, transparency, and broad engagement.

The GMJCB will be a Joint Committee where each participant makes joint decisions which are binding on each other

The GMJCB will only take GM wide commissioning decisions; any decision that currently sits with the commissioning responsibilities of LAs and CCGS will stay with these organisations (or at a locality level where new commissioning arrangements are being developed).

The GMJCB will function independently of providers.

One of the key principles of underpinning the activity of the GMCB will be that of co-design of services.

The GMJCB will be supported by specialist advisory groups, and will take decisions based on recommendations from them.

RESPONSIBILITIES OF SHADOW JOINT COMMISSIONING BOARD

The key responsibilities of the shadow Joint Commissioning Board are:

- To agree the form and function of a smaller Executive
- To develop and agree the process for the development of a GM Commissioning Strategy
- To agree what services will fall with the scope of the GMJCB from April 2016.
- To develop and agree the mechanism and protocol to determine what should be commissioned at a GM level
- To develop and agree the process by which Greater Manchester will accept commissioning responsibility for delegated functions
- To develop and agree the performance management and assurance role of the GMJCB
- To clearly define (and rationalise where required) the GMJCBs supporting architecture, and its linkages back into the GMJCB
- Reach collective agreement on the definition and understanding of what co-design means for Greater Manchester and the GMJCB.

MEMBERSHIP

The membership of the shadow GMJCB will be comprised of the 23 commissioning organisations in Greater Manchester, and the Greater Manchester Combined Authority:

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

NHSE will be represented on the GMJCB by the GM H&SC Chief Officer.

OTHER MEMBERS

The meeting will be supported by officers as dictated by the agenda. Subject specialists will attend meetings where it supports the progression of the agenda

CHAIR

The shadow GMJCB will be co-chaired by GMACGG and AGMA.
For AGMA it will be Steven Pleasant, Chief Executive of Tameside Council, and for GMACGG it will be Hamish Stedman, Chair Association of Greater Manchester CCGs

QUORUM

The quoracy of the meeting has yet to be defined.

VOTING

The GMCA, NHSE, CCGs and LAs will each have one vote (i.e. four votes in total).

Decisions will require a 75% majority of the participant organisations.
NHSE reserves a proportionate ability for NHSE to notify the GMJCB where an item due for consideration could have significant ramifications for NHSE, eg proposed spending beyond existing budget(s); or potential and significant adverse implications for communities beyond GM.

NHSE also reserve a right of veto over certain commissioning decisions relating to specialised services. This veto is not absolute and can only be exercise when agreed criteria are met.

DISPUTE RESOLUTION

In the event of dispute a dispute resolution process will be implemented. The focus of this process will be three fold: to understand why dispute has occurred; to determine/understand the potential implications of the dispute; and to resolve where possible.

Where appropriate disputes will be resolved at place level. Where disputes cannot be resolved at place level, a group comprised of an agreed number of members from each stakeholder group to arbitrate and make recommendation. The recommendations made by the dispute resolution group are binding

SUPPORT

Officers from the Greater Manchester Integrated Support Team (GMIST) will provide policy and administrative support to the shadow Joint Commissioning Board.

Additional support will be provided by the GM Health and Social Care Programme Management Office.

MEETING FREQUENCY

The shadow Joint Commissioning Board will meet monthly until April 2016.

ACCOUNTABILITY

The shadow Joint Commissioning Board is accountable to its constituent members.

REVIEW OF TERMS OF REFERENCE

These terms of reference will be formally reviewed by the shadow Joint Commissioning Board by mutual agreement of the membership. A review will be required prior to making the transition from shadow to full form.

Version Control

Title	**Terms of Reference for Greater Manchester Healthier Together Joint Committee**
Author	Alex Heritage (Programme Director)
Version	V 1.4
Target Audience	Greater Manchester Clinical Commissioning Group Governing Bodies
HTP Reference	
Created - date	28th November 2014
Date of Issue	
Document Status	Draft v0.8
Description	Terms of Reference for Greater Manchester Healthier Together Joint Committee
File name and path	

Document History:

Date	Version	Author	Notes
28/11/2014	0.1	Alex Heritage	Draft for legal advice
04/12/2014	0.2	Hempsons Solicitors	Amendments to draft
19/12/2014	0.3	Gemma Batchelor	Slight changes made to grammar following comments at CIC meeting
29/09/2015	0.4	Mandy Noble	Amendments to 'functions' and 'decisions' to take account of programme implementation
06/10/2015	0.5	Alex Heritage	Final draft review
13/10/2015	0.6	Hempsons Solicitors	Amendments to draft
28/10/2015	0.7	Mandy Noble	Amendments following comments at CIC meeting
22/12/2015	0.8	Rachel Volland	Amendments to membership lists
Approved by:			These TOR were considered and approved by the HT Joint Committee on:

NHS Greater Manchester Clinical Commissioning Groups
Healthier Together Joint Committee

Terms of Reference

These Terms of Reference are drawn up using the template in Appendix 2 of the CCG Establishment Agreement (clause 12.3.2). In the event of contradiction or dispute, this document should be seen as the authoritative document in respect of the Healthier Together Joint Committee functions.

1. Introduction

The Greater Manchester Clinical Commissioning Groups have established an association of them known as the Association of Greater Manchester Clinical Commissioning Groups (Association). The Association was established by an agreement dated 2nd April 2013 (Establishment Agreement).

The CCG members of the Association who are listed in the table below as Voting Members (CCGs) have decided to work together on the Healthier Together programme. To this end, the CCGs established the Healthier Together committees-in-common (HTCiC) and have now agreed to establish a Joint Committee, as the successor to the HTCiC, which shall be responsible for Level B decision making in relation to the Healthier Together programme. The CCGs' Joint Committee shall be called the Healthier Together Joint Committee (HTJC). The HTJC is comprised of one representative from each of the CCGs and its constitution; meeting arrangements etc are set out in these terms of reference.

Healthier Together is one part of an overall public sector service transformation programme led by Greater Manchester Local Authorities and the NHS, alongside other partners. 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):

- 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.

The HTJC will perform the functions delegated to it by the CCGs in relation to any healthcare service changes (either in hospital or out of hospital) proposed as part of the Healthier Together programme, which involve the oversight and assurance of programme implementation.

2. Establishment

The CCGs have agreed to establish and constitute a Joint Committee with these terms of reference to be known as the HTJC. The HTJC will supersede the Healthier Together Committees in Common (HT CiC) following the endorsement of the Decision Making Business Case (DMBC) and the conclusion of the Healthier Together decision making phase.

3. Functions of the Committee:

- Agree and oversee programme plans of the Healthier Together implementation process.
- Act as the decision making body; authorising subgroups (e.g. Programme Board) to oversee and lead Healthier Together changes.
- Determine and issue guidance for the formation of single services.
- Make decisions as to a sequencing approach for the implementation of single service changes.
- Make decisions as to each single service's state of readiness for implementation at the relevant stages of change.
- Agree and oversee a pan Greater Manchester HR and Workforce framework to deliver workforce standards as described in the Healthier Together Model of Care.
- Assure that a suitable pan Greater Manchester financial framework to detail activity and finance assumptions to support single service business cases is developed by Chief Finance Officers.
- Endorse GM clinical specifications and standards as recommended by the Greater Manchester Clinical Alliance.
- Assure appropriate patient engagement in each single service.
- Ensure compliance with public sector equality duties for the purposes of implementation.
- Assure appropriate communications and engagement in each single service.
- Assure the North West Ambulance Service implementation plan.
- Agree the benefits framework to underpin benefits realisation and monitor the consistency of service provision during transition.
- Assuring the attainment of the Healthier Together Implementation Conditions and the Equality Conditions.

In discharging its responsibilities the HTJC will also:

- Oversee pan Greater Manchester assurance and oversight to deliver implementation.
- Ensure appropriate mechanisms are in place to enable single services to develop and operate in concert for the benefit of Greater Manchester patients.

4. Category 1 and Category 2 decisions

The following decisions of the Joint Committee shall be Category 1 decisions:

i. To agree a sequencing order for the implementation of the 4 single services;
ii. To agree each single service's state of readiness for Go-Live patient level changes in relation to high risk general surgery patients.

All other decisions of the Joint Committee shall be Category 2 decisions, unless the Joint Committee specifically and unanimously agrees that another issue should be considered as a Category 1 decision.

5. Membership

The Joint Committee will be chaired by a Non-voting Independent Chair.

The voting members of the Joint Committee shall comprise one Governing Body member from each of the CCGs.

Each CCG's nominated Governing Body member is listed in the table overleaf ("Joint Committee Member").

Membership of the Joint Committee will combine both Voting and Non-voting members. Non-voting members of the Joint Committee represent other functions/parties/organisations or stakeholders who are involved in the programme and will provide support and advise the voting members on any proposals.

Independent Chair – Philip Watson CBE				
Voting Members				
	Organisation	**Member Nomination**	**Title**	**Remarks**
1	NHS Bolton CCG	Dr. Wirin Bhatiani	CCG Chair	
2	NHS Bury CCG	Dr. Kiran Patel	CCG Chair	
3	NHS Central Manchester CCG	Dr. Mike Eeckelaers	CCG Chair	
4	NHS Heywood, Middleton and Rochdale CCG	Dr. Chris Duffy	CCG Chair	
5	NHS North Manchester CCG	Dr. Martin Whiting	CCG Clinical Accountable Officer	
6	NHS Oldham CCG	Dr. Ian Wilkinson	CCG Clinical Accountable Officer	
7	NHS Salford CCG	Dr. Paul Bishop	CCG board member	
8	NHS South Manchester CCG	Dr. Bill Tamkin	CCG Chair	
9	NHS Stockport CCG	Dr. Ranjit Gill	CCG Clinical Accountable Officer	
10	NHS Tameside and Glossop CCG	Dr. Alan Dow	CCG Chair	
11	NHS Trafford CCG	Dr. Nigel Guest	CCG Clinical Accountable Officer	
12	NHS Wigan Borough CCG	Dr Tim Dalton	Clinical Chair	
Non - Voting Members				
1	Programme Sponsor	Ian Williamson		
2	Greater Manchester Association of Clinical Commissioning Groups	Hamish Steadman	Chair	
3	Greater Manchester Service Transformation	Leila Williams	Director of Service Transformation	
4	AGMA Representative	Steven Pleasant	Lead Local Authority Chief Executive for Health	
5	Health Watch representative	Jack Firth		
6	Greater Manchester Service Transformation	Sophie Hargreaves	Programme Director	
7	NHS Eastern Cheshire CCG	Dr Fleur Blakeman	Strategy & Transformation Director	
8	NHS East Lancashire CCG	Dr Peter Williams	GP	
9	NHS North Derbyshire CCG	Dr Debbie Austin	Governing Body GP	

Neighbouring CCGs have been engaged to participate as non-voting members, see above.

6. Deputies

The individual named in the table below (who is a Governing Body member) may deputise for the Joint Committee Member appointed by its CCG:

The table of individuals authorised by the CCGs to deputise for their representatives is shown below:

	Organisation	Deputy Nomination	Title
1	NHS Bolton CCG	Susan Long	CCG Chief Officer
2	NHS Bury CCG	Stuart North	CCG Chief Officer
3	NHS Central Manchester CCG	Edward Dyson	Interim CCG Chief Operating Officer
4	NHS Heywood, Middleton and Rochdale CCG		
5	NHS North Manchester CCG	Helen Speed	Programme Director Urgent Care and Collaborative Commissioning
6	NHS North Manchester CCG	Joanne Downs	Head of Finance
7	NHS North Manchester CCG	Moneeza Iqbal	Programme Director - Planned Care, Long Term Conditions and Public Health
8	NHS North Manchester CCG	Joanne Newton	Director of Finance
9	NHS Oldham CCG	Denis Gizzi	CCG Managing Director
10	NHS Oldham CCG	Julie Daines	Chief Finance Officer
11	NHS Salford CCG	Steve Dixon	Chief Finance Officer
12	NHS South Manchester CCG	Caroline Kurzeja	CCG Chief Officer
13	NHS Stockport CCG	Gaynor Mullins	CCG Chief Operating Officer
14	NHS Tameside and Glossop CCG	Steve Allinson	CCG Chief Officer
15	NHS Trafford CCG	Gina Lawrence	Director of Commissioning and Operations / Chief Operating Officer
16	NHS Trafford CCG	Joe McGuigan	Chief Finance Officer
17	NHS Wigan Borough CCG	Trish Anderson	CCG Chief Officer
18	NHS Wigan Borough CCG	Frank Costello	Vice Chair

Any other individual may deputise for any Joint Committee Member provided that the relevant CCG has sent a completed authorisation form (Appendix 4 to the Establishment Agreement for the Association of GM CCG) in respect of such individual's attendance at the meeting to the Chair of the Joint Committee to arrive no later than the day before the relevant meeting (or within such shorter period before the meeting as the Chair may in his or

her sole discretion decide). Any individual so authorised must be a member of the CCG's Governing Body.

7. Meetings

The Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members of the Joint Committee. Meetings will be scheduled to ensure they do not conflict with respective CCG Boards.

Meetings of the Joint Committee shall be open to the public unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. A protocol for public meetings is included at Appendix A.

8. Quorum

The quorum for a meeting of the Joint Committee shall be:

- For a meeting at which a Category 1 decision will be made, all of the voting members of the Joint Committee must be in attendance or able to participate virtually by using video or telephone or web link or other live and uninterrupted conferencing facilities.

- For a meeting at which no Category 1 decisions will be made, as close to 75% (in terms of whole numbers) of the voting members of the Joint Committee (therefore 9 out of 12) are required to be in attendance or able to participate virtually by using video or telephone or web link or other live and uninterrupted conferencing facilities.

9. Attendees

The Chair of the Joint Committee 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 of the Joint Committee shall not count towards the quorum or have the right to vote at such meetings.

10. Attendance at meetings

Members of the committee may participate in meetings in person or virtually by using video or telephone or web link or other live and uninterrupted conferencing facilities.

11. Voting

The voting members (which, for the avoidance of doubt, include any deputies attending a meeting on behalf of the Joint Committee Members in accordance with paragraph 6 above) shall each have one vote.

For Category 1 decisions, a majority vote would require the support of as close to 75% (in terms of whole numbers; therefore 9) of the total number of voting members at any given time.

Assuming that any meeting is quorate for Category 2 decisions, the support of as close to 75% (in terms of whole numbers, see Appendix B) of CCG voting members participating in the respective decision would be required for it to be agreed**.**

12. Administrative

Support for the Joint Committee will be provided by the Service Transformation Directorate.

Papers for each meeting will be sent to Joint Committee members no later than one week prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.

Appendix A

Protocol for Public Meetings

1. Introduction

Meetings of the Joint Committee shall be open to the public unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Category 1 decisions must be taken in a public meeting.

The purpose of this protocol is to provide guidance on the preparation and running of any public meeting arranged by the Service Transformation Directorate.

2. Preparation for a Meeting

The following issues should be considered at the initial preparation stage:

- **Objectives/purpose.** All Category 1 decisions should be taken at public meetings of the Joint Committee.

- **Time, date and venue.** Consideration should be given to the likely number of attendees, thinking particularly about places that have convenient access for people with disabilities. A suitable venue should be chosen which can accommodate the numbers expected to attend.

- **Publicity.** The event should be publicised, as agreed by the Joint Committee, at least four weeks in advance of the meeting so that people can plan to attend, know where to go and what to expect. The Joint Committee will be required to publicise the event as follows:

    - The Healthier Together website
    - All CCG member websites and in the normal places where local CCG Governing Board meetings are publicised (by CCG's).
    - Through key stakeholder groups to be identified when the agenda for the meeting is set (by CCGs where applicable).

    .

- **Chairing arrangements.** Meetings will be formally chaired by the appointed Independent Chair who will be required to work with the team to agree the use of presentational aids (where required) and general housekeeping matters.

- **Provide accessible and timely information.** The Joint Committee will publish the agendas (only) for all meetings one week in advance of the meeting taking place on the Healthier Together website. Unless otherwise directed by the Joint Committee, Members will receive papers for public meetings one week in advance of the meeting taking place at which point papers will be available to the public on request. To ensure papers are understandable each paper will have an overview summary or introduction to the topic that external audiences can easily understand.

3. Guidelines for the Meeting

The role of the Chairman should be to:

- open the meeting
- keep the meeting focused on the agenda – if necessary, to refer people back to the agenda
- make sure that everyone who wants to speak gets a chance – not allowing one or two people to dominate proceedings
- draws the meeting to a close at the appropriate time.

Creating the right atmosphere:

The organiser(s) should aim to arrive at the venue in good time to check that any equipment and facilities requested are in place. This will include any catering arranged, as well as the equipment needed at the meeting. The location of firedoors and alarms should also be checked. Those attending should be greeted as they arrive, avoiding any serious debates or discussions before the meeting starts.

Making a good start:

The meeting should be started at the time arranged, with the appropriate introductions and a summary of the purpose of the meeting. If it is likely to be a while before the attendees can express their views (e.g. because there is a short, initial presentation), this should be made clear, so that people have an expectation about the way the event is likely to proceed.

Getting the most from the meeting:

- Make good use of questions raised at the meeting to probe, challenge and fully understand the views that people may have
- Arrange for someone to keep notes on the main points raised
- Keep an attendance sheet, with contact details, so that those attending can be provided with follow up information
- At the end of the meeting thank people for attending and explain clearly what the next steps will be.

After the Meeting:

All agreed actions should be followed up after the event. Consideration should also be given to lessons learnt from the process, such as:

- did the meeting achieve what was expected?
- what aspects of the meeting were successful and what did not work?
- did things go as planned or were there any surprises?
- were there any problems that could have been avoided?

Appendix B

Quoracy & Voting for Category 2 Decisions

Quorate

For a meeting at which no Category 1 decisions will be made, as close to 75% (in terms of whole numbers) of the voting members of the Joint Committee (therefore 9 out of 12) are required to be in attendance or able to participate virtually by using video or telephone or web link or other live and uninterrupted conferencing facilities.

Voting

Assuming that any meeting is quorate for Category 2 decisions, the support of as close to 75% (in terms of whole numbers) of CCG voting members participating in the respective decision would be required for it to be agreed.

As a minimum of 9 CCG voting members are required to participate in a Category 2 decision the following rules apply.

Number of Voting Members Participating In the Category 2 Decision	***Number of Votes Required to Support Decision***
12	***9***
11	***8***
10	***8***
9	***7***

NHS
Stockport
Clinical Commissioning Group

Board Assurance Framework

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

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

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

Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
To approve the content of the revised Board Assurance Framework arising from the approval of the CCG's Risk Management Strategy. Comments are also sought from Governing Body Members on areas where further attention is required by the CCG.
Please detail the key points of this report
A copy of the Board Assurance Framework is appended to the report.
What are the likely impacts and/or implications?
The areas highlighted are the CCG's principal risks. Failure to monitor and put in place mitigating actions will impact directly on the CCG's ability to fulfil its statutory duties and responsibilities.
How does this link to the Annual Business Plan?
N/A
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
CCG's Management Team
Clinical Executive Sponsor: Ranjit Gill
Presented by: Tim Ryley
Meeting Date: 13 January 2016
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Detail

1.0 Purpose

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

2.0 Content

2.1 The CCG's Risk Management Strategy was reviewed during the summer of 2015 and a revised version approved by the Governing Body in October 2015. In light of the review, the Board Assurance Framework has also been reviewed to ensure it is fit for purpose in light of the CCG's current operations and is reflective of the new Strategy.

2.2 The Assurance Framework has adopted a theme based approach in line with the management of the CCG's overall risks with each theme being allocated a risk appetite to guide organisational behaviour when developing work streams and pursuing areas of work from which risks and opportunities arise.

2.3 The new framework was developed on the basis of the existing framework with a number of new risks added to reflect the CCG's current operating position as an individual organisation and across the Stockport economy. Many of the risks included on the previous framework were transferred across and refocused to reflect current exposure to principal risks.

2.4 The Framework has also started to incorporate alongside risk management the realisation and management of opportunity for the CCG. This is a new area introduced as part of the new Risk Management Strategy and will take time to embed across the organisation.

2.5 This report provides the CCG with assurance that a full review of principal risks, including re-scoring the risk impact and likelihood and consideration of controls and assurances has been undertaken by the risk leads to reflect the CCG's current position. This framework, subject to approval will form the basis of on-going monitoring by the Governing Body in line with the Risk Management Strategy.

2.6 In particular the Governing Body's attention is directed to the events and mitigating actions listed in the Framework to be assured that risks are being mitigated as far as can be reasonably be achieved.

2.7 The framework is also underpinned by an Operational Risk Register which is currently under review to meet the requirements of the new Risk Management Strategy.

2.8 The new framework is attached as an Appendix to this report.

Board Assurance Framework

Latest BAF Risk Ratings

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

Board Assurance Framework Summary

Drill Down	Risk	Risk Lead	Theme	Appetite	Impact Rating	Latest Likelihood Rating	Dec 15	Jan 16	12 mth Trend	Events and Mitigating Actions
...	01. The CCG does not have adequate systems in place for managing the quality and safety of the services which it commissions.	Chidgey, Mark	Quality Safety	Moderate / Low	3	2	●	●	↗	• E) Reconstitution and focus of the Quality committee • M) Full recruitment to the Q&PM team
...	02. The CCG fails to commission and design new models of care as part of the Stockport Together Programme.	Ryley, Tim	Innovation	High	4	3	▲	▲	↘	• E) Stockport received Vanguard monies and initial value propostition monies approved of ~£4m • M) CCG COO SRO of Stockport Together Programme • M) CCG Director of Strategic Planning and Performance seconded to role of Programme Director • M) CCG staff involved in establishment of integrated commissioning function proposals
...	03. The CCG does not fully maximise the opportunities for membership engagement in the development of its Strategy and priorities.	Ryley, Tim	Partnerships	High	3	3	■	■	→	• E) Redevelopment of CCG website will improve communication and engagement with GP Member Practices • M) Annual planning round includes consultation with Governing Body and wider GP Membership • M) Locality Meeting arrangements provide opportunity for engagement with GP Members on Key issues
...	04. The adoption of clinical best practice guidance and innovation by the CCG is limited or slow (due to provider mobilisation or CCG financial constraints)	Owen-Smith, Vicci	Innovation	High	2	4	■	■	↘	• M) Financial and capacity constraints in enacting the guidance reviewed • M) Process of review of clinical best practice to prioritise areas of importance

Board Assurance Framework Summary										
Drill Down	Risk	Risk Lead	Theme	Appetite	Impact Rating	Latest Likelihood Rating	Dec 15	Jan 16	12 mth Trend	Events and Mitigating Actions
...	05. The organisation's capacity, capability and/or internal engagement are inadequate (Including commissioned support services).	Ryley, Tim	Organisatio... Development	Moderate	4	3	■	■	↗	• M) Continued review of CCG Executive and Management Capacity to ensure sufficient resource available • M) OD programme in place focussing on development capacity to work collaboratively as commissioners • M) Workforce information and requirements linked to Stockport Together Workforce Strategy
...	06. Provider's capacity and capability fails to deliver in line with the CCG strategy and quality expectations.	Chidgey, Mark	Organisatio... Development	Moderate	4	3	■	■	↗	• M) This will be a key focus of Stockport Together and needs extending to include e.g. care homes
...	07. The CCG fails to remain within financial balance and operate within the Business Rules as required by NHS England.	Jones, Gary	Financial Resilience	Moderate	4	3	■	■	→	• E) Upcoming winter pressure period • M) Greater Manchester CCG's Support Through the Risk Share • M) Revised QIPP Scheme Governance
...	08. The CCG fails to put in place arrangements to plan, monitor and track in-year QIPP target activity resulting in overall failure to deliver.	Jones, Gary	Financial Resilience	Moderate	4	4	▲	▲	↘	• M) Revised QIPP Scheme Governance and In-Year Tracking against Operational Plan
...	09. The CCG fails to meet its statutory duties for compliance (including procurement)	Ryley, Tim	Compliance	Low	3	2	●	●	↗	• E) Programme of compliance audits agreed and underway • M) Internal Audit Plan focusses annually on a range of compliance and improvement audits • M) Process and timescales agreed for organisational rolling review of compliance and procedures
...	10. The CCG fails to deliver its planned improvements to the health inequalities of the patients and public of Stockport both through work at local and Greater Manchester Level.	Owen-Smith, Vicci	Partnerships	High	3	4	■	■	↘	• E) Devolution aims to address inequalities and address outcomes. Stockport playing an active part • E) GP Dashboard Scheme enables analysis of data and focussed intervention • E) GP Development Scheme places priority for practices with greatest idetified health inequalities • E) PMS monies reinvested into primary care standards which aim to improve outcomes and standards. • E) Stockport Together programme focus on prevention and inequalities at core
...	11. The CCG fails to enage the population in looking after its own health.	Ryley, Tim	Innovation	High	4	3	■	■	↗	• E) New models of care will incorporate elements of public consultation in early 2016 • M) CCG Communications focussed campaigns on elements of health education and self-management • M) Focus of Stockport Together work is prevention and empowerment.
...	12. The CCG fails to play a key leadership role in the Stockport Together Partnership and ensure the views of primary care are incorporated.	Mullins, Gaynor	Partnerships	High	4	2	●	●	»	• E) CCG Lead engagement in Vanguard programme nationally to apply learning. • M) Director of Strategic Planning and Performance • M) Good primary care representation in change programme governance and engagement in wider programme • M) SRO is Chief Operating Officer of CCG
...	13. The CCG fails to maximise the opportunities available for improvements in health and care for Stockport patients as part of the Greater Manchester Devolution	Mullins, Gaynor	Partnerships	High	2	3	●	●	»	• E) Used opportunity of Locality plan to develop a robust 'ask' from Stockport for Devolution. • M) Prioritised CCG CCO and COO to play lead roles in GM Devolution Development at Executive Level
...	14. The CCG fails to support the development of innovative integrated care models and the development of the Multi-Speciality	Chidgey, Mark	Quality	High	3	4	■	■	»	• M) Stockport Together programmes and leadership • M) The proactive Care Business Case

Board Assurance Framework Summary										
Drill Down	Risk	Risk Lead	Theme	Appetite	Impact Rating	Latest Likelihood Rating	Dec 15	Jan 16	12 mth Trend	Events and Mitigating Actions
	Provider									
...	15. The CCG fails to maximise the opportunities and benefits arising from commissioning of Primary Care Services through the NHS England Delegated Commissioning Programme.	Mullins, Gaynor	Partnerships	High	3	3			»	• E) Application submitted to NHSE for Level 3 • M) CCG expertise in primary care to be maximised • M) CCG need to review the capacity required for delegated commissioning
...	16. Developments in primary care IM&T fail to keep pace with and facilitate delivery of the CCG's Strategy for a single electronic patient record	Jones, Gary	Reputation	Moderate	2	2			»	• M) 97% of practices on EMIS Web with planned final migration in 16/17

NHS
Stockport
Clinical Commissioning Group

Public Sector Equality Duty

Annual Equality & Diversity Report, January 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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Website: www.stockportccg.org

Executive Summary

What *decisions* do you require of the Governing Body?
To note progress on the CCG's Equality Objectives. To approve the content of the CCG's Public Sector Equality Duty report for publication. To approve topics for 2016-2020 Equality Objectives (p4).
Please detail the key points of this report
In line with the CCG's Public Sector Equality Duty, this report sets out changing demographics, our approach to embedding equality in decision making, local NHS staffing structures and progress on the CCG's Equality Objectives. It identifies the upcoming priorities in embedding equality into new models of care and ensuring implementation of the new Accessible Information Standard, which are suggested as Equality Objectives for the next four years.
What are the likely impacts and/or implications?
Failure to publish annual equality information will impact directly on the CCG's ability to fulfil its statutory duties and responsibilities.
How does this link to the Annual Business Plan?
N/A
What are the potential conflicts of interest?
None
Where has this report been previously discussed?
CCG's Management Team
Clinical Executive Sponsor: Vicci Owen-Smith
Presented by: Tim Ryley
Meeting Date: 13 January 2016
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

Contents

1 Executive Summary

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

Stockport has changed significantly over the past decade and has become much more diverse, not only in terms of the ethnic mix of our local communities, but also in terms of the age of our population, the number of people with disabilities and long-term conditions, a more visual presence of communities of different sexualities, more people taking on caring responsibilities, and a change in the religious make-up of our borough.

To make a difference and improve health, we must address the inequalities that persist in our society. This means understanding the impact of our work on people who are made more vulnerable by their circumstances, and knowing that particular groups may experience inequalities in outcomes. Challenging discrimination and addressing inequalities are key to achieving our vision of high quality healthcare for Stockport.

This report looks at fairness in Stockport's NHS, staffing structures, service access, and what we have done to reduce inequalities.

A range of work has been undertaken this year to deliver our Equality Objectives, including a Transgender Health & Wellbeing Conference; sharing best practice at a national Deaf Health conference; improvements to equality monitoring in workforce data; improvements in mental health service access; supporting adults with a learning disability to live more independently; and new service developments to support people with disabilities and long-term conditions.

Equality & Diversity training is mandatory for all CCG employees. In addition, senior managers have been trained this year in Inclusive Leadership and Unconscious Bias and specific courses have also been run for our member GP Practices, covering Equality in Practice, Learning Disabilities, Mental Health and Children's Health.

Looking forward, the CCG will need to face upcoming challenges of:

- 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.

It is recommended that, subject to local engagement, these improvement projects are adopted by the CCG in its refreshed Equality Objectives for 2016-2020.

Angela Dawber
Head of Strategic Development

2 Diversity in Stockport

In general terms, Stockport is one of the healthier places to live in the North West. Although the overall picture is good, there are some areas where rates of illness are significantly higher than the national average. Taking action to cut these inequalities is one of the most important ways to improve the health of the entire population of Stockport.

Stockport has a population of 286,775 residents. Between our 47 Member Practices, the CCG has a registered population of 302,700 patients. The average life expectancy has risen over the past decade to 79.7 years for men and 83.0 years for women, however, the persistent gap in life expectancy between the most affluent and deprived areas of the borough is around a decade (10.3 years for women and 12.8 years for men).

Stockport is an older borough, with 19.4% of the population aged 65 or over and a particularly low rate of young adults ages 16-24 (9.7%).

Women tend to live longer than men and are more likely to use health services. Life expectancy in Stockport is around 79.7 years for men and 83.0 years for women.

Our ethnic minority communities have grown from just 4.3% in 2001 to 7.9% of the population at the 2011 census. Our ethnic minority communities have a much younger age profile than the white communities.

According to the 2011 census 18.4% of local people have a disability or a long-term illness. However, 41% of the people registered with Stockport GPs have one or more long-term condition. Instances of disabilities rise significantly with age from just 2% of 0-4 year olds to 90% of those aged 85 and over. By the age of 55, half of registered patients have one or more long-term condition. As life expectancy increases, so too are the numbers of people with complex care needs.

Most people in Stockport follow a religion: 63.2% are Christian, 3.3% are Muslim, 0.6% are Hindu and 0.5% are Jewish. Unlike the situation nationally, Stockport's Muslim population reports better than average health.

Around 17,000 people in Stockport are lesbian, gay or bisexual. Between 2001 and 2007 there were 101 civil partnership ceremonies in Stockport.

For a full breakdown, see our **Diversity in Stockport Report**[1].

[1] http://stockportccg.org/equality-diversity/public-sector-equality-duty/

3 Our Legal Obligations

The Equality Act (2010) is the UK's anti-discrimination law, which protects individuals from unfair treatment and promotes a fair and more equal society. It protects people from discrimination, harassment and victimization in work, education and when accessing services like healthcare.

The Equality Act protects anyone who falls into a 'protected characteristic':

- Age
- Disability
- Gender Identity
- Marriage & Civil Partnerships
- Pregnancy & Maternity
- Race
- Religion or belief
- Sex
- Sexual Orientation

Regardless of what protected group you are in, you should have equal access to healthcare.

Under the Public Sector Equality Duty, the CCG has an obligation to publish information to show what we are doing to:

- eliminate discrimination in healthcare
- reduce inequalities in health
- remove any barriers faced by certain community groups in accessing healthcare
- encourage people who are less likely to access our services to take advantage of the health benefits they can offer
- foster good relations between different community groups by tackling prejudices.

This report gives an overview of how we are meeting these legal duties. It also links to range of background reports[2], giving more detail on:

- the CCG's workforce, broken down by protected characteristics
- access to local health services
- use of interpretation for healthcare appointments
- and patient satisfaction levels by community group.

[2] http://stockportccg.org/equality-diversity/public-sector-equality-duty/

4 Taking Decisions

We want to be sure that the decisions we take make a real, positive difference to the lives of people in Stockport.

But inequalities in health between different groups are well documented and long-standing. We cannot simply assume that health policy will be equally beneficial for everyone.

NHS Stockport undertakes an assessment of the potential impact on equality groups of new strategies, services, projects and decommissioning decisions.

Over 2015, NHS Stockport undertook a number of Equality Impact Assessments, to ensure that its policies and services are equally beneficial to all community groups:

- Care Homes Project
- Patient Online project
- Stockport Together Values Alignment project
- Stockport Together Leadership Development project
- Potential QIPP savings plans
- Prescribing thresholds

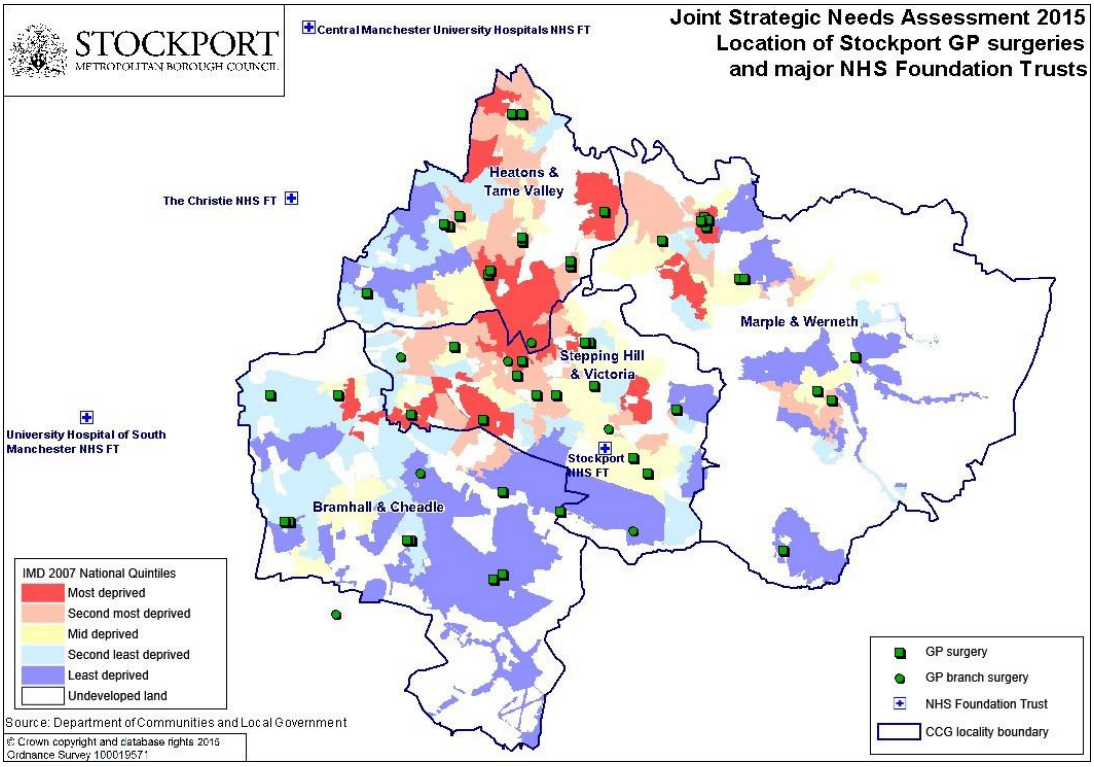
EIAs are published on our **Equality Impact Assessment Register**[3] on the CCG's website.

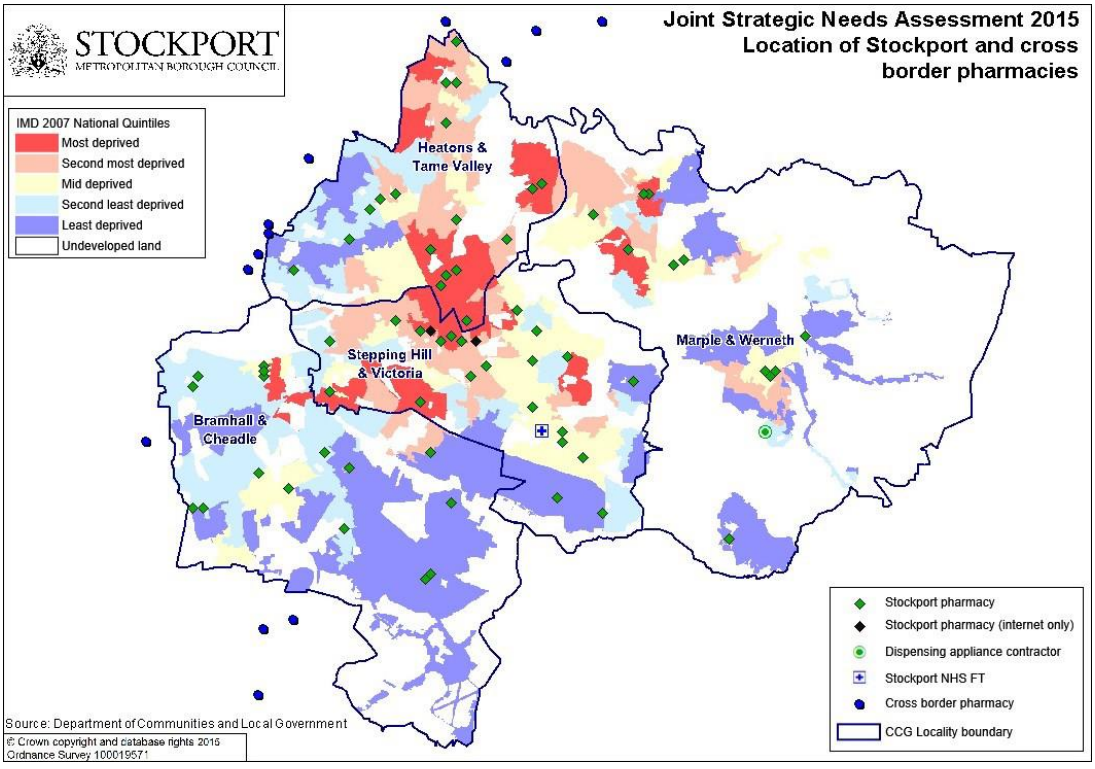
[3] http://stockportccg.org/equality-diversity/equality-impact-assessment-register/

5 Access To Services

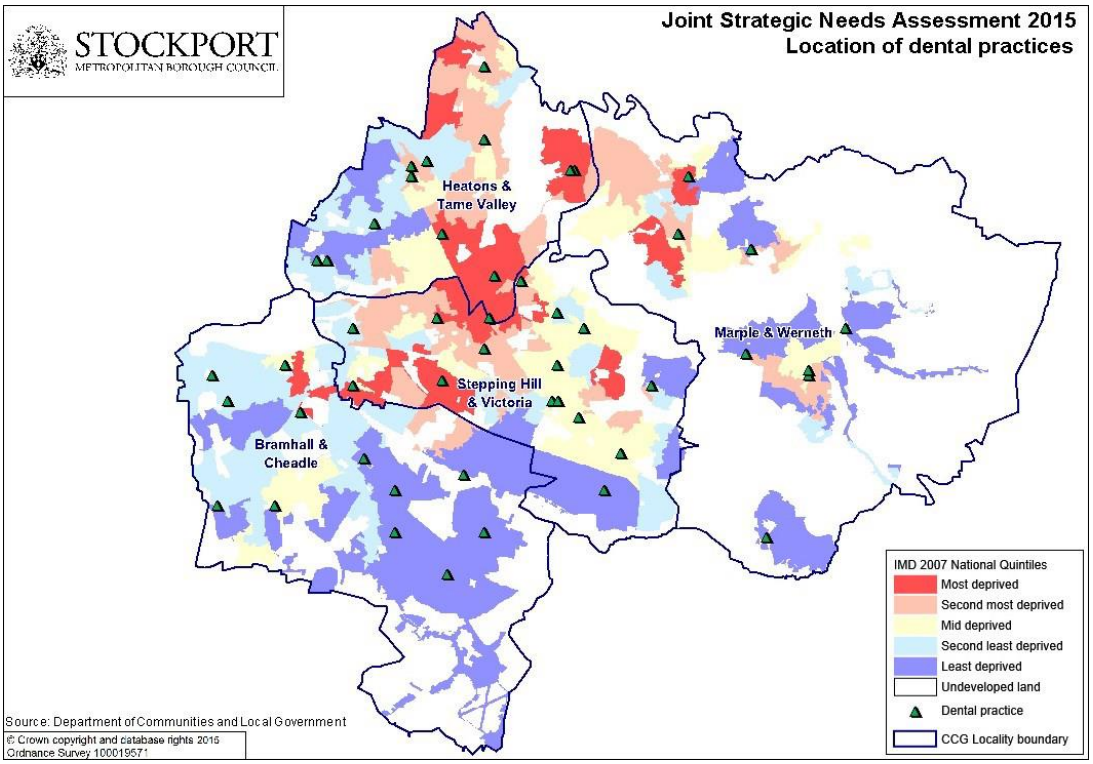
Health services within Stockport are reasonably well distributed throughout the borough with concentrations in the town centre and main district centres.

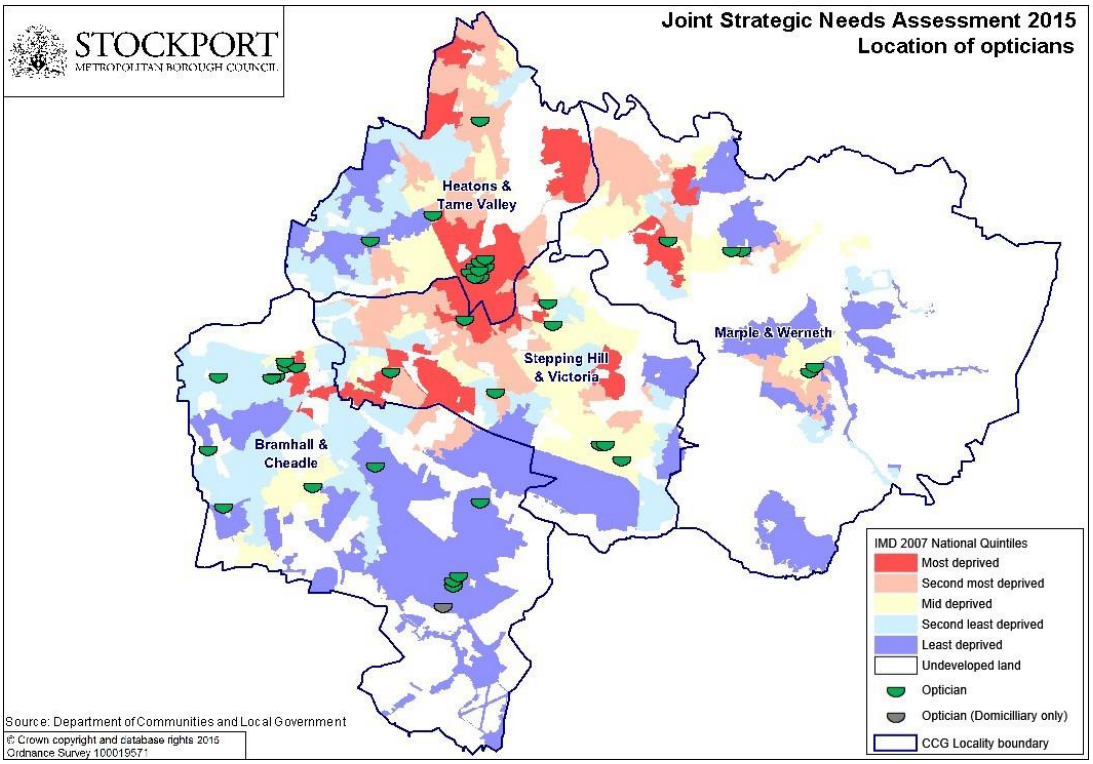
The vast majority of Stockport residents are within easy reach of a GP surgery and a pharmacy.





Access to dental surgeries and opticians is slightly more limited, but still equally spread throughout the borough. Use of interpretation for access to dental care and optometry has increased in recent years and residents and services become more aware of interpretation rights.





73% of hospital admissions by Stockport residents were at Stepping Hill hospital, 14% at South Manchester and 11! At Central Manchester Hospital Trust.

Access to Stockport's health services is similar to the local population in terms of ethnicity, and religion:

	General Practice	Hospital Services	Mental Health	Public Health
Age	Higher among older people and children	Higher among older people and children	Reflects local community	Reflects local community
Disability	Low levels of data	No data	Low access	Reflects local community
Ethnicity	Reflects local community	Reflects local community	Reflects local community	Reflects local community
Gender	Higher access among women	Higher access among women	Higher access among women	Higher access among women
Gender identity	No data	No data	No data	No data
Pregnancy & Maternity	No data	No data	No data	No data
Marriage & Civil Partnerships	No data	No data	No data	No data
Religion / Belief	No data	Reflects local community	Reflects local community	No data
Sexual Orientation	No data	No data	No data	No data

There are natural peaks in healthcare access at either end of the age spectrum, particularly among older people as their healthcare needs increase with age.

In 2015 the CCG made significant progress in giving patients access to their records online. Stockport has the highest rate of patient sign up to online records in Greater Manchester. In addition, there were over 2,000 downloads of the CCG's health and social care app, supporting people to find health services and information through their smart phone.

Women are more likely to access primary and community care services. People with some disabilities and long-term conditions have higher rates of access to services, dependent on the nature of their condition. However, there is very little data recorded on disability. 14 patients at Stockport GP Practices registered their first language as British Sign Language, in 2014-15 they used signers for 150 primary care appointments.

Over 2014-15, interpretation was used for 1,783 healthcare appointments. The main languages used were Farsi; Polish; Arabic; British Sign Language; Mandarin & Cantonese. Our full **Interpretation Report** can be found on the CCG's website[4].

In April 2016 all health and social care service providers will be contractually required to **ask** patients if they have any communication needs relating to a disability or sensory loss; **record** those needs; **flag** any requirements in care records; **share** information when referring patients to another part of the system; and **act** to ensure that patients receive information in a way which they can access and understand. This will go a long way to improving access among patients with a disability and reduce inequalities caused by a lack of understanding of health-related information.

[4] http://stockportccg.org/equality-diversity/public-sector-equality-duty/

6 Workforce

A diverse and culturally aware workforce is better placed to understand and respond to the needs of everyone in our community. We want to ensure that equality and human rights are woven into the way we work and the way we treat our staff.

As at 3 November 2015, NHS Stockport employed 129 staff, 95.54 full-time equivalents, of whom:

- 53.49% work full-time and 46.51% work part-time
- The CCG did not employ anyone under the age of 20; 5.43% of staff were in their 20s; 19.38% were in their 30s; 29.46% in their 40s; 39.53% in their 50s; and 6.2% of staff were in their 60s. The average age of a CCG employee was 47.
- 67.44% of staff were female, and 27.45% male employees. This represents an improvement in the overall gender balance compared to the previous year when there were 5.1% less male employees in the organisation.
- 82.95% of staff were White British; 13.17% came from other ethnic groups (including minority white ethnicities); 9.3% came from non-white ethnic minorities; and 3.88% had not recorded their ethnicity. This represents a significant improvement in data recording over the past year with a 4% reduction in the number of staff who did not wish to declare their ethnicity.
- 4.65% declared a disability - more than double last year's figure of 1.96%. 62.02% declared no disability; while 33.33% did not wish to declare – down from 49.02% last year. This represents a major improvement in disability reporting.
- 68.99% disclosed their religion: 50.39% were Christian; 9.3% were Atheist; 3.1% were Muslim; 0.78% were Buddhist; 0.78% were Hindu; and 4.65% follow an 'other' religion. Again, reporting levels have increased on last year, when only 57.84% of employees declared their religion or belief.
- Two members of staff was on maternity or adoption leave at some point throughout the year
- 65.12% of employees disclosed their sexual orientation – an increase of 12.18% on last year; 62.79% of staff said they were heterosexual; 2.33% were lesbian or gay; 34.88% have not disclosed their sexual orientation.

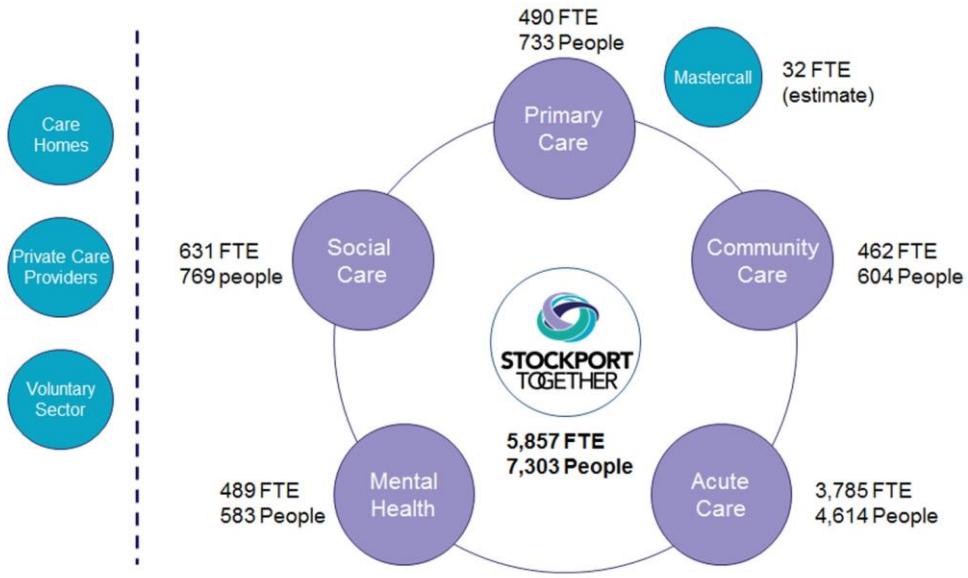
This year has seen significant improvements in data collection – one of our equality objectives - including:

- 4% increase in ethnicity reporting
- 15.69% improvement in disability reporting
- 11.15% improvement in religion and belief reporting
- and a 12.18% increase in sexual orientation reporting.

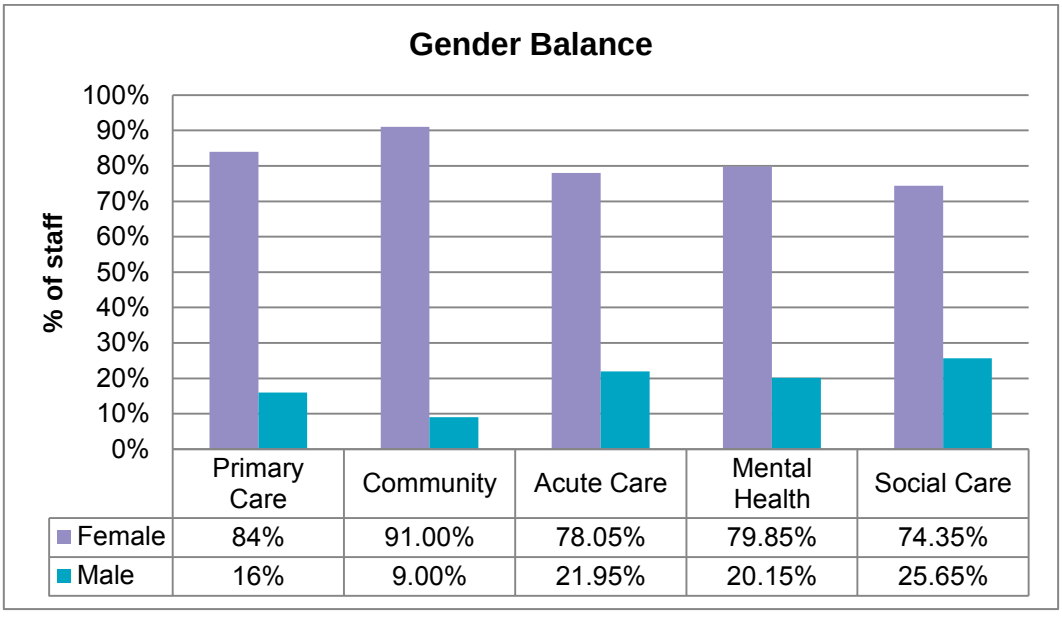
Our full **Workforce Report** and the CCG's submission to the NHS's new **Workforce Race Equality Standard** can be found on the CCG's website[5].

[5] http://stockportccg.org/equality-diversity/public-sector-equality-duty/

As part of our role in commissioning care across Stockport, in 2015 the CCG undertook a major project to map the local health and social care workforce. Stockport is the first health and social care economy to develop a joined-up picture of all staff across primary care; community services; mental health; social care; and hospital services.

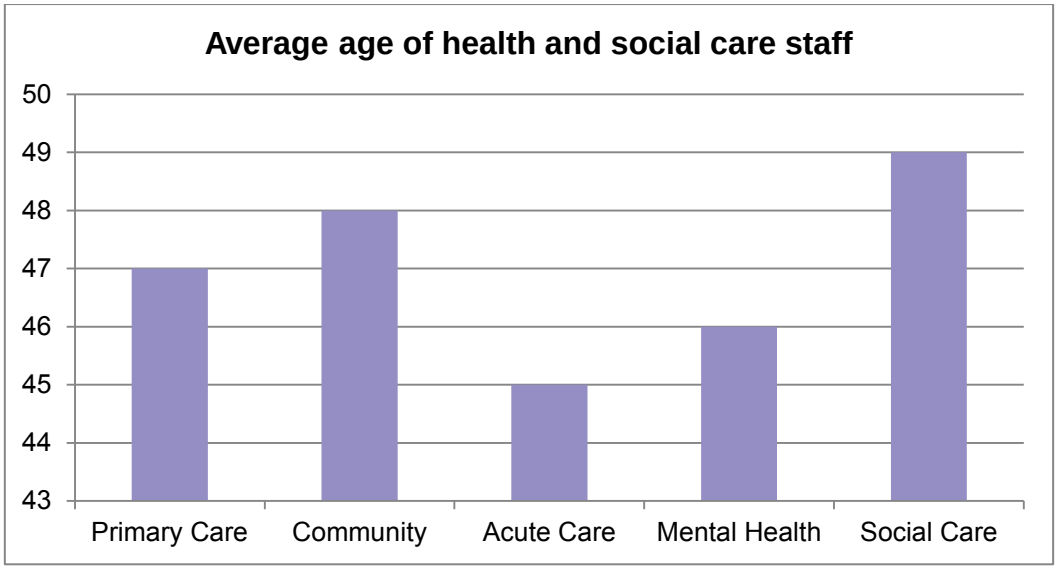


Like most health and social care workforces, the vast majority of employees are female. This is particularly noticeable among Community health services and the nursing profession. Community services have the least male employees - just 9% of full-time equivalents. The gender differential is least stark in social care, but even here men make up just a quarter of the workforce.



	Primary Care	Community	Acute Care	Mental Health	Social Care
Female	84%	91.00%	78.05%	79.85%	74.35%
Male	16%	9.00%	21.95%	20.15%	25.65%

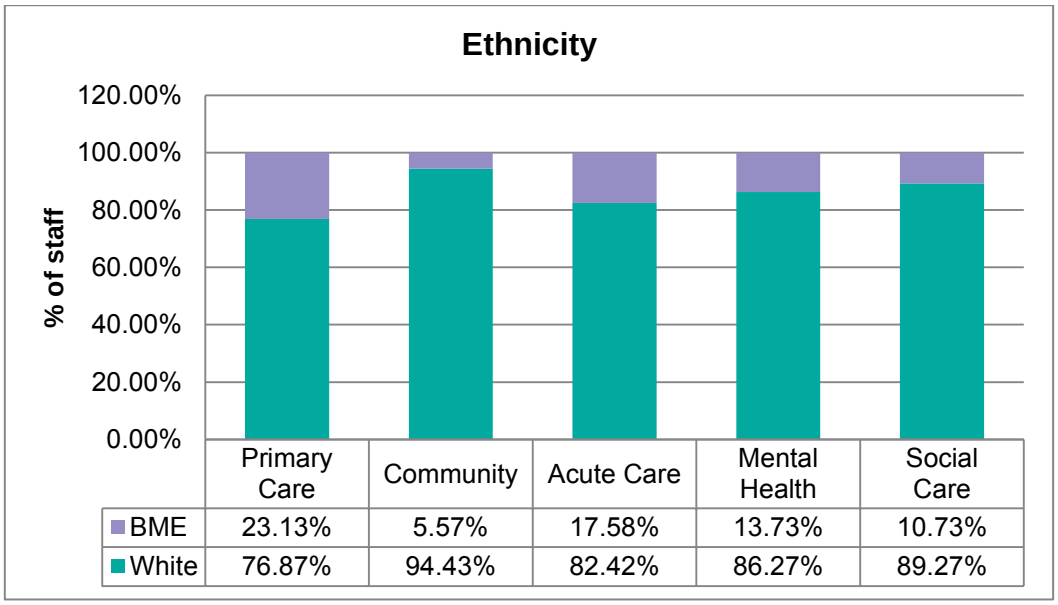
The most prominent feature of the workforce is its age profile. The majority of employees across the system are in their fifties. Social care has the oldest age profile of all sectors, the youngest being in hospital services.



A high proportion of the workforce is already in their fifties and therefore more likely to retire in the coming years:

- 54% of community staff
- 50% of social care staff
- 47% of primary care staff
- 41% of mental health staff
- 38% of acute staff

Primary Care has the most ethnic diversity, the least being in community services, where 94.43 % of employees are white:



	Primary Care	Community	Acute Care	Mental Health	Social Care
BME	23.13%	5.57%	17.58%	13.73%	10.73%
White	76.87%	94.43%	82.42%	86.27%	89.27%

Across the sectors, ethnic diversity varies according to roles. In acute services, there is more ethnic diversity among medical and estates teams. In primary care, it is GPs who provide the most ethnic diversity to the overall workforce makeup.

In 2016 this data will be used to ensure that any changes to the local workforce as part of Stockport Together's programme of transformation are fair and give due regard to our collective equality duties.

7 Achievements 2015

Trans Healthcare & Wellbeing Masterclass
In September 2015 the CCG and our local Foundation Trust jointly hosted the biggest ever transgender equality event for NHS and social care staff in the UK.

The event was attended by around 150 doctors, nurses, social workers and other NHS and social care staff. The conference included a wide range of speakers on the topics of: identity; legal rights; health inequalities; sexual health; pan-sexuality; supporting patients; children & younger trans people; and supporting older trans people.

Deaf Health
710 people n Stockport are registered with the Council as deaf or hard of hearing and around 1 in 6 are affected by hearing loss – around 47,000 residents. This year, the CCG's led for Equality & Diversity was a guest speaker at a national Deaf Health Conference, sharing examples of best practice from Stockport with colleagues across health and social care.

DEAF+HEALTH CHAMPIONS

www.deafhealthchampions.org.uk

Examples included the CCG's health information videos in British Sign Language, deaf awareness training and accessibility audits for GP Practices, the introduction of sign language interpretation via Skype for all GP Practices, and an online BSL patient satisfaction survey.

Learning Disabilities
The CCG has worked with its commissioning partners in the Local Authority to open Heys Court – a residential scheme for adults with learning disabilities based in Cheadle Heath. Heys Court has been remodelled to create 19 accessible apartments designed to enable residents to live more independently, as well as 6 further apartments to be used as assessment units for adults with higher dependency care needs.

The £1.55m refurbishment took 47 weeks to complete and includes a warden call system, which allows for bespoke assistive technology additions. The development will support residents with learning disabilities to live independently and have a better quality of life.

Work is continuing on our key challenge of reducing the number of hospital placements for people with Learning Disabilities and autism – the final service user on a hospital placement is due to be discharged in February

Mental Health
Work has been undertaken to increase access to psychological therapies in Stockport (IAPT). Stockport has already met the NHS's new 18 week standard and is on track to meet the 6 week waiting time standards by the deadline of March 2016.

The CCG set aside a non-recurrent investment to commission additional community capacity for children and young people with eating disorders. And the CCG has continued to invest in our Rapid Access service (RAID) to support mental health needs in urgent care services.

Dementia Care
A re-fresh of Stockport's dementia strategy is underway with colleagues in the Local Authority and the CCG has maintained its achievement of the national dementia diagnosis targets for local residents.

Diabetes Patient Education Courses
The CCG has invested in SOCCER (Stockport, Optimising, Carbohydrate Counting , Education and Results) – a patient education course for people with type 1 diabetes. The aim of the course is to help people with Type n1 Diabetes lead as normal a life as possible, controlling blood glucose levels and reducing their risk of complications.

The 4 day training course and follow-up sessions will be run 5 times a year by the run by the diabetes specialist nursing team and a dietician.

A 6 week training course is also running for patients with Type 2 diabetes. The X-PERT course helps patients to understand more about their condition and the lifestyle changes that can improve their quality of life.

This year, the CCG funded the first X-PERT patient diabetes course for deaf patients. Almost 1 in 12 deaf people have high blood sugar levels and deaf people are 4 times more likely to be on the verge of diabetes. The course was undertaken with British Sign Language Interpreters to support deaf patients to better understand and manage their condition.

Next year plans are in place to run a similar course in Urdu, given the higher rates of obesity and diabetes among our Asian community.

Supporting Care Homes
The CCG is working with the Local Authority to agree a set of common standards for care homes. Training and education for care home staff has also been undertaken and started to realise benefits in reduced attendances at A&E as patients are better supported in care

Neigbourhood Working
Our ageing population has meant a change in local health needs over recent years, with a growing number of long-term health conditions and people with complex care needs. Local engagement has highlighted the difficulties of managing multiple appointments with different health and social care teams. As a result, one of the CCG's key priorities has been to join-up health and social care services and better manage care for people with complex care needs to reduce unnecessary hospital stays.

Throughout the year the CCG and its health and social care partners have collaborated to develop a new model of care – a Multi-Speciality Community Provider, which will deliver integrated health and social care services in local neighbourhoods. The first two neighbourhood teams have been launched in Cheadle & Bramhall – involving co-located teams of social workers and district nurses working closely with GP Practices to support patients with complex care needs. The remaining neighbourhood teams will be launched early in 2016 to provide a high standard of support for the most vulnerable adults in the borough.

Staff Training

- All CCG staff undertook Equality & Diversity training
- Senior Managers undertook development sessions in Inclusive Leadership and Unconscious Bias training.
- The CCG ran GP Masterclasses on Equality in Practice, Learning Disabilities and Children's Health.
- LTC masterclasses

In light of this year's achievements, the CCG has submitted its self-assessment to the **NHS's Equality Delivery System** which can be found on the CCG's website[6].

[6] http://stockportccg.org/equality-diversity/public-sector-equality-duty/

8 Future Challenges

From the 31st July 2016, all organisations providing health and social care services must follow a new Accessible Information Standard (SCCI1605), ensuring a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of patients, carers and parents, whose needs are related to a disability, impairment or sensory loss.

All of NHS Stockport CCG's contracts include Equality Schedules outlining the need to ensure equal access to their services. Our providers already use interpretation services to support people with sensory disabilities, learning disabilities or English as a second language in healthcare appointments.

The new standard will also require services to make all information – such as healthcare leaflets and appointment letters – available in an accessible format such as Braille, Large Print, Easy Read formats, or sending information via email rather than traditional letters or phone calls which can be difficult for those with visual or hearing impairments.

In preparation for the introduction of the new standard, work will be undertaken to support service providers:

- update policies and procedures
- train staff in correct procedures and patient rights
- update record systems
- keep a record of patients' communication support needs
- flag communications needs on patient records to ensure that information is always made available in the correct format
- ensure that any information needs are included in any referrals to other health or social care services
- develop accessible tools, such as the CCG's health information clips in British Sign Language.

More information on the Accessible Information Standard can be found on the NHS England website www.england.nhs.uk/accessibleinfo.

It is recommended that this becomes the focus of the CCG's new Equality Objectives, due for a refresh in 2016.

NHS
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Clinical Policy Committee Update

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

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

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Executive Summary

What *decisions* do you require of the Governing Body?
• To note the update on NICE TA compliance • To note the update from CPC on rebate schemes. • To note CPC have endorsed the additions to the Blacklist listed in section 3.2. • To note the updated costing summary for NICE TA's.

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

1.0 Purpose

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

2.0 Context

2.1 The Governing Body is asked to note the TA costing summary for 2015/16. The total cost impact has been adjusted to £406, 860.

3.0 General Policies and NICE Guidance

3.1 CPC have requested but not received updates from Stockport FT on their compliance with NICE technology appraisals. This has been escalated to the Medical Director, Stockport FT.

3.2 CPC have endorsed the following additions to the blacklist: Eye lid hygiene preps, heated eye pads, Finasteinde, Topical gabapentin and Oral pentasan.

3.3 CPC have accepted rebates from drug companies in principle and would like to recommend we reinvest this money into support tools for primary care to support good clinical decision making prescribing.

4.0 Duty to Involve

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

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

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

5.0 Equality Analysis

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

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

Dr Vicci Owen- Smith

Compliance Checklist:

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

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Report from QIPP Committee

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Executive Summary

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

This report provides an overview of the discussions at the QIPP Committee which took place on 22 December 2015. The meeting was not quorate on this occasion. It is important that Governing Body is aware of the progress in delivering the CCG's QIPP Schemes in year and able to identify schemes which are off track and actions to mitigate / support delivery.

Please detail the key points of this report

A key role of the CCG's QIPP Committee is to maintain a strategic overview of the delivery of QIPP schemes and track progress and implementation. To further develop this role, a review of the Committee was undertaken and arising from the wider review of CCG Governance, the Committee will re-focus to become a Finance and Performance Committee from 1 January 2016.

The report provides an overview of the discussions which took place at the meeting relating to the following matters:

- QIPP Scheme Monitoring and Reporting
- Operational Plan Progress Report
- QIPP Project Review – General Practice Development
- QIPP Project Review –Prescribing
- QIPP Scheme Project Review Follow Up – GP Referral Management and Maximising EUR

What are the likely impacts and/or implications?

Non delivery of QIPP impacts significantly on the CCG's financial plans and the delivery of required efficiencies (both non-financial and financial.)

How does this link to the Annual Business Plan?

QIPP is an integral part of the CCG's Operational Plan.

What are the potential conflicts of interest?

None

Where has this report been previously discussed?

The issues covered by this report were considered at the QIPP Committee on 22 December 2015

Clinical Executive Sponsor: Ranjit Gill

Presented by: John Greenough

Meeting Date: 13 January 2016

Agenda item: 12

QIPP Committee Update for Governing Body

QIPP Scheme Monitoring and Reporting

The Committee considered a report which set out the governance arrangements of the CCG for managing its Quality Innovation, Productivity and Prevention (QIPP) Schemes including how schemes were reported on and monitored by the organisation and the Committee. The Committee considered how the monitoring and reporting processes would be resourced and acknowledged the importance of embedding monitoring processes across the organisation linked to management of risks and appropriate ratings and escalation processes. It was noted that the Terms of Reference of the new Finance and Performance Committee as they were being finalised needed to ensure the continued robust operation of the Committee across both Finance and Performance areas.

Operational Plan Progress Report

A report was presented which updated the Committee on the progress to date in the delivery of the CCG's Operational Plans. Detailed discussion took place regarding the implementation in particular of the designated Priority Projects as agreed by the Governing Body and those which linked to QIPP and CIP (Cost Improvement Plan) targets. The Committee considered how those Plans linked to the Stockport Together Programme would continue to be monitored given the close alignment of CCG Plans to those of the Programme and wider Stockport economy.

QIPP Project Review – Prescribing

As part of its role in holding to account those responsible for the delivery of QIPP Schemes the Committee received an update from the Project Lead and Senior Responsible Officer for Prescribing. In reviewing delivery of the project, the Committee debated the following matters:

- Savings achieved to date against the financial milestones as outlined in the Plan
- Benchmarking of Stockport against the England averages for prescribing
- Prescribing variation within Stockport and across Greater Manchester
- The links between prescribing and the GP Referral Management project and management of long term conditions and the work being undertaken by the Clinical Director of General Practice Development to pull relevant information together to look at correlation and help develop action plans.
- Emerging evidence to demonstrate the potential benefits on prescribing costs for those practices with pharmacists in place.

In addition the Committee acknowledged the importance of communicating strong messages around appropriate and cost effective prescribing to those working in secondary care settings, particularly around high cost drugs and in continuing to investigate approaches being undertaken by CCG's across Greater Manchester and more widely to manage prescribing effectively.

QIPP Project Review – General Practice Development

As part of its role in holding to account those responsible for the delivery of QIPP Schemes the Committee received an update from the Project Lead and Senior Responsible Officer for the General Practice Development Scheme.

In considering progress of the delivery of the Scheme, the Committee noted the commencement of an effectiveness review of schemes supported to review delivery of the outcomes agreed with Practices and the need for continued challenge where benefits had not been realised. It was noted

that where schemes had required staff to be recruited, the demonstration of benefit in year may have been delayed. A discussion took place regarding the implementation of NHS 111 and evidence about the impact across the system which was currently being gathered.

The Committee considered how the scheme supported the CCG's Strategic direction, including the development of Neighbourhood Working and the importance of working collaboratively with practices to maximise the impact of the scheme investment and the ongoing development of General Practice in Stockport.

QIPP Scheme Project Review Follow Up – GP Referral Management and Maximising EUR

Further to individual QIPP Scheme reviews at the meeting held in November 2015, the Committee received a combined report tying together activity and actions for the GP Referral Management and Maximising EUR Project Reviews. The Committee considered the 10 practice pilot work being undertaken with the aim of standardising referrals through use of EMIS based standardised templates, clinical pathway information, smoking cessation work and other measures including Fitness for Surgery. Work was underway to seek approvals from Stockport Foundation Trust to commence the pilot.

The project plan for Consultant Connect had been signed off by the Planned Care Board and following a questionnaire to GPs, 6 initial specialities had been identified to be included as part of the initial launch. The Committee considered the benefits of the system for GP's, in particular greater access to secondary care clinical advice and guidance and the milestones against which referral variation would be considered, in particular potential reductions in patients discharged after the first out-patient appointment.

In considering the links between the two schemes, the importance of strong relationships between GPs and consultants was noted. Also identified was the importance of ensuring continued support and collaborative working with practices to manage and review referrals.

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Audit Committee Report to Governing Body

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What *decisions* do you require of the Governing Body?
To note the recent activity undertaken by the Audit Committee and approve the process for the formation of a Panel to appoint the CCG's External Auditors.
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 16 December 2015.
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 have 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: 13 January 2016
Agenda item:
Reason for being in Part 2 (if applicable)
N/A

1.0 Update from Audit Committee meeting 16 December 2015

1.1 The most recent meeting of the CCG's Audit Committee was held on 16 December 2015 to consider a range of matters as detailed in its comprehensive annual Work Programme.

1.2 The Committee discussed a range of matters which included the following:

- Month 6 and 7 Financial Position
- Financial Control Assessment – In considering this the Committee noted the difficult budgetary circumstances faced by the CCG and linked to the Financial Turnaround position which had impacted on elements which had been scored red.
- CCG's Policy Review Schedule – This was considered by the Committee in response to the findings of a recent Corporate Governance review by Internal Audit. Following an initial introductory overview, the document will be reviewed on a sixth monthly basis and key policy and procedure updates highlighted.
- Review of routine reports from Internal and External Audit.
- Standards for Commissioners – Fraud, Bribery & Corruption – In considering this report, the Committee agreed that the scoring contained within the report reflected in their view unfairly on the CCG as a number of red ratings had been incurred as a result of matters beyond the organisation's control. The Committee therefore did not approve the report as presented and requested that it be forwarded back to the Auditors.
- Appointment of Panel to Consider External Auditor Appointments – The Committee agreed an approach to the formation of a Panel to consider the appointment of the CCG's External Auditors, noting the information shared regarding a Greater Manchester suggested approach and the right of the Panel to make a decision independent of other CCG's. The Panel would be comprised of the Audit Chair, Locality Chair Member and 2 Lay Members and 1 of the following individuals – Chief Clinical Officer, Chief Operating Officer or Governing Body Chair. The Panel would be advised by the Chief Finance Officer and Deputy Chief Finance Officer.

1.3 The Committee will next meet in February 2016.