PUBLIC MEETING OF NORTH STAFFORDSHIRE AND STOKE-ON-TRENT CLINICAL COMMISSIONING GROUPS GOVERNING BOARDS  
Tuesday, 7th March 2017 at 2.30pm – 5.00pm  
The Sky Room, YMCA, Harding Road, Stoke-on-Trent ST1 3AE

AGENDA

<table>
<thead>
<tr>
<th>Agenda No</th>
<th>Item description</th>
<th>Enc / Table / Pres.</th>
<th>Decision / To Note / Discussion / Information</th>
<th>Item Presenter</th>
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<tbody>
<tr>
<td>1</td>
<td>Welcome and Apologies for Absence: Dr Alison Bradley, Dr Steve Fawcett</td>
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<tr>
<td>2</td>
<td>Declarations of Interest North Staffordshire CCG &amp; Stoke-on-Trent CCG: If any member of the Committee or invited attendee has any pecuniary interest, in any contract, proposed contract or other matter under consideration at this meeting he/she shall disclose the fact to the Chairman and shall not take part in the consideration or discussion of the matter or vote on any question with respect to it unless agreed by the Chairman and members of the committee</td>
<td>Verbal</td>
<td>To Note</td>
<td>RC 2.30pm</td>
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<tr>
<td>3</td>
<td>Confirmation of Quoracy (following consideration of interests declared pertaining to the agenda) North Staffordshire CCG Stoke-on-Trent CCG</td>
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<td>4</td>
<td>Minutes from: The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common, held on 7th February 2017 and Action List and Matters Arising; Dr Ruth Chambers, Stoke-on-Trent CCG Chair</td>
<td>Enc 4.1 Enc 4.2</td>
<td>To Note / Decision</td>
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<td>5</td>
<td>Strategic</td>
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<td>2.35pm</td>
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<tr>
<td>5.1</td>
<td>Chairs Address</td>
<td>Enc 5.1</td>
<td>To Note</td>
<td>RC (5 mins)</td>
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<tr>
<td>5.2</td>
<td>Matters Discussed in the Closed Section Chair’s Action Dr Ruth Chambers, Stoke-on-Trent CCG Chair</td>
<td>Enc 5.2</td>
<td>Decision</td>
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<tr>
<td>5.3</td>
<td>Accountable Officers Report Marcus Warnes, Accountable Officer</td>
<td>Enc 5.3</td>
<td>To Note</td>
<td>MWa (10 mins)</td>
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<td>6</td>
<td>Quality</td>
<td></td>
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<td>2.50pm</td>
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<td>6.1</td>
<td>Quality Report Tracey Shewan, Director of Nursing and Quality</td>
<td>Enc 6.1</td>
<td>To Note / Decision</td>
<td>TS (10 mins)</td>
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<td>7</td>
<td>Finance</td>
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<td>3.00pm</td>
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<tr>
<td>7.1</td>
<td>Financial Update – North Staffordshire and Stoke-on-Trent CCG Alistair Mulvey, Chief Finance Officer</td>
<td>Enc 7.1</td>
<td>To Note</td>
<td>AM (10 mins)</td>
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<td>8</td>
<td>Strategy, Planning and Performance</td>
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<td>3.10pm</td>
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<tr>
<td>8.1</td>
<td>Governing Board Performance Report</td>
<td>Zara Jones, Director of Strategy, Planning and Performance Supported by CCG Clinical Directors</td>
<td>Enc 8.1</td>
<td>Assurance / To Note</td>
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<tr>
<td>8.2</td>
<td>Planning and Commissioning Committee Report</td>
<td>Cheryl Hardisty, Director of Commissioning</td>
<td>Enc 8.2</td>
<td>Assurance / To Note</td>
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<td>9</td>
<td>Commissioning</td>
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<td>9.1</td>
<td>STP Update</td>
<td>Marcus Warnes, Accountable Officer</td>
<td>Verbal</td>
<td>Assurance</td>
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<tr>
<td>9.2</td>
<td>Primary Care Update Report</td>
<td>Dr John Gilby, Clinical Director Primary Care</td>
<td>Enc 9.2</td>
<td>Assurance / Decision</td>
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<tr>
<td>9.3</td>
<td>Better Care Fund - Update on 17/18 guidance and changes to Drug and Alcohol services in North Staffordshire</td>
<td>Cheryl Hardisty, Director of Commissioning</td>
<td>Enc 9.3</td>
<td>Assurance / To Note</td>
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<tr>
<td>9.4</td>
<td>Joint Organisational Development Committee Report</td>
<td>Fiona Hamill, Chief Operating Officer</td>
<td>Enc 9.4</td>
<td>Assurance / Decision</td>
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<td>Assurance</td>
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<td>10.1</td>
<td>Transforming Care Partnership Board (Quarterly Update)</td>
<td>Dr Waheed Abbasi, Clinical Director Mental Health and Specialised Services</td>
<td>Enc 10.1</td>
<td>Assurance</td>
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<td>10.2</td>
<td>PwC Review of Capability and Capacity Report Action Plan</td>
<td>Zara Jones, Director of Strategy, Planning and Performance</td>
<td>Enc 10.3</td>
<td>Assurance</td>
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<td>11</td>
<td>Any Other Business</td>
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- Questions from the Public
- Any other key issues

**DATE/TIME OF NEXT MEETING:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
<th>Chair</th>
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<tr>
<td>4th April 2017</td>
<td>2.30pm</td>
<td>Churnet Room, Moorlands House, Stockwell Street, Leek</td>
<td>AB</td>
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<tr>
<td>9th May 2017</td>
<td>2.30pm</td>
<td>Sky Room, YMCA, Harding Rd, Stoke-on-Trent ST1 3AE</td>
<td>AB</td>
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<tr>
<td>4th July 2017</td>
<td>2.30pm</td>
<td>Bridge Centre, Birches Head Road, Birches Head, ST2 8DD</td>
<td>RC</td>
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<tr>
<td>5th September 2017</td>
<td>2.30pm</td>
<td>Bridge Centre, Birches Head Road, Birches Head, ST2 8DD</td>
<td>RC</td>
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<tr>
<td>3rd October 2017</td>
<td>2.30pm</td>
<td>Bridge Centre, Birches Head Road, Birches Head, ST2 8DD</td>
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<tr>
<td>7th November 2017</td>
<td>2.30pm</td>
<td>Bridge Centre, Birches Head Road, Birches Head, ST2 8DD</td>
<td>RC</td>
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<tr>
<td>5th December 2017</td>
<td>2.30pm</td>
<td>Bridge Centre, Birches Head Road, Birches Head, ST2 8DD</td>
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Joint Interim Accountable Officer: Marcus Warnes

NS Clinical Chair: Dr Alison Bradley

SOT Clinical Chair: Dr Ruth Chambers OBE
### Minutes of the Open Meeting of North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups

**Governing Boards – Public Session**

**Held on Tuesday 7th February 2017 between 1.00pm – 2.00pm**

**The Conference Suite, The Bridge Centre, Birches Head, Stoke-on-Trent, ST2 8DD**

**UNCONFIRMED MINUTES**

<table>
<thead>
<tr>
<th>Voting Members both CCGs:</th>
<th>Marcus Warnes (MWa)</th>
<th>CCG Joint Accountable Officer</th>
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<tbody>
<tr>
<td></td>
<td>Dr Steve Fawcett (SF)</td>
<td>CCG Medical Director</td>
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<td></td>
<td>Zara Jones (ZJ)</td>
<td>CCG Director of Director of Strategy, Planning and Performance</td>
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<td></td>
<td>Tracey Shewan (TS)</td>
<td>CCG Director of Nursing and Quality</td>
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<td></td>
<td>Sally Parkin (SP)</td>
<td>CCG Clinical Director of Partnerships and Engagement</td>
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<td></td>
<td>Dr Richard Paige (RP)</td>
<td>CCG Non Executive GP</td>
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<td>Dr Latif Hussain (LH)</td>
<td>CCG Non Executive GP</td>
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<thead>
<tr>
<th>Voting Members Stoke-on-Trent CCG:</th>
<th>Dr Ruth Chambers OBE (RC)</th>
<th>Stoke-on-Trent CCG Clinical Chair (Meeting Chair)</th>
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<tbody>
<tr>
<td>Dr Simon Mellor (SM)</td>
<td>Stoke-on-Trent CCG Secondary Care Consultant</td>
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<tr>
<td>Dr John Gilby (JG)</td>
<td>Stoke-on-Trent CCG Clinical Director Primary Care</td>
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<td>John Howard (JH)</td>
<td>Stoke-on-Trent CCG Lay Member Governance</td>
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<tr>
<td>Margy Woodhead (MWo)</td>
<td>Stoke-on-Trent CCG Lay Member Patient and Public Involvement</td>
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<tr>
<td>Dr Waheed Abbasi (WA)</td>
<td>Stoke-on-Trent CCG Clinical Director, Mental Health &amp; Specialist Groups</td>
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<tr>
<td>Tim Bevington (TB)</td>
<td>Stoke-on-Trent CCG Lay Member</td>
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<thead>
<tr>
<th>Voting Members North Staffordshire CCG:</th>
<th>Dr Alison Bradley (AB)</th>
<th>North Staffordshire CCG Chair</th>
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<tbody>
<tr>
<td>Neil McFadden (NMcF)</td>
<td>North Staffordshire CCG Lay Member Governance</td>
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<tr>
<td>Dr Doug Robertson (DR)</td>
<td>North Staffordshire CCG Secondary Care Doctor</td>
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<td>Peter Dartford (PD)</td>
<td>North Staffordshire CCG Lay Member Patient and Public Involvement</td>
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<tr>
<td>Doug Robertson (DR)</td>
<td>North Staffordshire CCG Secondary Care Consultant</td>
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<tr>
<th>In attendance:</th>
<th>Rachel Barker (RB)</th>
<th>CCG Executive Assistant</th>
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<tr>
<td>Jess Chaplin (JC)</td>
<td>CCG Personal Assistant</td>
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<tr>
<td>Alex Palethorpe (AP)</td>
<td>CCG Associate Director Corporate Services</td>
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<tr>
<td>Anna Collins (AC)</td>
<td>CCG Head of Communication and Engagement</td>
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<tr>
<td>Adrian Tomkins (AT)</td>
<td>CCG Deputy Chief Finance Officer (representing A Mulvey)</td>
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<tr>
<td>Debbie Danher (DD)</td>
<td>CCG Senior Commissioning Manager (Item 9.4 only)</td>
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<tr>
<th>Observers</th>
<th>Dr Zafar Iqbal (ZI)</th>
<th>Stoke-on-Trent Public Health Consultant</th>
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<tr>
<td>Simmy Akhtar (SA)</td>
<td>Healthwatch Stoke-on-Trent</td>
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<td>Dr Paul Scott (PS)</td>
<td>LMC Chair</td>
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<td>David Hardy (DH)</td>
<td>PPG Representative</td>
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<tr>
<td>Mark Docherty (MD)</td>
<td>WMAS (Item 10.12 only)</td>
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<table>
<thead>
<tr>
<th>Apologies:</th>
<th>Cheryl Hardisty (CH)</th>
<th>CCG Director of Commissioning</th>
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</thead>
<tbody>
<tr>
<td>Alistair Mulvey (AM)</td>
<td>CCG Chief Financial Officer</td>
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<tr>
<td>Mike Edgley (ME)</td>
<td>North Staffordshire CCG Lay Member</td>
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<tr>
<td>Harald van der Linden (HvL)</td>
<td>LMC Secretary</td>
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| Public / Press | 6 members of the public in attendance |

### Action

1. **Chair’s Introduction, Welcome and Apologies**

RC welcomed members to the public meeting of the Joint Governing Board of North Staffordshire and Stoke-on-Trent CCGs and formally welcomed Tim Bevington, Stoke-on-Trent CCG Lay member
and Fiona Hamill, Chief Operating Officer to the meeting.

Apologies were received and noted as above.

### 2. Members’ Declarations of Interest

- **North Staffordshire CCG** - There were no declarations of interest declared at the meeting.
- **Stoke-on-Trent CCG** – There were no declarations of interest declared at the meeting.

### 3. Confirmation of Quoracy

The meeting was confirmed as quorate for both North Staffordshire and Stoke-on-Trent CCGs.

### 4. Minutes, Actions and Matters Arising

The minutes from the Joint Public Governing Board meeting held on 6th December 2016 were **approved** as an accurate record.

**Actions:** RC advised that all actions were completed as recorded on the action sheet, or would be verbally updated as part of the Directorate Reports.

**Matters Arising – Delegated Commissioning:**

MWa advised that (1) a meeting had been undertaken around delegated commissioning and MCPs, with the footprints of both confirmed, and member practices had been updated; (2) the Providers and Federation would now establish a Board to oversee the process and to support the Practices, and work would continue utilising the MCP guidance to create the virtual MCP alliance framework; (3) the MCPs would be commissioned through the CCG Commissioning intentions in 2018/19; and (4) each CCG would continue to receive the allocation for Primary Care spending, which would be used locally, and not be spread across the whole of the Staffordshire footprint.

PD reiterated concerns that there was not sufficient public engagement in the STP plans, and raised a concern that a Patient Network Group had been established which the CCG Patient Congress was not aware of. It was imperative that these decisions were communicated in a timely manner to ensure that the public could engage accordingly.

SP advised that the CCG were aware of the Patient Group, however this had not been captured in the PPI Report, as the information was received after publication of the papers. An update report would be presented to the February Patient Congress Meeting. There was a Communications and Engagement workstream published on the STP website which contained further details.

PS thanked MWa for the update, but highlighted that a number of concerns remained particularly relating to the STP agenda and the temptation to merge and offset the money in order to balance the spends.

MWa advised that the discussion nationally was focused on the control total but there would not be any movement of money. The budget would remain with the CCGs and be used across the local footprint. Stoke-on-Trent and North Staffordshire CCGs would continue to work together but there would be two separate allocations, as two independent CCGs.

JH thanked MWa for his update but requested that a formal STP report be provided to each public meeting of the Joint Governing Board, which highlighted the decisions made and any actions required as well as providing an update on the plans and progress. **ACTION:** To include in board business cycle

RC advised members that the interviews for the Independent Chair of the STP would be undertaken that week and an update provided at the next meeting. The position had been advertised nationally. **ACTION:** Include in Chairs’ Report.

### 5. Matters Discussed in the Closed Session

AB provided a brief update on items discussed in the closed session of the meeting including the
closed Quality Committee Report, the Remuneration Report, a Financial Escalation Meeting update and Governing Board Development Programme.

6.1 Month 9 Financial Position

AT presented the Finance Report which provided an outline summary of the CCGs financial performance as at the end of December 2016 (Month 9). Details as follows:

AT advised that (1) the CCGs were both reporting adverse variances from their financial plans, as at month 9 year to date the CCGs were reporting deficits of £7.9m against planned surpluses of £2.1m; (2) the forecast outturn for the year was consistent with that reported at month 8, which was an in year deficit of £10.1m which would increase the CCGs cumulative deficit to £13.7m; (3) the CCGs position highlighted a significant variance against the initially submitted plan. In month 9 the CCGs identified an adverse movement to trajectory against its agreed recovery plan position; (4) Stoke-on-Trent CCG was close to trajectory with only a £1k adverse variance, whereas North Staffordshire CCG had a £450k adverse variance; (5) the CCGs had developed a series of mitigating actions to recover the position, which if achieved would deliver the control total deficit target. It was noted that achieving the actions continued to attract a level of risk; and (6) expenditure variances were driven by cost pressures associated with acute contracts, adverse community arbitration settlement, orthotics activity, Mental Health Out of Area placements and Funded Nursing Care (FNC) rate increases of £2.2m (North Staffs £1.2m, Stoke-on-Trent £1.0m).

AT highlighted that the majority of the risk was within Acute and Community Services, but was partially offset by GP prescribing being under spent and the use of the contingency. The forecast under spend assumed future QIPP delivery of £0.41m; however some level of risk remained.

QIPP

AT highlighted that the CCGs had a planned QIPP programme of £21.9m (North Staffs £8.6m, Stoke-on-Trent £13.3m). As part of the recovery and stretch process, the planned targets were revised to £22.6m. Following a further detailed forecasting analysis carried out for month 9, it was forecast that delivery would now be c£20.0m, a shortfall against the stretch target of £2.6m. Other areas of mitigation were being explored to address this shortfall.

JH informed members that significant scrutiny and challenge was undertaken at the Finance and Performance Committee and the Finance Recovery Group, and reiterated the significant challenges that remained for the CCGs.

The Joint Governing Board duly noted (1) the contents of the report and executive summary regarding the combined CCGs performance against 2016-17 financial duties to the end of Month 9; (2) the key drivers of risk that are impacting the financial position; (3) that some risks remain unmitigated in-year and actions are being taken to deliver the CCGs back to a more sustainable financial position in 2017/18; and (4) the detrimental financial position of the CCGs results in a failure to deliver to its constitutional requirements.

6.2 Finance Performance and Planning Escalation Meeting

AT presented the report. Details as follows:

AT advised that as part of the on-going dialogue with NHS England the CCGs were asked to attend a series of discussions with NHSE on Thursday 19th January 2016 and Friday 20th January 2016, to review the in-year financial performance and forecast outturn position and the financial plan for 2017/18 and 2018/19.

AT reiterated that the CCGs had a revised in-year control total deficit of £10.1m against which financial achievement was being measured. As at month 9 (December 2016), the CCGs were c£0.5m off (adversely) the planned trajectory with the identification of in-year risks to the year-end of c£3m.
The drivers of the forecast risks being related to (1) continued pressure within acute based care contracts, both from an unplanned care perspective and from a planned care perspective with increased costs associated with excess bed days and additional activities to support achievement of the 18 week Refer to Treatment (RTT) target being identified; (2) a step in costs associated with Out of Area placements; (3) additional pressures associated with Continuing Health Care (CHC) costs; and (4) QIPP slippage specifically with regards to the Nursing Homes Scheme, where support from Intermediate Care Teams into the homes was less than anticipated, resulting in a lower than forecast impact of the scheme.

In mitigating these risks, the CCGs had identified a series of specific actions to abate these in-year pressures and were in the process of enacting these mitigations, which would support the achievement of the in-year deficit control total. Failure to achieve these actions, or the manifestation of further pressures would potentially jeopardise the achievement of the in-year control total deficits for each CCG.

2017/18 and 2018/19 Planning Review

The CCGs submitted two year Operational and Financial Plans to NHSE on 23rd December 2016. Specifically within 2017/18 the CCGs identified pressures against the required deficit control total of £3.5m of a further £2.3m associated with the national changes in the Payment By Results (PbR) system update to Healthcare Resource Group v4 (HRGv4). Included within the plan was a savings target of 3.07%, which equated to c£21m across the two CCGs. Of the required savings c£19m had been sufficiently developed to be classified as “identified”, with the balance continuing to be further developed.

Following the initial review of the plans, the CCGs were required to develop further plans to meet the identified control totals, via a further series of savings programmes, across specifically identified areas. This would add a further £7m of savings, increasing the savings requirement from 3.07% to 4.1% (in line with the regional average) with the absolute target being increased to c£28m. These plans were being developed by CCG officers with an expectation that a further planning submission would be required by the end of February 2017.

The Joint Governing Board duly noted the forecast position for 16/17 including the identified pressures and associated mitigations and noted the 17/18 planning position, specifically with regards to the additional savings required to achieve the in-year control total and the risks and mitigations identified within the overall planning base process, with an anticipated re-submission of plans towards the end of February 2017.

7.1 Chairs’ Address

AB presented the report to provide an update to the Governing Board around the current environment that the CCGs have been operating in. Highlights as follows:

AB confirmed that the CCGs continue to work closely and effectively with system partners and advised that in response to the extreme and sustained pressure, leaders from across health and social care meet daily in order to increase the flow across the system. A multi-agency operational group led by the CCGs had been established, with key operational leads to drive forward discharge solutions with a home first priority. A Pan Staffordshire Chairs Meeting had also been established with proposed bi-monthly meetings.

North Staffordshire and Stoke-on-Trent CCG Revised Constitution - NHS England Approval

AB advised that the CCGs submitted proposed Constitution changes to NHS England in November 2016, which reflected the revised Joint Governing Board structure. The CCGs were still awaiting formal approval from NHS England in respect of the Constitution, but had received confirmation that they could work to the new Constitutions.
Governing Board Member Update
AB advised that as a result of the changes to the Constitutions, two additional lay members had been appointed and commenced in post from the 1st January 2017. Mike Edgley, a former police Superintendent who served at Staffordshire and Merseyside forces and more recently, worked at Her Majesty’s Inspectors of Constabulary (HMIC), joined North Staffordshire CCG; and Tim Bevington, a former Head of Planning, Performance and Communications at Cheshire Fire & Rescue, joined Stoke-on-Trent CCG.

CCG Assurance Process 2016/17
AB advised that members of the Executive Team attended the Quarter 3 Formal Assurance Meeting with NHS England (NHSE) on 25th January, which was a broadly positive meeting. Assurance was provided to NHSE on the actions being taken to address urgent and planned care access waiting time standard performance, and there were discussions about next steps and regulatory support.

RightCare Approach
AB confirmed that as part of developing the Strategic Framework, both CCGs were preparing to adopt the ‘RightCare Approach’ to commissioning, comparing with CCGs with similar demographics to review healthcare pathway variations related to quality outcomes, care and efficiency. The CCGs would be asked to work collaboratively with providers and system partners to redesign pathways to achieve better efficiencies and most importantly, better patient outcomes.

National IAPT (Improving Access to Psychological Therapies)
AB advised that the National IAPT (Improving Access to Psychological Therapies) Lead from NHS England visited the CCGs in December, the meeting was extremely positive and that the pilot was ahead of other pilot sites in many areas. Clinical leads from both IAPT services had been requested to present at a national conference hosted by the Kings Fund in 2017 on Long Term Conditions.

The Joint Governing Board praised the CCG teams for their hard work and duly noted the Chairs Report.

7.2 Accountable Officer’s Report
MWa presented the report to provide an update to the Governing Boards around the current environment that the CCGs have been operating in. Key headlines as follows:

Consultation on Community Hospitals
MWa provided an update relating to the consultation on Community Hospitals, advising that currently some of the beds commissioned for Adult Intermediate Rehabilitation Services (“AIRS beds”) situated in community hospitals were temporarily closed to new admissions. No decision on the future of community hospitals had been taken by the CCGs Governing Boards. A seven week engagement exercise was undertaken with the public and stakeholders on the AIRS community beds between November and December, and the findings would be used to inform the formal consultation on the future of community hospitals.

A public commitment had been made that the consultation would commence in February 2017, however, a local bi-election had now been triggered following the MP for Stoke on Trent Central, Tristram Hunt, standing down, resulting in the pre-election period known as purdah commencing. In addition, the local elections for Staffordshire County Council were now set for 4 May, with purdah commencing on 30 March 2017. As a result the CCGs took legal advice from its solicitors and advice from NHS England, Staffordshire County Council, Newcastle under Lyme Borough Council’s Health & Wellbeing Scrutiny Committee and Stoke-on-Trent City Council on whether it would be appropriate to launch such a sensitive consultation during the purdah period.

Responses received were mixed, and there was no definitive legal position relating to CCGs, therefore, it was considered prudent to recommend that the Board followed the advice of NHS England, who recommended that the CCGs paused launching any consultation until after the pre-
election period, noting that NHS England would have to give final approval for the consultation to proceed. Therefore it was recommended that the start of formal consultation be postponed for three months, and commence on Monday 8 May.

A discussion took place around the pause in consultation on community hospitals (1) the disappointment in the pause but the acceptance of the reasons; (2) the possible benefits as the public would be able to see the positive impact of D2A, which would provide confidence in the proposals; (3) that the additional 3 months would provide time to build on outcomes and enable further work on options for the future use of community hospitals; and (4) that the work to continue to improve outcomes would continue as ‘business as usual’.

MWa confirmed that no decisions regarding community hospitals would be made until after the consultation, the results of which would be made available after the bi-elections and before the County Council elections.

MWo expressed the need to ensure that contact was made with those that had engaged with the engagement, to ensure that they remained involved in the process, and were clear as to the reasons why the consultation had been delayed.

AC advised that a press release would be released following the meeting.

A&E Delivery Plan and A&E Sustainability Plan

MWa advised that as a consequence of A&E performance remaining poor and 4 hour performance not achieving 95%, the system was being held to account through weekly escalation meetings chaired by the Regional Director from NHS Improvement. The meetings generated a series of actions for UHNM in terms of internal system and process and for partners in terms of out of hospital care. This had led to significant improvements in a number of areas across the system, most notably in the reduction in medically fit for discharge (MFFD), unmet demand patients and the reduction in 12 hour breaches.

MWa highlighted that an area of particular focus had been the implementation of Discharge to Assess (D2A), which moved assessment of patients for their ongoing care needs out of acute community beds to home and where required, a community bed. D2A underpinned the CCGs ‘My Care, My Way – Home First’ initiative and would be fully implemented by 1 April 2017. Further work was ongoing with Stoke-on-Trent City Council to ensure that they were able to respond in a timely way to demand for home based discharge.

The A&E Sustainability Plan was submitted on 16 January following assurance from NHSE and NHSI. The plan assesses the systems implementation of the nationally mandated actions to improve and sustain urgent care performance, and sets out the actions required to ensure compliance. The system has prioritised D2A along with primary care front door streaming of all A&E attendances and support to nursing homes, as its three key areas of focus through the A&E Delivery Board.

Sustainability and Transformation Plan (STP)

MWa confirmed that the Staffordshire STP was published on 15 December 2016 and work to develop the programme, proposals and option appraisals across Prevention, Urgent and Emergency Care, Planned Care, Enhanced Primary and Community Care and Productivity and Efficiency would increase with a clear focus on the plan for consultation in the summer of 2017.

The Governing Boards duly approved the proposal that the CCGs pause the consultation on the future of the community hospitals until after purdah, and that the consultation starts on 8 May 2017, running for three months; and noted the contents of the report.

8.1 Quality Report

TS presented the report to provide members with assurance that structures and processes were in place to promote, monitor and ensure safe, high quality health services for the people of North
Staffordshire and Stoke-on-Trent. Details as follows:

**Quality Impact Assessment: Bradwell and Cheadle Hospitals**
TS confirmed that at the November Quality Committee, members had reviewed the Quality Impact Assessment (QIA) for Cheadle Hospital, which would be reviewed again together with the Bradwell Hospital QIA at future meetings.

**Care Home Quality Monitoring**
As part of the CCGs monitoring of the implementation of the CCGs Care Home Strategy, the Quality Committee discussed the proposals for closer, integrated working between the CCG, Staffordshire County Council and Stoke-on-Trent City Council, with respect to quality monitoring and service improvements in care homes. It was agreed that the newly appointed Care Home Matron, Safeguarding Nurse for Adults and Director of Nursing and Quality would review how the established Quality, Safeguarding and information Sharing meeting (QSISM) could be utilised as the formal mechanism for providing assurance on quality monitoring across care homes.

**Infection Prevention & Control**
TS confirmed that North Staffordshire CCG was over trajectory at Month 8, with 57 reportable cases of Clostridium difficile infection (CDI) against a cumulative objective of 40 cases. Stoke-on-Trent CCG was over trajectory at Month 8, with 80 reportable cases of Clostridium difficile infection (CDI) against a cumulative objective of 56 cases.

The Head of Infection Prevention and Control had convened a Clostridium difficile focus group, chaired by the Director of Nursing and Quality. The aim of the group was to determine the possible causes of the higher than expected incidence of CDI so that targeted actions could be initiated to address any gaps or challenges. The first meeting took place on 9th January 2017 and had generated a number of actions.

**Learning from Experience Report**
TS advised that members received the quarterly report focussing on the top harms experienced by patients using the services from the main providers. The CCGs worked with providers to support learning, appropriate actions and improvements. This quarter, the report focussed on suicide; not only on the loss of life but also the impact on families, carers and others and national / local trends and future strategies. In addition, members received an update focussing on falls, pressure ulcers and mortality with a general overview of serious incidents. Members noted that all three main providers were compliant in the last quarter with duty of candour requirements.

ZI noted that data showed that a large number of people who want to commit suicide do have contact with Primary Care Services. **ACTION:** TS to liaise directly with ZI.

**University Hospitals of North Staffordshire NHS Trust (UHNM)**
TS confirmed that the CCGs continued to work closely with UHNM to improve patient flow and timeliness of being seen, and to ensure patient safety during times of pressure.

**North Staffordshire Combined Healthcare NHS Trust (NSCHT)**
The CCGs continued to review Child and Adolescent Mental Health Community Service (CAMHS) waiting list, seeking assurance that this was conducted in a safe manner which did not put patients at risk. The significant focus on recruitment over the last 12 months was noted, with members updated that within the last 6 months the benefits had been seen, with only 10 patients breaching the 18 week waiting time target.

**Staffordshire Doctors Urgent Care (SDUC)**
TS confirmed that the CCGs continued to monitor the increase in activity at the CQRM meetings and it was noted that during October the minimal workforce requirements were met.
PS raised concerns around the response times for SDUC, and questioned the minimum workforce requirements being met, highlighting the increased pressure on the GP workforce and that local practices were close to collapse due to the increased pressures. **ACTION:** TS to investigate the minimum workforce requirements and update PS outside the meeting. The information to be captured within the action tracker.

MWa highlighted the positive results of the CQC inspections, noting that of 54 practices inspected, 4 were rated outstanding, 39 rated good, and 11 as requiring improvement. None were rated as inadequate. This showed that despite the pressures the majority of practices were still providing a quality service.

The Joint Governing Boards duly **noted** the contents of the report and the request for further information as required.

<table>
<thead>
<tr>
<th>9.1 Joint Audit Committee Chairs Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>JH presented the report which summarised the key issues discussed at the Joint Audit Committee held on the 17 January 2017, and to provide the Governing Boards with formal assurance on the CCGs systems and processes, and highlight any areas of concern. Details as follows:</td>
</tr>
</tbody>
</table>

  **Internal Audit Progress Report**
  PWC presented three reports two advisory (1) Internal Audit follow up report; QIPP report.; and one assurance Contract management, rag rated medium risk. Members discussed the findings and the opinions, in particular the QIPP findings and the conclusions drawn from the observation of the performance delivery sub group, agreeing that attendance by officers needed to be improved and strengthened.

  JH highlighted that members expressed concerns regarding the significant amount of work still to be delivered during quarter 4 by internal audit, and the potential impact on CCG staff.

  A discussion took place around the number of audits the CCGs would expect to be completed, and the need for balance throughout the year, in order to not put undue pressure on the CCG. It was agreed that there was a need for the Audit Chairs to review processes with other CCGs as the appointment of the auditors was a Staffordshire wide procurement. **ACTION:** Audit Chairs to follow up.

  **IG toolkit**
  JH highlighted that the score for the IG toolkit for both CCG’s was 20%, which although low, would gradually build over the year as work was completed in line with the improvement plan and evidence obtained in readiness for the toolkit submission in March 2017. AP advised that since the Audit Committee meeting the score had increased to 75% for both CCGs.

  **IG Handbook/ Standard Operating Procedure (SOP) for the Management of Subject Access Requests**
  JH confirmed that the CSU IG Team had reviewed both of the above and at this time there were no substantial updates required to the handbook, and no changes to the SOP. Therefore the Joint Audit Committee members had re-approved both of the above for a further 12 month period and requested that the Joint Board ratified this decision.

  **Mandatory Information Governance Training**
  JH advised that as at December 2016 the current training compliance for North Staffordshire CCGs was 45% and for Stoke-on-Trent CCG compliance was 55%, however further training sessions were delivered during January so compliance would have increased. **ACTION:** It was agreed to send reminders to all staff to complete the training.

  **Assurance Framework Risk Register (AFRR)**
  JH advised that the joint assurance framework risk register (AFRR) was received at the January
meeting, and members discussed the register including the varying approaches to the definition of risks and the alignment of the mitigations and the succinctness of the reporting. The Committee expressed that they were not assured that there was relevant mitigations in place for the Recruitment and Retention of GPs in Stoke-on-Trent and North Staffordshire, and had tasked the executive directors to review and revise the detail of each of the risks they are recorded as leading on, so that the risk and the mitigations were appropriate and fully aligned.

The Joint Governing Board duly noted the contents of the Audit Committee Chair’s report and items of business discussed at its last meeting and in particular:

- Noted the review by the Committee of the Joint Assurance Framework Risk Register and the members not being assured that there was relevant mitigations in place for the Recruitment and Retention of GP’s in Stoke-on-Trent and North Staffordshire;
- Noted the Audit Committee have tasked the executive directors to review and revise the detail of each of the risks they are recorded as leading on so that the risk and the mitigations are appropriate and fully aligned;
- Noted in view of the above work the board assurance framework detailing risks of 15 and over would be delayed for presentation at the Board meeting;
- Ratified the IG Handbook/ Standard Operating Procedure for the Management of Subject Access Requests; and
- Were assured on the systems and processes in place in respect of FOI, Information Governance and for managing conflicts of interest and recording gifts and hospitality.

### 9.2 Report from Joint Organisational Development Committee on 20th December 2016 and 24th January 2017

FH presented the report summarising of the business discussed at the Organisational Development Committees held on 20th December 2016 and 24th January 2017. Details as follows:

**Policies**

FH advised that since the in-housing of the HR post in October 2016, the Head of HR and OD had reviewed the current HR polices across both CCGs, and developed a work programme to ensure all polices were reflective of current practices, any change to terms and conditions, and any new or emerging employment legislation. A quarterly policy review programme of work was presented for information, and the Committee were assured that staff would be signposted to the updates.

The Committee received and approved the Homeworking Policy and Guidance, the Employee and Managers Guidance – Stress, and the Lone Working Policy and sought Board ratification

**Apprenticeship scheme**

FH advised that the Head of HR and OD had met with a representative from Stoke-on-Trent College as it was recognised that neither CCG had any staff in the 16-19 year age range. The Committee approved introducing the apprenticeship scheme and agreed to the recruitment of two apprentices.

**Staff Survey**

The Staff Survey would be finalised and conducted before the end of the financial year.

The Joint Governing Board duly noted the contents of the report and ratified the Homeworking Policy and Guidance; the Employee and Managers Guidance – Stress; the Lone Working Policy; and ratified the decision to recruitment two apprentices.

### 9.3 Patient and Public Involvement Update

SP presented the report to provide assurance to the Joint Governing Bodies that the CCGs have measures in place to fulfil their duties to engage with our local population in North Staffordshire and Stoke-on-Trent. Details as follows:
Annual Report
SP advised that work was in progress to produce the 2016/17 annual reports. It was proposed that this year the CCGs would submit a word document which would meet the statutory obligations, and be available on the CCG websites, alongside a graphic based public facing, 12 page summary, which would be launched at the Annual General Meeting (AGM) on 18 July.

CCG Website
SP highlighted that the contract with the current website provider for both CCGs had been extended to the end of June 2017. An invitation to tender for a new website was in development.

TB questioned if this proposal would meet the CCGs statutory obligations and be accessible to patients and stakeholders, and if the tender for the website would incorporate the guidelines for accessibility.

AC confirmed that the websites would meet the CCGs statutory obligations, and that there was a new specification for the website tender, which adhered to all of the accessibility standards.

Joint Two Year Operating Plan
SP advised that a user friendly version of the plan was being produced, which would set out what the CCGs hoped to achieve, in plain, user friendly language. The document would be aligned to the Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan (STP).

Patient & Public Involvement
SP confirmed that the third North Staffordshire and Stoke-on-Trent Community Conversation was held in January and focussed on maternity and infant health. A report containing recommendations was being developed and would be shared with the Joint PPI Steering Group before being used to inform the commissioning of services. The future programme of Community Conversations included ‘A focus on Patient Participation Groups – sharing good practice and identifying gaps’ in April and ‘Health Technology Expo’ in July, coinciding with the Joint AGM.

Citizens Jury
SP advised that the next Citizens Jury (led by the Lay Members for PPI) would place mental health services under the microscope, and 10 jurors had been selected following a competitive recruitment process. The first task of the jury would be to define the question and to set a timetable of activities over the subsequent two months. Following completion, the results would be reviewed by the CCGs Communications and Engagement Team. There had been a lot of interest from the third sector following the previous Citizens Jury, and a number of other CCGs were keen to look at how the process worked. PD confirmed that the Jury would be meeting on the 28 February to confirm the Terms of Reference, and identify the appropriate contacts, with the process concluding in July / August, and a report presented to the Joint Governing Board in September.

MWa praised the positive impact on the local diabetes services as a result of the previous Citizen Jury, and thanked those involved for the insightful data collected.

MWo emphasised the need to raise the profile further of the process and to provide a clear evaluation to the Board and highlighted the need for the CCGs to make use of the local reporting channels such as the Sentinel and Radio Stoke for signposting local services. ACTION: AC to look at how to publicise the outcomes and to investigate the possible signposting services of local media.

The Joint Governing Board duly considered the ongoing PPI work of the CCGs and noted the actions being taken to strengthen the CCGs progress in this area of work; and approved the proposal to produce a short public facing summary of the annual report.

9.4 Better Care Fund - Update on Changes to Drug and Alcohol Services
DD, MWa and FH presented the report to provide an update to the Joint Governing Board on the Staffordshire Better Care Fund. Details as follows:
PS declared a conflict of interest as was employed as a GPSI in substance misuse in Newcastle for Combined Healthcare for 1 session a week and worked in a practice that provided substance misuse shared care. It was agreed that PS would remain in the room for the discussion.

DD advised that Staffordshire County Council had anticipated receiving an additional £15m in 2016/17 and 2017/18; therefore to address the £15m financial gap 2016/17, a number of proposals in principle for savings were agreed by the County Council including a review of Drug and Alcohol Services; reablement, rehabilitation and intermediate care services – Review of the Living Independently Staffordshire (LIS) service; and reablement, rehabilitation and intermediate care services – Brighton House, CCGs were not sighted on the content of these documents or able to comment on the contents of the reports.

As a consequence of these decisions, the drug and alcohol care pathway was being redesigned to reduce the service budgets over a three year period (2016-19), £5.9m in 2017/18 and £5m in 2018/19, compared with around £10.6m in 2015/16. The new care pathway would seek to achieve the same outcomes but delivery would change significantly. A Community Impact Assessment had been undertaken by the Council, but CCGs had yet been unable to complete a Quality Impact Assessment as the service model was being defined.

DD highlighted that the most significant changes to the pathway were likely to relate to the capacity and activity of the services, patients would be prioritised red / amber / green. Those categorised as red would receive access to treatment, those as amber would be put on a waiting list and those categorised as green would only be eligible for an online offer of support. From April, around six of the twelve dedicated premises were likely to close with their functions thereafter being delivered in part through the Access and Choice locations, or on an outreach basis.

DD confirmed that (1) a revised clinical model for the provision of drug and alcohol treatment services was being developed and would be refined over the coming months; (2) Staffordshire CCGs would continue to raise concerns about the planned service changes; that a Quality Impact Assessment had not been completed; and, that limited information had been available which had impacted on the ability to plan and mitigate; and (3) the CCGs would continue to work with the County Council to mitigate against the impact.

DD highlighted that North Staffordshire and Stoke-on-Trent CCGs currently commissioned a number of initiatives/services to support this patient cohort, and that North Staffordshire CCG normally allocated an additional investment to the County Council of £389k, to support drug and alcohol services for North Staffordshire patients. Following discussion at the Joint Planning Committee in January, it had been recommended that options should be developed for how this could be spent by the CCGs, rather than transferred to the County Council, to mitigate against the impact of the County Council’s decisions.

MWa highlighted that there were currently two BCFs in North Staffordshire, across the five counties, and that currently there had been no decision made by Stoke-on-Trent City Council to cut services. It was clear what was in the BCF submission, which drug and alcohol did not form part of. This was part of a previous Public Health transfer of services. It would be difficult to mitigate the impact of the service cuts as responsibility and funding had been passed to the Council.

PS highlighted the seriousness of the situation, the unprecedented cut to services, and the impact it would have on all other local services, patient safety and clinical governance. The remaining service would put patients at severe risk. The services would be redesigned as best as they could, but limited staff would result in widespread safeguarding implications. There was a risk to GPs who would be forced to make difficult decisions.

A discussion took place around (1) the need for the CCG to undertake a QIA as there were serious concerns relating to the process; (2) that the decision to cut services so drastically opposed the
principles of the BCF; (3) the inadvertent effect to other local services such as A&E, ambulance services, paramedics; police, etc. (4) the possible impact to Stoke-on-Trent GPs, as patients may transfer GPs in order to receive services, and the resulting two tier system in operation locally; (5) the considerable impact to a vulnerable group in society; and (6) that the level of scrutiny required by the CCGs had not been undertaken.

TS advised that she would work with the other Staffordshire CCGs to undertake a thorough QIA and assess the wider impact.

MWa reiterated that these were council decisions, made as a result of funding reductions. The CCGs had clear and valid concerns and would need to work to manage the risks, to redirect resources where possible, and to identify possible alternative services. There was a need to review the CCGs prioritisation process through CPAG, as it was clear that a number of these patients would present in A&E. A full detailed report with recommendations would be presented to the March Governing Board meeting. **ACTION:** DD to produce with CH, to link with PS as a GP with Special Interests.

It was noted that there was no representation from Staffordshire County Council / Public Health and it was requested that members were invited to the next meeting. **ACTION:** RB to invite.

The Joint Governing Board noted the Better Care Fund Update on Changes to Drug and Alcohol Services and that further information would be received at the next meeting.

### 10.1 Staffordshire and Stoke-on-Trent 2 year Operational Plan 2017-19

ZJ presented the report. Details as follows:

ZJ confirmed that the CCGs submitted their final operational plan by the deadline of 23rd December, which included activity, finance and narrative explaining how the NHS standards and targets would be met. Activity and finance templates were submitted on a CCG basis with one Operational plan for Stoke-on-Trent and North Staffordshire CCGs. The CCGs across Staffordshire had agreed to work collaboratively on developing a public facing version of the plan, with Communications Leads leading on the process, supported by Strategy and Planning.

The plans demonstrated (1) how the CCGs control totals contributed to achieve local system financial control totals; (2) how the CCGs would be in financial balance in each of 2017/18 and 2018/19 by implementing local STP plans; (3) how along with partner CCGs across Staffordshire, the agreed STP milestones would be implemented in 2017 to 2019; (4) how CCGs would ensure the sustainability of general practice by implementing the General Practice Forward View; (5) the work with the Local A&E Delivery Board to implement the five elements of the A&E Improvement Plan, to deliver Urgent and Emergency care standards; and (6) the delivery of the NHS Constitution standard for 18 weeks from referral to treatment.

ZJ advised that no formal feedback had been received from NHS England as yet, and that a public facing document would be produced once the plans were approved.

PS raised concerns around the Primary Care monies, and highlighted the need to ensure that the allocated money was not absorbed by the deficit. There were serious pressures within Primary Care and every penny counted. Primary Care played a significant role in the future of the health service. JG and MWa advised that there was no intention to take money from Primary Care, it would be managed and used appropriately and QIF had been fully allocated in previous years. The CCGs recognised the need for investment in Primary Care and that the Primary Care Strategy required further development alongside the development of MCPs to reverse the current trend.

The Joint Governing Body duly approved the plan retrospectively which was submitted to NHS England by the due deadline of 23rd December 2016.
ZJ presented the report to provide a summary of performance and activity across North Staffordshire (NS) and Stoke-on-Trent (SOT) Clinical Commissioning Group across Six Clinical Priority areas, Improvement and Assessment Framework Better Health and Better Care indicators, and NHS constitution standards. Details as follows:

ZJ advised that NHSE had indicated that the 6 clinical priority areas would be refreshed for an end of year rating only, and the enclosed report outlined performance against IAF indicators based on quarter 3 vs quarter 2.

ZJ highlighted the improved position in Q3 for (1) falls for both CCGs, however both still in worst quartile nationally; (2) e-referrals, both CCGs had seen an increase in performance from Q2 to Q3 and were above national average; (3) % of deaths in hospital for both CCGs; and (4) personal health budgets (SOT), now above the national average.

ZJ highlighted the worsening position from Q2 to Q3 for (1) smoking at time of delivery for both CCGs, North Staffordshire was now in the lowest quartile; (2) people supported to manage their conditions for Stoke-on-Trent, but still in line with national average; and (3) the slight worsening in broad spectrum antibiotic prescribing for both CCGs, but still in line with national average.

Maternity
ZJ advised that SOT Tobacco Strategy had an improvement trajectory for smoking at time of delivery. The CCG were successful in bidding for £75k NHSE funding for maternal smoking at delivery. Meetings with key partners to develop and agree a detailed plan on smoking in pregnancy support took place in January 2017. A workshop to commence design of transformational plans based on the local outcomes of National Maternity Review and Better Births was planned for February 2017.

PS highlighted the decommissioning of the smoking cessation programme. ACTION: ZJ to investigate.

Cancer
ZJ highlighted the worsening position for cancer 62 day for NS CCG, and the maintained position for SOT CCG. Cancer diagnosis at early stage and cancer patient experience for both NS CCG and SOT CCG remained in line with national average. Issues remained around capacity, patient choice and increased demand. A number of Trusts nationally were struggling to achieve the targets. Continued CCG and Provider actions were in place, and the CCGs continued to work closely with UHNM on a revised action plan.

18 week standard
Both CCGs were not meeting the 92% target, but were slightly above the national average. The backlog had increased to 3921 at UHNM and continues to rise.

SF highlighted the process issue relating to 62 day waits and the need for a pathway review and for UHNM to ensure consultants were processing cases quicker. UHNM had established an internal Board to review. The CCGs continue to progress actions for improvement.

FH highlighted that the PASS system had been updated and as a result waiting lists were being revalidated, which could result in material shifts. A meeting had been arranged to further discuss and understand the consequences.

The Joint Governing Board duly noted the contents of the month eight 2016/2017 performance report.

WMAS Ambulance Response Programme
RC welcomed Mark Docherty to the meeting to provide an update on WMAS.
MD explained that The Ambulance Response Programme (ARP) aimed to increase operational efficiency whilst maintaining a clear focus on the clinical need of patients, particularly those with life threatening illness and injury. It was expected that the programme would deliver improved outcomes for all patients contacting the 999 ambulance service, with a generally reduced clinical risk. Nationally, Ambulance Services were now facing unprecedented demand as they were no longer contacted solely for emergencies, with increased calls of 1.25 million calls in the last 5 years. Current time based ambulance respond standards, (75% performance target in 8 minutes), in the face of rising demand, had led to inefficient operational behaviours. A review had been undertaken of (1) current behaviours; (2) dispatch on disposition and aims; (3) clinical coding review; (4) identifying the clinical severity of the patient through the categorisation, and grouping the patients within these categories according to their treatment requirements, in order to move away from the 75% target to percentile times, this would encourage better behaviours for urgent categories.

MD highlighted (1) the four categories and sub-categories of responses; (2) the current waiting times and ‘stop the clock’ processes; (3) that the changes would ensure that that the majority of patients received the quickest response time with the most appropriate dispatch; (4) that the ARP trial was being closely monitored by NHSE and that monthly data submissions were supplied from all Trusts, and that trial sites were providing daily, weekly and monthly data returns; (5) that the University of Sheffield was the academic partner, and were evaluating the trial; and (6) that a meaningful report would be produced that would help patients to understand the changes.

A discussion took place around (1) the governance and monitoring of the trial to ensure that there were no unintended consequences and the need to continue to monitor through the Trust Board; (2) the need for specific data for the local area to be provided; (3) the need to ensure that the triage process was more robust and the correct questions were being asked to ensure that the appropriate response was sent; and (4) the possibilities of working closer with the local Fire and Rescue Service as in other areas, noting the need for the same training procedures to be followed to ensure that the governance remained in place. 

**ACTION:** MD to forward the presentation and local area data to MWa for circulation to the Board members. PD to discuss further with local Fire and Rescue Service.

The Joint Governing Board duly received and noted the Performance Report and the WMAS Update.

### 10.3 Summary of key issues from the Joint Planning and Commissioning Committee (JPCC) held on 17 January 2017

SF presented the report. Details as follows:

**Child & Adolescent Mental Health Services (CAMHS)**
A report on the Transformation plan and national funding for CAMHS, approved by NHS England, was considered. The allocation of £173k would enable the backlog of 230 children waiting for ASD assessment to be cleared within 4 months.

**Integrated Urgent Care Centre/GPOOHs service**
SF advised that the Integrated Urgent Care Centre/GPOOHs service was currently out to tender and that there had been a delay in the procurement. The decision regarding award of contract would require approval at the April Joint Governing Board.

The Governing Board duly noted the key issues discussed and decisions made by the JPCC.

### 11 Questions from the public

1. IS raised concerns regarding the STP and that decisions were being taken prior to public
consultation being completed. MWa advised that the STP had a formal communications plan and consultation plan in place. The process around the Community Hospitals had been started prior to the STP.

2. IS requested clarification that there would be no change of use to the Community Hospitals prior to the public consultation.

MWa responded that as discussed earlier in the agenda, as a result of purdah, the consultation would commence after the bi-elections and no decisions would be made prior to this. The closure of the wards at Bradwell had already been planned, with notice received from UHNM that would expire in July, and arrangements were being made to ensure that patients were moved to the appropriate destination. Discharge to Asses was ensuring that the patients were receiving the right care in the right place, which would result in fewer people in the beds at the Community Hospitals, and the process would need to be managed appropriately. No decisions would be made over the use of the Community Hospitals until the consultation had ended.

3. IS raised concerns around the lack of information included within the Performance Report around Patient Transport Services.

SF advised that the CCGs could share the reports received and would discuss this outside of the meeting with IS. Feedback received from the teams at UHNM had been positive.

TS advised that there would be further discussion around Patient Transport Services at the Joint Quality Committee which was taking place the following day, and an update would be included in the next Quality Report.

4. David Rogers (Chair of North Staffs Combined Healthcare Trust) praised the Governing Boards for the balanced meeting and reiterated the need for the Providers and CCGs to work together collaboratively to develop a greater understanding of each other. This would then help to resolve the local issues. DR questioned if it would be beneficial to invite representatives from local Providers to attend the Board meetings to further develop collaborative working.

RC and MWa thanked DR for his positive feedback and advised that the two CCG Governing Boards already meet together in order to ensure they were working efficiently and effectively and not duplicating work, noting that this resulted in a large number of Board members already in attendance. Stakeholders including Local Authority and Public Health were provided with standing invitations to attend when available and consideration would be made to the suggestion of inviting other stakeholders. ACTION: MW/RC/AB

All parties should note that the minutes of the meeting are for record purposes only. Any action required should be noted by the parties concerned during the course of the meeting and actions carried out promptly without waiting for the issue of the minutes.

These minutes are signed as being a true record of the meeting, subject to any necessary amendments being made, which will, if any, be recorded in the following meeting’s minutes.

Signed: ..................................................................... Position: ................................. Date:............................
### Action Tracker from February’s Meeting (Public Meeting)

<table>
<thead>
<tr>
<th>MEETING DATE</th>
<th>REFERENCE</th>
<th>AGENDA ITEM</th>
<th>Action</th>
<th>Responsible Officer</th>
<th>Outcome / update</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/06/16 – 01/11/16</td>
<td>9.1</td>
<td>Governing Body Assurance Report</td>
<td>It was agreed that there was a need to include additional detail within the front sheets so that members could see the pertinent points and asks of the item; and to detail the ‘so what’ within the report to allow focused discussion. The content of the reports needed to be specific and concise.</td>
<td>Alex Palethorpe / Fiona Hamill</td>
<td>Ongoing. Part of a wider piece of work.</td>
</tr>
<tr>
<td>07/02/2016</td>
<td>4</td>
<td>Matters Arising</td>
<td>To include an STP Update on the monthly Board agenda To include an update in the Chairs Report regarding the Independent Chair of the STP recruitment</td>
<td>Marcus Warnes / Rachel Barker</td>
<td>Include on the agenda Included within the report</td>
</tr>
<tr>
<td>07/02/2016</td>
<td>8.1</td>
<td>Quality Report</td>
<td>Tracey Shewan to liaise with Dr Zafar Iqbal regarding the data showing that a large number of people who want to commit suicide have contact with Primary Care services. Tracey Shewan to investigate the minimum workforce requirements being met for SDUC and update Dr Paul Scott following the meeting.</td>
<td>Tracey Shewan</td>
<td></td>
</tr>
<tr>
<td>07/02/2016</td>
<td>9.1</td>
<td>Joint audit Committee Chairs Report</td>
<td>Audit Chairs to review the Internal Audit process with other local CCGs to identify if similar issues are being experienced (the auditor procurement was part of a Staffordshire wide procurement process) Reminders to be sent to all staff regarding mandatory IG training</td>
<td>John Howard / Neil McFadden / Marcus Warnes</td>
<td>Verbal update will be provided at the meeting. Completed.</td>
</tr>
<tr>
<td>07/02/2016</td>
<td>9.4</td>
<td>Better Care Fund</td>
<td>To provide a full and detailed report to the next meeting including recommendation, how the CCG would manage</td>
<td>Cheryl Hardisty / Debbie Danher</td>
<td>Included on the agenda.</td>
</tr>
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the risks and redirect resources to mitigate the funding reductions of the drug and alcohol service in Staffordshire. To link with Dr Paul Scott.

Invite Staffordshire County Council and Public Health representatives to the meeting.

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<th>Item</th>
<th>Description</th>
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<tr>
<td>07/02/2016</td>
<td>10.2</td>
<td>Joint Performance Report Month 8: Zara Jones to investigate the decommissioning of the smoking cessation programme.</td>
<td>Zara Jones</td>
<td>Verbal update will be provided at the meeting.</td>
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**ENCLOSURE: 5.1**

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**Report to**
North Staffordshire and Stoke-on-Trent CCG Governing Boards in common

**Meeting Date**
7th March 2017

**Which other CCG committee and/or Group has considered this report**

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**Purpose of the paper, executive summary of key issues, points and outcomes**

This report will provide an update to the North Staffordshire and Stoke-on-Trent CCG Governing Boards in common around the current environment that the CCGs have been operating in.

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**Recommendation:**

The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to note the Chairs’ Address.

**Summary of risks relating to the proposal**

N/A

**Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications**

N/A

**Is a Quality and/or Equality impact assessment required**

N/A

**Any engagement activity with stakeholders/practices/public and patients**

N/A

**Strategic objectives supported by this paper (identify appropriate goals)**

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**ACRONYMS**

N/A
**Introduction**
The CCGs continue to work closely and effectively with system partners during this nationally difficult time across both the health and social care economy.

We would like to acknowledge the outstanding efforts across the CCG and in collaboration with our partners to respond to the pressures on urgent care, NHS constitutional standards, our financial position, planning requirements, delivery of our financial recovery plan, and the Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan. These continue to be our key priorities.

We are, as always, grateful for the hard work and dedication of the CCG staff and front line staff in primary, community and hospital settings, and would like to thank everyone for their continued professionalism and support.

**Weekly Health Column – The Sentinel**
The Head of Communications & Engagement recently met with Martin Tideswell, Editor in Chief of the Sentinel, and agreed to provide a weekly Health column for their print and online readers. The aim is to link the column to national awareness and advice days, and is written by Dr Ruth Chambers. The column is published every Tuesday.

**Pan-Staffordshire and Stoke-on-Trent Chairs Group**
A Pan-Staffordshire and Stoke-on-Trent Chairs Group has been established and is meeting monthly. The purpose of the Group is to:
- Lead on building trust and relationships between ourselves and our organisations
- Confidentially share information to support collaborative working
- Lead on a ‘no blame culture’
- Promote collaborative working across our organisations
- Adopt a transformational and long term focus
- Provide credible links to the wider Health and Social Care economy
- Lead on setting and sustaining the culture
- Give a united message
- Support the Health and Social care drive to engage & involve patients and citizens in their care and delivery of the STP
- Support alignment and the progress of the Staffordshire STP and LDR

**Academic Health Science Network, Quality Improvement Event**
In collaboration with the Academic Health Science Network, the CCGs are holding a Quality Improvement Event on Tuesday 13th June in Birmingham. This regional event is aimed at nurses with a key role in education and quality, the focus being on long term condition management and minimising unwarranted clinical variation.

**GP Career Plus – NHS England Pilot Scheme Bid**
The CCGs have been successful in securing £100,000 from NHS England for the GP Career Plus pilot. This will be delivered locally by the North Staffordshire GP Federation, with Dr John Gilby as the CCG Lead.

The General Practice Forward View committed to a range of measures to expand the general practice workforce as well as retaining the considerable experience already in general practice. Data shows that the number of GPs leaving in most ages groups particularly those aged 55–59 and 60-64, has risen over the last 10 years. Research that we have commissioned suggests that experienced GPs may remain practising if they had an opportunity to work more flexibly.
GP Career Plus will be piloted in 11 areas in England from the summer 2017. The pilot areas will test a range of ways to offer greater flexibility and support for approximately 80 GPs to keep hold of the vital skills and experience of GPs on the verge of leaving general practice.

The pilot sites will assess the demand and effectiveness of employing GPs through pooled arrangements, the most effective form of employer and the scope for a GP pool arrangement to become a sustainable model for local use. If the model is proved to be successful it may be advocated for use by CCGs or providers to help support GP retention.

**NHS England GP IT Bid - Making technology enabled care services (TECS) a reality in elderly care**

The two CCGs were successful in their bid for capital funding for technology to support innovation. A bid was pulled together in a very short time scale (24 hours) and submitted to NHSE for £136k for each CCG (total £272k). The funding will be utilised to purchase technology which will facilitate remote access and enhanced communication between residential care settings and wider stakeholders e.g. GP practices extended primary care, community pharmacists, geriatrician/elderly care team, palliative care etc. The aim will be to improve outcomes for patients, whilst making best use of professionals’ time by reducing the need for face to face appointments/attendances where this is clinically appropriate.

Technology enabled care services, refers to the use of telehealth, telecare, telemedicine, tele coaching and self-care in providing care for patients with long term conditions that is convenient, accessible and cost-effective. These solutions could potentially transform the way people engage in and control their own healthcare, empowering them to manage their care in a way that is right for them.

This investment will enable improved outcomes for patients and assist in the realisation of the wider ambitions for patient care of Stoke-on-Trent and North Staffordshire CCG’s.

**NHS England GP IT - Staffordshire Connected**

The 6 Staffordshire CCG’s have collectively successfully requested funding of £750,000 from NHS England for Staffordshire Connected. The bid represented a series of digital initiatives that provide a platform to drive forward the Staffordshire Connected and Local Digital Roadmap (LDR) programmes of work whilst also supporting healthcare professionals to become more efficient, which is vital to the sustainability and transformation workstreams across primary care as demand and expectations of citizens continue to grow. The funding will support the practices once the licensing issues have been resolved.

The initiatives are directing primary care towards the use of more innovative Information Technology and with an Enhanced Primary and Community Care programme, supporting the STP footprint.
ENCLOSURE: 5.2

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Report to North Staffordshire and Stoke-on-Trent CCG Governing Boards in common

Title Chairs’ Action

Meeting Date 7th March 2017

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The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to ratify the Chairs’ Action taken to proceed with the contract award for the re-procurement of community podiatry services.

Summary of risks relating to the proposal
N/A

Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications
N/A

Is a Quality and/or Equality impact assessment required
N/A

Any engagement activity with stakeholders/practices/public and patients
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**ACRONYMS**

N/A
**Chairs Action - Re-procurement of Community Podiatry Services**

At the Joint Planning and Commissioning Committee an options paper was presented regarding the re-procurement of community podiatry services (which applied to both North Staffordshire and Stoke-on-Trent CCGs), and following the meeting, as a result of the timescales to implement the new contract from 01 April 2017, a Chairs Action was requested. The Chairs of North Staffordshire and Stoke on Trent CCGs agreed to ratify the decision made by the Planning and Commissioning Committee to proceed with the contract award.

In summary, the CCGs sought to re-procure the service to commission in line with national benchmarking, maintaining quality for patients in line with the current service specification. To achieve this, the re-procurement of the service was necessary.

Following the release of the tender documentation and the bids received, two options were presented to the Joint Planning and Commissioning Committee for consideration (1) to award the contract which provided the CCGs with savings over the contract period of 3 years; or (2) withdraw the tender and re-open the procurement at a later date, noting the risks and the likely eradication of all savings that were initially identified.

The Governing Boards in common are asked to ratify the Chairs’ Action taken to proceed with the contract award for the re-procurement of community podiatry services.
This report will provide an update to the Governing Boards around the current environment that the CCGs have been operating in as well as describe progress with regard to the A&E sustainability plan, the Sustainability and Transformation Plan (STP) and Right Care.

I provide an update on the CCGs’ financial escalation meeting with NHS England as well as matters of local and national interest.

Recommendation:

The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are requested to note the contents of the report.
**Summary of risks relating to the proposal**
N/A

**Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications**
N/A

**Is a Quality and/or Equality impact assessment required**
N/A

**Any engagement activity with stakeholders/practices/public and patients**
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**ACRONYMS**
N/A
Financial Escalation Meeting with the NHS England Regional Director 16th February 2017

1.1 The Chief Financial Officer and I met with Mick Cawley, Finance Director of the NHS England North Midlands Area Team for a financial escalation meeting. The CCG has an agreed control total deficit of £10.04m and a recovery plan and trajectory to achieve this; the position deteriorated in month 9 and stabilised through month 10. The CCG has identified c£3m of risk against which it has mitigation plans in place

1.2 We discussed outstanding contract challenges with UHNM for month 1 and 2 and steps to agree the position. We also discussed our 2017/18 plan submission and an increased QIPP target to £28.1m (4.1%)

2.0 A&E Delivery Plan and A&E Sustainability Plan

2.1 A&E performance remains unacceptably poor with little sign of improvement. 12 hour breaches continue to occur, although in far smaller numbers than was the case previously. 4 hour performance is well below the required 95%.

2.2 As a consequence, the system is held to account through weekly escalation meetings chaired by the Regional Director from NHS Improvement. The meetings are attended by CEOs and AOs and are given the highest priority.

2.3 The meetings generate a series of actions for UHNM in terms of internal system and process and for partners in terms of out of hospital care. This has led to significant improvements in a number of areas across the system, most notably in the reduction in medically fit for discharge (MFFD) and unmet demand patients and the reduction in 12 hour breaches.

2.4 An area of particular focus has been the implementation of Discharge to Assess (D2A). This programme moves assessment of patients for their ongoing care needs out of acute community beds to home and where required, a community bed. D2A underpins the CCGs’ ‘My Care, My Way – Home First’ initiative.

2.5 D2A is a Staffordshire and Stoke on Trent wide initiative and is led by myself and Dr Richard Harling, Staffordshire County Council’s Director of Health and Care. It has been the main reason for the increase in discharges and reduction in MFFD delays.

2.6 D2A will be fully implemented by 1 April 2017, however further work is ongoing with Stoke on Trent City Council to ensure that their planned increase in home based enablement and maintenance packages are in place and can respond in a timely way to demand for home based discharge. If all of the required capacity is not immediately available from 1 April, beds will be commissioned in residential homes for patients to be assessed or await a home care package. Whilst not ideal, this will be a better environment than a ward in a community hospital in which to carry out assessments. It will also be far more cost effective for the CCG.

2.5 As reported last month, Paula Clarke, CEO of UHN M and I signed off the A&E Sustainability Plan, which was submitted on 16 January following assurance from NHSE and NSHI. The plan assesses the systems implementation of the nationally mandated actions to improve and sustain urgent care performance and sets out the actions required to ensure compliance.

2.6 The system prioritised D2A along with primary care front door streaming of all A&E attendances and support to nursing homes as its three key areas of focus through the A&E Delivery Board. The implementation of D2A is well advanced. In advance of the contract award to a new provider of the
integrated Front of House and Out of Hours service in August, the CCGs are working with the GP Federation to implement an interim streaming service from 1 April 2017. The 15 nursing homes that make the most referrals to A&E are receiving targeted support from the intermediate care team to reduce admissions.

3.0 Right Care

3.1 During January & February 2017, internal RightCare Workshops were held to identify pathways for redesign for report to NHS England by 24 February 2017. The requirement from NHSE is that each CCG undertakes work to analyse in detail 40% of the total RightCare variance presented in the commissioning for value packs over a 40 week cycle (December 2016 – September 2017).

3.2 Outcomes of the internal workshops were reviewed and approved at the Joint Planning & Commissioning Committee held on 17 February, with a decision made to redesign those pathways with the biggest opportunity to improve patient outcomes and efficiency. These pathways are:

- Trauma & Injuries for Falls
- Respiratory
- Endocrine Diabetes

3.3 Additional projects have been identified in mental health and maternity care that will also be worked on using RightCare methodologies.

3.4 In total, this shows Stoke CCG to be reviewing in detail 46% of its total RightCare variance and North Staffordshire CCG 43% and as such, meeting the NHSE ask.

3.5 The first design event will be Trauma & Injuries for Falls. This will take place on Monday 10th April 2017 with Dr Bhushan Rao, GP and Clinical Associate for Stoke CCG confirmed as clinical lead. Dr Steve Fawcett, the CCGs’ Medical Director and local GP, is the confirmed clinical lead for Respiratory and Dr John Gilby, Clinical Director and local GP, the clinical lead for Diabetes. Respiratory and diabetes design events are planned to take place in May and June 2017 respectively with final dates to be confirmed.

4.0 Sustainability and Transformation Plan (STP)

4.1 The Staffordshire STP was published on 15 December 2016. As we move into 2017 the work to develop the programme, proposals and option appraisals across Prevention, Urgent and Emergency Care, Planned Care, Enhanced Primary and Community Care and Productivity and Efficiency will increase with a clear focus on the plan for consultation in the summer of 2017.

4.2 In advance of formal consultation, members of the Health and Care Transformation Board have accompanied the Programme Director to meetings of the local authority scrutiny committees to present the plan and answer questions. It is important to note that the plan is not a consultation document and any formal consultation on specific service changes will follow in line with the development of options for delivery of the plan.

4.3 Recruitment of a new STP Chair and Programme Director is underway and will be completed shortly.

5.0 Recommendations

5.1 The Governing Bodies are requested to note the contents of the report.
The purpose of this report is to provide the North Staffordshire and Stoke-on-Trent CCGs’ Boards with assurance that structures and processes are in place to promote, monitor and ensure safe, high quality health services for the people of North Staffordshire and Stoke-on-Trent. This report focusses on items of business discussed at the Quality Committee meeting held in February 2017.

Key points to note are:

1. **Quality Impact Assessment: Bradwell and Cheadle Hospitals**
   Members received an update on the Quality Impact Assessment (QIA) for Bradwell Hospital, noting factors to be included, such as: the Domiciliary Care Service which has now commenced. The Committee expressed an interest in hearing patient stories from those patients who had been positively impacted from a placement in a care home across a wide geographical area to ensure a balanced picture was being portrayed of this change in service.

2. **Directly Commissioned Beds**
   The CCGs have commissioned a number of health beds within care homes within Northern Staffordshire with a number of monitoring mechanisms in place to ensure the quality of care at these homes. The Committee noted a gap in therapy at present in respect of a physiotherapist and occupational therapist which are currently being sourced.

   The service with the highest number of feedback items this quarter is Audiological Medicine at AQP Adult Hearing Services (25 pieces of feedback). Members received assurance on the actions being taken by the CCG as a result of these changes in service providers and the positive impact these were having.

   The CCGs received 287 events reported via the GP Event Reporting System (Datix) during quarter 3, 2016 /2017. Members noted the planned focus of the GP Event Reporting Manager to attend locality meetings.

5. **Patient and Public Involvement**
   Members received the Patient and Public Involvement quarterly report to note the actions being taken to strengthen the CCGs progress in this area of work, covering the following areas:
   - Governance arrangements
   - Organisational Development
6. **Healthwatch Stoke-on-Trent**  
A detailed quarterly report was received outlining the current work plan of Healthwatch Stoke-on-Trent.

7. **Healthwatch Staffordshire**  
A detailed quarterly report was received outlining the current work plan of Healthwatch Staffordshire.

8. **Quality Strategy Implementation Plan – We Said, We Did**  
Members received the first quarterly implementation report and noted progress against the high level actions detailed within year one of the strategy. The Quality Team will be sharing progress with each Patient Congress at the next joint meeting on the 12th April 2017. In addition, members noted that the CCGs Quality Team is hosting a Valentines ‘Lunch and Learn’ on the 14th February 2017, where the three main providers will be showcasing work along with the work of the CCGs’ Quality Team.

9. **Infection Prevention & Control**  
The CCGs Director of Nursing and Quality presented a C.difficile recovery action plan ‘deep dive’ also advised the committee of the current positions in respect of C difficile reported across the two CCGs.

10. **University Hospitals of North Midlands NHS Trust: Quality Assurance Narrative for Breached NHS Constitutional Standards Exception Report**  
A detailed discussion took place in respect of the length of time these constitutional targets have continued to breach and the additional actions and assurances the CCGs have been seeking, including the use of all contractual levers and additional quality monitoring. The Quality Committee is seeking that QSG consider whether there are any additional actions that can be taken to support the Trust towards achievement of the constitutional targets given that commissioners have been utilising all contract levers available to them.

11. **Safeguarding**  
Members approved an extension up to the 30th September 2017 to the current suite of Safeguarding Policies; namely Safeguarding Policy and Managing Safeguarding Allegations Against Staff, whilst these are currently being reviewed. The Boards are being requested to ratify this decision.

12. **North Staffordshire Combined Healthcare NHS Trust (NSCHT) – Flu Vaccination Performance**  
NSCHT has been officially recognised as the highest performing Mental Health Trust in England for flu vaccination of frontline staff. The Trust achieved a vaccination rate of 79.7% by the end of the year - exceeding the 75% national target set by the NHS - and almost doubling its performance compared with the 2015. The success was partly down to the efforts of a team of “roving vaccinators” led by the Deputy Director of Nursing and the Infection and Control Team Practitioner.

13. **University Hospitals of North Midlands – Flu Vaccination Performance**  
The Committee noted UHNMs’s flu vaccination performance with the Trust achieving performance within the top 5 of the country.

14. **Ezec Patient Transport Service**  
Members noted that as the Lead Commissioner for the Patient Transport Service, quality reports will be received at future Quality Committee meetings, in line with the CCGs’ other main providers. A Lead Nurse – Quality has been allocated to this contract and is attending the Clinical Quality Review Meetings. Furthermore, a quality visit is scheduled to be undertaken shortly to the Renal Unit with a patient transport focus.
Recommendation:
The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to:
- **Note** the contents of the report and request further information as required.
- **Ratify** the decision of the Quality Committee to provide an extension up to the 30th September 2017 to the current suite of Safeguarding Policies; namely Safeguarding Policy and Managing Safeguarding Allegations Against Staff whilst these are currently being reviewed.

Summary of risks relating to the proposal
Detailed within the main body of the report.

Any statutory/regulatory/legal/NHS constitutional/NHSE assurance/governance implications
Paper includes reference to NHS Constitution standards

Is a Quality and/or Equality impact assessment required
N/A

Any engagement activity with stakeholders/practices/public and patients
Quality Assurance processes with providers.

Strategic objectives supported by this paper
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</tbody>
</table>

ACRONYMS
Detailed within the main body of the report.
Quality Committee  
(Report of business and activities considered during the February 2017 Committee meeting)

1. **Quality Impact Assessment: Bradwell and Cheadle Hospitals**  
Members received an update on the Quality Impact Assessment (QIA) for Bradwell Hospital, noting factors to be included such as the Domiciliary Care Service which has now commenced. Members continued to be supportive of this approach, noting that the rationale for doing this is that quality of care for patients will improve, when they are medically fit for discharge to a care home, rather than remaining in an acute bed. The Committee were interested in hearing patient experience stories from those patients who had been positively impacted from a placement in a care home across a wide geographical area to ensure a balanced picture was being portrayed of this change in service. Members noted that the CCGs Director of Nursing and Quality and members of the Quality Team had spent time in all areas of the system from the Control Room at the University Hospital of North Midlands NHS Trust, the Hub and undertaking visits to Care Homes.

The importance of understanding the trajectory for the Domiciliary Care Service expanding was discussed to be able to assess the impact of this. The Committee requested updates on a regular basis.

2. **Directly Commissioned Beds**  
The CCGs have commissioned a number of health beds within care homes within Northern Staffordshire at the following homes; Stadium Court, Hilltop Manor, Hilton House and Farmhouse, along with wrap around services to support these. The Committee noted that the Care Home Matron is now in post and building relationships with care homes with the aim to focus on the quality agenda. The CCGs have implemented a number of monitoring mechanisms to ensure the quality of care at these homes through its CCG Safeguarding Team, Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP) therapy staff working within the care homes, quality visits undertaken by the CCGs Quality Team, Primary Care, and SSOTP community bed flow team. The Committee noted a gap in therapy at present in respect of a physiotherapist and occupational therapist which are currently being sourced.

The Committee noted the measures in place to ensure the quality of these services and that Healthwatch Stoke had recently undertaken a positive Enter and View visit to the Wedgwood Unit at Stadium Court. Healthwatch confirmed that they would be undertaking further visits across care homes in the near future, although there were no immediate concerns regarding Wedgwood Unit would be happy to undertake a further visit if the CCG wished to receive further external assurance.

The Committee noted that there had been 202 pieces of feedback received in quarter three; this is an increase when compared with the previous quarters 167. The number of PALS enquiry records is in line with the previous quarter from 63 to 62. 22 complaints were received; this is also a decrease from the previous quarters 26. 28 MP letters were received; this is an increase from the previous quarters 22.

The service with the highest number of feedback items (25) this quarter is Audiological Medicine at AQP Adult Hearing Services. Audiological Medicine is a new emergent theme reported as a result of two providers who made the decision to withdraw services following the award of contracts (leaving one provider). This has resulted in increasing levels of demand for the remaining provider and, therefore, longer wait times for patients.
Examples of patient feedback received related to long waits for an appointment with a new provider; a difference in what the old provider and new provider can repair and the process, resulting in further delays; concerns around no longer meeting the NHS funded criteria and communication delays for patients in understanding who the provider is and the process for appointments.

The Quality Committee was advised of a number of actions the CCGs have undertaken to improve these areas as follows:

- Close working with the remaining provider to increase capacity. This has included pulling in additional staff from other areas to provide support; for November and December this amounted to just under 250 additional hours to deal with the backlog. There are also additional clinics in existing locations e.g. extra weekend clinics/double clinics. We also have additional locations being sourced and scoped in order to meet demand e.g. 2-3 days a week in Leek from Moorland Medical Centre was added to the list of locations. We have recently added a mobile unit in the area which is operational an extra 6 days per week with the flexibility to move where the demand is coming in;
- Introduction of an additional provider. This is to ensure we do have that additional capacity in the system, but it is also to offer patients choice of provider;
- The CCG is undertaking further analysis on demand in the area and where the gaps are so to work closely with the new provider to ensure we get the right capacity in the right places.


The CCGs received 287 events reported via the GP Event Reporting System (Datix) during quarter 3, 2016/2017. This is a decrease from quarter 3 in 2015/2016 with 359 events. Members noted the decrease in reporting and the planned focus of the GP Event Reporting Manager to attend locality meetings.

Members noted that events in respect of care homes are also reported by GPs via Datix and these events are shared with the Adult Safeguarding Nurse Leads and the Local Authority Quality Monitoring Teams providing a further mechanism for sharing information and creating ‘early warning’ processes between partners. The information from these events helps the Local Authority with their care home profiling.

5. **Patient and Public Involvement**

Members received the Patient and Public Involvement quarterly report to note the actions being taken to strengthen the CCGs progress in this area of work, covering the following areas;

(1) Governance arrangements
(2) Organisational Development
(3) Annual Report
(4) Communication
(5) Patient and Public Involvement
(6) My Care, My Way – Home First
(7) Pan Staffordshire Transformation Programme
(8) LEAF
(9) Patient Congress and
(10) Citizens Jury.

In particular, members noted progress on developing the draft Communication and Engagement Strategy, co-produced with both Patient Congresses, which will be submitted to the Patient and Public Involvement Steering Group on 21st February and the Joint Governing Body in March 2017.
An update was provided in relation to My Care, My Way – Home First in which the proposed formal 12 week consultation on the future of community hospitals has been delayed due to the announcement of the by-election for the Stoke Central MP seat on the 23rd February. Members noted the legal advice sought and opinions sought of our local authorities and NHS England prior to the Joint Governing Body approving a decision to delay the start of the consultation.

The next Citizens Jury is underway with 10 jurors selected following a competitive recruitment process to focus on mental health services.

6. **Healthwatch Stoke-on-Trent**

A detailed quarterly report was received outlining the current work plan of Healthwatch Stoke-on-Trent, examples of which include:

- **Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan:** A report has been produced which summarises the issues raised following two events hosted with the Together We’re Better Programme. The full report can be accessed via: [http://www.healthwatchstokeontrent.co.uk/wp-content/uploads/2016/12/Big-Conversation-Events-Report-FINAL.pdf](http://www.healthwatchstokeontrent.co.uk/wp-content/uploads/2016/12/Big-Conversation-Events-Report-FINAL.pdf)
- **Community Hospital Beds:** Questions are being developed from information received in response to an online survey designed to better understand people’s concerns about the future of community hospitals beds. The full report will be published following discussions with the CCGs over coming weeks;
- **While we were waiting – Children and Adolescent Mental Health Service CAMHS:** The Mental Health Sub-Group of Healthwatch Stoke-on-Trent has been focussed on the While we were Waiting project which aims to better understand what happens when people wait for mental health services for young people. This has included a visit to the CAMHS Hub at Dragon Square and an event at which Special Educational Need Coordinators and CAMHS staff discussed areas for improvement. A report is due to be shared with educators and NSCHT shortly.
- **My Care My Way (On-going):** Questionnaires are currently being distributed to patients identified by the University Hospital of North Midlands on pathways to understand their experiences whilst following these pathways through to discharge.
- **Enter and View (Dignity and Respect Charter):** During 2016 Healthwatch Stoke undertook visits to 18 different venues. Reports are available at [http://bit.ly/1Fmi74d](http://bit.ly/1Fmi74d) 2017 will see continued visits to care homes, nursing homes and health facilities throughout the city including health centres where services are being provided by Staffordshire and Stoke on Trent Partnership Trust (SSOTP).

7. **Healthwatch Staffordshire**

A detailed quarterly report was received outlining the current work plan of Healthwatch Staffordshire, examples of which include:

- **Enter and View Programme** in three themed areas of work focussing on hospital discharge; activities in care home and hospital food. Good progress has been made on 2 of the projects, hospital discharge and activities in care homes. The hospital food project is currently on hold pending the outcome of recent PLACE visits at the three main provider hospitals.
- **Hospital Discharge:** A number of visits have taken place at the Discharge Lounge at Royal Stoke and County Hospital Stafford and a resulting action plan and response provided for each site. The report will be published shortly on the Healthwatch Staffordshire website.
- **Activities in Care Homes:** A comparative study looking at the physical and mental wellbeing of residents who may or may not have access to a range of activities. 24 care homes were identified and the schedule of visits is now complete (6 of which were care homes in North
Staffordshire). The report will be submitted to the commissioner, home owners and managers shortly.

- **Enter and View:** During September-November, 4 Enter and View Visits have taken place to 3 residential care homes in North Staffordshire and 1 to a ward at the Royal Stoke. The reports are awaited.
- **Staffordshire Drugs and Alcohol services:** Provider and service user surveys have been compiled to understand the potential impact of these cuts and the opinions of local communities, particularly relating to Early Intervention, Treatment and Aftercare.

8. **Quality Strategy Implementation Plan – We Said, We Did**

North Staffordshire CCG and Stoke-on-Trent CCG launched our Joint Quality Strategy 2016-2021 in November 2016. This was co-produced with each Patient Congress who have taken a key role in its development. Our Quality Strategy sets out the approach and shared focus to deliver the Northern Staffordshire Five Year Strategic Plan. Members received the first quarterly implementation report and noted progress against the high level actions detailed within year one of the strategy under the following aims:

- All patients feel safe;
- All patients receive effective healthcare;
- All patients have a positive experience of care.

The Quality Team will be sharing progress with each Patient Congress at the next joint meeting on 12th April 2017. In addition, members noted that the CCGs Quality Team is hosting a Valntines ‘Lunch and Learn’ on the 14th February 2017 where the three main providers will be showcasing work along with the work of the CCGs Quality Team.

9. **Infection Prevention & Control**

The CCGs Director of Nursing and Quality presented a C.difficile recovery action plan ‘deep dive’ also advised the committee of the current performance against trajectory as follows:

North Staffordshire CCG is over trajectory at Month 8 with 57 reportable cases of *Clostridium difficile infection* (CDI) against a cumulative objective of 40 cases. Of the 50 CDI cases, 17 occurred within an acute setting and 40 in a non-acute setting (e.g. samples sent from a Nursing Home, General Practice or within 48 hours of admission to an acute or bedded community facility other than a Care Home).

Stoke-on-Trent CCG is over trajectory at Month 8 with 80 reportable cases of *Clostridium difficile infection* (CDI) against a cumulative objective of 56 cases. Of the 80 CDI cases, 30 occurred within an acute setting and 50 in a non-acute setting.

Members received detailed assurance on the range of actions being undertaken to understand this position and to triangulate any potential themes in cases reported. The Director of Nursing & Quality has convened a Clostridium *difficile* focused work group, which she chairs. Examples of immediate actions being taken in line with the action plans include:

- To work collaboratively with Public Health England (PHE) to determine any important epidemiological factors and to implement disease control measures where appropriate;
- To review all cases of CDI in the previous six month period to establish any links with inpatient settings by time, place and ribotype;
- UHNM and SSOTP to collaboratively pilot the use of UV light equipment as an additional deep cleaning measure, where the use of HPV is problematic or impracticable;
- The CCG Head of Infection Prevention and UHNM to explore a project to reduce hospital admissions with Keele University by immediate investigation of the causative organism where patients present with suspected UTI, enabling targeted treatment regimens to be implemented;
- To undertake assurance visits to areas where more than one case has been reported;
To reintroduce the C. difficile passport and include advice on actions to be taken in the event of recurrence of symptoms;
Increase IPC training threshold from 85% to 95% across all providers.

10. **University Hospitals of North Midlands NHS Trust: Quality Assurance Narrative for Breached NHS Constitutional Standards Exception Report**

The Quality Committee received a quality assurance exception report on UHNM’s current performance noting the continued breach of a number of the NHS Constitution standards.

Members noted that the following Standards were not achieved in December 2016:
- 4 hour emergency access standard (76.5%) – national standard 95%;
- 12 hour trolley waits (344) – national standard zero;
- 18 week referral to treatment (RTT) standard (88.3% unvalidated) – national standard 92%;
- 52 week breaches of the RTT standard (23) – national standard zero;
- 28 day cancelled operations standard – (10) – national standard zero;
- Cancer, Subsequent surgery 88% - national standard 94%;
- Cancer, 62 day 67.2% – national standard is 85%;
- Cancer, 62 day screening 87.5% – national standard 90% (provisional).

A detailed discussion took place in respect of the length of time these constitutional targets have continued to breach and the additional actions and assurances the CCGs have been seeking, including the use of all contractual levers and additional quality monitoring. The Quality Committee is seeking that QSG consider whether there are any additional actions that can be taken to support the Trust towards achievement of the constitutional targets given that commissioners have been utilising all contract levers available to them.

11. **Safeguarding**

Members approved an extension to the current suite of Safeguarding Policies; namely Safeguarding Policy and Managing Safeguarding Allegations Against Staff whilst these are currently being reviewed. Members approved an extension date up to the 30th September 2017 to allow the required scrutiny and approval processes to be undertaken via the Safeguarding Sub-group, Quality Committee and ratification by Joint Governing Body.

12. **North Staffordshire Combined Healthcare NHS Trust (NSCHT) – Flu Vaccination Performance**

NSCHT has been officially recognised as the highest performing mental health Trust in the country for flu vaccination of frontline staff. The Trust achieved a vaccination rate of 79.7% by the end of the year - beating the 75% national target set by the NHS - and almost doubling its performance compared with the 2015. The success was partly down to the efforts of a team of “roving vaccinators” led by the Deputy Director of Nursing and the Infection and Control Team Practitioner.

13. **University Hospitals of North Midlands – Seasonal Staff Influenza Vaccination Campaign**

UHNM has achieved the national CQUIN for staff seasonal flu vaccination during 2016-17. To date in excess of 80% of frontline staff have been vaccinated, and UHNM was amongst the top 5 Trusts in England.

14. **Ezec Patient Transport Service**

Members noted that as the lead commissioner for the Patient Transport Service contract awarded to Ezec, quality reports will be received at future Quality Committee meetings in line with the CCGs other main providers. A Lead Nurse – Quality has been allocated to this contract and is attending the Clinical Quality Review Meetings. Furthermore, a quality visit is scheduled to be undertaken shortly to the Renal Unit.
This paper provides a summary of the CCGs financial performance as at the end of January 2017 (Month 10).

The CCGs are both reporting adverse variances from their financial plans at month 10. Year to date the CCG’s are reporting deficits of £6.9m against planned surpluses of £2.3m.

The forecast outturn for the year is consistent with that reported at month 9 which is an in year deficit of £10.1m, this is an adverse variance of £6.7m against the full year planned deficit of £3.4m.

The delivery of an in year deficit of £10.1m will increase the CCG’s cumulative deficit to £13.7m.

The component elements of the above financial performance are reflected within the table below:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Plan to Month 10</th>
<th>Actual to Month 10</th>
<th>Variance to Month 10</th>
<th>Full Year Plan</th>
<th>Cumulative Forecast</th>
<th>Full Year Variance</th>
<th>Bought Forward</th>
<th>In Year Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Staffordshire</td>
<td>(1,439)</td>
<td>(4,114)</td>
<td>(2,675)</td>
<td>(5,875)</td>
<td>(8,591)</td>
<td>(2,716)</td>
<td>(4,215)</td>
<td>(4,376)</td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>3,766</td>
<td>(2,790)</td>
<td>(6,556)</td>
<td>(1,207)</td>
<td>(5,161)</td>
<td>(3,954)</td>
<td>503</td>
<td>(5,664)</td>
</tr>
<tr>
<td>Total</td>
<td>2,327</td>
<td>(6,904)</td>
<td>(9,231)</td>
<td>(7,082)</td>
<td>(13,752)</td>
<td>(6,670)</td>
<td>(3,712)</td>
<td>(10,040)</td>
</tr>
</tbody>
</table>

The CCGs position is highlighting a significant variance against the initially submitted plan, in month 10 the CCGs are reporting an adverse variance to trajectory against its agreed recovery plan position as reflected below although the position has improved from month 9 which reported an overall adverse variance of £451k across the two CCGs. North Staffordshire has a £524k adverse variance, whereas Stoke on Trent has a £80k favourable variance against trajectory.
Expenditure variances are driven by cost pressures associated with acute contracts, adverse community arbitration settlement, orthotics activity, Mental Health Out of Area placements and Funded Nursing Care (FNC) rate increases of £2.2m (North Staffs £1.2m, Stoke on Trent £1.0m). These pressures are partly offset by Prescribing expenditure being significantly under spent with a favourable variance year to date of £2.1m (North Staffs £1.0m, Stoke on Trent £1.1m).

Full utilisation of the 0.5% contingency reserve of £3.3m (North Staffs £1.4m, Stoke on Trent £1.9m) has been applied.

The forecast relating to the CCGs QIPP programme has been revised following a detailed forecasting analysis which was undertaken at the end of January. The forecast QIPP delivery has been adjusted to £20.3m (North Staffs £8.3m, Stoke on Treant £12.0m) from the £20.0m (North Staffs £8.2m, Stoke on Trent £11.8m) reported at month 9. The movement was due to forecasts being revised based on the latest data with several schemes now seeing improved delivery including medicines optimisation schemes and children’s urgent care.

The CCGs have not committed the 1% headroom reserve of £6.6m (North Staffs £2.8m, Stoke on Trent £3.8m) and it is unlikely that the CCGs will be able to apply this as mitigation over the course of the financial year.

<table>
<thead>
<tr>
<th>CCG</th>
<th>FRP Trajectory</th>
<th>Actual to Month 10</th>
<th>Variance to Month 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month 10 £'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>North Staffordshire</td>
<td>(3,590)</td>
<td>(4,114)</td>
<td>(524)</td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>(2,870)</td>
<td>(2,790)</td>
<td>80</td>
</tr>
<tr>
<td>Total</td>
<td>(6,460)</td>
<td>(6,904)</td>
<td>(444)</td>
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</table>

**Action required**

**Decision**

**Discussion**

**To note**

**For assurance/ For information**

**Recommendation:**

The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to note:-

I. The contents of this report and executive summary regarding the combined CCG performance against 2016-17 financial duties to the end of Month 10;

II. The key drivers of risk that are impacting the financial position;

III. The CCGs sub-committees and working groups have discussed in detail the forecast outturn and range of mitigating actions to deliver the CCGs back to its planned control totals. That work has been undertaken to develop the Financial Recovery Plan as solutions to mitigate the financial and operational risks.

IV. Some risks remain unmitigated in-year and actions are being taken to deliver the CCG back to a more sustainable financial position in 2017/18. These plans are fully outlined in the Financial Recovery Plan.

V. The detrimental financial position of the CCGs results in a failure to deliver to its constitutional requirements.

**Summary of risks relating to the proposal**

**QIPP** - The CCGs have a planned QIPP programme of £21.9m (North Staffs £8.6m, Stoke on Trent £13.3m), as part of the recovery and stretch process the planned targets were revised to £22.6m. Against the revised
position the CCG forecast, following a further detailed forecasting analysis carried out for month 10, it is forecast that delivery will now be £20.3m, a shortfall against the stretch target of £2.3m. Other areas of mitigation are being explored to address this shortfall.

**Demand Management** - The month 10 position and forecast for UHNM includes significant unscheduled care over-performance and contractual challenges which the CCGs expect to mitigate & realise. Month 9 data has seen expenditure relating to Non-Elective excess bed days move back within budget, this is in contrast to month 8 which was significantly higher than budget due to the hospital discharging a high number of long stay patients.

**Drivers of Cost Pressures** – Section 12 identifies CCG risks and mitigations. It is essential the mitigations are delivered in full which includes delivery of QIPP.

<table>
<thead>
<tr>
<th>Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications</th>
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<tbody>
<tr>
<td>The CCGs revised cumulative deficit agreed with NHS England is now set at £13.7m (North Staffs £8.6m cumulative deficit, Stoke on Trent £5.1m cumulative deficit) and therefore any adverse variance from the position will result in the CCG not meeting one of its key financial targets. As a consequence of the movement in forecasted position the CCGs have been subject to a robust assurance process with NHS England.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Is a Quality and/or Equality impact assessment required</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any engagement activity with stakeholders/practices/public and patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>The range of mitigations to redress the financial position are in line with the CCGs Commissioning strategy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic objectives supported by this paper (identify appropriate goals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Staffordshire CCG Yes No</td>
</tr>
<tr>
<td>1. We will commission safe effective and high quality sustainable services</td>
</tr>
<tr>
<td>2. We will deliver better patient outcomes through effective federated and collaborative arrangements with key partners</td>
</tr>
<tr>
<td>3. We will improve patient experience through patient engagement, feedback</td>
</tr>
<tr>
<td>4. We will reduce health inequalities and inappropriate clinical variation</td>
</tr>
<tr>
<td>5. Governance &amp; Statutory Requirements</td>
</tr>
<tr>
<td>6. We will achieve all of the above while remaining within financial balance and achieving best value</td>
</tr>
</tbody>
</table>

**ACRONYMS**
Set out in the body of the report
Month 10 Financial Position 2016/17

1. Background

North Staffordshire CCG & Stoke on Trent CCG report achievement against their key financial duties and plans both monthly and annually. This report discusses the position to the end of January 2017 (Month 10) and the forecast for the remainder of the financial year 2016/17.

2. Executive Summary

The CCGs are both reporting a divergence from their financial plans at month 10 of the financial year and as a consequence will not deliver their initial financial plans for 2016/17, although as at month 10 the CCGs are slightly behind trajectory to achieve the revised plan’s control total, an element of risk is recognised for which mitigations have been developed. The high level dashboard below provides performance detail against each key metric. This report further outlines the key drivers of the adverse financial performance, areas of mitigation and a revised forecast for the year in line with the revised control total agreed with NHSE.

<table>
<thead>
<tr>
<th>Combined Northern Staffordshire CCGs</th>
<th>North Staffordshire CCG</th>
<th>Stoke-on-Trent CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure against Total Revenue Allocation</td>
<td>£662.91m</td>
<td>£276.71m</td>
</tr>
<tr>
<td>Expenditure against Programme Allocation</td>
<td>£652.29m</td>
<td>£272.06m</td>
</tr>
<tr>
<td>Expenditure against Running Cost Allocation</td>
<td>£10.61m</td>
<td>£4.64m</td>
</tr>
<tr>
<td>Delivery of QIPP Target</td>
<td>£21.85m</td>
<td>£8.61m</td>
</tr>
<tr>
<td>Position against revised cumulative control total of £13.75m deficit</td>
<td>£8.59m deficit</td>
<td>£5.16m deficit</td>
</tr>
</tbody>
</table>

3. Financial Duties and Plans 2016-17

In 2016-17, the high level Income & Expenditure plans of the 2 CCGs are shown in Table 1 overleaf and illustrate both the in-year and cumulative financial targets:-

- Deliver a £3.37m in year deficit (North Staffs £1.66m, Stoke on Trent £1.71m) and a £7.09m cumulative deficit (North Staffs £5.88m, Stoke on Trent £1.21m). This is against the allocated Revenue Resource Limit (RRL) and a mandated planning requirement of 1% surplus.
- Whilst both CCGs have set a planned deficit, the business rules require the delivery of a planned surplus at 1% of the core allocation. As such, to deliver the business rules this year,
Stoke would have had to improve its financial position by £5.04m and North Staffordshire by £8.68m.

### Table 1 - In Year & Cumulative Top Line Plans

<table>
<thead>
<tr>
<th></th>
<th>Cumulative B/fwd from 2015/16</th>
<th>2016/17 In-Year</th>
<th>2016/17 Cumulative C/fwd to 2018/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Allocation</td>
<td>-3.72</td>
<td>664.39</td>
<td>660.67</td>
</tr>
<tr>
<td>Forecast Expenditure</td>
<td>-674.43</td>
<td>-674.43</td>
<td></td>
</tr>
<tr>
<td>Forecast Deficit</td>
<td>-3.72</td>
<td>-10.04</td>
<td>-13.76</td>
</tr>
<tr>
<td>Stoke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Allocation</td>
<td>0.5</td>
<td>383.51</td>
<td>384.01</td>
</tr>
<tr>
<td>Forecast Expenditure</td>
<td>-389.17</td>
<td></td>
<td>-389.17</td>
</tr>
<tr>
<td>Forecast Surplus/Deficit</td>
<td>0.5</td>
<td>-5.66</td>
<td>-5.16</td>
</tr>
<tr>
<td>North Staffordshire</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Allocation</td>
<td>-4.22</td>
<td>280.88</td>
<td>276.66</td>
</tr>
<tr>
<td>Forecast Expenditure</td>
<td>-285.26</td>
<td></td>
<td>-285.26</td>
</tr>
<tr>
<td>Forecast Deficit</td>
<td>-4.22</td>
<td>-4.38</td>
<td>-8.60</td>
</tr>
</tbody>
</table>

Other high level targets are:
- Contain expenditure within an overall cash limit
- Contain expenditure within the Running Cost target of £10.61m (North Staffs £4.64m, Stoke on Trent £5.97m) for the CCGs
- Deliver planned QIPP at £21.85m (North Staffs £8.61m, Stoke on Trent £13.24m)

The summary financial performance dashboard is shown below:

### Description of financial duties

- **Maintain expenditure within the revenue resource limit and deliver to a planned surplus (normally 1%)**
  - North Staffordshire CCG: The CCGs original financial plan was a year end deficit of £5.88m - at month 10 the control total is forecast to be a £8.59m deficit. This control total was revised as part of the Month 6 assurance process with NHS England. Unmitigated risk is now reported at zero at month 10.
  - Stoke on Trent CCG: The CCGs original financial plan was a year end deficit of £1.207m - at month 10 the control total is forecast to be a £5.16m deficit. Unmitigated risk is now reported at zero at month 10.

- **Maintain expenditure within a Maximum Cash Drawdown limit (cash limit).**
  - North Staffordshire CCG: The CCG has drawn down £199.2m in the year and with BSA requirements of £29.8m giving a total cash requirement of £299.0m. The drawdown is lower than planned, but this is expected to move closer to plan as payments begin to reflect contract values.
  - Stoke on Trent CCG: The CCG has drawn down £277.52m in the year and with BSA requirements of £41.77m giving a total cash requirement of £319.29m. The drawdown is lower than planned year to date, and represents 83.04% of the Maximum Cash Drawdown.

- **Maintain capital expenditure within the delegated limit from the Area Team.**
  - North Staffordshire CCG: £0.294m allocation received in month 10, expenditure is forecast in line with allocation.
  - Stoke on Trent CCG: £0.294m received in month 10, expenditure is forecast in line with allocation.

- **Ensure running costs are within the set allocation per head of population.**
  - North Staffordshire CCG: The CCG has an allocation of £4.646m for running costs which is slightly reduced from last year. At month 10 the CCG is within budget and is forecast to be within its running cost allocation at year end.
  - Stoke on Trent CCG: The CCG has an allocation of £5.968m for running costs which is slightly reduced from last year. At month 10 an underspending of £318k is reported.

- **Ensure a minimum of 0.5% contingency is held.**
  - North Staffordshire CCG: The CCG has 0.5% contingency within the financial plan this is fully utilised in forecasting the outturn position for the control total target.
  - Stoke on Trent CCG: The CCG has 0.5% contingency within the financial plan this is fully utilised in forecasting the outturn position for the control total target.

- **Ensure that 1% of funds remain uncommitted.**
  - North Staffordshire CCG: The CCG has a reserve which remains uncommitted as required by financial planning guidelines. Its value is £2.75m (1%).
  - Stoke on Trent CCG: The CCG has a reserve which remains uncommitted as required by financial planning guidelines. Its value is £3.79m (1%).

- **Delivery of QIPP targets**
  - North Staffordshire CCG: The CCGs QIPP Plan is valued at £8.6m. There is evidence of slippage at M10, planned savings £6.97m, delivery £6.54m. For the majority of schemes, contracts will have to under perform to achieve much of the QIPP programme and/or additional schemes are required to deliver plan.
  - Stoke on Trent CCG: The CCGs QIPP Plan is valued at £13.24m. There is evidence of slippage at M10, planned savings £10.75m, delivery £9.18m. For the majority of schemes, contracts will have to under perform to achieve delivery of the QIPP programme and/or additional schemes are required to deliver plan.

- **Ensure compliance with the Better Payment Practice Code (BPPC) – “Late Payment of Commercial Debt”**
  - North Staffordshire CCG: The CCG delivered 96.4% in 30 days against the number of NHS and 95.9% against non NHS invoices paid to the end of January 2017.
  - Stoke on Trent CCG: The CCG delivered 96.2% in 30 days against the number of NHS and 98.6% against non NHS invoices paid to the end of January 2017.
4. **Position to Date - Maintain expenditure within the resources allocated**

The year to date position for both CCGs combined is an £6.90m cumulative deficit against budget (North Staffs £4.11m deficit, Stoke on Trent £2.79m deficit). This compares to a planned position that would generate a £2.33m surplus (North Staffs £1.44m deficit, Stoke on Trent £3.77m surplus).

The table below details the financial performance against key budgetary elements. In summary the table highlights:

- **Acute Services** is the most significant variance year to date, this is predominantly UHNM but includes adverse variances at Nuffield, West Midlands Ambulance and other private providers.
- **Mental Health services** saw significant over performance in month driven by an increase in the number of out of area mental health placements.
- **Community Health services** variance includes the outcome of the arbitration ruling and over performance on PbR elements of the SSOTP contract and Orthotics.
- **Running Costs** is £318k under spent year to date and the CCGs are forecast to remain within their running costs allocation at year end.

**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>Plan Annual Budget £000</th>
<th>In Month Budget £000</th>
<th>In Month Spend £000</th>
<th>In Month Variance Over / (Under) £000</th>
<th>Budget to Date £000</th>
<th>Spend to Date £000</th>
<th>Variance Over / (Under) £000</th>
<th>Forecast Variance £000</th>
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<tbody>
<tr>
<td>Revenue Resource Limit</td>
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<td>-55,474</td>
<td>0</td>
<td>55,474</td>
<td>550,995</td>
<td>0</td>
<td>550,995</td>
<td>662,908</td>
</tr>
<tr>
<td>Sub-total Acute services</td>
<td>322,012</td>
<td>27,001</td>
<td>26,896</td>
<td>-105</td>
<td>266,783</td>
<td>276,065</td>
<td>9,282</td>
<td>6,873</td>
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<tr>
<td>Sub-total MH services</td>
<td>73,568</td>
<td>6,054</td>
<td>6,529</td>
<td>475</td>
<td>61,279</td>
<td>64,183</td>
<td>2,903</td>
<td>3,003</td>
</tr>
<tr>
<td>Sub-total Community Health Services</td>
<td>92,910</td>
<td>7,679</td>
<td>7,976</td>
<td>297</td>
<td>77,564</td>
<td>82,037</td>
<td>4,473</td>
<td>5,604</td>
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<tr>
<td>Sub-total Continuing Care Services</td>
<td>44,639</td>
<td>3,641</td>
<td>3,330</td>
<td>-311</td>
<td>37,357</td>
<td>36,531</td>
<td>-827</td>
<td>-177</td>
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<tr>
<td>Sub-total Primary Care Services</td>
<td>103,720</td>
<td>8,903</td>
<td>8,296</td>
<td>-607</td>
<td>86,345</td>
<td>82,821</td>
<td>-3,524</td>
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<td>Sub-total Other Programme services</td>
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<td>1,312</td>
<td>693</td>
<td>-619</td>
<td>12,822</td>
<td>7,736</td>
<td>-5,087</td>
<td>1,412</td>
</tr>
<tr>
<td>Total - Commissioning services</td>
<td>652,294</td>
<td>54,590</td>
<td>53,720</td>
<td>-869</td>
<td>542,151</td>
<td>549,372</td>
<td>7,221</td>
<td>13,752</td>
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<tr>
<td>Total - Running Costs Allowance</td>
<td>10,614</td>
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<td>726</td>
<td>-158</td>
<td>8,844</td>
<td>8,526</td>
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</tr>
<tr>
<td>Total Spend - Programme + Running Costs Allowance</td>
<td>662,908</td>
<td>55,474</td>
<td>54,447</td>
<td>-1,027</td>
<td>550,995</td>
<td>557,898</td>
<td>6,903</td>
<td>13,752</td>
</tr>
</tbody>
</table>

Less Cumulative B/fwd (see Top Line plans) - 3,712

In Year Outturn Variance 10,040

The variances year to date are as reported at month 10, the Plan FOT is the forecasted variance at year end based on the CCGs forecasting methodologies. The forecasted variance also takes into account future QIPP delivery and Financial Recovery Plan actions which is a reason why forecasted variances may be less than the variances incurred year to date such as Acute Services for which future QIPP and Financial Recovery Plan actions which are expected to be delivery in months 11-12.

On a forecast out-turn basis the drivers of the adverse financial performance have been quantified and mitigations sought. The table above shows both the cumulative and in year deficit.
The pie chart above highlights the proportion of the overall forecast variance by each category of spend.

5. **Financial Recovery Plan**

The CCGs were designated as being in ‘escalated turnaround’ by NHS England and as such were placed under a greater degree of assurance scrutiny. As a consequence the CCG has produced a Financial Recovery Plan as part of an assurance process with NHS England. This has resulted in a revised forecast cumulative deficit now set at £13.75m across both CCGs which was a movement of £6.67m.

As part of the Financial Recovery Plan the CCG must adhere to a clear in-year trajectory which monitors the CCGs performance on a monthly basis and determines whether the CCGs are on track to deliver the revised control total.

The CCGs saw a continued movement at Month 10 away from trajectory with an adverse variance of £0.44m, the CCGs reporting an actual deficit of £6.90m against a trajectory plan of £6.46m; this was driven by pressures within operational performance in particular acute and mental health expenditure.

In month 9 the CCGs reported unmitigated risk of £3m (£0.9m North Staffs, £2.1m Stoke on Trent), in month 10 the CCGs are now reporting unmitigated risks of zero, this is due to the CCG identifying mitigations in January through a full baseline review and by identifying contractual opportunities across providers.
This is reflected in the diagram below, with the purple line demonstrating mitigations to be delivered to reach the £10.04m

2016/17 In Year Financial Performance

Achievement in meeting the £10.04m deficit is also based on the assumption that future QIPP delivery will be as per the latest M10 forecasts and financial recovery actions identified at month 6 as part of the NHS E assurance process will continue to deliver the expected savings.

6. Ensure running costs are contained within the allocation of £10.61m

Running Cost allocation is £10.61m (North Staffs £4.64m, Stoke on Trent £5.97m) which the CCGs should not exceed. At month 10 the CCGs are under spent in this area by £318k which is an improvement against the position reported at month 9 as the CCGs continue to exercise control over expenditure. The CCGs are forecast to remain within budget at year end.

7. Quality, Innovation, Productivity and Prevention (QIPP)

The opening QIPP plan totalled £21.85m (North Staffs £8.61m, Stoke on Trent £13.24m). Appendix 2 highlights the original plan summary; delivery to M10 and the forecast out-turn. As at M10 there is slippage in the QIPP programme of £2.0m (North Staffs £0.4m, Stoke on Trent £1.6m) against planned levels as reported in the Non-ISFE submission. Risk has also been identified in the Non-ISFE against QIPP delivery.

At month 10 the QIPP forecast has been updated following a detailed analysis of anticipated future QIPP delivery by each individual scheme. As a consequence the forecast QIPP delivery has now been increased to £20.3m (North Staffs £8.3m, Stoke on Trent £12.0m) from the £20.0m (North Staffs £8.2m, Stoke on Trent £11.8m) reported at month 9. The movement is due to forecasts being revised based on the latest data with several schemes now seeing an improved level of delivery including schemes within medicines optimisation and children’s urgent care.

8. Cash Flow - Maintain expenditure within a maximum cash drawdown limit

The CCGs had drawings to the end of January 2017 of £548.29m (North Staffs £229.00m, Stoke on Trent £319.29m) against its planned requirement of £557.45m (North Staffs £232.61m, Stoke on Trent £324.84m), for the same period, including the requirements notified from the Business Services Authority. It is expected that cash payments will increase in future months relating to agreements with local authorities for BCF and other joint agreements.
9. **Ensure compliance with the Better Payment Practice Code (BPPC)**
   The CCGs are expected to comply with the Confederation of British Industry (CBI) Prompt Payment Code. This requires the CCGs to pay 95% of valid invoices within 30 days of receipt. North Staffs CCG performance up to 31st January stood at 96.4% based on count for NHS payables (98.8% by value). For non NHS payables the position was 95.9% based on count (93.7% by value). Stoke on Trent CCG performance up to 31st January stood at 96.2% based on count for NHS payables (96.8% by value). For non NHS payables the position was 98.6% based on count (97.3% by value). Both CCGs met the targets for the period to the end of January 2017.

10. **Strategic Support**
    The CCGs are required to set aside 1% of their baseline recurrent allocation to be used each year on a non-recurrent expenditure basis; this equates to £6.54m (North Staffs £2.75m, Stoke on Trent £3.79m). For 2016/17 these sums are to remain uncommitted and cannot be directly applied to mitigate the financial risks being faced by the CCG. The views of the external auditor have been sought in terms of how this situation would be transacted as part of the annual accounts process. The 1% is forecast as expenditure at month 12 but remains uncommitted as directed from NHS England, if this resource was available it would support the CCGs position.

11. **Balance Sheet**
    The CCGs individual Statements of Financial Position as at 31st January 2017 (Appendix 3) shows the level of inter-indebtedness between the CCGs and other parties (mainly NHS providers). Significant entries include the value of Accounts Payable at £50.18m (North Staffs £24.86m, Stoke on Trent £25.32m). Stoke on Trent CCG has a £50k accrued liability which relates to a provision in relation to a HMRC investigation.

12. **Financial Risks**
    The risks and mitigations schedule has been further developed to include the issues emerging up to month 10. At month 10 the CCG is reporting unmitigated risks of zero, this has reduced from month 9 where £3m (North Staffs £0.9m, Stoke on Trent £2.1m) due to mitigations being developed by the CCGs through a full baseline review and identifying contractual opportunities across providers.

    There remains an element of risk attached to QIPP for schemes which are intended to deliver over the remaining months of the financial year. This is attached to the revised forecast which was updated at month 10 based on the latest data available. An element of risk has also been identified against the contractual challenges issued against UHNM for which the CCG is including in forecasts. The net risk is reported as nil as it is assumed a robust mediation case will mitigate the risk, it is assumed in forecasts that contractual challenges will deliver a benefit of £3.6m across both CCGs.
13. Recommendation

The Governing Board is asked to note:

1. The contents of this report and executive summary regarding CCG performance against 2016-17 financial duties to the end of Month 10.

2. The key drivers of risk that are impacting the financial position

3. That work has been undertaken to develop the Financial Recovery Plan as solutions to mitigating the financial and operational risks.
Appendix 1

Explanatory Notes to Support the Combined Summary Board Table (April to January 2017) [Section 4] and the bridge chart [Section 12]

Contractual Performance of Providers/Budgetary Performance

University Hospitals North Midlands NHS Trust (UHNMM) contract position for M10 and the forecast to the year-end has been based upon activity and financial data received up to December. Activity levels are above contracted levels indicating over performance at the end of month 10 of £5.97m (North Staffs £4.52m, Stoke on Trent £1.45m). The forecast position for the UHNMM contract is £8.35m (North Staffs £6.37m, Stoke on Trent £1.98m) prior to adjustments, once the adjustments for Front of House, RDA, Penalties and the marginal rate tariff this is reduced to £7.97m (North Staffs £6.22m, Stoke on Trent £1.75m).

Current over-performance is prevalent in A&E, emergency care, and outpatient attendances. December saw non-elective excess bed day’s expenditure move back within budget after being significantly over spent in November. Other acute private provider contracts are over performing in planned care to the value of £1.39m (North Staffs £1.00m over spent, Stoke on Trent £0.98m over spent) at M10, a large proportion of this over spend is within the Nuffield contract. Further analysis is required to clarify the growth above plan in these contracts. This indicates further traction is required to ensure QIPP delivery; managing elective demand and managing activity in the unscheduled care system.

West Midlands Ambulance Service activity is significantly above contracted values with overspending of £0.86m (North Staffs £0.34m, Stoke on Trent £0.52m) incurred year to date, the contract is currently forecast to be over spent by £1.03m (North Staffs £0.41m, Stoke on Trent £0.62m) at year end. Further analysis is being undertaken to determine the increase and any links to other services e.g. NHS 111.

Prescribing data received to the end of November continues to indicate that spending is to be below planned levels for both CCGs. The position at month 10 is an under spend of £2.10m (North Staffs £1.00m, Stoke on Trent £1.10m), this is forecast to be an under spend of £2.93m (North Staffs £1.37m, Stoke on Trent £1.56m). The forecast under spend assumes future QIPP delivery of £0.74m (North Staffs £0.30m, Stoke on Trent £0.44m), some level of risk is still recognised and forecasts will be further developed based on dialogue with the Associate Director of Medicines Optimisation.

Continuing Care information has now been received for expenditure up to December. In month 10 prior year benefits are reflected in the position, this has moved the North Staffordshire position to a favourable variance. The YTD position is now recording an under spend of £0.83m (North Staffs £1.52m under spent, Stoke on Trent £0.69m over spent), which if projected to the year-end would result in under spending of around £0.17m (North Staffs £1.17m under spent, Stoke on Trent £1.00m over spent) after taking account of the assessed increased payments of £2.20m (North Staffs £1.22m, Stoke on Trent £0.98m). The M10 forecast takes into account the FNC impact. Mitigations are being sought through challenge on assessment and timing of payments for CHC and FNC and there is a potential for some relief against the increases from a National pharmaceutical pricing agreement.

Costs of individual patients with mental health/learning disability care requirements have over spent at month 10 by £2.57m (North Staffs £0.59m over spent, Stoke on Trent £1.98m over spent). This is an area that has seen a significant increase in levels of over spending in recent months. At month 10 a review of forecasting methods is underway in this area to determine if the overspending is likely in the remainder of the year, if there is any likelihood of discharge to alternative settings, and to ensure that contributions from the CCG and Local Authorities are appropriately assigned under S117 requirements. This will take into account the focus of the Transforming Care Programme.
## Appendix 2

### North Staffordshire & Stoke on Trent CCGs - Combined QIPP Delivery April to January 2016/17

<table>
<thead>
<tr>
<th></th>
<th>16/17 Target</th>
<th>YTD</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>% of Allocation</td>
<td>Plan £m</td>
</tr>
<tr>
<td><strong>Transactional QIPP</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Acute services</td>
<td>6.47</td>
<td>1.0%</td>
<td>5.34</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>3.1</td>
<td>0.0%</td>
<td>0.76</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>5.26</td>
<td>0.8%</td>
<td>4.29</td>
</tr>
<tr>
<td>Continuing Care Services</td>
<td>0.45</td>
<td>0.1%</td>
<td>0.38</td>
</tr>
<tr>
<td>Primary Care services</td>
<td>0.80</td>
<td>0.1%</td>
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<tr>
<td>Other Programme Services</td>
<td>0.00</td>
<td>0.0%</td>
<td>0.00</td>
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<tr>
<td>Commissioning Services Total</td>
<td>13.29</td>
<td>2.0%</td>
<td>10.92</td>
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<td><strong>Running Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transactional QIPP TOTAL</strong></td>
<td>13.29</td>
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<td>10.92</td>
</tr>
<tr>
<td><strong>Transformational QIPP</strong></td>
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<td></td>
</tr>
<tr>
<td>Acute services</td>
<td>7.40</td>
<td>1.1%</td>
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<tr>
<td>Mental Health Services</td>
<td>0.91</td>
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<td>0.00</td>
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<td>Community Health Services</td>
<td>1.04</td>
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<td>Continuing Care Services</td>
<td>0.10</td>
<td>0.0%</td>
<td>0.11</td>
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<tr>
<td>Primary Care services</td>
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<td>Other Programme Services</td>
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<td>Commissioning services Total</td>
<td>8.57</td>
<td>1.3%</td>
<td>6.80</td>
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<tr>
<td><strong>Running Costs</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
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</tr>
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<td><strong>Transformational QIPP TOTAL</strong></td>
<td>8.57</td>
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<tr>
<td><strong>Unidentified QIPP</strong></td>
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<tr>
<td><strong>TOTAL QIPP</strong></td>
<td>21.85</td>
<td>3.3%</td>
<td>17.73</td>
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### North Staffs - Statement of Financial Position
As at 31st January 2017

<table>
<thead>
<tr>
<th>Statement of Financial Position</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Current Assets</td>
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<tr>
<td>Cash</td>
<td>184,288</td>
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<tr>
<td>Accounts Receivable</td>
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<td>Current Assets</td>
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<td><strong>TOTAL ASSETS</strong></td>
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<tr>
<td>Accounts Payable</td>
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<tr>
<td>Accrued Liabilities</td>
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<tr>
<td>Current Liabilities</td>
<td>24,862,054</td>
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<tr>
<td>Long Term Liabilities</td>
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<tr>
<td>Retained Earnings incl. In Year</td>
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<tr>
<td>Total Taxpayers Equity</td>
<td>(20,256,121)</td>
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<tr>
<td><strong>TOTAL EQUITY + LIABILITIES</strong></td>
<td>4,605,933</td>
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### Stoke on Trent - Statement of Financial Position
As at 31st January 2017

<table>
<thead>
<tr>
<th>Statement of Financial Position</th>
<th>£</th>
</tr>
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<tbody>
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<td>Total Taxpayers Equity</td>
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<tr>
<td><strong>TOTAL EQUITY + LIABILITIES</strong></td>
<td>3,652,877</td>
</tr>
</tbody>
</table>

Note. The accrued liability of £50k in Stoke on Trent CCG relates to a provision for a potential liability in regards to a HMRC investigation.
Purpose of the paper, executive summary of key issues, points and outcomes

The purpose of the Month 9 performance report is to provide a summary of performance and activity across North Staffordshire (NS) and Stoke-on-Trent (SOT) Clinical Commissioning Group (CCG). The attached report provides a narrative update against the Improvement and Assessment Framework indicators based on quarter 3 vs quarter 2 and other key performance/activity measures for month 9.

The purpose of the attached briefing is to outline the changes and updates to the IAF indicators. Section One outlines The Six Clinical Priority Areas Assessment indicators to be used in the 2016/2017 year end rating and Section Two outlines the Improvement and Assessment Framework indicators proposed for use in 2017/18.

Six Clinical Priorities Current Assessment

The current assessment is outlined on page 21/22 and shows that SOT are currently top performing for 3/6 indicators (Dementia, Diabetes and Mental Health), Needs Improvement for 3/6 indicators (Cancer, Learning Disabilities, Maternity). NS are currently top performing in 1/6 indicators (Diabetes), performing well in 1/6 (Mental Health), Needs Improvement for 4/6 indicators (Cancer, Dementia, Learning Disabilities and Maternity).

Better Health and Better Care Indicators Quarter 3

A range of indicators were not updated as part of the quarter 3 dashboard released by NHSE. Quarter 3 performance against updated indicators shows

- Both CCG’s are in the lowest quartile nationally for smoking at delivery. Performance deteriorated in quarter 3 for North Staffordshire by 4.3%.
- Improved performance has been seen in the number of falls for quarter 3 attributed to the improvement plan with the current provider, however both CCGs remain in the lowest quartile
Quality of life for carer’s indicator is in the lowest quartile at quarter 2 (not updated for quarter 3). Performance is only 5% away for SOT and 2% away for NS, from the national average.

Both CCGs have met the 50% target for people with first episode of psychosis seen within 2 weeks in quarter 3; however SOT has seen a downward trend.

Personal health budgets (PHBs) saw an improvement in quarter 3 for SOT but remained static for NS.

**NHS Constitution at Month 9**

The following constitutional standards are not achieving at M9:

- 18 weeks RTT shows a further deterioration in performance (SOT 87.86%, NS 88.12%).
- 52 week breach numbers have increased for SOT and decreased for NS (SOT 19, NS 10).
- Cancer access standards both CCGs:
  - 2 week wait for urgent breast for SOT 89.13% (10.87% deterioration) and NS 92.86% (7.14% deterioration).
  - 31 day drug therapy for SOT 87.50% (4.81% deterioration) and NS 97.06% (2.94% deterioration).
  - 62 day urgent referral from GP for SOT 69.09% (4.38% improvement) and NS 73.58% (7.35% improvement).
  - 62 day wait from screening service for SOT 85.71% (4.29% deterioration) and NS 80% (18.89% improvement).
- Cancer access standards NS only, 31 day surgery 91.67% (7.46% improvement).
- 75% Category A ambulance SOT 66.18% (3% deterioration) and NS 63.69% (2% deterioration).
- A&E 4 hour wait at UHNM 73.37% (2.6% deterioration).
- A&E 12 hour wait - UHNM: 178 breaches (decreased from 233).

**Performance and Activity at Month 9**

**WMAS**
- “See and Treat” for SOT 39.4% (3% improvement) and NS 42.8% (4% improvement) with both CCG’s now above the local target.
- “See and Convey” for SOT 57.2% (2% improvement) but still not achieving and NS 54% (6% improvement) taking it to within the local target.
- Turnaround times have deteriorated to 32 minutes at the Royal Stoke.

**A&E**
- Activity is over performing by 3% YTD for SOT and 10% YTD for NS.
- 46.9% (45% M8) of patients arriving in A&E were via Emergency Services and the other 53.1% were via ‘other’ categories.
- 33.2% (31.4% M8) of patients arriving at A&E were admitted to a hospital bed and 22.3% (24.5% M8) were discharged with no follow up.
- Of those patients arriving at A&E via the Emergency services referral Source 51.7% (M8 50.9%) were admitted to a hospital bed in comparison to 11.6% (11% M8) admitted with the ‘self referral’ referral source.

**Planned Care**
- YTD Activity for 1st outpatient is over-performing by 2% for Stoke and 3% for NS. At Month 9 SOT was below plan by -5% and NS was under plan by -2%.
- YTD Activity for Follow Up is over-performing by 4% for Stoke and 5% for NS. At Month 9 Stoke had a -1% variance from plan and NS 0% variance from plan.

**Six Clinical Priority Areas End of Year Assessment Changes 2016/17**

NHSE have shared that additional indicators will be used in the end of year assessment. The additional indicators, outlined below along with the existing indicators and anticipated assessment, will inform the panel assessments.
• Cancer no new indicators added. Likely to remain ‘needs improvement’ based on early stage diagnosis and 62 day targets.
• Dementia – five new indicators. Likely to move to ‘needs improvement’ due to acute admissions and prescribing of anti-psychotics.
• Diabetes – six new indicators. Likely to move to ‘needs improvement’ for both CCGs based on amputations and quality of foot care.
• Learning Disabilities – one new indicator. Likely to remain as ‘needs improvement’ as not meeting inpatient trajectories and annual health checks have deteriorated in numbers.
• Maternity – three new indicators. Likely to remain ‘needs improvement’ for both CCGS.
• Mental Health – eleven new indicators. Likely to move to ‘needs improvement’ for both CCGs based on suicide and self-harm.

The draft high level milestones that NHSE have set for the end of year assessment are outlined below.

• February 2017  The final approach to the assessments will be communicated
• Mid-May 2017  Assessments will be made in clinical priority areas
• Early June 2017  Overall year end assessments will be made
• End of June 2017  Commissioning committee ratification
• July 2017  Publication of year-end report on MyNHS

Improvement and Assessment Framework Changes for 2017/18 - 2018/19

NHSE have proposed the addition of 5 new indicators, to remove 4 indicators and update or replace 19 indicators.

The principles NHSE are applying to the development of the IAF in 2017/18 – 2018/19 are that

• It will cover two financial years to align with the two year planning guidance.
• A small number of indicators will be added.
• In other cases indicators will be added on a “one in one out” basis.
• Additional burden to CCG’s will be considered.
• The domains in the IAF will remain the same to maintain alignment with the Five Year Forward View.
• The final publication of the new IAF indicators will be at the end of March 2017.

**Action required**

<table>
<thead>
<tr>
<th>Decision</th>
<th>Discussion</th>
<th>To Note</th>
<th>For assurance / For information</th>
</tr>
</thead>
</table>

**RECOMMENDATION**

The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to:

1. **Note** the contents of the month nine 2016/2017 performance report.
2. **To share** the Improvement and Assessment Framework briefing with key leads within their Directorate.

**Summary of risks relating to the proposal**

The mitigating actions being taken to address areas of non-delivery of constitutional targets and IAF indicators could have an impact on levels of CCG contracted activity. There is a further risk that non-delivery of some indicators will impact on CCG eligibility to qualify for quality premiums.

**Any statutory / regulatory / legal / NHS constitution/NHSE assurance / governance implications**

Monitoring performance is a statutory duty of the CCG as stated in their respective Constitutions. Where non-delivery of NHS Constitutional Standards indicates an adverse impact on patient safety this is investigated by the CCG Quality Team and pursued through the Clinical Quality Review Meeting (CQRM).

**Is a quality and/or equality impact assessment required**

N/A
### Strategic objectives supported by this paper

(identify appropriate goals)

<table>
<thead>
<tr>
<th>NORTH STAFFORDSHIRE CCG</th>
<th>YES</th>
<th>NO</th>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will commission safe effective and high quality sustainable services</td>
<td>x</td>
<td></td>
<td>Improve access</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>2. We will deliver better patient outcomes through effective federated and collaborative arrangements with key partners</td>
<td>x</td>
<td></td>
<td>Improve health outcomes</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>3. We will improve patient experience through patient engagement, feedback</td>
<td></td>
<td></td>
<td>Improve quality</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>4. We will reduce health inequalities and inappropriate clinical variation</td>
<td></td>
<td></td>
<td>Reduce health inequalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Governance &amp; Statutory Requirements</td>
<td>x</td>
<td></td>
<td>Cross Cutting / Statutory Duties (more than one of the above)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>6. We will achieve all of the above while remaining within financial balance and achieving best value</td>
<td>x</td>
<td></td>
<td></td>
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</tr>
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</table>

### ACRONYMS

N/A
Month 9
Performance Report
2016/17
KEY MESSAGES - AT MONTH 9 – DECEMBER 2016

Performance area | Update February 2017
--- | ---
Six Clinical Priorities | • Additional indicators will be used in the end of year assessment that will contribute to the rating received in each clinical area
• The current assessment is outlined on page 21/22 and shows that
  • Stoke-on-Trent (SOT) are currently top performing for 3/6 indicators (Dementia, Diabetes and Mental Health), Needs Improvement for 3/6 indicators (Cancer, Learning Disabilities, Maternity)
  • North Staffordshire (NS) are currently top performing in 1/6 indicators (Diabetes), performing well in 1/6 (Mental Health), Needs Improvement for 4/6 indicators (Cancer, Dementia, Learning Disabilities and Maternity)

Better Health Better Care

Smoking | • The implementation plan for the £75k of NHSE funding for maternal smoking at delivery has been developed with key partners and was finalised in February.
• For North Staffordshire the Lifestyles service which delivers stop smoking support to pregnant women will cease at the end of March 2017.

Cancer | • The Macmillan Cancer nurse commenced in post in January 2017 to support early diagnosis in primary care.

Falls | • Improved performance has been seen in quarter 3 for both CCG’s which is attributed to the improvement plan with the current provider.
• Falls has been selected as an area to accelerate through the RightCare initiative with a design event to be held on 10 April.

Quality of Life for Carers | • More intensive performance monitoring of the Carers Hubs is being pursued to understand numbers being supported and what impact the service is having on carers quality of life.

Mental Health | • Three new indicators for Crisis Care, Out of Area placements and Children and Young Peoples provision were published in quarter 3 based on self-reported assessment. Performance is currently mixed between ‘not compliant’ or ‘partially compliant.’
• There are action plans in place to address ‘non-compliant’ and ‘partially compliant’ areas.

Personal Health Budgets (PHB) | • PHBs brokered by Continuing Healthcare team year to date figures are 21 against a trajectory of 30 by March 17 for Stoke-on-Trent and 16 against CCG trajectory of 25 by March 17 for North Staffordshire. The PHB have assured us we are likely to meet both trajectories by the end of financial year.
• The IAF figure for Stoke-on-Trent is higher in Q3 as the legacy PHBs brokered by Disability Solutions are included. These PHBs are currently being reviewed and are likely to be reassigned to social care direct payments.

NHS Constitution

4 hour and 12 hour target | • As part of the actions agreed in the 4 hour/12 hour remedial action plan (RAP) a range of patients notes will be audited by March 2017.

Referral to Treatment and 52 weeks | • Clinical triage of all urology referrals is now in place, this has led to a 13.8% increase in the number of patients being diverted.
• Meeting dates have been booked during February and March for General Surgery and Urology to explore alternatives for face to face follow up.
• A joint meeting was held between the CCG Chief Operating Officer, Head of Commissioning, UHNM Chief Operating Officer and key leads. UHNM shared the first cut specialty recovery plan templates for both Cancer and RTT.

Cancer | • Work started mid-February with UHNM to further understand the breakdown of ‘patient choice’ reasons.
• The 31 day contract performance notice was issued and on 31 January 2017 it was agreed that the Joint Investigation could commence and a Terms of Reference meeting was held on 16 February 2017.
• 62 day RAP actions completed, no impact on performance to date; further action plans as part of RAP process to be pursued.
• The CCG are withholding part of the CQUIN payment for non-delivery of the 104 day target.
• NHSE have asked that the CCG report all new 104-day breaches to the Chair/COO of the Trust and monitor breaches via the Quality Surveillance Group processes.
<table>
<thead>
<tr>
<th>AREA</th>
<th>INDICATORS</th>
<th>ENG Q3</th>
<th>TREND</th>
<th>SOT Q1</th>
<th>SOT Q2</th>
<th>SOT Q3</th>
<th>TREND</th>
<th>NS Q1</th>
<th>NS Q2</th>
<th>NS Q3</th>
<th>TREND</th>
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</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>Maternal smoking at delivery (L)</td>
<td>10.4%</td>
<td>↑</td>
<td>18%</td>
<td>18.5%</td>
<td>19.4%</td>
<td>↑</td>
<td>12.3%</td>
<td>11.9%</td>
<td>16.2%</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td>SOT/NS</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Child Obesity</td>
<td>Year 6 overweight or obese (L)</td>
<td>33.2%</td>
<td>N/A</td>
<td>39%</td>
<td>39%</td>
<td>39%</td>
<td>N/A</td>
<td>35%</td>
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<td>35%</td>
<td>N/A</td>
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<td>Diabetes</td>
<td>3 NICE recommended treatments (H)</td>
<td>39.4%</td>
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<td>42.8%</td>
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<td>42.8%</td>
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<td>39.4%</td>
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<tr>
<td></td>
<td>Structured education course (H)</td>
<td>5.7%</td>
<td>N/A</td>
<td>9.8%</td>
<td>9.8%</td>
<td>9.8%</td>
<td>N/A</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>N/A</td>
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<tr>
<td>Falls</td>
<td>Falls injuries people aged 65 and over per 100,000 population (L) SOT/NS</td>
<td>1,985</td>
<td>↓</td>
<td>2,905</td>
<td>2,949</td>
<td>2,873</td>
<td>↓</td>
<td>2,351</td>
<td>2,388</td>
<td>2,338</td>
<td>↓</td>
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<tr>
<td>Personalisation and Choice</td>
<td>NHS e-referral service utilisation (H)</td>
<td>51.1%</td>
<td>↓</td>
<td>82%</td>
<td>73.7%</td>
<td>74.1%</td>
<td>↑</td>
<td>81%</td>
<td>75.5%</td>
<td>75.9%</td>
<td>↑</td>
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<tr>
<td></td>
<td>Personal health budgets (H)</td>
<td>18.7%</td>
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<td>2.11</td>
<td>2.1</td>
<td>32.5</td>
<td></td>
<td>4.18</td>
<td>4.6</td>
<td>4.6</td>
<td>↔</td>
</tr>
<tr>
<td></td>
<td>% of deaths in hospital (L)</td>
<td>47.1%</td>
<td>↑</td>
<td>53.7%</td>
<td>53.9%</td>
<td>53.1%</td>
<td>↓</td>
<td>52.6%</td>
<td>52.4%</td>
<td>51.5%</td>
<td>↓</td>
</tr>
<tr>
<td></td>
<td>People with LTCs feeling supported to manage their conditions (H)</td>
<td>64.3%</td>
<td>↔</td>
<td>64.7%</td>
<td>68.7%</td>
<td>65.7%</td>
<td>↓</td>
<td>64%</td>
<td>69.4%</td>
<td>69.4%</td>
<td>↔</td>
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<tr>
<td>Health Inequalities</td>
<td>Inequality ACS emergency admissions (L) SOT</td>
<td>929</td>
<td>N/A</td>
<td>916</td>
<td>1,307</td>
<td>1,307</td>
<td>N/A</td>
<td>950</td>
<td>1,101</td>
<td>1,101</td>
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<tr>
<td></td>
<td>Inequality emergency admissions for urgent sensitive conditions (L) SOT/NS</td>
<td>2,168</td>
<td>N/A</td>
<td>2,227</td>
<td>2,917</td>
<td>2,917</td>
<td>N/A</td>
<td>2,503</td>
<td>2,933</td>
<td>2,933</td>
<td>N/A</td>
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<tr>
<td>Anti-microbial Resistance</td>
<td>Appropriate prescribing of antibiotics in primary care (L)</td>
<td>1.1</td>
<td>↔</td>
<td>1.2</td>
<td>1.2</td>
<td>1.2</td>
<td>N/A</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Appropriate prescribing of broad range antibiotics in primary care (L)</td>
<td>9.1%</td>
<td>↓</td>
<td>8.1%</td>
<td>7.9%</td>
<td>7.8%</td>
<td>↓</td>
<td>10.6%</td>
<td>10.1%</td>
<td>9.9%</td>
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<tr>
<td>Carers</td>
<td>Quality of life for carers (EQ5D) (H) SOT/NS</td>
<td>80%</td>
<td>N/A</td>
<td>80%</td>
<td>75.2%</td>
<td>75%</td>
<td>N/A</td>
<td>77%</td>
<td>77.1%</td>
<td>77%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Purple boxes - lowest quartile nationally (but not indicative if we are achieving/failing)
White writing in purple boxes - indicates which CCG is in the lowest quartile
Grey boxes containing NA - no trend data as quarter data has not been refreshed or it is an indicator not previously reported.
<table>
<thead>
<tr>
<th>AREA</th>
<th>INDICATOR</th>
<th>ENG Q3</th>
<th>TREND</th>
<th>SOT Q1</th>
<th>SOT Q2</th>
<th>SOT Q3</th>
<th>TREND</th>
<th>NS Q1</th>
<th>NS Q2</th>
<th>NS Q3</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Cancers diagnosed at early stage (H)</td>
<td>50.7%</td>
<td>N/A</td>
<td>49.2%</td>
<td>49.2%</td>
<td>49.2%</td>
<td>N/A</td>
<td>51.7%</td>
<td>51.7%</td>
<td>51.7%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Urgent GP cancer referral having treatment within 62 days of referral (H) SOT/NS</td>
<td>82.3%</td>
<td>↑</td>
<td>73.7%</td>
<td>73.7%</td>
<td>73%</td>
<td>↔</td>
<td>80.7%</td>
<td>77.3%</td>
<td>72.8%</td>
<td>↓</td>
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<tr>
<td></td>
<td>One-year survival rate from all cancers (H) SOT/NS</td>
<td>70.2%</td>
<td>N/A</td>
<td>66.1%</td>
<td>66.1%</td>
<td>66.1%</td>
<td>N/A</td>
<td>68.4%</td>
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<tr>
<td></td>
<td>Cancer patient experience (H)</td>
<td>N/A</td>
<td>N/A</td>
<td>90.4%</td>
<td>8.8</td>
<td>8.8</td>
<td>N/A</td>
<td>89.5%</td>
<td>8.8</td>
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<td>N/A</td>
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<tr>
<td>Mental Health</td>
<td>IAPT recovery rate (H)</td>
<td>48.4%</td>
<td>↓</td>
<td>59.1%</td>
<td>57.8%</td>
<td>57.4%</td>
<td>↓</td>
<td>61.5%</td>
<td>63.8%</td>
<td>64.5%</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td>People with first episode of psychosis seen within 2 weeks (H) NS</td>
<td>77.2%</td>
<td>↑</td>
<td>78.3%</td>
<td>81.8%</td>
<td>71.4%</td>
<td>↓</td>
<td>62.5%</td>
<td>40%</td>
<td>50%</td>
<td>↑</td>
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<tr>
<td></td>
<td>CYP MH transformation % compliance against self-assessment</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>60%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>60%</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Crisis care % compliance against self-assessment SOT/NS</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>35%</td>
<td>N/A</td>
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<td>N/A</td>
<td>35%</td>
<td>N/A</td>
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<tr>
<td></td>
<td>OOA placements % compliance against self-assessment SOT/NS</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>25%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>Reliance on specialist inpatient care for people with a learning disability and/or autism (L) SOT/NS</td>
<td>N/A</td>
<td>N/A</td>
<td>74</td>
<td>76</td>
<td>76</td>
<td>N/A</td>
<td>74</td>
<td>76</td>
<td>76</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Proportion of people with a learning disability on the GP register receiving annual health check (H)</td>
<td>37.1%</td>
<td>↓</td>
<td>44%</td>
<td>44%</td>
<td>34.8%</td>
<td>↓</td>
<td>56%</td>
<td>56%</td>
<td>36.4%</td>
<td>↓</td>
</tr>
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</table>
# BETTER CARE AT Q3 2016/17

<table>
<thead>
<tr>
<th>AREA</th>
<th>INDICATORS</th>
<th>ENG Q3</th>
<th>TRENDS</th>
<th>SOT Q1</th>
<th>SOT Q2</th>
<th>SOT Q3</th>
<th>TRENDS</th>
<th>NS Q1</th>
<th>NS Q2</th>
<th>NS Q3</th>
<th>TRENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity</td>
<td>Neonatal mortality and stillbirths (L) SOT</td>
<td>7.1</td>
<td>N/A</td>
<td>8.89</td>
<td>8.9</td>
<td>8.9</td>
<td>N/A</td>
<td>7.64</td>
<td>7.6</td>
<td>7.6</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Women’s experience of maternity services (H) NS</td>
<td>N/A</td>
<td>N/A</td>
<td>78.09</td>
<td>78.1</td>
<td>78.1</td>
<td>N/A</td>
<td>75.8</td>
<td>75.8</td>
<td>75.8</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Choices in maternity services (H) SOT/NS</td>
<td>N/A</td>
<td>N/A</td>
<td>60%</td>
<td>60.2%</td>
<td>60.2%</td>
<td>N/A</td>
<td>57%</td>
<td>57%</td>
<td>57.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Dementia</td>
<td>Estimated diagnosis rate (H)</td>
<td>68%</td>
<td>↑</td>
<td>87.6%</td>
<td>89.8%</td>
<td>92.2%</td>
<td>↑</td>
<td>71.1%</td>
<td>72.8%</td>
<td>73.6%</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td>Dementia care planning and post-diagnostic support (H)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>78.6%</td>
<td>78.5%</td>
<td>↓</td>
<td>N/A</td>
<td>76.8%</td>
<td>79.1%</td>
<td>↑</td>
</tr>
<tr>
<td>Urgent and emergency</td>
<td>Achievement of milestones in the delivery of an integrated urgent care service SOT/NS</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
<td>2</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td>care</td>
<td>Emergency admissions for urgent care sensitive conditions per 100,000 (L) SOT</td>
<td>2,359</td>
<td>N/A</td>
<td>3,260</td>
<td>3,410</td>
<td>3,410</td>
<td>N/A</td>
<td>2,614</td>
<td>2,655</td>
<td>2,655</td>
<td>N/A</td>
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<tr>
<td></td>
<td>% patients admitted, transferred or discharged from A&amp;E within 4hrs (95%) SOT/NS</td>
<td>88.4%</td>
<td>↓</td>
<td>78.8%</td>
<td>83.6%</td>
<td>76%</td>
<td>↓</td>
<td>79%</td>
<td>83.6%</td>
<td>76%</td>
<td>↓</td>
</tr>
<tr>
<td></td>
<td>Delayed transfers of care per 100,000 population (L) SOT</td>
<td>15%</td>
<td>↑</td>
<td>22.5%</td>
<td>39.4%</td>
<td>29.7%</td>
<td>↓</td>
<td>14.1%</td>
<td>19.6%</td>
<td>16.8%</td>
<td>↓</td>
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<tr>
<td></td>
<td>Population use of hospital beds following emergency admission (L) per 1000 population</td>
<td>1</td>
<td>N/A</td>
<td>0.66</td>
<td>1</td>
<td>1.06</td>
<td>N/A</td>
<td>0.65</td>
<td>1</td>
<td>1</td>
<td>N/A</td>
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</tbody>
</table>

Purple boxes - lowest quartile nationally (but not indicative if we are achieving/failing)
White writing in purple boxes - indicates which CCG is in the lowest quartile
Grey boxes containing NA - no trend data as quarter data has not been refreshed or it is an indicator not previously reported

---

*Stoke-on-Trent Clinical Commissioning Group*
<table>
<thead>
<tr>
<th>AREA</th>
<th>INDICATORS</th>
<th>ENG Q3</th>
<th>TRENDS</th>
<th>SOT Q1</th>
<th>SOT Q2</th>
<th>SOT Q3</th>
<th>TRENDS</th>
<th>NS Q1</th>
<th>NS Q2</th>
<th>NS Q3</th>
<th>TRENDS</th>
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<tr>
<td>Primary Medical Care</td>
<td>Management of Long Term Conditions (L)</td>
<td>795</td>
<td>N/A</td>
<td>1,215</td>
<td>1,215</td>
<td>N/A</td>
<td>N/A</td>
<td>900</td>
<td>900</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Primary Medical Care</td>
<td>Patient experience of GP services (H)</td>
<td>85.2%</td>
<td>N/A</td>
<td>87.1%</td>
<td>87.3%</td>
<td>87.3%</td>
<td>N/A</td>
<td>87.2%</td>
<td>88.5%</td>
<td>88.5%</td>
<td>N/A</td>
</tr>
<tr>
<td>Primary Medical Care</td>
<td>Primary care access - % practices offering full provision</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>3.1</td>
<td>N/A</td>
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<tr>
<td>Primary Medical Care</td>
<td>Primary care workforce (H) FTE number of GP, nurse and direct patient care staff per 1,000 weighted patients</td>
<td>1</td>
<td>N/A</td>
<td>0.91</td>
<td>0.9</td>
<td>0.9</td>
<td>N/A</td>
<td>1.07</td>
<td>1.1</td>
<td>1.1</td>
<td>N/A</td>
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<tr>
<td>Elective Access</td>
<td>18 week standard (H)</td>
<td>89.4%</td>
<td>↓</td>
<td>90.9%</td>
<td>90%</td>
<td>90.6%</td>
<td>↑</td>
<td>90.8%</td>
<td>89.6%</td>
<td>90.6%</td>
<td>↑</td>
</tr>
<tr>
<td>NHS Continuing Healthcare</td>
<td>People eligible for standard NHS Continuing Healthcare (H)</td>
<td>46.2</td>
<td>↑</td>
<td>39</td>
<td>34.5</td>
<td>34</td>
<td>↓</td>
<td>54</td>
<td>50.8</td>
<td>51</td>
<td>↑</td>
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**UPDATE BY INDICATOR**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Area</th>
<th>Indicator</th>
<th>Update</th>
</tr>
</thead>
</table>
| SOT/NS| 6CP BH BC     | Maternity                                                                 | • Both CCG’s are in the lowest quartile nationally, smoking at delivery performance deteriorated in quarter 3 for North Staffordshire by 4.3%  
• The implementation plan for the £75k of NHSE funding for maternal smoking at delivery has been developed with key partners and was finalised in February.  
• A successful stakeholder event was held on the 3rd February. The outputs of the event are being written up and will help start to establish priorities and work streams for the local maternity system (LMS)                                                                 |
| SOT/NS| 6CP BC BH     | Cancer                                                                    | • The Macmillan Cancer nurse commenced in post in January 2017 to support early diagnosis. A work programme is to be developed.  
• See pages 19 and 20 for cancer access performance                                                                                                                                                                                                                     |
| SOT   | BH            | Child Obesity                                                            | • Indicator not updated for quarter 3  
• National Child Measurement Programme report (November 2016) shows the prevalence of very overweight children in Year 6 has fallen from 24.6% to 22.7% between 2014/15 and 2015/16  
• The inequalities gap between Stoke on Trent and England continues to narrow  
• Actions against the Stoke on Trent Health and Wellbeing Board, Healthy Weight Strategy continue to be implemented                                                                                                                                                        |
| SOT/NS| BH            | Falls                                                                     | • Improved performance has been seen in quarter 3 for both CCG’s which is attributed to the improvement plan with the current provider, however both CCGs remain in the lowest quartile nationally  
• Falls has been selected as an area to accelerate through the RightCare initiative with a design event to be held on 10 April  
• The re-procurement of the falls prevention service will look at whole pathway provision                                                                                                                                                                   |

**Key:**
- 6CP – Six Clinical Priorities Indicator  
- BC – Better Care Indicator  
- BH – Better Health Indicator  
- Constitution – Constitution Target
## UPDATE BY INDICATOR

<table>
<thead>
<tr>
<th>CCG</th>
<th>Area</th>
<th>Indicator</th>
<th>Update</th>
</tr>
</thead>
</table>
| SOT/NS| BH   | Health Inequalities                    | • Indicator not updated for Quarter 3  
• The CCG leads are utilising the NHSE toolkit to promote discussion. The toolkit identifies areas of variation in emergency admissions down to neighbourhood level  
• The data is being reviewed to support the long term condition service re-design |
| SOT/NS| BH   | Quality of life for carers             | • Indicator in lowest quartile for last reporting period (not updated for quarter 3)  
• Performance is 5% away for SOT and 2% away for NS, from the national average  
• Staffordshire Strategy meeting to outline actions/ideas on strategy implementation - February 2017  
• Stoke-on-Trent have delayed their implementation plan and steering group due to lack of carers identified to input |
| NS    | BH   | Personalisation and Choice             | • Quarter 3 PHB performance has improved for SOT but remained static for NS  
• An improvement trajectory to achieve 0.1% -0.2% of the population in receipt of a PHB by 2020, low growth to the end of March 2017 with a greater rate of growth in 2018  
• SOT Q3 figure: Total CYP 2, Total adults 96  
• NS Q3 figures: Total CYP 3, Total adults 7  
• The CHC team have identified jointly funded patients where a PHB could be offered; to date 12 possible PHB’s have been identified for SOT and 5 for NS.  
• PHBs are currently delivered by a small specialist PHB team (2 FTE clinical posts) for Staffordshire and Shropshire CCGs, an action plan for expanding this team has been developed.  
• Revised draft Strategy due for March 2017  
• CCG support Continuing Healthcare Team Nurses to offer PHB’s including the offer of notional budgets and managed budgets (all current PHBs are direct payments)  
• Review of PHB to confirm the numbers reported on in each quarter  
• Improve PHB reporting including monthly review of PHB delivery against individual CCG trajectories - March 2017  
• SOT Pilot Project legacy PHBs to be reviewed by PHB Panel - February 2017 |
| NS    | BC   | Mental Health                          | • People with first episode of psychosis seen within 2 weeks  
• Crisis Care in Mental Health  
• Out of area placements  
• CAMHS  
• Both CCGs have met the 50% target for quarter 3, however SOT has seen a downward trend. This is attributed to low numbers accessing the service.  
• Three new indicators were published in quarter 3 based on self-reported assessment  
• CCGs are reporting ‘not compliant’ or ‘partially compliant’ across Crisis Care, OOA and CYP provision  
• There are action plans in place to address ‘non-compliant’ and ‘partially compliant’ areas |
### UPDATE BY INDICATOR

<table>
<thead>
<tr>
<th>CCG</th>
<th>Area</th>
<th>Indicator</th>
<th>Update</th>
</tr>
</thead>
</table>
| SOT/NS | BC | Learning Disability | • Reliance on specialist inpatient care for people with a learning disability and/or autism  
• Learning Disability Annual Health Checks | • A total of 15 clients are in NHS care (SOT -10, NS 5). The target is to have only 6 clients in NHS treatment by March 2020. All current clients have an Expected Discharge Date (EDD). All 5 NS clients will be discharged by November 2017. 6 SOT clients will be discharged in 2017/18 and the remaining 4 will be discharged in 2018/19.  
• The CCG commission 6 beds for assessment with Combined Healthcare so potential admissions in the future should be able to access local in-patent services subject to throughput.  
• All potential admissions have a review to determine if in-patient care is absolutely necessary or if the person can be supported in their current place by the Intensive Support Service.  
• Specialised Services also have a target for discharges of clients in their care. These clients are likely to be future admissions for CCG care. Further work is being undertaken with specialist commissioner to develop a clear trajectory and funding arrangements. The trajectory will be shared in the month 10 performance report.  
• Health Care Facilitators are commissioned to work with GP Practices in carrying out Annual Health Checks. Work is on-going to identify practice performance across SOT and NS with support being offered to practices where numbers of checks are low. |
| SOT/NS | BC Constitution | Urgent and Emergency Care | • % patients admitted, transferred or discharged from A&E within 4hrs (95%) | • See page 15 for 4 hour performance |
| SOT | BC | Continuing Healthcare (CHC) | • Quarter 3 CHC performance has improved for NS but declined for SOT  
• Underperformance is due to the high use of fast track referrals (these are not measured as part of this indicator and form 50% of SOT referrals to CHC for assessment) |

**Key:**  
6CP – Six Clinical Priorities Indicator  
BC – Better Care Indicator  
BH – Better Health Indictor  
Constitution – Constitution Target
### NHS CONSTITUTIONAL STANDARDS AT M9 – STOKE ON TRENT CCG

#### Indicator Target Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

#### Referral To Treatment waiting times for non-urgent consultant-led treatment

- **Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral**
  - 92% 90.06% 90.48% 90.99% 90.68% 90.32% 90.52% 91.08% 90.88% 91.40% 90.85% 90.37% 90.02% 89.91% 89.90% 89.91% 87.86%

- **Zero tolerance of over 52 week waiters**
  - 0 1 2 2 0 1 3 2 4 5 6 5 10 15 7 12 11 13 12 9 12 19

#### Diagnostic test waiting times

- **Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral**
  - 99% 97.30% 98.62% 99.54% 99.47% 99.67% 99.88% 99.88% 99.79% 99.35% 99.64% 99.52% 99.65% 98.37% 99.70% 99.81% 99.88% 99.87% 99.56% 99.56% 99.63% 99.63%

#### Cancer waits

- **Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP**
  - 93% 92.46% 96.96% 93.35% 96.21% 94.42% 94.94% 92.34% 86.43% 86.89% 92.14% 97.18% 98.47% 93.70% 94.58% 90.28% 93.01% 93.78% 92.32% 93.59%

- **Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)**
  - 93% 61.45% 96.63% 63.91% 91.84% 93.48% 85.71% 39.18% 11.00% 22.43% 77.78% 90.07% 96.74% 97.20% 96.33% 93.81% 94.69% 93.80% 94.58% 93.31% 87.50%

- **Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers**
  - 96% 92.55% 94.85% 91.23% 97.37% 95.00% 97.88% 98.06% 96.74% 95.05% 95.00% 94.87% 90.14% 95.77% 92.68% 100.00% 100.00% 90.37% 90.85% 91.40% 89.13%

- **Maximum 31-day wait for subsequent treatment where that treatment is surgery**
  - 94% 88.89% 92.31% 92.32% 86.67% 100.00% 90.48% 90.48% 100.00% 100.00% 75.00% 81.75% 100.00% 100.00% 75.00% 84.21% 88.46% 100.00% 100.00% 94.44% 100.00%

- **Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen**
  - 98% 100.00% 100.00% 100.00% 95.45% 96.55% 100.00% 100.00% 100.00% 100.00% 97.30% 100.00% 100.00% 100.00% 100.00% 96.55% 100.00% 92.59% 96.30% 92.31% 87.50%

- **Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy**
  - 94% 100.00% 100.00% 100.00% 96.00% 97.50% 100.00% 97.22% 95.35% 100.00% 94.12% 93.22% 95.83% 97.44% 100.00% 95.65% 90.91% 92.59% 96.30% 92.31% 87.50%

- **Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer**
  - 85% 7.50% 72.31% 78.87% 75.76% 82.26% 77.14% 81.82% 82.14% 75.44% 72.41% 69.84% 79.25% 72.58% 70.97% 75.64% 80.60% 69.33% 67.31% 69.77% 64.71% 69.09%

- **Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient**
  - No Target 95.24% 88.89% 80.00% 88.24% 91.67% 78.95% 81.82% 80.95% 92.59% 95.24% 89.47% 92.59% 90.91% 92.59% 94.44% 97.37% 100.00% 93.75% 92.86% 93.33% 94.74%

#### Ambulance

- **Category A calls resulting in an emergency response arriving within 8 minutes – Red (New ARP Measure)**
  - 75% 75.00% 70.96% 73.46% 70.99% 68.21% 68.88% 66.18%

- **Category A calls resulting in an emergency response arriving within 8 minutes – Red 1**
  - 75% 85.71% 73.53% 83.65% 81.03% 86.73% 84.55% 84.73% 84.68% 84.50% 72.95% 80.65% 79.20% 80.91% 78.95%

- **Category A calls resulting in an emergency response arriving within 8 minutes – Red 2**
  - 75% 78.88% 79.89% 79.31% 81.48% 84.31% 84.38% 79.19% 79.91% 78.32% 77.28% 75.90% 74.48% 77.92% 74.42%

- **Category A calls resulting in an ambulance arriving at the scene within 19 minutes (Red 19)**
  - 95% 98.77% 98.68% 98.95% 99.11% 99.38% 98.78% 98.69% 98.82% 99.12% 99.00% 98.70% 99.28% 99.41% 98.72%

#### A&E Waits (University Hospitals of North Midlands NHS Trust)

- **Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department**
  - 95% 80.32% 83.20% 89.05% 85.24% 93.29% 88.49% 85.24% 85.25% 82.78% 76.65% 77.68% 75.64% 78.75% 79.26% 79.93% 79.50% 83.58% 79.36% 76.50% 75.97% 73.37%

- **No waits from decision to admit to admission (trolley waits) over 12 hours**
  - 0 4 6 15 0 0 0 0 1 47 7 8 4 12 15 2 4 6 56 231 178

#### Healthcare Acquired Infections (*2016/17 Full Year Target*)

- **HCAI measure (MRSA)**
  - 0 2 1 0 0 0 1 3 1 0 0 0 1 0 0 0 0 1 0 0 0

- **HCAI measure (Clostridium difficile infections)**
  - 87* 8 7 11 13 3 13 6 10 11 8 11 11 18 9 12 10 8 3 9 4

#### Mixed Sex Accommodation Breaches

- **Mixed Sex Accommodation Breaches**
  - 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
### NHS CONSTITUTIONAL STANDARDS AT M9 – NORTH STAFFORDSHIRE CCG

#### Indicator: Referral To Treatment waiting times for non-urgent consultant-led treatment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral To Treatment waiting times for non-urgent consultant-led treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92%</td>
<td>89.76%</td>
<td>90.77%</td>
<td>91.18%</td>
</tr>
<tr>
<td></td>
<td>0</td>
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#### Indicator: Diagnostic test waiting times

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<th>Target</th>
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<th>2016/17</th>
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<tbody>
<tr>
<td>Diagnostic test waiting times</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99%</td>
<td>98.02%</td>
<td>99.66%</td>
<td>99.57%</td>
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#### Indicator: Cancer waits

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<th>Target</th>
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<th>2016/17</th>
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<td>Cancer waits</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
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<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient</td>
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</table>

#### Indicator: Ambulance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2015/16</th>
<th>2016/17</th>
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</thead>
<tbody>
<tr>
<td>Ambulance</td>
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<td></td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes (New ARP Measure)</td>
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</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)</td>
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<td></td>
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</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category A calls resulting in an emergency arrival at the scene within 19 minutes (Red 19)</td>
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#### Indicator: A&E Waits (University Hospitals of North Midlands NHS Trust)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
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<tbody>
<tr>
<td>Healthcare Waits (University Hospitals of North Midlands NHS Trust)</td>
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<td></td>
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</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td></td>
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</tbody>
</table>

#### Indicator: Healthcare Acquired Infections (*2016/17 Full Year Target)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Acquired Infections (*2016/17 Full Year Target)</td>
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</table>

#### Indicator: Mixed Sex Accommodation Breaches

<table>
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<tr>
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<th>Target</th>
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<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed Sex Accommodation Breaches</td>
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</tbody>
</table>
NHS 111

SDUC NHS111 continue to miss the trajectories previously agreed on a number of KPIs including answered within 60 seconds, A&E referrals and ambulance referrals.

A number of contract performance notices (CPNs) have been served.

### Explanation of performance issues

There are a number of factors that are affecting the performance issues within NHS111 and these include:

- Staffing levels and expected surges
- NHS Pathways being risk adverse
- Skill mix and clinical support

### CCG actions

- Continued communications to support improved awareness of NHS111
- Continued management of the provider via the contract with a number of CPNs open and money withheld.
- Monitoring of quality through call reviews every month and a series of announced and unannounced visits.

### Provider actions

- Currently undertaking a rota realignment to ensure that the staffing profile meets the current demand
- The provider is targeting the staff with the highest referral rates for A&E and ambulances
- To continue work with commissioners in the development of the primary care access hub (PCAH) to book patients directly into the service via EMIS web
- Using Emergency Medical Doctors to support the service as a part of a pilot to reduce the numbers of patients who are referred to A&E
- Part of a workforce development project with NHS England (NHSE) to build skill mix and support the service in growing their own advanced clinicians

<table>
<thead>
<tr>
<th>Calls answered (all commissioners)</th>
<th>Plan</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016/17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls answered within 60 seconds</td>
<td>&gt;= 95%</td>
<td>&gt;= 95%</td>
</tr>
<tr>
<td>Abandoned calls</td>
<td>&lt;= 5%</td>
<td>&lt;= 5%</td>
</tr>
<tr>
<td>Referral to ambulance services</td>
<td>&lt;= 9%</td>
<td>&lt;= 9%</td>
</tr>
<tr>
<td>Plan</td>
<td>&lt;= 9%</td>
<td>&lt;= 9%</td>
</tr>
<tr>
<td>Referral to Emergency Dispositions</td>
<td>&lt;= 5%</td>
<td>&lt;= 5%</td>
</tr>
<tr>
<td>Plan</td>
<td>&lt;= 5%</td>
<td>&lt;= 5%</td>
</tr>
<tr>
<td>Abandoned calls</td>
<td>&lt;= 5%</td>
<td>&lt;= 5%</td>
</tr>
<tr>
<td>Plan</td>
<td>&lt;= 5%</td>
<td>&lt;= 5%</td>
</tr>
</tbody>
</table>

| Referral to ambulance services    | <= 9% | <= 9% |
| Plan                              | <= 9% | <= 9% |
| All commissioners                 | <= 9% | <= 9% |
| NS CCG                            | <= 9% | <= 9% |
| SoT CCG                           | <= 9% | <= 9% |
| **Plan**                          | <= 9% | <= 9% |
| Referral to Emergency Dispositions| <= 5% | <= 5% |
| Plan                              | <= 5% | <= 5% |
| All commissioners                 | <= 5% | <= 5% |
| NS CCG                            | <= 5% | <= 5% |
| SoT CCG                           | <= 5% | <= 5% |
| **Plan**                          | <= 5% | <= 5% |
| Calls answered within 60 seconds  | <= 9% | <= 9% |
| Plan                              | <= 9% | <= 9% |
| All commissioners                 | <= 9% | <= 9% |
| **Plan**                          | <= 9% | <= 9% |

| Calls answered within 60 seconds  | <= 9% | <= 9% |
| Plan                              | <= 9% | <= 9% |
| All commissioners                 | <= 9% | <= 9% |
| **Plan**                          | <= 9% | <= 9% |

**Trajectories**

- SDUC NHS111 continue to miss the trajectories previously agreed on a number of KPIs including answered within 60 seconds, A&E referrals and ambulance referrals.
- A number of contract performance notices (CPNs) have been served.

**Explanation of performance issues**

There are a number of factors that are affecting the performance issues within NHS111 and these include:

- Staffing levels and expected surges
- NHS Pathways being risk adverse
- Skill mix and clinical support

**CCG actions**

- Continued communications to support improved awareness of NHS111
- Continued management of the provider via the contract with a number of CPNs open and money withheld.
- Monitoring of quality through call reviews every month and a series of announced and unannounced visits.

**Provider actions**

- Currently undertaking a rota realignment to ensure that the staffing profile meets the current demand
- The provider is targeting the staff with the highest referral rates for A&E and ambulances
- To continue work with commissioners in the development of the primary care access hub (PCAH) to book patients directly into the service via EMIS web
- Using Emergency Medical Doctors to support the service as a part of a pilot to reduce the numbers of patients who are referred to A&E
- Part of a workforce development project with NHS England (NHSE) to build skill mix and support the service in growing their own advanced clinicians

---

**NHS 111**

**Stoke-on-Trent Clinical Commissioning Group**

---
<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>SOT M9</th>
<th>Trend from M8</th>
<th>YTD</th>
<th>NS M9</th>
<th>Trend from M8</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat A (new ARP measure)</td>
<td>75%</td>
<td>66.2%</td>
<td>↓</td>
<td>69.9%</td>
<td>63.7%</td>
<td>↓</td>
<td>65.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 1: 8 Minutes 75th percentile</th>
<th>Total</th>
<th>Time</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North Staffs</td>
<td>179</td>
<td>00:09:58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>414</td>
<td>00:08:49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WMAS Performance</td>
<td>5953</td>
<td>00:09:10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 1: 8 Minutes 90th percentile</th>
<th>Total</th>
<th>Time</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North Staffs</td>
<td>179</td>
<td>00:13:05</td>
<td></td>
</tr>
<tr>
<td>Stoke on Trent</td>
<td>414</td>
<td>00:11:02</td>
<td></td>
</tr>
<tr>
<td>WMAS Performance</td>
<td>5953</td>
<td>00:12:07</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance</th>
<th>Local Target</th>
<th>SOT M9</th>
<th>Trend from M8</th>
<th>NS M9</th>
<th>Trend from M8</th>
<th>Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hear and Treat</td>
<td>&gt;7%</td>
<td>3.4%</td>
<td>↑</td>
<td>3.3%</td>
<td>↑</td>
<td>4.4%</td>
</tr>
<tr>
<td>See and Treat</td>
<td>&gt;37%</td>
<td>39.4%</td>
<td>↑</td>
<td>42.8%</td>
<td>↑</td>
<td>36.6%</td>
</tr>
<tr>
<td>See and Convey</td>
<td>&lt;56%</td>
<td>57.2%</td>
<td>↓</td>
<td>54.0%</td>
<td>↓</td>
<td>58.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Turnaround Times</th>
<th>Target</th>
<th>M9 actual</th>
<th>Trend from M8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Stoke University Hospital</td>
<td>15 mins</td>
<td>32 mins</td>
<td>↑</td>
</tr>
<tr>
<td>County Hospital</td>
<td>15 mins</td>
<td>23 mins</td>
<td>↓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assigned Incident Volume Against Contract Volume</th>
<th>variance:</th>
<th>Red = 'above contract'</th>
<th>Green = 'within contract'</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr '16</td>
<td>May '16</td>
<td>Jun '16</td>
</tr>
<tr>
<td>North Staffordshire CCG</td>
<td>actual</td>
<td>2,853</td>
<td>3,040</td>
</tr>
<tr>
<td>contract</td>
<td>2,782</td>
<td>2,847</td>
<td>2,786</td>
</tr>
<tr>
<td>variance vol +/-</td>
<td>71</td>
<td>193</td>
<td>161</td>
</tr>
<tr>
<td>variance % +/-</td>
<td>2.54%</td>
<td>6.78%</td>
<td>5.77%</td>
</tr>
<tr>
<td>Stoke on Trent CCG</td>
<td>actual</td>
<td>4,679</td>
<td>5,044</td>
</tr>
<tr>
<td>contract</td>
<td>4,539</td>
<td>4,646</td>
<td>4,546</td>
</tr>
<tr>
<td>variance vol +/-</td>
<td>139</td>
<td>398</td>
<td>181</td>
</tr>
<tr>
<td>variance % +/-</td>
<td>3.07%</td>
<td>8.56%</td>
<td>3.99%</td>
</tr>
</tbody>
</table>
AMBULANCE – WMAS

CCG actions
• The Local Staffordshire Ambulance Group are producing a revised action plan focusing on reducing volumes against contracted levels. The action plan will be in a first draft for the next local group in March
• Working on Service Development Improvement Plans that will have a focus on reduction in conveyances
• Defining a specific action plan to support reduction in conveyances. The action plan to be in first draft for next local group in March.

WMAS Actions
The Ambulance Response Programme (ARP) trial is monitored and evaluated by Sheffield School of Health and Related Research. The National ARP Board and development Group will be reviewing three reports at the end of February 2017 with a view to sharing final recommendations in early April.
• The Sheffield University report which is seen as the case for change with recommendations on what needs to happen
• Impact assessment from the CSU
• New outcome measures (AQI/performance standards)
**UHNM A&E**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>UHNM M9</th>
<th>Trend from M7</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% of patients discharged or admitted within 4 hours</td>
<td>95%</td>
<td>73.37%</td>
<td>↓</td>
<td>78.50%</td>
</tr>
<tr>
<td>Zero tolerance for 12 hour waits from decision to admit</td>
<td>0</td>
<td>178</td>
<td>↓</td>
<td>510</td>
</tr>
</tbody>
</table>

**UHNM A&E Activity**

<table>
<thead>
<tr>
<th>North Staffordshire CCG</th>
<th>Planned Growth -0.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual (incl. F. &amp; P)</td>
<td>3,400</td>
</tr>
<tr>
<td>Variance above Plan</td>
<td>5</td>
</tr>
</tbody>
</table>

| Variance above Plan | 9% | 17% | 12% | 5% | 12% | 11% | 10% | 9% | 16% | 4% |

**UHNM A&E Outcome of Attendance**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to Hospital Bed</td>
<td>33.7%</td>
<td>35.2%</td>
<td>36.0%</td>
<td>36.0%</td>
<td>36.6%</td>
<td>36.9%</td>
<td>35.7%</td>
<td>36.0%</td>
<td>37.0%</td>
<td>36.4%</td>
</tr>
<tr>
<td>Discharged - No Follow Up</td>
<td>24.2%</td>
<td>24.6%</td>
<td>25.0%</td>
<td>25.7%</td>
<td>24.1%</td>
<td>24.1%</td>
<td>23.9%</td>
<td>24.6%</td>
<td>24.9%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Discharged - Follow-Up by GP</td>
<td>17.6%</td>
<td>17.2%</td>
<td>16.7%</td>
<td>16.7%</td>
<td>16.9%</td>
<td>15.0%</td>
<td>15.9%</td>
<td>16.5%</td>
<td>15.8%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Transferred to other Health Care Provider</td>
<td>5.7%</td>
<td>5.1%</td>
<td>5.1%</td>
<td>3.8%</td>
<td>5.5%</td>
<td>6.7%</td>
<td>7.2%</td>
<td>7.7%</td>
<td>8.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Referred to Fracture Clinic</td>
<td>5.7%</td>
<td>6.1%</td>
<td>6.1%</td>
<td>6.0%</td>
<td>6.4%</td>
<td>6.0%</td>
<td>5.8%</td>
<td>5.2%</td>
<td>4.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Left Department Before Being Treated</td>
<td>5.2%</td>
<td>4.9%</td>
<td>4.0%</td>
<td>4.1%</td>
<td>3.2%</td>
<td>2.8%</td>
<td>4.1%</td>
<td>3.3%</td>
<td>4.4%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Referred to Out-Patient Clinic</td>
<td>4.6%</td>
<td>4.7%</td>
<td>4.7%</td>
<td>4.6%</td>
<td>4.4%</td>
<td>4.5%</td>
<td>4.6%</td>
<td>4.5%</td>
<td>3.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Referred to other Health Care Professional</td>
<td>21.1%</td>
<td>15.1%</td>
<td>18.1%</td>
<td>18.1%</td>
<td>19.1%</td>
<td>19.1%</td>
<td>20.0%</td>
<td>1.7%</td>
<td>2.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Left Department Having Received Treatment</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

- Only 3 Trusts nationally achieved >95%. The national average at M9 stands at 79.3%; a 3.4% deterioration
- Activity for A&E is over performing by 10% YTD for NS and 3% YTD for Stoke.
- NELs are over-performing at M9 YTD +3% for NSCCG and for SOTCCG at M9 YTD -3%
- 46.9% (45% M8) of patients arriving in A&E were via Emergency Services and the other 53.1% were via ‘other’ categories
- 33.2% (31.4% M8) of patients arriving at A&E were admitted to a hospital bed and 22.3% (24.5% M8) were discharged with no follow up
- Of those patients arriving at A&E via the Emergency services referral source, 51.7% (M8 50.9%) were admitted to a hospital bed in comparison to 11.6% (11% M8) admitted with the ‘self referral’ referral source.
CCG Actions
• As part of the agreed 4 hour/12 hour RAP a range of patients notes will be audited in February/March.

System Wide Actions
• The West Staffordshire A&E Delivery Board is yet to assign a revised trajectory for attaining 4 hour performance.
• To agree the operational policies for the discharge to assess workstream. The policies are scheduled to be presented to various forums for approval.
• To confirm the medical model details for discharge to assess and to work through the detail by 1 April 2017.
• Stoke on Trent City Council will have:
  • 1200 hours of in house domiciliary service in place to increase capacity
  • Self-contained accommodation for step down will be available from April 2017 for patients awaiting assessment
• Wards 80/81 at UHNM have been converted to be solely used for MFFD patients to help with ease of discharge.
• The system has a purpose built AEC Unit which currently operates between 08:00 and 20:00, 5 days per week. The service has agreed plans in place to extend operating hours consistently to 23:00, from the 01/07/17. The implementation timeline is directly affected by recruitment of the clinical workforce. ANPs will be in place by July 2017 but there is a national shortage of Acute Physicians. Resultantly, UHNM is pursuing overseas recruitment and the use of alternative workforce models.
• The plan to implement the Trusted Assessor arrangements from the 31 March 2017 is on track. The CCG continue to liaise with Stoke City Council, in regards to the Trusted Assessor Model.
• The Choice Policy has been signed off by all partners across the LHE and continues to be fully implemented. The Policy is in the process of being amended to accommodate the D2A pathways with implementation planned to coincide with the start of D2A on 01 April 2017.
### REFERRAL TO TREATMENT & PATIENTS WAITING OVER 52 WEEKS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>SOT M9</th>
<th>Trend from M8</th>
<th>YTD</th>
<th>NS M9</th>
<th>Trend from M8</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of incomplete pathways waiting less than 18 weeks</td>
<td>92%</td>
<td>87.86%</td>
<td>↓</td>
<td>90.07%</td>
<td>88.12%</td>
<td>↓</td>
<td>89.80%</td>
</tr>
<tr>
<td>Zero tolerance for patients waiting over 52 weeks</td>
<td>0</td>
<td>19</td>
<td>↑</td>
<td>N/A</td>
<td>10</td>
<td>↓</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### UHNM Specialty Performance

<table>
<thead>
<tr>
<th>Treatment Function</th>
<th>Total number of incomplete pathways</th>
<th>Total within 18 weeks</th>
<th>% within 18 weeks M9</th>
<th>% within 18 weeks M8</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>3,575</td>
<td>2,689</td>
<td>75.20%</td>
<td>77.7%</td>
<td>↓</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>3,144</td>
<td>2,369</td>
<td>75.30%</td>
<td>85.6%</td>
<td>↓</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>786</td>
<td>597</td>
<td>76.00%</td>
<td>74.8%</td>
<td>↑</td>
</tr>
<tr>
<td>General Medicine</td>
<td>60</td>
<td>47</td>
<td>78.30%</td>
<td>78.5%</td>
<td>↓</td>
</tr>
<tr>
<td>Urology</td>
<td>1,367</td>
<td>1,143</td>
<td>83.60%</td>
<td>85.6%</td>
<td>↓</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>163</td>
<td>137</td>
<td>84.00%</td>
<td>92.9%</td>
<td>↓</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>693</td>
<td>606</td>
<td>87.40%</td>
<td>88.6%</td>
<td>↓</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1,584</td>
<td>1,391</td>
<td>85.80%</td>
<td>89.8%</td>
<td>↓</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1,185</td>
<td>1,043</td>
<td>88.00%</td>
<td>89.6%</td>
<td>↓</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>1,524</td>
<td>1,342</td>
<td>88.10%</td>
<td>90.9%</td>
<td>↓</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2,545</td>
<td>2,248</td>
<td>88.30%</td>
<td>90.2%</td>
<td>↓</td>
</tr>
<tr>
<td>Other</td>
<td>5,743</td>
<td>5,095</td>
<td>88.70%</td>
<td>89.9%</td>
<td>↓</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>1,623</td>
<td>1,454</td>
<td>89.60%</td>
<td>91.3%</td>
<td>↓</td>
</tr>
<tr>
<td>ENT</td>
<td>2,660</td>
<td>2,465</td>
<td>92.70%</td>
<td>92.6%</td>
<td>↑</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1,025</td>
<td>954</td>
<td>93.10%</td>
<td>94.7%</td>
<td>↓</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1,642</td>
<td>1,596</td>
<td>97.20%</td>
<td>97.0%</td>
<td>↑</td>
</tr>
<tr>
<td>Neurology</td>
<td>1,294</td>
<td>1,275</td>
<td>98.50%</td>
<td>97.9%</td>
<td>↑</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>24</td>
<td>24</td>
<td>100.00%</td>
<td>100.00%</td>
<td>↔</td>
</tr>
</tbody>
</table>

- Of the 29 breaches 14 were in general surgery, 5 in T&O, 3 ophthalmology, 4 were in urology and, 3 in neurosurgery
- 14 out of 18 reportable specialties at UHNM are not achieving the 18 week target
- YTD Activity for 1st outpatient is over performing by 2% for Stoke and 3% for NS. At Month 9 SOT were -5% below plan and NS were under plan -2%
- YTD Activity for outpatient follow up is over performing by 4% for Stoke and 5% for NS. Activity has decreased in Month 9 for both CCGs Stoke -1% and NS 0%
- The key specialties that are contributing to follow-up over-performance are Dermatology, Neurology, Urology, Nephrology, Respiratory Medicine, Plastic Surgery, Cardiology, Gastroenterology, Cardiology and Plastic Surgery

#### Month Performance

<table>
<thead>
<tr>
<th>Month</th>
<th>Total number of patients on incomplete pathways</th>
<th>Trend from previous month</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td>30637</td>
<td>↑</td>
</tr>
<tr>
<td>November</td>
<td>30549</td>
<td>↑</td>
</tr>
<tr>
<td>October</td>
<td>30403</td>
<td>↓</td>
</tr>
</tbody>
</table>
REFERRAL TO TREATMENT & PATIENTS WAITING OVER 52 WEEKS

CCG Actions

- Clinical triage of all urology referrals by the Choice and Referrals Centre is now in place, this has led to a 13.8% increase in the number of patients being diverted.
- The CCG was successful in securing £800,000 NHSE funding to support the achievement of 18 weeks. Alternative provider capacity has been identified at the Nuffield in Wolverhampton and patients that fit the criteria are being identified.
- The transfer of cataract patients has already commenced, 170 referrals received to date (30/01/17) of which 61 (35.8%) have been successfully transferred.
- The Outsourcing plan and targets are in place until end of March 2017 with a target of 75% of diverts to other providers. YTD (06/02/17) performance is 72.8%.
- Meeting dates have been booked during February and March for General Surgery and Urology to explore appropriate patient cohorts where follow up can be delivered by telephone and Skype.
- A joint meeting was held between the CCG Chief Operating Officer, Head of Commissioning, UHNM Chief Operating Officer and key leads. From the meeting it was agreed that the CCG would join the weekly waiting list review meetings. UHNM shared the first cut specialty recovery plan templates for both Cancer and RTT. IST will undertake an RTT diagnostic in March 2017.
- The Medway transfer went ahead at the end of January. Waiting lists are being revalidated, which could result in material shifts. A meeting had been arranged to discuss further and understand the consequences.
### Measure Service Access

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>SOT M9</th>
<th>Trend from M8</th>
<th>YTD</th>
<th>NS M9</th>
<th>Trend from M8</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum 2 week wait for breast symptoms</td>
<td>93%</td>
<td>89.13%</td>
<td>↓</td>
<td>94.74%</td>
<td>92.86%</td>
<td>↓</td>
<td>94.69%</td>
</tr>
<tr>
<td>31 day surgery</td>
<td>94%</td>
<td>100.00%</td>
<td>↔</td>
<td>92.95%</td>
<td>91.67%</td>
<td>↑</td>
<td>89.81%</td>
</tr>
<tr>
<td>31 day drug</td>
<td>98%</td>
<td>87.50%</td>
<td>↓</td>
<td>96.14%</td>
<td>97.06%</td>
<td>↓</td>
<td>99.18%</td>
</tr>
<tr>
<td>62 day GP referral to treatment</td>
<td>85%</td>
<td>69.09%</td>
<td>↑</td>
<td>73.58%</td>
<td>73.58%</td>
<td>↑</td>
<td>72.51%</td>
</tr>
<tr>
<td>62 day referral from screening service</td>
<td>90%</td>
<td>85.71%</td>
<td>↓</td>
<td>80.00%</td>
<td>80.00%</td>
<td>↑</td>
<td>85.23%</td>
</tr>
</tbody>
</table>

#### 2 week
- 2 week breast performance has seen a deterioration due to patient choice over the Christmas period (5 patients SOT, 2 patients NS)
- Work started mid-February with UHNM to further breakdown the ‘patient choice’ reasons

#### 31 day
- Both CCG’s 31 day target performance across both CCGs have been attributed to capacity issues at UHNM
- NS 31-day surgery performance equates to 1 patient and is due to capacity issues
- NS drug regime performance equates to 1 patient and is due to capacity issues
- SOT 31-day drug regime equates to 2 patients and is due to inadequate elective capacity
- The 31 day contract performance notice has been issued. A meeting on 31 January agreed that the Joint Investigation could commence and a Terms of Reference meeting will be scheduled
CANCER SERVICE ACCESS

62 day
- All breaches due to complex patients/capacity issues. NS 62 day: 14 patients breached, all due to complexity of patients/capacity issues
- UHNM performance poor against all cancer sites (table below) with only breast achieving for December
- SOT 62 day: 17 patients breached, all due to complexity of patients/capacity issues
- 62 day RAP actions completed, no impact on performance to date
- Action plans as part of RAP process to be pursued as part of the contract with a focus on colorectal
- Diagnostic Bid monies to focus on lung and upper GI but also looking where we can implement changes that will affect whole pathways

104 day
- UHNM had 35 total 104 day breaches w/e 5 February
- The CCG are withholding part of the CQUIN payment for non-delivery of the 104 day target, back stop policy CQUIN
- NHSE have asked that the CCG report all new 104-day breaches to the Chair/COO of Trust and monitor via QSG processes

The national 62 Day Performance for November was 82.1%. For UHNM only Lung achieved above the national average for their cancer site.

<table>
<thead>
<tr>
<th>62 Day Monthly Performance</th>
<th>Quarterly Benchmarking – Q2 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National % Meeting Standard</strong></td>
<td><strong>UHNM % Meeting Standard</strong></td>
</tr>
<tr>
<td><strong>Brain</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td>88.9%</td>
</tr>
<tr>
<td><strong>Colorectal</strong></td>
<td>41.7%</td>
</tr>
<tr>
<td><strong>Gynae</strong></td>
<td>76.9%</td>
</tr>
<tr>
<td><strong>Haematology</strong></td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Head &amp; Neck</strong></td>
<td>85.7%</td>
</tr>
<tr>
<td><strong>Lung</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>Sarcoma</strong></td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Skin</strong></td>
<td>93.3%</td>
</tr>
<tr>
<td><strong>Upper GI</strong></td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>Urology</strong></td>
<td>77.2%</td>
</tr>
<tr>
<td><strong>Trust (UHNM)</strong></td>
<td>81.1%</td>
</tr>
<tr>
<td><strong>Royal Stoke</strong></td>
<td>80.1%</td>
</tr>
<tr>
<td><strong>County Hospital</strong></td>
<td>86.5%</td>
</tr>
</tbody>
</table>

*small volume pathways therefore if any breaches occur in these pathways it is difficult to achieve the 85% standard in those areas.
**Provisional data
### SIX NATIONAL CLINICAL PRIORITIES AT Q1 2016 (WILL BE AN ANNUAL REFRESH ONLY)

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Overall Rating</th>
<th>Indicator Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td>Needs Improvement</td>
<td>49.2% 73.7% 66.1% 90.4%</td>
</tr>
<tr>
<td></td>
<td>New cases of cancer diagnosed at stage 1 and stage 2 as a proportion of all new cases of cancer diagnosed</td>
<td>Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of responses which were positive to the question “Overall, how would you rate your care?”</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>Top Performing</td>
<td>87.9% 78.6%</td>
</tr>
<tr>
<td></td>
<td>Estimated diagnosis rates for people with dementia</td>
<td>Of patients diagnosed with dementia who have received a face to face review of their care plan in the preceding 12 months</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>Top Performing</td>
<td>42.8% 9.8% 61.5%</td>
</tr>
<tr>
<td></td>
<td>Of diabetes patients have achieved all of the NICE recommended treatment targets</td>
<td>Of people with diabetes diagnosis for less than a year who attended a structured education course</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of GP practices that participated in the National Diabetes Audit</td>
</tr>
<tr>
<td><strong>Learning Disabilities</strong></td>
<td>Needs Improvement</td>
<td>74 44%</td>
</tr>
<tr>
<td></td>
<td>Rate of inpatients per million GP registered adult population for each Transforming Care Partnership. CCGs are then assigned the score of the TCP they belong to</td>
<td>Of people with a learning disability who are on the GP register and receiving an annual health check during the year. Measured as a percentage of the CCGs registered learning disability population.</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Needs Improvement</td>
<td>78.1 60.2 8.9 18%</td>
</tr>
<tr>
<td></td>
<td>The score out of 100 for women’s experience maternity services based on the 2015 CQC National Maternity Services Survey</td>
<td>The score out of 100 for choices offered to women in maternity services based on the National Maternity Services Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths, reported at CCG of residence level by calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of women who were smokers at the time of delivery</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Top performing</td>
<td>59.1% 78.3%</td>
</tr>
<tr>
<td></td>
<td>Of people who were initially assessed as ‘at caseness’, attended at least two treatment contacts, are coded as discharged and are assessed as moving to recovery</td>
<td>Of people with first episode of psychosis starting treatment with a NICE recommended package of care and treated with 2 weeks of referral</td>
</tr>
</tbody>
</table>
### Clinical Area Overall Rating Indicator Ratings

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Overall Rating</th>
<th>Cancer</th>
<th>Dementia</th>
<th>Diabetes</th>
<th>Learning Disabilities</th>
<th>Maternity</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td>Needs Improvement</td>
<td>51.7%</td>
<td>71.9%</td>
<td>39.4%</td>
<td>75.8</td>
<td>61.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New cases of cancer diagnosed at stage 1 and stage 2 as a proportion of all new cases of cancer diagnosed</td>
<td>Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
<td>Of patients diagnosed with dementia who have received a face to face review of their care plan in the preceding 12 months</td>
<td>Of diabetes patients have achieved all of the NICE recommended treatment targets</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis</td>
<td>Of responses which were positive to the question “Overall, how would you rate your care?”</td>
<td>Estimated diagnosis rates for people with dementia</td>
<td>Of diabetes patients who have achieved all of the NICE recommended treatment targets</td>
<td>The score out of 100 for choices offered to women in maternity services based on the National Maternity Services Survey</td>
<td>Of people with first episode of psychosis starting treatment with a NICE recommended package of care and treated with 2 weeks of referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needs Improvement</td>
<td>80.7%</td>
<td>76.8%</td>
<td>9%</td>
<td>57.2</td>
<td>62.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New cases of cancer diagnosed at stage 1 and stage 2 as a proportion of all new cases of cancer diagnosed</td>
<td>Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
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<td>Of people with first episode of psychosis starting treatment with a NICE recommended package of care and treated with 2 weeks of referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needs Improvement</td>
<td>68.4%</td>
<td>50%</td>
<td></td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Needs Improvement</td>
<td>89.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Of responses which were positive to the question “Overall, how would you rate your care?”</td>
<td></td>
<td></td>
<td></td>
<td>Of women who were smokers at the time of delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needs Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Of women who were smokers at the time of delivery</td>
<td></td>
</tr>
</tbody>
</table>
briefing on improvement and assessment framework (iaf)
2016/2017 annual assessment indicators and proposed changes to indicators for 2017/18

nhs england has a statutory duty to assess each ccg’s performance. it meets this duty through its ccg improvement and assessment framework.

this briefing outlines in
- section one - the six clinical priority areas assessment indicators to be used in 2016/2017 year end rating
- section two - the improvement and assessment framework indicators proposed for the 2017/2018 - 2018/2019 refresh

section one

1. six clinical priority areas assessment - indicators to be used in 2016/2017 year end rating

as part of ccg’s 2016/17 iaf process, an assessment is undertaken in 6 clinical priority areas; cancer, dementia, diabetes, learning disabilities, maternity, mental health.

the ‘assessments’ are carried out by an independent panel for the six clinical areas and these panels have defined their approach to combining the individual indicators in the ccg’s iaf framework to reach a composite banding for each priority area.

nhse have shared that additional indicators will be used in the end of year assessment. the additional indicators, outlined below along with the existing indicators and anticipated assessment, will inform the panel assessments.

1.1 cancer – no new indicators added - likely to remain ‘needs improvement’ based on early stage diagnosis and 62 day targets
- cancer diagnosed at an early stage
- 62 day wait standard
- one-year survival rates
- overall experience of care

1.2 dementia – five new indicators* - likely to be ‘needs improvement’ due to acute admissions and prescribing of anti-psychotics
- dementia diagnosis rate
- dementia care planning and support
- age standardised rate of emergency inpatient hospital admissions of people (65+) with a mention of dementia per 100,000 resident population *
- percentage of emergency inpatient admission for people (65+) with dementia that are short stays (1 night or less) *
- percentage of deaths of people aged 65+ with a recorded mention of dementia occurring in a hospital *
- emergency readmissions to hospital within 30 days of discharge for people (aged 65+) with dementia *
- people aged 65 and over receiving prescriptions for antipsychotic medicines *

1.3 diabetes – six new indicators* - likely to be ‘needs improvement’ for both cccgs based on amputations and quality of foot care
- diabetes patients that have achieved all the nice recommended treatment targets
- people with diabetes diagnosed less than a year who attend a structured education course
- attendance at structured education in the prevalent diabetes population (%) *
- achievement of the 3 nice recommended treatment targets in patients with type 1 diabetes *
- indirectly standardised rate of 3-year amputations in patients with diabetes *
- directly standardised rate of bed-days for patients admitted with diabetes where diabetes is coded in any of the diagnosis fields *
- mdt foot care team coverage across a cccgs commissioning footprint *
- diabetes inpatient specialist nursing service coverage across a cccgs commissioning footprint *

1.4 learning disabilities – one new indicator * - likely to remain as ‘needs improvement’ as not meeting inpatient trajectory and annual health checks have deteriorated in numbers
- reliance on inpatient specialist beds
- annual health checks
- proportion of population on a gp learning disability register *
1.5 Maternity – three new indicators * - likely to remain ‘needs improvement’ for both CCGS
- Maternal smoking at delivery
- Avoidable stillbirth and neonatal mortality
- Women’s experience of maternity services
- Choices in maternity services
- Seasonal influenza vaccine uptake amongst pregnant women *
- Status of local maternity systems *
- Breastfeeding at 6 to 8 weeks *

1.6 Mental Health – eleven new indicators * - likely to be ‘needs improvement’ for both CCGs based on suicide, self harm, crisis care
- Improving access to psychological therapies recovery rate
- People with first episode of psychosis starting treatment with a NICE recommended package of care within 2 weeks of referrals
- IAPT access to treatment *
- Suicide: age-standardised death rate per 100,000 population – age 10+ *
- Age standardised rate of 10-24 admitted for self-harm *
- Hospital admissions for self-harm: rate per 100,000 age 25+ *
- Proportion of patients on care programme approach discharged from hospital and followed up within 7 days *
- IAPT referral to treatment waiting times *
- IAPT access to treatment for older people *
- Mental health investment standard *

The draft high level milestones NHSE have set for the end of year assessment are outlined below:

- **February 2017**  The final approach to the assessments will be communicated
- **Mid-May 2017**  Assessments will be made in clinical priority areas
- **Early June 2017**  Overall year end assessments will be made
- **End of June 2017**  Commissioning committee ratification
- **July 2017**  Publication of year end report on MyNHS
Section Two

2. Improvement and Assessment Framework indicators proposed in 2017/18 refresh

The principles NHS England are applying for the CCG IAF in 2017/18 – 2018/19 are that:

- It will cover two financial years to align with the two year planning guidance.
- A small number of indicators will be added
- In other cases indicators will be added on a “one in one out” basis
- Additional burden to CCG’s will be considered
- The domains in the IAF will remain the same to maintain alignment with the Five Year Forward View

NHSE have proposed the addition of 5 new indicators (table 1), to remove 4 indicators (table 2) and update or replace 19 indicators (table 3). The final publication of the new IAF agreed indicators will be at the end of March 2017.

Proposed Indicators to be added

<table>
<thead>
<tr>
<th>Area</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and community engagement (placeholder)</td>
<td>Based on significant feedback from engagement exercise of the 2016/17 CCG IAF. Proposal for a non-data indicator</td>
</tr>
<tr>
<td>Patient safety-sepsis</td>
<td>Commitment made in the 2016/17 framework</td>
</tr>
<tr>
<td>Dementia</td>
<td>Emergency readmissions to hospital within 30 days of discharge for people with dementia; and, Percentage of deaths of people aged 65+ with a recorded mention of dementia occurring in a hospital</td>
</tr>
<tr>
<td>Diabetes prevention programme (17/18 placeholder, added 18/19)</td>
<td>The number attending an initial assessment for the diabetes prevention programme per 10,000 people estimated to be at risk using National Cardiovascular Intelligence Network (NCVIN) prevalence estimates</td>
</tr>
<tr>
<td>End of life care</td>
<td>Three or more emergency admissions in the last 90 days; and, Time spent in hospital in the last 90/180 days</td>
</tr>
</tbody>
</table>

Table 1

Proposed Indicators to be removed

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>143a. Adoption of new models of care</td>
<td>This programme will be embedded by the end of 2017/18. Key lines of enquiry (KLOE) on new models of care will be included in the assessment of leadership</td>
</tr>
<tr>
<td>161a. Sustainability and transformation plans (STP)</td>
<td>This programme will be embedded by the end of 2017/18. KLOE on the STP will be included in the assessment of leadership</td>
</tr>
<tr>
<td>105c. Percentage of deaths which take place in hospital</td>
<td>Replaced with end of life care metric</td>
</tr>
<tr>
<td>142a. Outcome in areas with identified scope for improvement</td>
<td>Agreed that 142b expenditure in areas with identified scope for improvement, will be used</td>
</tr>
</tbody>
</table>

Table 2

Proposed Indicators to be updated or replaced

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Proposed update</th>
</tr>
</thead>
<tbody>
<tr>
<td>101a. Maternal smoking at delivery</td>
<td>The number of women with an unknown smoking status will no longer be included in the denominator</td>
</tr>
<tr>
<td>105a. Utilisation of the NHS e-referral service to enable choice at first routine elective referral</td>
<td>Current proxy measure to be replaced with a direct measure, likely to be available no earlier than Q2 2017/18</td>
</tr>
<tr>
<td>105b. Personal health budgets</td>
<td>Change in source/collection</td>
</tr>
<tr>
<td>Mental Health: 123c. Children and young people’s mental health services transformation 123d. Crisis care and liaison mental health services</td>
<td>Likely that transformation indicators will be replaced by indicators from the mental health dashboard</td>
</tr>
<tr>
<td>Indicator</td>
<td>Proposed update</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>123e. Out of area placements for acute mental health inpatient care</td>
<td></td>
</tr>
<tr>
<td>124b. Proportion of people with a learning disability on the GP register receiving an annual health check</td>
<td>Ensure that the CCG denominator matches the indicator definition</td>
</tr>
<tr>
<td>125a. Neonatal mortality and stillbirths</td>
<td>Change in data source from ONS to Mbrace Perinatal Mortality Surveillance Report</td>
</tr>
<tr>
<td>125b. Women’s experience of maternity services</td>
<td>In line with changes to the CQC survey for 2017 following consultation</td>
</tr>
<tr>
<td>125c. Choices in maternity services</td>
<td>As 125b (above)</td>
</tr>
<tr>
<td>127d. Ambulance waits</td>
<td>Looking to replace with ‘the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&amp;E department’</td>
</tr>
<tr>
<td>128a. Management of long term conditions</td>
<td>Retitled to make the name more descriptive</td>
</tr>
<tr>
<td>130a. Achievement of clinical standards in the delivery of 7 day services</td>
<td>To be determined</td>
</tr>
<tr>
<td>131a. People eligible for standard NHS Continuing Healthcare</td>
<td>Replacement with ‘percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting’</td>
</tr>
<tr>
<td>141a. Financial plan/ 141b. In year financial performance</td>
<td>Updated to reflect the two year planning process</td>
</tr>
<tr>
<td>144b. Digital interaction between primary and secondary care</td>
<td>Proposal to change existing composite and replace with an updated e-referrals indicator</td>
</tr>
<tr>
<td>162a. Probity and corporate governance</td>
<td>To be in line with new guidance on conflict of interest</td>
</tr>
<tr>
<td>163b. Progress against workforce race equality standard</td>
<td>To be confirmed whether this will be a composite or a single indicator</td>
</tr>
<tr>
<td>Well led domain indicators, including 165a. Quality of leadership</td>
<td>To align with the NHSI/CQC well led framework</td>
</tr>
</tbody>
</table>

Table 3
Summary of key issues from the Joint Planning and Commissioning Committee held on 14 February 2017

Date of the meeting 7th March 2017

What other CCG committee and/or group has considered this report?

COMMITTEE/GROUP Joint Planning and Commissioning Committee (JPCC)

Other agreements

Purpose of the report, executive summary of key issues, points, and outcomes

Planning update
Members were updated: 1) that no feedback has been received from NHSE on the CCG Operational Plan submissions from 23 December; 2) the SPP Directorate continue to work with Communication colleagues to develop a public facing operational plan by the end of March 2017; and 3) a programme plan to monitor the implementation of operational plans is being developed and will be shared with JPC in March.

Paediatric Cancer Referral Pathway
An audit of two week cancer referrals for children during 2015/16 identified: 1) 62.5% increase in referrals from 2013/14; 2) 169 referrals reviewed - only one had a confirmed diagnosis of malignancy; 3) Vast majority of new diagnoses of malignancy were identified via other routes particularly CAU. The JPC discussed the current childhood cancer referral pathway and agreed 1. Referral pathways should be 2 week compliant rather than 48 hour 2. UHN will introduce a dedicated telephone advice line for GPs which will be available daily. A Map of Medicine pathway is to be developed for GPs.

Refresh of Local Improvement Scheme (LIS) for Admission Avoidance
Members were asked to approve in principle the proposal for a refreshed Admission Avoidance LIS scheme and funding for the scheme for a two year period to 2019. Concerns were raised: 1) transitional support from existing schemes to new schemes needs to be robust especially where there were employed staff; 2) there needs to be more clarity on the metrics included in the scheme especially as it was felt there might be too many; and 3) more needs to be done to understand funding/penalties. The Committee asked that more work was done to refine the LIS scheme and for the LIS to be brought back to the next meeting.

Membership and Transformation Scheme for 2017/19
Members were asked to approve in principle the proposal for a refreshed Membership and Transformation LIS scheme and funding for the scheme for a two year period to 2019. Issues were raised: 1) regarding the future of the GP Federation; 2) removal of Apex from the LIS; 3) whether GP federation bidding for transformation funding would be sourced from this offer; 4) links with primary care development re: new
models of care and MCPs; and 5) governance arrangements. The scheme is to be discussed at Primary Care Leads group and a revised version brought back to JPCC for approval.

**Staffordshire Mental Health Helpline**
Members approved a proposal for the current Staffordshire Mental Health Helpline commissioning arrangements to come under the CCG from Staffordshire County Council.

**Maternity – Implementation of National Strategy**
Members were briefed on proposals to establish a pan-Staffordshire Local Maternity System. On hearing the proposals the group felt that 1) there needed to be stronger representation from the North; 2) concern was raised over smoking and pregnancy and the deterioration of targets; 3) more needed to be done to communicate service provisions/changes to primary care; and 4) more work was needed to understand the business of the group and outline outputs and actions to deliver a transformation plan by October 2017.

**Neurology Review**
The JPC received the neurology review and agreed the proposed redesign of the community rehabilitation team and Whitfield unit. The group discussed the QIPP delivery proposals for both 2017/18 and 2018/19: 1) it was felt that nurse consultant costs need to be reviewed as these benchmarked high against peers; 2) that any work which assessed or benchmarked referrals from primary care need to be underpinned by clinical audit of their appropriateness; and 3) that work needed to be aligned with the neurology Commissioning for Value deep dive desktop exercise.

**Podiatry Procurement**
JPC approved the proposal to award a three year contract with a one year optional extension for the Community Podiatry Service. Discussion over the proposal included 1) concerns over the cost per volume of the award; 2) confidence in the provider to meet requirements; and 3) alignment of services with future MCP models

**Impact of Staffordshire County Council budget reductions on Children’s Services**
Members were made aware of Staffordshire County Council cuts to Health Visiting, Special School Nursing, and Looked After Children. Members were also briefed on the future of commissioning children’s services with the County Council. A further report was requested for the March JPCC meeting.

Concerns were raised over Staffordshire County Council cuts to public health services. It was agreed that Cheryl Hardisty would draft a letter on Dr Steve Fawcetts behalf to the County Council. It was also put forward that MOUs with both councils should be assessed and managed.

**RightCare update**
Members approved three pathways for redesign identified in the recent Commissioning for Value deep dive exercise: Endocrine diabetes, Trauma and Orthopaedics for Falls and Respiratory. Members also approved the content of the collection template for the National RightCare team which outlines our ambitions using the RightCare methodology.

<table>
<thead>
<tr>
<th>Action required</th>
<th>Decision</th>
<th>Discussion</th>
<th>To note</th>
<th>For assurance/ For information</th>
</tr>
</thead>
</table>

**Recommendation:**
The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to note the key issues discussed and decisions made by the JPCC at its February meeting.
**Summary of risks relating to the proposal**

Not applicable

**Any statutory / regulatory / legal / NHS constitution/NHSE assurance / governance implications**

None

**Is a Quality impact and/or Equality impact required**

QIAs and EIAs will be undertaken as part of any particular service change.

**Any engagement activity with stakeholders/practices/public and patients**

Patient representatives are part of the membership of the JPCC.

**Strategic objectives supported by this paper**

(identify appropriate goals)

<table>
<thead>
<tr>
<th>NORTH STAFFORDSHIRE CCG</th>
<th>YES</th>
<th>NO</th>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will commission safe effective and high quality sustainable services</td>
<td>Improve access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. We will deliver better patient outcomes through effective federated and collaborative arrangements with key partners</td>
<td>Improve health outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. We will improve patient experience through patient engagement, feedback</td>
<td>Improve quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. We will reduce health inequalities and inappropriate clinical variation</td>
<td>Reduce health inequalities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Governance &amp; Statutory Requirements</td>
<td>Cross Cutting / Statutory Duties (more than one of the above)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. We will achieve all of the above while remaining within financial balance and achieving best value</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACRONYMS**

N/A
Purpose

Further to the decision by NHS England to approve NHS North Staffordshire Clinical Commissioning Group and NHS Stoke-On-Trent Clinical Commissioning Group to take forward Delegated Commissioning of Primary Care Medical Services from 1st April 2017. This paper sets out for information:

- Part A: the requirements of Delegation Agreement (Appendix 1.)
- Part B: the financial due diligence work undertaken by the CCGs ahead of delegation
- Part C: the timetable to full delegation on 1st April 2017.
- The Paper also seeks the Governing Bodies approval to the signing of the delegation agreement.

Key issues

- The Delegation Agreement sets out how the CCGs will exercise their delegated primary medical care commissioning functions. The agreement is a national template and cannot be modified locally.

- Functions relating to the commissioning of pharmacy, dental and optical primary care are not delegated to CCGs.

- Funds delegated for primary care are separate to the funds allocated to the CCGs under section 223G of the NHS Act (known as the ‘Annual Allocation’) and may not be used for any other purpose.

- The establishment by of a Primary Care Committee is a key requirement of the Agreement. The governance arrangements for which are very explicit to ensure that conflicts of interest are managed.

- Financial due diligence, to provide assurance that there are no unknown issues or risks, and that systems and processes are in place to enable transition to delegated commissioning.

- It is a condition of delegation that CCGs have a plan agreed with NHS England which complies with the control total set by the Regional Director for 2017-18 in advance of the Agreement being signed.

Action required

<table>
<thead>
<tr>
<th>Decision</th>
<th>X</th>
<th>For assurance/ For information</th>
</tr>
</thead>
</table>
| Recommendation:

The North Staffordshire and Stoke-on-Trent CCGs Governing Boards in common are asked to agree:

I. That the request for the Clinical Commissioning Groups to sign the Delegated Agreement is approved
The Boards are asked to note:

I. The details of the Delegated Agreement highlighted in the paper
II. The Primary Care Delegated Commissioning - Finance Due Diligence update
III. The timeline to transition to Delegated Commissioning

Summary of risks relating to the proposal
As a financial condition for delegation the Clinical Commissioning Groups are required to have a plan agreed with NHS England which complies with the control total set by the Regional Director for 2017-18. This plan and agreement must be in place in advance of the Delegation Agreement being signed. There is a risk that Delegated Commissioning may not be approved if an agreed plan is not in place.

There is risk that financial due diligence may not obtain satisfactory resolution of the issues identified to enable the Clinical Commissioning Group to provide assurance to the Governing Board that there are no unknown issues or risks, and systems and processes are established to enable a transition to Delegated Commissioning within the specified timeline (1st April 2017).

Any statutory/ regulatory/legal/NHS constitutional/NHSE assurance / governance implications
- The Primary Care Commissioning Committee will be required to comply with the Clinical Commissioning Groups statutory governance arrangements.
- The Delegation Agreement is a legally binding agreement between Clinical Commissioning Groups and NHS England
- Reporting mechanisms will be established to provide assurance to NHS England

Is a Quality and/or Equality impact assessment required
None

Any engagement activity with stakeholders/practices/public and patients
None

Strategic objectives supported by this paper (identify appropriate goals)

<table>
<thead>
<tr>
<th>North Staffordshire CCG</th>
<th>Yes</th>
<th>No</th>
<th>Stoke on Trent CCG</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will commission safe effective and high quality sustainable services</td>
<td></td>
<td></td>
<td>Improve access</td>
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<tr>
<td>5. Governance &amp; Statutory Requirements</td>
<td>X</td>
<td></td>
<td>Cross cutting /statutory duties (more than one of the above)</td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

ACRONYMS

Include within the paper
Part A: Delegation Arrangements

1. **Delegated Commissioning of Primary Medical Services**

   1.1. The Clinical Commissioning Groups applied to NHS England for the delegated commissioning of primary medical services in December 2016. Both NHS North Staffordshire Clinical Commissioning Group and NHS Stoke-on-Trent Clinical Commissioning Group have been approved to take forward these new arrangements from 1st April 2017, subject to the signing of the Delegation Agreement and delivery of the specified financial requirements. A copy of the Delegation Agreement is located in Appendix 1.

   1.2. As a financial condition for delegation the Clinical Commissioning Groups are required to have a plan agreed with NHS England which complies with the control total set by the Regional Director for 2017-18. This plan and agreement must be in place in advance of the Delegation Agreement being signed.

2. **The Delegation Agreement**

   2.1. The Delegation Agreement sets out the arrangements for how the Clinical Commissioning Group will exercise its delegated primary medical care commissioning functions and the agreement is in a standard format to be signed by NHS England and the relevant Clinical Commissioning Group. The agreement contains details of the primary medical care commissioning functions delegated to the Clinical Commissioning Group and include but are not limited to:

   - Decisions about enhanced services, local incentive schemes, establishment of new GP practices (including branch surgeries) and GP practice closures, decisions about ‘discretionary’ payments and commissioning of urgent care (including home visits) for out of area registered patients;
   - Approval of practice mergers;
   - Planning primary medical care services in the Area and undertaking reviews of services;
   - Decisions in relation to the management of poorly performing GP practices;
   - Management of Delegated Funds in the Area;
   - Premises Costs Directions Functions;
   - Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate.

   2.2. The Agreement details the functions reserved to NHS England in relation to primary medical services which includes the management of the national performers list, management of the revalidation and appraisal process, administration of payments and related performers list management activities, Section 7A Functions, Capital Expenditure Functions and complaints management.

   2.3. The functions relating to the commissioning of primary care pharmacy, dental and optical contracts are not delegated to the Clinical Commissioning Groups under delegated arrangements.
2.4. The Delegation Agreement sets out the principles to be adhered to by both Clinical Commissioning Groups and NHS England in their dealings with each other which includes the sharing of information and best practice, avoiding duplication, risk mitigations, cost reduction and acting in good faith at all times.

2.5. Financial provisions and liability are included within the Agreement and the Delegated Funds do not form part of and are separate to the funds allocated annually to the Clinical Commissioning Groups under section 223G of the NHS Act (known as the ‘Annual Allocation’). In-year spending against delegated and overall primary care budgets will be closely monitored by NHS England and reporting requirements are detailed within the Agreement.

3. **The Primary Care Commissioning Committee**

3.1. A key requirement of the Delegation Agreement is the establishment by the Clinical Commissioning Groups of a Committee to exercise its Delegated Functions. The Clinical Commissioning Group is in the process of establishing a Primary Care Commissioning Committee to exercise the discharge of the Primary Medical Services function. To support the collaborative working across Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups, the Committee will hold meetings ‘in common’, where appropriate, to discuss items of common interest.

3.2. The Draft Terms of Reference for the Committee were approved by NHS England as a part of the Delegated Commissioning Submission. The Terms of Reference will be presented for formal approval at the first meeting of the Primary Care Commissioning Committee. There will be a minimum of nine meetings held each year in public. Details of the meetings will be made available on the Clinical Commissioning Groups public website.

4. **The Staffing Model - Memorandum of Understanding**

4.1. The Delegation Agreement provides for three staffing models under which the Clinical Commissioning Groups may engage staff to undertake the Delegated Functions. NHS North Staffordshire Clinical Commissioning Group and NHS Stoke-on-Trent Clinical Commissioning Group have been working collaboratively with the Clinical Commissioning Groups in Staffordshire to agree working arrangements between the Clinical Commissioning Groups and NHS England. These working arrangements focus on “Model 1 – Assignment” whereby the staff of NHS England will remain in their current roles covering Staffordshire and they will continue to be hosted by NHS England and support the Clinical Commissioning Groups in discharging their duties under delegated commissioning. A Memorandum of Understanding is being developed to reflect the national Delegation Agreement and this will be tabled for approval at the Pan Staffordshire Joint Commissioning Committee once the final document has been agreed by all Clinical Commissioning Groups.

4.2. There will be a requirement for the Clinical Commissioning Groups to have direct involvement in the commissioning of primary care and its development and financial management as well as providing quality assurance of General Practice. The Clinical Commissioning Groups will also be required to support the delivery of the GP Forward View. This will need to be considered against the available capacity within the Team.
PART B: Financial Due Diligence

1. **Primary Care Delegated Commissioning - Finance Due Diligence**

1.1. The NHS North Staffordshire Clinical Commissioning Group and NHS Stoke-on-Trent Clinical Commissioning Group are planning to take responsibility for the primary care budgets from April 2017. Based upon information provided by NHS England as at month 7, the budgets would be £27.412m for North Staffs Clinical Commissioning Group and £37.573m for Stoke-on-Trent Clinical Commissioning Group.

1.2. As part of the due diligence process the Clinical Commissioning Groups are seeking assurance on a number of aspects and a ‘task and finish’ group has been established between finance colleagues across the six Staffordshire Clinical Commissioning Groups and the NHS England finance team to progress and complete this work. The Clinical Commissioning Groups require satisfactory resolution of the issues to enable us to provide assurance to the Governing Board that there are no unknown issues or risks, and systems and processes are established to enable a smooth transition to Delegated Commissioning from 1st April 2017.

1.3. The financial due diligence process encompasses a number of areas including the accuracy / completeness of the budgets to be transferred from NHS England to the Clinical Commissioning Groups. Further detail is being sought on the annual transactions (recurrent and non-recurrent) to ensure that this is reflective of the overall budget transfer value. The majority of the primary care payment is nationally determined based upon list size and the national global sum rate, however there are areas where this is not the case or where changes are made mid-year such as PMS / APMS contract values. A number of the PMS practices changed to a GMS contract during 2016 and the full year effect of these changes will be reflected in the baseline 2017/18 budget.

1.4. The changes agreed as part of the 2017-18 GMS contract negotiations will be assessed and it is expected that any financial impact will be reflected in the 2017-18 baseline budget.

1.5. Premises payments are included in the due diligence process and an up to date register of all practice rent reimbursements, including most recent valuation figures has been requested. There are a number of practices that have rent reviews that are not yet agreed. NHS England has confirmed that any financial impact as a result of rent reviews due prior to 31/3/17 will be recurrently adjusted in 2017/18.

1.6. There are also a number of non-recurrent payments made from contingencies (not all relevant for our Clinical Commissioning Groups) and the Clinical Commissioning Groups need to understand the rationale for payment, the funding source, and if it is actually non-recurrent in nature. The most significant payment is for winter pressures, and the Clinical Commissioning Groups were assured that this would not be part of the delegated budget. Although NHS England have not ruled out the potential to provide additional financial resource for winter funding they equally are not able to confirm that there will be an additional resource.

1.7. The Clinical Commissioning Groups are also clarifying the growth element that the Groups should receive as part of the baseline for primary care particularly in relation to the requirements of the GP Forward View.
1.8. Financial Due diligence will also focus on any changes required to CCG financial systems and Standing Financial Instructions. This will mainly relate to changes in authorised signatories and Standing Financial Instructions associated with the new payments that the Clinical Commissioning Groups will be responsible for, for example premises payments, GP superannuation. The review also includes ledger coding and reporting requirements, and understanding what is required for the procurement of GP services, e.g. APMS contracts re-procurement, or for new GP practice developments.

1.9. A number of direct supplier services such as clinical waste, interpreting services and property valuations will remain the contractual and financial responsibility of NHS England. One important area is the control process for the ledger, as NHS England staff will require access to the CCG financial ledgers.

2. **Assessment of Financial Risks for the Next Three Years and Thereafter**

2.1. In reviewing the completeness of the budgets transferred, the Clinical Commissioning Groups are also identifying any areas where there may be a financial risk to ensure the Groups have appropriate financial planning in place. The key areas being discussed are:

- GP forward view requirements – the financial values are already known, however, clarification is being sought on the source of the funding, i.e. from CCG growth or central NHS England funding.

- Rent abatements – five GP practices in North Staffordshire Clinical Commissioning Group and 10 in Stoke-on-Trent Clinical Commissioning Group have received capital contributions for premises improvements over time, and rent payments have been reduced (abated) to reflect this. The Clinical Commissioning Groups have now mapped when each of these abatements will end and these figures can be factored into future year financial plans.

<table>
<thead>
<tr>
<th></th>
<th>2017/18 £’000s</th>
<th>2018/19 £’000s</th>
<th>2019/20 £’000s</th>
<th>2020/21 £’000s</th>
<th>2021/22 £’000s</th>
<th>Later £’000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Staffs</td>
<td>2.1</td>
<td>2.3</td>
<td>6.7</td>
<td>5.0</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>Stoke</td>
<td>3.1</td>
<td>10.5</td>
<td>14.5</td>
<td>15.5</td>
<td>6.2</td>
<td></td>
</tr>
</tbody>
</table>

2.2. Risks associated with rent reviews – clarity is required on when rents are due for review. There are a number currently outstanding and NHS England have confirmed that they will provide funding for any that are due before 31 March 2017, regardless of when they are finally agreed.

2.3. The Clinical Commissioning Groups will need to be aware of the timing of future rent reviews, and also the recurrent financial implications of any capital proposals, e.g. the Estates and Technology Transformation Scheme, and ensure these are reflected in future financial plans.
3. **Risk Pooling Between the Clinical Commissioning Groups**

3.1. Although each Clinical Commissioning Group will have a primary care contingency budget, the option of pooling risks between the six Staffordshire CCGs has been raised. This would be to avoid any significant financial pressure due to an unforeseen or exceptional event, e.g. where a GP practice suddenly closes and alternative arrangements need to be put into place quickly. This issue will be discussed by the Clinical Commissioning Groups Directors of Finance before any firm proposals are put to the Governing Board for approval.


4.1. The finance team in NHS England will continue to provide the majority of day to day financial management of primary care budgets on behalf of all six Clinical Commissioning Groups in Staffordshire. The Clinical Commissioning Groups are reviewing their systems processes and timetables to ensure that these fit within the requirements of the Clinical Commissioning Groups financial reporting. Issues such as coding of transactions, completion of journal entries and monthly accruals will be agreed, and form part of a ‘Finance Memorandum of Understanding’ which will be part of the main Memorandum of Understanding which detail staffing arrangements with NHS England.

5. **Financial Due Diligence Next Steps**

5.1. It is expected that the remaining budget queries will be resolved prior to the next task and finish meeting which is scheduled for early March. Following this meeting the Clinical Commissioning Groups should be in a position to finalise the Finance MOU and provide assurance to the CCG Governing Boards on a satisfactory conclusion of the financial due diligence process.
## PART C: Delegated Commissioning Transition Plan

The table below details current actions to support the Clinical Commissioning Groups transition to delegated commissioning, including support for the Primary Care Commissioning Committee.

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Anticipated Date/Completion Date</th>
<th>RAG Status</th>
<th>Comments/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Members to shadow the Pan Staffordshire Joint Commissioning Committee</td>
<td>Lay Members</td>
<td>21.03.2017</td>
<td>*</td>
<td>Peter Dartford attended on 21.02.2017, Tim Bevington, Margy Woodhead &amp; John Howard to attend on 21.03.2017</td>
</tr>
<tr>
<td>Educational Packs to be pulled together for Lay Members, for Primary Care Commissioning Committee</td>
<td>Jess Chaplin</td>
<td>03.03.2017</td>
<td>*</td>
<td>In process - documents being sent by NHS England</td>
</tr>
<tr>
<td>Development Session for Lay Members with NHS England - re. delegated commissioning and Primary Care Commissioning Committee</td>
<td>NHS England/Alex Palethorpe</td>
<td>TBC - Need to be before Primary Care Commissioning Committee</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td></td>
</tr>
<tr>
<td>Schedule of Dates to be drawn up for Primary Care Commissioning Committee/Venues Booked</td>
<td>Rachel Barker</td>
<td>TBC - First meeting needs to take place in April 2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>Initial scoping for dates has taken place, anticipated to be the 4th Tuesday of the Month - unclear if first meeting will be held in Public</td>
</tr>
<tr>
<td>Information to be taken to Public Governing Board around the future Primary Care Commissioning Committees - to be included in March Board paper</td>
<td>Alex Palethorpe/Rachel Barker</td>
<td>07.03.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>* Item under ‘Primary Care Update’ Header on March Public Governing Board Agenda</td>
</tr>
<tr>
<td>Terms of Reference for Primary Care Commissioning Sign off</td>
<td></td>
<td>Apr-17</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>TCR were signed off by NHS England as a part of the Delegated Commissioning Submission, TCR will be signed off formally at the inaugural Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>Cycle of Business to be drawn up for Primary Care Commissioning Committee</td>
<td>Sarah Blenkinsop/Rebecca Woods</td>
<td>30.03.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>Conference call to take place on the 30th March 2017, Cycle of Business to be Drawn up on a pan Staffordshire Basis, to ensure alignment across the county.</td>
</tr>
<tr>
<td>Governing Board paper to include Delegated Agreement and Delegated Commissioning Timeline</td>
<td>Vicky Oxford</td>
<td>27.02.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>* Paper drawn up - including the Delegated Agreement</td>
</tr>
<tr>
<td>Financial Requirements to be looked at and assurance obtained - to be included in paper to March Governing Board</td>
<td>Alan Howgate</td>
<td>27.02.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>Update included in Governing Board paper</td>
</tr>
<tr>
<td>Financial due diligence to be completed and finance MOU finalised.</td>
<td>Alan Howgate</td>
<td>31.03.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td></td>
</tr>
<tr>
<td>Final M.O.U Document to be obtained from NHS England - following on from sign-off by CCGs &amp; Joint-Commissioning Committee in March 2017</td>
<td>Vicky Oxford</td>
<td>31.03.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td>Draft MOU to be finalised for discussion and CCG approval</td>
</tr>
<tr>
<td>Formal sign off from Governing Board for the Delegation Agreement</td>
<td>Dr John Gilby</td>
<td>07.03.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td></td>
</tr>
<tr>
<td>Delegation Agreement to be formally submitted to the NHS England National Team once signed off by Clinical Commissioning Group</td>
<td>Sarah Blenkinsop</td>
<td>07.03.2017</td>
<td>Preliminary Email has been sent to NHS England for dates</td>
<td></td>
</tr>
</tbody>
</table>
Delegation Agreement

1. Particulars

1.1. This Agreement records the particulars of the agreement made between NHS England and the Clinical Commissioning Group named below.

<table>
<thead>
<tr>
<th>Area</th>
<th>North Staffordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Commissioning Group</td>
<td>North Staffordshire CCG</td>
</tr>
<tr>
<td>CCG Representative</td>
<td>Sarah Blenkinsop</td>
</tr>
<tr>
<td>CCG Address for Notices</td>
<td>Floor 3, One Smithfield Leonard Coates Way Hanley Stoke-on-Trent ST1 4FA</td>
</tr>
<tr>
<td>Date of Agreement</td>
<td>[Leave Blank]</td>
</tr>
<tr>
<td>Delegation</td>
<td>means the delegation made by NHS England to the CCG of certain functions relating to primary medical services under section 13Z of the NHS Act and effective from 1 April 2015 (as amended pursuant to the Delegation)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS England Representative</th>
<th>Rebecca Woods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local NHS England Team</td>
<td>North Midlands</td>
</tr>
<tr>
<td>NHS England Address for Notices</td>
<td>Anglesey House Towers Business Park Wheelhouse Road Rugeley Staffordshire WS15 1UL</td>
</tr>
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1.2. This Agreement comprises:

1.2.1. the Particulars (Clause 1);
1.2.2. the Terms and Conditions (Clauses 2 to 24 and Schedule 1 to Schedule 6 and Schedule 8 to this Agreement); and

1.2.3. the Local Terms (Schedule 7).

Signed by

NHS England
Paul Bauman (for and on behalf of NHS England)

Signed by

[Insert name] Clinical Commissioning Group
[Insert name of Authorised Signatory] [for and on behalf of] [ ]
Terms and Conditions

A. Introduction

2. Interpretation

2.1. This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2. If there is any conflict or inconsistency between the provisions of this Agreement and the provisions of the Delegation, the provisions of the Delegation will prevail.

2.3. If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

2.3.1. the Particulars and Terms and Conditions (Clauses 1 to 24 and, in particular, clause 8.7);
2.3.2. Schedule 1 to Schedule 6 and Schedule 8 to this Agreement; and
2.3.3. Schedule 7 (Local Terms).

2.4. This Agreement and any ancillary agreements it refers to constitute the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

3. Background

3.1. NHS England has delegated the Delegated Functions to the CCG under section 13Z of the NHS Act and as set out in the Delegation.

3.2. Arrangements made under section 13Z of the NHS Act may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.
3.3. This Agreement sets out the arrangements that apply in relation to the exercise of the Delegated Functions by the CCG.

3.4. For the avoidance of doubt, functions relating to the commissioning of primary care pharmacy, dental and optical contracts are not delegated to the CCG under the Delegation. The Delegation relates only to the delegation and reservation of primary medical services commissioning functions as set out in this Agreement.

4. Term

4.1. This Agreement has effect from the date set out in paragraph 5 of the Delegation and will remain in force unless terminated in accordance with clause 17 (Termination) below.

5. Principles

5.1. In performing their obligations under this Agreement, NHS England and the CCG must:

5.1.1. at all times act in good faith towards each other;
5.1.2. at all times exercise functions effectively, efficiently and economically;
5.1.3. act in a timely manner;
5.1.4. share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
5.1.5. at all times observe relevant statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, and Information Law; and
5.1.6. have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

B. Role of the CCG

6. Performance of the Delegated Functions
6.1. The role of the CCG will be to exercise the Delegated Functions in the Area.

6.2. The Delegated Functions are the functions set out in Schedule 1 of the Delegation and being:

6.2.1. decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

   6.2.1.1. decisions in relation to Enhanced Services;
   6.2.1.2. decisions in relation to Local Incentive Schemes (including the design of such schemes);
   6.2.1.3. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
   6.2.1.4. decisions about ‘discretionary’ payments;
   6.2.1.5. decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

6.2.2. the approval of practice mergers;
6.2.3. planning primary medical care services in the Area, including carrying out needs assessments;
6.2.4. undertaking reviews of primary medical care services in the Area;
6.2.5. decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
6.2.6. management of the Delegated Funds in the Area;
6.2.7. Premises Costs Directions Functions;
6.2.8. co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
6.2.9. such other ancillary activities that are necessary in order to exercise the Delegated Functions.
6.3. Schedule 2 *(Delegated Functions)* sets out further detail in relation to the Delegated Functions and the exercise of such Delegated Functions.

6.4. The CCG agrees that it must perform the Delegated Functions in accordance with:

6.4.1. the Delegation;
6.4.2. the terms of this Agreement;
6.4.3. all applicable Law;
6.4.4. the CCG’s constitution;
6.4.5. Statutory Guidance; and
6.4.6. Good Practice.

6.4A The CCG must have due regard to Guidance and Contractual Notices.

6.5. Without prejudice to clause 6.4, the CCG agrees that it must perform the Delegated Functions in such a manner as to ensure NHS England’s compliance with NHS England’s statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions.

6.6. When performing the Delegated Functions, the CCG will not do anything, take any step or make any decision outside of its delegated authority as set out in the Delegation.

6.7. Without prejudice to any other provision in this Agreement, the CCG must comply with the NHS England central finance team’s operational process (as such process is updated from time to time) for the reporting and accounting of the Delegated Funds. In particular, the CCG will be required to permit the NHS England central finance team and/or their agents and contractors authorised by them to have the ability to access the CCG ledger to provide the services required to deliver financial support and assistance to the CCG necessary to enable them to manage the Delegated Funds and exercise the Delegated Functions. NHS England and the CCG will agree any accruals to be made including any adjustments related to the relevant Financial Year expenditure to ensure no net financial impact or gain on the CCG.

6.8. The decisions of the CCG in exercising the Delegated Functions will be binding on the CCG and NHS England.
7. Committee

7.1. The CCG must establish a committee to exercise its Delegated Functions.

7.2. The structure and operation of the committee must be constituted so as to take into account Guidance issued by NHS England including the revised statutory guidance on managing conflicts of interest for CCGs https://www.england.nhs.uk/commissioning/pc-co-comms/coi/.

C. Functions reserved to NHS England

8. Performance of the Reserved Functions

8.1. The role of NHS England will be to exercise the Reserved Functions.

8.2. Subject to clause 8.3, the Reserved Functions are all of NHS England’s functions relating to primary medical services other than the Delegated Functions and including those functions set out in Schedule 2 of the Delegation and being:

8.2.1. management of the national performers list;
8.2.2. management of the revalidation and appraisal process;
8.2.3. administration of payments in circumstances where a performer is suspended and related performers list management activities;
8.2.4. Capital Expenditure Functions;
8.2.5. Section 7A Functions;
8.2.6. functions in relation to complaints management;
8.2.7. decisions in relation to the GP Access Fund; and
8.2.8. such other ancillary activities that are necessary in order to exercise the Reserved Functions.

8.3. For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended and additional functions may be delegated to the CCG, in which event consequential changes to this Agreement
shall be agreed with the CCG pursuant to clause 22 (Variations) of this Agreement.

8.4. Schedule 3 (Reserved Functions) sets out further detail in relation to the Reserved Functions.

8.5. To support and assist NHS England in carrying out the Reserved Functions, the CCG will share information with NHS England in accordance with section E (Information) below.

8.6. NHS England will work collaboratively with the CCG when exercising the Reserved Functions, including discussing with the CCG how it proposes to address GP performance issues.

8.7. If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions then such functions shall be interpreted as Reserved Functions.

8.8. The Parties acknowledge that, as at the date of this Agreement, the CCG shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.8.1. the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 13.13 to 13.16; and

8.8.2. the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 13.17 to 13.20.

8.9. The Parties further acknowledge that NHS England may ask the CCG to provide certain administrative and management services to NHS England in relation to other Reserved Functions as more particularly set out in clauses 13.21 to 13.23. Such administrative and management services shall only be provided by the CCG following agreement by the CCG.
8.10. Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

D. Commissioning

9. Monitoring and Reporting – General Requirements

9.1. The CCG must comply with any reporting requirements under:

9.1.1. this Agreement (including, without limitation, as required by clause 9 (Monitoring and Reporting – General Requirements), clause 12 (Public Information and Access Targets), clause 13 (Financial Provisions and Liability), clause 14 (Claims and Litigation) and Schedule 2 Part 1 paragraph 2 (Primary Medical Services Contract Management) and paragraph 5 (Information Sharing with NHS England));

9.1.2. the CCG Assurance Framework; and

9.1.3. the CCG’s constitution.

9.2. NHS England shall monitor the exercise and carrying out of the Delegated Functions by the CCG under the terms of this Agreement and as part of the CCG Assurance Framework.

9.3. The CCG will notify NHS England of all primary medical services commissioning committee meetings at least seven (7) days in advance of such meetings and NHS England will be entitled to attend such meetings at its discretion.

9.4. The CCG must provide to NHS England:

9.4.1. all information in relation to the exercise of the Delegated Functions (including in relation to the Delegation or this Agreement), (and in such form) as requested by NHS England from time to time; and

9.4.2. all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.
9.5. Nothing in this Agreement shall affect NHS England’s power to require information from the CCG under sections 14Z17, 14Z18, 14Z19 and 14Z20 of the NHS Act.

E. Information

10. Information Sharing and Information Governance

10.1. Schedule 4 (Further Information Sharing Provisions) makes further provision about information sharing and information governance.

10.2. NHS England and the CCG will enter into a Personal Data Agreement that will govern the processing of Relevant Information that identifies individuals under this Agreement. A template Personal Data Agreement is set out in Schedule 4 (Further Information Sharing Provisions).

10.3. The Personal Data Agreement:

10.3.1. sets out the relevant Information Law and best practice, including the requirements of the NHS Digital IG Toolkit;
10.3.2. sets out how that law and best practice will be implemented, including responsibilities of the Parties to co-operate properly and fully with each other;
10.3.3. identifies the Relevant Information that may be processed, including what may be shared, under this Agreement;
10.3.4. identifies the purposes for which the Relevant Information may be so processed and states the legal basis for the processing in each case;
10.3.5. states who is/are the data controller/s and, if appropriate, the data processor/s of Personal Data;
10.3.6. sets out what will happen to the Personal Data on the termination of this Agreement (with due regard to clause 17 (Termination) of the Agreement); and
10.3.7. sets out such other provisions as are necessary for the sharing of Relevant Information to be fair, lawful and meet best practice.

10.4. NHS England and the CCG will share all Non-Personal Data in accordance with Information Law and their statutory powers as set out
in section 13Z3 (for NHS England) and section 14Z23 (for the CCG) of the NHS Act.

10.5. The Parties agree that, in relation to information sharing and the processing of Relevant Information under the Delegation and this Agreement, they must comply with:

10.5.1. all relevant Information Law requirements including the common law duty of confidence (unless disapplied by statute) and other legal obligations in relation to information sharing including those set out in the NHS Act and the Human Rights Act 1998;
10.5.2. Good Practice; and
10.5.3. relevant guidance (including guidance given by the Information Commissioner, the Caldicott Principles, the requirements of the NHS Information Governance Toolkit to level 2, and guidance issued further to sections 263 and 265 of the HSCA) and consistent with guidance issued under section 13S of the NHS Act to providers.

11. IT inter-operability

11.1. NHS England and the CCG will work together to ensure that all relevant IT systems operated by NHS England and the CCG in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

11.2. The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

12. Public Information and Access Targets

12.1. The CCG must promptly make available to NHS England such information as is required in respect of the Delegated Functions to ensure NHS England’s discharge of its statutory duties.
12.2. The CCG must ensure that all new Primary Medical Services Contracts contain appropriate provisions such that the CCG is able to discharge its obligations in clause 12.1.

12.3. The CCG must ensure that any information provided under this Agreement complies with all relevant national data sets issued by NHS England and NHS Digital.

**F. General**

13. **Financial Provisions and Liability**

*Notification of the Delegated Funds and Adjustments to the Delegated Funds*

13.1. NHS England will, in respect of each Financial Year, notify the CCG of the proportion of the funds allocated to NHS England by the Secretary of State pursuant to Chapter 6 of the NHS Act and which are to be paid to the CCG for the purpose of meeting expenditure in respect of the Delegated Functions for that Financial Year (the “**Delegated Funds**”).

13.2. Except in relation to pooled funds and subject to the terms of this clause 13 (**Financial Provisions and Liability**) and, in particular, clause 13.4, the CCG must use the Delegated Funds to meet expenditure in respect of the exercise of the Delegated Functions. Without prejudice to the generality of the foregoing, the CCG must make:

13.2.1. all payments in relation to the Primary Medical Services Contracts including payments in relation to QOF and implementing financial adjustments or sanctions (including in relation to breaches of provider obligations); and

13.2.2. all payments under the Premises Costs Directions.

13.3. NHS England may, in any Financial Year by sending a notice to the CCG of such increase or decrease, increase or reduce the Delegated Funds:

13.3.1. in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate (following discussions with the CCG), including without limitation adjustments following any changes to the Delegation or Delegated Functions (including changes
pursuant to paragraph 6 or paragraph 16 of the Delegation), changes in allocations, changes in contracts or otherwise;

13.3.2. in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

13.3.3. to take into account any Losses arising under clause 13.35;

13.3.4. to take into account any Claim Losses;

13.3.5. to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the CCG in respect of the Delegated Funds and/or funds transferred (or that should have been transferred) to the CCG and in respect of which the CCG has management or administrative responsibility under clauses 13.13 to 13.23 of this Agreement; or

13.3.6. in order to ensure compliance by NHS England of its obligations under the NHS Act (including without limitation, Chapter 6 of the NHS Act) or the HSCA or any action taken or direction made by the Secretary of State under the NHS Act or the HSCA.

13.3A NHS England acknowledges that the intention of clause 13.3 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments (including but not limited to a change in the mandate published by the Department of Health or other external factors).

13.4. The CCG acknowledges that it must comply with its statutory financial duties, including those under sections 223H and 223I of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

13.5. The CCG acknowledges its duty under section 14S of the NHS Act to assist and support NHS England in discharging its duty under section 13E so far as relating to securing continuous improvement in the quality of primary medical services and agrees that it shall take this duty into
account in relation to the exercise of the Delegated Functions and the use of the Delegated Funds.

13.6. The CCG must ensure that it uses the Delegated Funds in such a way as to ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently in accordance with this Agreement.

13.7. NHS England may in respect of the Delegated Funds:

13.7.1. notify the CCG of the capital resource limit and revenue resource limit that will apply in any Financial Year;
13.7.2. notify the CCG regarding the payment of sums by the CCG to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;
13.7.3. by notice, require the CCG to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS Act or the HSCA (including without limitation, Chapter 6 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act or the HSCA (including, without limitation, Chapter 6 of the NHS Act).

13.8. Schedule 5 (Financial Provisions and Decision Making Limits) sets out further financial provisions in respect of the exercise of the Delegated Functions and, in particular, Table 1 in Schedule 5 (Financial Provisions and Decision Making Limits) sets out certain financial limits and approvals required in relation to the exercise of the Delegated Functions. NHS England’s Standing Financial Instructions shall be updated accordingly.

Payment and Transfer

13.9. The CCG acknowledges that the Delegated Funds do not form part of and are separate to the funds allocated annually under section 223G of the NHS Act (the “Annual Allocation”).
13.10. NHS England will pay the Delegated Funds to the CCG monthly using the same revenue transfer process as used for the Annual Allocation or using such other process as notified to the CCG from time to time.

13.11. Without prejudice to any other obligation upon the CCG, the CCG agrees that it must deal with the Delegated Funds in accordance with:

13.11.1. the terms and conditions of this Agreement;
13.11.2. the business rules as set out in NHS England’s planning guidance or such other documents issued by NHS England from time to time;
13.11.3. any Capital Investment Guidance or Primary Medical Care Infrastructure Guidance;
13.11.4. any Guidance or Contractual Notice issued by NHS England from time to time in relation to the Delegated Funds (including in relation to the form or contents of any accounts in relation to the Delegated Funds); and

13.12. Without prejudice to any other obligation upon the CCG, the CCG agrees that it must provide all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of the Delegated Funds and the discharge of the Delegated Functions.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

13.13. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

13.14. The Parties further acknowledge that:

13.14.1. accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions ("Capital Expenditure Funds"); and

13.15. Without prejudice to clause 13.14 above, the CCG will comply with any Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

13.15.1. the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

13.15.2. if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

13.15.3. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

13.16. NHS England may, at the same time as it transfers the Delegated Funds to the CCG under clause 13.10, transfer to the CCG such amounts as are necessary to enable the discharge of the CCG’s obligations under this clause 13 (Financial Provisions and Liability) in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

13.17. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

13.18. The Parties further acknowledge that:
13.18.1. accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Medical Services Contracts or not) (“Section 7A Funds”); and

13.18.2. NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 13 (Financial Provisions and Liability) shall be construed as a divestment or delegation of the Section 7A Functions.

13.19. The CCG will provide the following services to NHS England in respect of the Section 7A Funds:

13.19.1. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

13.19.2. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

13.20. NHS England shall, at the same time as it transfers the Delegated Funds to the CCG under clause 13.10, transfer to the CCG such amounts as are necessary to enable the discharge of the CCG’s obligations under this clause 13 (Financial Provisions and Liability) in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

13.21. NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to:

13.21.1. the carrying out of any of the Reserved Functions; and/or

13.21.2. without prejudice to the generality of clause 13.21.1, the handling and consideration of complaints.
13.22. If NHS England makes such a request to the CCG, then the CCG will, but only if the CCG agrees to provide such services, from the date requested by NHS England, comply with:

13.22.1. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 13.13 to 13.16) and the Section 7A Functions (clauses 13.17 to 13.20) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

13.22.2. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the CCG.

13.23. If NHS England asks the CCG to provide certain management and administrative services in relation to the handling and consideration of complaints and if the CCG agrees to provide such management and administrative services (with such agreement to be recorded as a variation pursuant to clause 22 (Variations)) then:

13.23.1. NHS England may, in any Contractual Notice issued by NHS England in respect of such service (and as referred to in clause 13.22.2), specify procedures and responsibilities of the CCG and NHS England in relation to such complaints under the Complaints Regulations and all other Law; and

13.23.2. such Contractual Notice may specify procedures in relation to the provision of an annual report to the Chief Executive of NHS England, procedures in relation to the approval of decisions in relation to complaints and/or the appointment of a responsible person by NHS England pursuant to the Complaints Regulations;

13.23.3. such services shall be arrangements made under the provisions of Regulation 3 of the Complaints Regulations; and

13.23.4. provided that any Contractual Notice issued pursuant to this clause shall be discussed and agreed with the CCG prior to the issue of the Contractual Notice by NHS England.
Pooled Funds

13.24. The CCG may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with NHS England in accordance with section 13V of the NHS Act except that the CCG may only do so if NHS England (at its absolute discretion) consents in writing to the establishment of the pooled fund (including any terms as to the governance and payments out of such pooled fund).

13.25. At the date of this agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the CCG are set out in the Local Terms.

Business Plan, Commissioning Plan and Annual Report

13.26. Within two (2) months of the date of the Delegation and thereafter three (3) months before the start of each Financial Year, the CCG must prepare a plan setting out how it proposes to exercise the Delegated Functions in that Financial Year and in each of the next two (2) Financial Years (or over such longer period as NHS England may require).

13.27. The plan must, in particular, explain how the CCG proposes to ensure NHS England’s compliance with its duties in relation to the Delegated Functions under the NHS Act, including without limitation:

13.27.1. sections 223C (expenditure), 223D (controls on total resource use) and 223E (additional controls on resource use) of the NHS Act; and
13.27.2. sections 13E (duty as to improvement in quality of services), 13G (duty as to reducing inequalities) and 13Q (public involvement and consultation) of the NHS Act.

13.28. The plan must include the following:

13.28.1. details of how the CCG proposes to exercise the Delegated Functions in that Financial Year and in each of the next two (2) Financial Years; and
13.28.2. details of how the CCG proposes to ensure NHS England’s compliance with its duties to achieve any objectives and requirements relating to the Delegated Functions which are specified in the mandate published by the Department of Health to NHS England for the first Financial Year to which the plan relates; and

13.28.3. any other information or detail that NHS England considers necessary to ensure NHS England’s compliance with its obligations under section 13T of the NHS Act or any other provision of the NHS Act or other Law.

13.29. The CCG must revise the plan at the request of NHS England and submit a revised plan to NHS England before the date specified by NHS England from time to time.

13.30. As soon as practicable after the end of each Financial Year (and in any event within two (2) months of the end of each Financial Year or such longer period as NHS England may specify), the CCG must provide to NHS England a report on how the CCG has exercised the Delegated Functions during the previous Financial Year.

13.31. The report referred to in clause 13.30 above must include sufficient detail to ensure NHS England’s compliance with its statutory obligations under section 13U of the NHS Act.

13.32. Following receipt of the report referred to in clause 13.30 above, NHS England may (at its absolute discretion) require such further information from the CCG as NHS England considers necessary to ensure NHS England’s compliance with its obligations under section 13U of the NHS Act.

13.33. The CCG shall comply with any Contractual Notices issued from time to time by NHS England in relation to the inclusion of information in relation to the Delegated Functions in any plan prepared by the CCG under section 14Z11 of the NHS Act or in any report prepared under section 14Z15 of the NHS Act.

Risk sharing

13.34A For the avoidance of doubt, NHS England retains liability in respect of any Losses arising in respect of NHS England’s negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and, if the CCG suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Delegated Funds (or other amounts payable to the CCG) in order to reflect any Losses suffered by the CCG (except to the extent that the CCG is liable for such Loss pursuant to clause 13.35).

13.35. The CCG is liable (and shall pay) to NHS England for any Losses suffered by NHS England that result from or arise out of the CCG’s negligence, fraud, recklessness or deliberate breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the CCG or make such adjustments to the Delegated Funds pursuant to clause 13.3. The CCG shall not be liable to the extent that the Losses arose prior to the date of this Agreement.

13.36. Nothing in this clause 13 (Financial Provisions and Liability) or this Agreement shall affect or prejudice NHS England’s right to exercise its rights (whether arising under administrative law, common law or statute) in relation to actions or steps of the CCG, including any actions or steps that exceed the authority conferred by the Delegation or are a breach of the terms and conditions of this Agreement.

14. Claims and Litigation

14.1. Schedule 2 (Delegated Functions) sets out further detail in relation to the performance management of the Primary Medical Services Contracts.
14.2. Nothing in this clause 14 *(Claims and Litigation)* shall be interpreted as affecting the reservation to NHS England of the Reserved Functions (including the reservation to NHS England of all functions in relation to the performers list activities).

14.3. Except in the circumstances set out in clause 14.7 and subject always to compliance with this clause 14 *(Claims and Litigation)*, the CCG shall be responsible for and shall retain the conduct of any Claim.

14.4. The CCG must:

14.4.1. comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

14.4.2. without prejudice to clause 14.4.1, in respect of legal advice or assistance in relation to a Claim, comply with any requirements of NHS England from time to time (whether set out in a policy issued pursuant to clause 14.4.1 or otherwise) in relation to the use of solicitors or barristers and, at the date of this Agreement, NHS England's requirement is that a CCG must obtain prior approval from NHS England in respect of the firm of solicitors instructed to provide legal advice or assistance in relation to a Claim;

14.4.3. if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

14.4.4. co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

14.4.5. provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

14.4.6. at the request of NHS England, take such action or step or provide such assistance as may in NHS England’s discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the
requirements of the NHSLA or any insurer in relation to such Claim.

14.5. NHS England shall use its reasonable endeavours to keep the CCG informed in respect of the conduct and/or outcome of the Claim except that NHS England shall have no obligation to do so due to any administrative or regulatory requirement, the requirement of any insurer or the NHSLA or for any other reason that NHS England may consider necessary or appropriate, at its absolute discretion, in relation to the conduct of that Claim or related matter.

14.6. Subject to clause 14.4 and Schedule 5 (Financial Provisions and Decision Making Limits) the CCG is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

*NHS England Stepping into Claims*

14.7. NHS England may, at any time following discussion with the CCG, send a notice to the CCG stating that NHS England will take over the conduct of the Claim and the CCG must immediately take all steps necessary to transfer the conduct of such Claim to NHS England. In such cases, NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

*NHS England Stepping out of Claims*

14.8. NHS England may, at any time after it has exercised its rights set out in clause 14.7 above and following discussion with the CCG, send a notice to the CCG stating that the CCG will be required to take over the conduct of the Claim from NHS England and NHS England must immediately take all steps necessary to transfer the conduct of such Claim to the CCG. In such cases, the CCG shall be entitled to conduct the Claim in the manner it considers appropriate in accordance with its obligations under this clause 14 (Claims and Litigation) and subject to Schedule 4 (Further Information Sharing Provisions) and Schedule 5 (Financial Provisions and Decision Making Limits).

*Claim Losses*
14.9. The CCG and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

14.10. If the CCG considers that, as a result of a Claim Loss, the Delegated Funds will be insufficient to meet the Claim Loss as well as discharge the Delegated Functions, then the CCG shall immediately notify NHS England and the Parties shall meet to discuss and agree any adjustment that may be needed pursuant to clause 13.3 (and taking into account any funds, provisions or other resources retained by NHS England in respect of such Claim Losses).

14.11. The CCG acknowledges that NHS England will pay to the CCG the funds that are attributable to the Delegated Functions. Accordingly, the CCG acknowledges that the Delegated Funds are required to be used to discharge and/or pay any Claim Losses. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the CCG for such Claim Losses or pursuant to clause 13.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 13.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the CCG pursuant to clause 13.3.

15. Breach

15.1. If the CCG does not comply with the Delegation or the terms of this Agreement, then NHS England may:

  15.1.1. exercise its rights under this Agreement; and/or
  15.1.2. take such steps as it considers appropriate under the CCG Assurance Framework.
15.2. Without prejudice to clause 15.1, if the CCG does not comply with the Delegation or the terms of this Agreement (including if the CCG exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

15.2.1. waive such non-compliance in accordance with clause 15.3 and the Delegation;
15.2.2. ratify any decision in accordance with paragraph 15 of the Delegation;
15.2.3. revoke the Delegation and terminate this Agreement in accordance with clause 17 (Termination) below;
15.2.4. exercise the Escalation Rights in accordance with clause 16 (Escalation Rights); and/or
15.2.5. exercise its rights under common law.

15.3. NHS England may waive any non-compliance by the CCG with the terms of this Agreement provided that the CCG provides a written report to NHS England pursuant to clause 15.4 and, after considering the CCG’s written report, NHS England is satisfied that the waiver is justified.

15.4. If:

15.4.1. the CCG does not comply (or the CCG considers that it may not be able to comply) with this Agreement and/or the Delegation; or
15.4.2. NHS England notifies the CCG that it considers the CCG has not complied, or may not be able to comply with, this Agreement and/or the Delegation,

then the CCG must provide a written report to NHS England within ten (10) days of the non-compliance (or the date on which the CCG considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 15.4.2 setting out:

15.4.3. details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and
15.4.4. a plan for how the CCG proposes to remedy the non-compliance.
16. Escalation Rights

16.1. If the CCG does not comply with this Agreement and/or the Delegation, NHS England may exercise the following Escalation Rights:

16.1.1. NHS England may require a suitably senior representative of the CCG to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

16.1.2. NHS England may require the CCG to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the CCG proposes to remedy the non-compliance).

16.2. Nothing in clause 16 (Escalation Rights) will affect NHS England’s right to revoke the Delegation and/or terminate this Agreement in accordance with clause 17 (Termination) below.

17. Termination

17.1. The CCG may:

17.1.1. notify NHS England that it requires NHS England to revoke the Delegation; and

17.1.2. terminate this Agreement

with effect from midnight on 31 March in any calendar year, provided that:

17.1.3. on or before 30 September of the previous calendar year, the CCG sends written notice to NHS England of its requirement that NHS England revoke the Delegation and intention to terminate this Agreement; and

17.1.4. the CCG meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 17.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,
in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from midnight on 31 March in the next calendar year.

17.2. NHS England may revoke the Delegation at midnight on 31 March in any year, provided that it gives notice to the CCG of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 17.4 will apply.

17.3. The Delegation may be revoked and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

17.3.1. the CCG acts outside of the scope of its delegated authority;
17.3.2. the CCG fails to perform any material obligation of the CCG owed to NHS England under the Delegation or this Agreement;
17.3.3. the CCG persistently commits non-material breaches of the Delegation or this Agreement;
17.3.4. NHS England is satisfied that its intervention powers under section 14Z21 of the NHS Act apply;
17.3.5. to give effect to legislative changes;
17.3.6. failure to agree to a National Variation in accordance with clause 22 (Variations);
17.3.7. NHS England and the CCG agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or
17.3.8. the CCG merges with another CCG or other body.

17.4. This Agreement will terminate immediately upon revocation or termination of the Delegation (including revocation and termination in accordance with this clause 17 (Termination)) except that the Survival Clauses will continue in full force and effect. This Agreement shall not terminate immediately if the Delegation is amended by a revocation and re-issue of an amended Delegation.
17.5. Upon revocation or termination of the Delegation and this Agreement (including revocation and termination in accordance with this clause 17 (Termination)), the Parties must:

17.5.1. agree a plan for the transition of the Delegated Functions from the CCG to the successor commissioner, including details of the transition, the Parties’ responsibilities in relation to the transition, the Parties’ arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor commissioner will take responsibility for the Delegated Functions;

17.5.2. implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 17.5.1 above; and

17.5.3. use all reasonable endeavours to minimise any inconvenience or disruption to the commissioning of healthcare in the Area.

17.6. Without prejudice to clause 15.3 and for the avoidance of doubt, NHS England may waive any right to terminate this Agreement under this clause 17 (Termination).

18. Staffing

18.1. The Parties acknowledge and agree that the CCG may only engage staff to undertake the Delegated Functions under one of the following three staffing models:

18.1.1. “Model 1 – Assignment” under the terms of which the staff of NHS England remain in their current roles and locations and provide services to the CCG under a service level agreement;

18.1.2. “Model 2 – Secondment” under the terms of which certain staff of NHS England are seconded to the CCG (and, for the avoidance of doubt, such secondments will terminate on revocation or termination of the Delegation); or

18.1.3. “Model 3 – Employment” under the terms of which the CCG may create new posts within the CCG to undertake the Delegated Functions provided that the CCG may only do so if it first offers to existing staff of NHS England an opportunity to
apply for such posts and such staff must be appointed if they are deemed appointable,

together, the “Staffing Models”.

18.2. The CCG and NHS England, must within six (6) months of the date of this Agreement, agree which of the Staffing Models (set out at clauses 18.1.1 to 18.1.3 above) will be adopted by the CCG and the date on which such Staffing Model shall take effect.

18.3. In the absence of any agreement under clause 18.2, and up until such date as the CCG’s preferred Staffing Model shall take effect (as referred to in clause 18.2 above), Model 1 described in clause 18.1.1 above will apply. The terms on which Model 1 will apply are set out in Schedule 8 (Assignment of NHS England Staff to the CCG).

18.4. The CCG must comply with any Guidance issued by NHS England from time to time in relation to the Staffing Models and such Guidance may make changes to the Staffing Models from time to time.

18.5. For the avoidance of doubt, any breach by the CCG of the terms of this clause 18 (Staffing), including any breach of the Guidance issued in accordance with clause 18.4 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 13.3 and 13.35.

18.6. Without prejudice to clause 18.7, it is the understanding of the Parties that the provisions of the Transfer Regulations will not operate to transfer the employment of any staff of NHS England or any other party to the CCG on the commencement of the Delegation and this Agreement.

18.7. The Parties acknowledge that if at any time before or after the revocation or termination of the Delegation and this Agreement the Transfer Regulations do apply, the Parties must co-operate and comply with their obligations under the Transfer Regulations.

19. Disputes
19.1. This clause does not affect NHS England’s right to take action under the CCG Assurance Framework.

19.2. If a dispute arises out of or in connection with this Agreement or the Delegation (“Dispute”) then the Parties must follow the procedure set out in this clause:

19.2.1. either Party must give to the other written notice of the Dispute, setting out its nature and full particulars (“Dispute Notice”), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

19.2.2. if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Accountable Officer (or equivalent person) of the CCG and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

19.2.3. if the people referred to in clause 19.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing (“ADR notice”) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

19.3. If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary
of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

20. **Freedom of Information**

20.1. Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 (“**FOIA**”) and the Environmental Information Regulations 2004 (“**EIR**”).

20.2. Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

20.2.1. each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

20.2.2. each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and

20.2.3. subject only to clause 14 (**Claims and Litigation**), each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

20.3. NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions. The CCG shall comply with such FOIA or EIR protocols.

21. **Conflicts of Interest**

21.1. The CCG must comply with its statutory duties set out in:

21.1.1. Chapter A2 of the NHS Act (including those statutory duties relating to the management of conflicts of interest as set out at section 14O of the NHS Act);

21.1.2. the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500; and

21.1.3. Regulation 24 of the Public Contracts Regulations 2015/102,
and must perform its obligations under this Agreement in such a way as to ensure NHS England’s compliance with its statutory duties in relation to conflicts of interest.

21.2. The CCG must have regard to all relevant guidance published by NHS England in relation to conflicts of interest in the co-commissioning context.

22. Variations

22.1. The Parties acknowledge that, under paragraph 16 of the Delegation, the Delegation may be reviewed and amended from time to time and that such amendments may be effected by a revocation and re-issue of an amended Delegation.

22.2. The Parties acknowledge that, under paragraph 6 of the Delegation, certain additional functions may be delegated from time to time by NHS England to the CCG on a date or dates to be notified to the CCG by NHS England in accordance with clause 8.3. If NHS England amends the Delegation and/or delegates additional functions to the CCG, then NHS England and the CCG shall agree such consequential changes to this Agreement pursuant to this clause 22 (Variations).

22.3. Subject to clauses 22.4 to 22.10 below, a variation of this Agreement will only be effective if:

22.3.1. it is materially in the form of the template variation agreement set out at Schedule 6 (Template Variation Agreement); and

22.3.2. it is signed by NHS England and the CCG (by their Agreement Representatives or other duly authorised representatives).

22.4. The Parties may not vary any provision of this Agreement if the purported variation would contradict or conflict with the Delegation.

22.5. NHS England may notify the CCG of any proposed National Variation by issuing a National Variation Proposal by whatever means NHS England may consider appropriate from time to time.
22.6. The CCG will be deemed to have received a National Variation Proposal on the date that it is issued by NHS England.

22.7. The National Variation Proposal will set out the National Variation proposed and the date on which NHS England requires the National Variation to take effect.

22.8. The CCG must respond to a National Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving a written notice on NHS England confirming either:

22.8.1. that it accepts the National Variation Proposal; or
22.8.2. that it refuses to accept the National Variation Proposal, and setting out reasonable grounds for that refusal.

22.9. If the CCG accepts the National Variation Proposal in accordance with clause 22.8.1, the CCG agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any National Variation by the date on which the proposed National Variation takes effect as set out in the National Variation Proposal.

22.10. If the CCG refuses to accept the National Variation Proposal in accordance with clause 22.8.2 or to take such steps as set out in clause 22.9, NHS England may terminate this Agreement and revoke the Delegation in accordance with clause 17.3.6.

23. Counterparts

23.1. This Agreement may be executed in counterparts, each of which shall be regarded as an original, but all of which together shall constitute one agreement binding on both of the Parties.

24. Notices

24.1. Any notices given under this Agreement must be in writing, must be marked for the appropriate department or person and must be served by hand, post or email to the following address:

24.1.1. in the case of NHS England, to NHS England’s address for notices set out in the Particulars; or
24.1.2. in the case of the CCG, to the CCG’s address for notices set out in the Particulars.

24.2. Notices sent:

24.2.1. by hand will be effective upon delivery;
24.2.2. by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or
24.2.3. by email will be effective when sent (subject to no automated response being received).

24.3. NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions should be exercised by the CCG.

24.4. NHS England may, at its discretion, issue Guidance from time to time, including any protocol, policy, guidance or manual relating to the exercise of the Delegated Functions under this Agreement. NHS England acknowledges that in considering the need and/or content of new Guidance it will engage appropriately with CCGs.
Schedule 1
Definitions and Interpretation

In this Agreement, the following words and phrases will bear the following meanings:

**Agreement** means this agreement between NHS England and the CCG comprising the Particulars, the Terms and Conditions and the Schedules;

**Agreement Representatives** means the CCG Representative and the NHS England Representative as set out in the Particulars;

**APMS Contract** means an agreement made in accordance with section 92 of the NHS Act;

**Assigned Staff** means those NHS England staff as agreed between NHS England and the CCG from time to time;

**Caldicott Principles** means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – “To Share or Not to Share?”) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;

**Capital** shall have the meaning set out in the Capital Investment Guidance or such other replacement Guidance as issued by NHS England from time to time;

**Capital Expenditure Functions** means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);

**Capital Investment Guidance** means any Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to:

- the expenditure of Capital, or investment in property, infrastructure or information and technology; or
- the revenue consequences for commissioners or
third parties making such investment;

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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>CCG Assurance Framework</strong></td>
<td>means the assurance framework that applies to CCGs pursuant to the NHS Act;</td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>means, for or in relation to the Primary Medical Services Contracts (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;</td>
</tr>
<tr>
<td><strong>Claim Losses</strong></td>
<td>means all Losses arising in relation to any Claim;</td>
</tr>
<tr>
<td><strong>Complaints Regulations</strong></td>
<td>means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;</td>
</tr>
<tr>
<td><strong>Contractual Notice</strong></td>
<td>means a contractual notice issued by NHS England to the CCG or all CCGs (as the case may be) from time to time and relating to the manner in which the Delegated Functions should be exercised by the CCG, in accordance with clause 24.3;</td>
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<tr>
<td><strong>CQC</strong></td>
<td>means the Care Quality Commission;</td>
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<td><strong>Data Controller</strong></td>
<td>shall have the same meaning as set out in the DPA;</td>
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<tr>
<td><strong>Data Subject</strong></td>
<td>shall have the same meaning as set out in the DPA;</td>
</tr>
<tr>
<td><strong>Delegated Functions</strong></td>
<td>means the functions delegated by NHS England to the CCG under the Delegation and as set out in detail in this Agreement;</td>
</tr>
<tr>
<td><strong>Delegated Funds</strong></td>
<td>shall have the meaning in clause 13.1;</td>
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<tr>
<td><strong>DPA</strong></td>
<td>means the Data Protection Act 1998;</td>
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</table>
Enhanced Services means the nationally defined enhanced services, as set out in the Primary Medical Services (Directed Enhanced Services) Directions 2014 or as amended from time to time, and any other enhanced services schemes locally developed by the CCG in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);

Escalation Rights means the escalation rights as defined in clause 16 (Escalation Rights);

Financial Year shall bear the same meaning as in section 275 of the NHS Act;

GMS Contract means a general medical services contract made under section 84(1) of the NHS Act;

Good Practice means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;

Guidance means any protocol, policy, guidance or manual (issued by NHS England whether under this Agreement or otherwise) and/or any policy or guidance relating to the exercise of the Delegated Functions issued by NHS England from time to time, in accordance with clause 24.4;

HSCA means the Health and Social Care Act 2012;

Information Law the DPA, the EU Data Protection Directive 95/46/EC; regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of
Personal Data and privacy;

**Law** means any applicable law, statute, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including, for the avoidance of doubt, the Premises Costs Directions, the Statement of Financial Entitlements Directions and the Primary Medical Services (Directed Enhanced Services) Directions 2014 as amended from time to time);

**Local Incentive Schemes** means an incentive scheme developed by the CCG in the exercise of its Delegated Functions including (without limitation) as an alternative to QOF;

**Local Terms** means the terms set out in Schedule 7 *(Local Terms)*;

**Losses** means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges;

**National Variation** an addition, deletion or amendment to the provisions of this Agreement mandated by NHS England (whether in respect of the CCG or all or some of other Clinical Commissioning Groups) including any addition, deletion or amendment to reflect changes to the Delegation, changes in Law, changes in policy and notified to the CCG in accordance with clause 22 *(Variations)*;

**National Variation Proposal** a written proposal for a National Variation, which complies with the requirements of clause 22.7;

**Need to Know** has the meaning set out in paragraph 6.2 of Schedule 4 *(Further Information Sharing Provisions)*;

**NHS Act** means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>NHS England</td>
<td>means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;</td>
</tr>
<tr>
<td>Non-Personal Data</td>
<td>means data which is not Personal Data;</td>
</tr>
<tr>
<td>Operational Days</td>
<td>a day other than a Saturday, Sunday or bank holiday in England;</td>
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<tr>
<td>Particulars</td>
<td>means the Particulars of this Agreement as set out in clause 1 (Particulars);</td>
</tr>
<tr>
<td>Party/Parties</td>
<td>means a party or both parties to this Agreement;</td>
</tr>
<tr>
<td>Personal Data</td>
<td>shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;</td>
</tr>
<tr>
<td>Personal Data Agreement</td>
<td>means the agreement governing Information Law issues completed further to Schedule 4 (Further Information Sharing Provisions);</td>
</tr>
<tr>
<td>Personnel</td>
<td>means the Parties’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;</td>
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<tr>
<td>PMS Contract</td>
<td>means an arrangement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);</td>
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<tr>
<td>Premises Agreements</td>
<td>means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;</td>
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| Premises Costs              | means the National Health Service (General Medical
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<tr>
<th><strong>Directions</strong></th>
<th>Services Premises Costs) Directions 2013, as amended;</th>
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<tr>
<td><strong>Premises Costs Directions Functions</strong></td>
<td>means NHS England’s functions in relation to the Premises Costs Directions;</td>
</tr>
<tr>
<td><strong>Primary Medical Care Infrastructure Guidance</strong></td>
<td>means any Guidance issued by NHS England from time to time in relation to the procurement, development and management of primary medical care infrastructure and which may include principles of best practice;</td>
</tr>
<tr>
<td><strong>Primary Medical Services Contracts</strong></td>
<td>means: • PMS Contracts; • GMS Contracts; and • APMS Contracts, in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements;</td>
</tr>
<tr>
<td><strong>GP Access Fund</strong></td>
<td>Means the former Prime Minister's challenge fund, announced in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services;</td>
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<tr>
<td><strong>Principles of Best Practice</strong></td>
<td>means the Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;</td>
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<tr>
<td><strong>QOF</strong></td>
<td>means the quality and outcomes framework;</td>
</tr>
<tr>
<td><strong>Relevant Information</strong></td>
<td>means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “To Share or Not to Share?”</td>
</tr>
</tbody>
</table>
Reserved Functions means the functions relating to the commissioning of primary medical services which are reserved to NHS England (and are therefore not delegated to the CCG under the Delegation) and as set out in detail in clause 8.2 and Schedule 3 (Reserved Functions) of this Agreement;

Secretary of State means the Secretary of State for Health from time to time;

Section 7A Functions means those functions of NHS England exercised pursuant to section 7A of the NHS Act relating to primary medical services;

Section 7A Funds shall have the meaning in clause 13.18.1;

Sensitive Personal Data shall have the same meaning as in the DPA;

Specified Purpose means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the CCG’s Delegated Functions and NHS England’s Reserved Functions as specified in paragraph 2.1 of Schedule 4 (Further Information Sharing Provisions) to this Agreement;

Statement of Financial Entitlements Directions means the General Medical Services Statement of Financial Entitlements Directions 2013, as amended or updated from time to time;

Statutory Guidance means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement to which the CCG and/or NHS England have a duty to have regard, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the CCG by NHS England from time to time;

Survival Clauses means clauses 10 (Information Sharing and Information Governance), 13 (Financial Provisions and Liability), 14 (Claims and Litigation) 17 (Termination), 18 (Staffing), 19 (Disputes) and 20 (Freedom of Information), together
with such other provisions as are required to interpret these clauses (including the Schedules to this Agreement); and

**Transfer Regulations** means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended.
Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 (Delegated Functions) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England’s obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;

2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;
2.1.6.2. location of provision of services; and
2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 (Financial Provisions and Liability) or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;
2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;
2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital IG Toolkit SIRI system);
2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;
2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and
2.4.7. complying with and implementing any relevant Guidance issued from time to time.

**Enhanced Services**

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;
2.7.2. support Data Controllers in providing ‘fair processing’ information as required by the DPA;
2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;
2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;
2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;
2.7.6. obtain the appropriate read codes, to be maintained by NHS Digital;
2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and
2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG’s assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.
2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 (Procurement and New Contracts) and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England’s
obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 (Approving GP Practice Mergers and Closures), the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice’s registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 (Approving GP Practice Mergers and Closures), the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 (Procurement and New Contracts), where applicable.
5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 (Information Sharing with NHS England) is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;
5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;
5.1.3. any other data/data sets as required by NHS England; and
5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
6.2.2. ensure that any risks identified are managed and escalated where necessary;
6.2.3. respond to CQC assessments of GP practices where improvement is required;
6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
6.2.5. take appropriate contractual action in response to CQC findings.

7. **Premises Costs Directions Functions**

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and
7.2.2. revisions to existing payments being made under the Premises Costs Directions.
7.3. The CCG must comply with any decision-making limits set out in Schedule 5 (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.
Schedule 2
Part 2 – Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 (Delegated Functions) sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

   2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;
   2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and
   2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause 6 (Performance of the Delegated Functions) of this Agreement and paragraph 1 of this Schedule 2 (Delegated Functions), the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor’s guidance Substantive guidance on the Procurement, Patient Choice and Competition Regulations
3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).
Schedule 3  
Reserved Functions

1. Introduction

1.1. This Schedule 3 (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.

1.2. The CCG will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1. NHS England will continue to perform its primary medical care functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2. NHS England’s functions in relation to the management of the national performers list include:

   2.2.1. considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;

   2.2.2. identifying, managing and supporting primary care performers where concerns arise; and

   2.2.3. managing suspension, imposition of conditions and removal from the national performers list.

2.3. NHS England may hold local Performance Advisory Group (“PAG”) meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.4. NHS England may notify the CCG of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the CCG to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.
2.5. The CCG must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The CCG will comply with any Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. **Management of the revalidation and appraisal process**

3.1. NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2. All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

   3.2.1. the funding of GP appraisers;
   3.2.2. quality assurance of the GP appraisal process; and
   3.2.3. the responsible officer network.

3.3. Funding to support the GP appraisal is incorporated within the global sum payment to GP practices.

3.4. The CCG must not remove or restrict the payments made to GP practices in respect of GP appraisal.

4. **Administration of payments and related performers list management activities**

4.1. NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2. NHS England may continue to pay GPs who are suspended from the national performers list under the Secretary of State’s Determination: Payments to Medical Practitioners Suspended from the Medical Performers List (1 April 2013).
4.3. For the avoidance of doubt, the CCG is responsible for any ad hoc or discretionary payments to GP practices (including those under section 96 of the NHS Act) in accordance with clause 6.2.1.4 and Schedule 2 (Delegated Functions) Part 1 paragraphs 2.13 and 2.14 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. **Section 7A Functions**

5.1. In accordance with clauses 13.17 to 13.20, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2. In accordance with clauses 13.17 to 13.20, the CCG will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

6. **Capital Expenditure Functions**

6.1. In accordance with clauses 13.13 to 13.16, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

7. **Functions in relation to complaints management**

7.1. NHS England retains its functions in relation to complaints management and will be responsible for taking decisions in relation to the management of complaints. Such complaints include (but are not limited to):

7.1.1. complaints about GP practices and individual named performers;
7.1.2. controlled drugs; and
7.1.3. whistleblowing in relation to a GP practice or individual performer.

7.2. The CCG must immediately notify the Local NHS England Team of all complaints received by or notified to the CCG and must send to the Local NHS England Team copies of any relevant correspondence.
7.3. The CCG must co-operate fully with NHS England in relation to any complaint and any response to such complaint.

7.4. In accordance with clauses 13.21 to 13.23, NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to the handling and consideration of complaints.

8. **Such other ancillary activities that are necessary in order to exercise the Reserved Functions**

8.1. NHS England will carry out such other ancillary activities that are necessary in order for NHS England to exercise the Reserved Functions.

8.2. NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.3. The CCG must assist NHS England’s controlled drug accountable officer (“CDAO”) to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.4. The CCG must nominate a relevant senior individual within the CCG (the “CCG CD Lead”) to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.5. The CCG CD Lead must, in relation to the Delegated Functions:

8.5.1. on request provide NHS England’s CDAO with all reasonable assistance in any investigation involving primary medical care services;

8.5.2. report all complaints involving controlled drugs to NHS England’s CDAO;

8.5.3. report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England’s CDAO;

8.5.4. analyse the controlled drug prescribing data available; and
8.5.5. on request supply (or ensure organisations from whom the CCG commissions services involving the regular use of controlled drugs supply) periodic self-declaration and/or self-assessments to NHS England’s CDAO.
Schedule 4
Further Information Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 (Further Information Sharing Provisions) and the associated Personal Data Agreement is to set out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis between individual Personnel in order to enable the Parties to exercise their primary medical care commissioning functions in accordance with the law. This Schedule and the associated Personal Data Agreement is designed to:

1.1.1. inform about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the organisations involved;
1.1.2. describe the purposes for which the Parties have agreed to share Relevant Information;
1.1.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;
1.1.4. describe roles and structures to support the exchange of Relevant Information between the Parties;
1.1.5. apply to the sharing of Relevant Information relating to GPs where necessary;
1.1.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
1.1.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
1.1.8. apply to the activities of the Parties’ Personnel; and
1.1.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose
2.1. The Specified Purpose(s) of the data sharing initiative is to facilitate the exercise of the CCG’s Delegated Functions and NHS England’s Reserved Functions:

2.1.1. the management of the primary medical service performers’ list in accordance with section 91 of the NHS Act;
2.1.2. management of GP revalidation and appraisal;
2.1.3. administration of payments and related performers list management activities;
2.1.4. planning and delivering the provision of appropriate care services;
2.1.5. improving the health of the local population;
2.1.6. performance management of GP providers;
2.1.7. investigating and responding to incidents and complaints; and
2.1.8. reducing risk to individuals, service providers and the public as a whole.

2.2. Specific and detailed purposes are set out in the Personal Data Agreement appended to this Schedule.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purposes set out above, with benefits for service users and other stakeholders in terms of the improved local delivery of primary healthcare services.

4. Legal basis for Sharing

4.1. Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the attached Personal Data Agreement.
5. **Relevant Information to be shared**

5.1. The Relevant Information to be shared is set out in the attached Personal Data Agreement.

6. **Restrictions on use of the Shared Information**

6.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Sensitive Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and Personnel should only have access to Personal Data on a justifiable **Need to Know** basis for the purpose of performing their duties in connection with the services they are there to deliver. The **Need to Know** requirement means that the Data Controllers' Personnel will only have access to Personal Data or Sensitive Personal Data if it is lawful for such Personnel to have access to such data for the Specified Purpose and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Sensitive Personal Data specified.

6.3. Having this Agreement in place does not give licence for unrestricted access to data that the other Data Controller may hold. It lays the parameters for the safe and secure sharing and processing of information for a justifiable **Need to Know** purpose.

6.4. Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same
obligations as are imposed on the Data Controllers under this Agreement.

6.5. Neither Party shall cause or allow Data to be transferred to any territory outside the European Economic Area without the prior written permission of the responsible Data Controller.

6.6. Any particular restrictions on use of certain Relevant Information are included in the attached Personal Data Agreement.

7. **Ensuring fairness to the Data Subject**

7.1. In addition to having a lawful basis for sharing information, the DPA generally requires that the sharing must be fair. In order to achieve fairness to the Data Subjects, the Parties will put in place the following arrangements:

   7.1.1. amendment of internal guidance to improve awareness and understanding among Personnel;
   7.1.2. amendment of privacy notices and policies; and
   7.1.3. consideration given to further activities to promote public understanding where appropriate.

7.2. Each Party shall procure that its notification to the Information Commissioner's Office reflects the flows of information under this Agreement.

7.3. Further provision in relation to specific data flows is included in the attached Personal Data Agreement.

8. **Governance: Personnel**

8.1. Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any Personnel who have access to the Personal Data (and Sensitive Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.
8.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where the Personnel are not healthcare professionals (for the purposes of the DPA) the employing Parties must procure that its Personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

8.3. Each Party shall ensure that all Personnel required to access the Personal Data (including Sensitive Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all Personnel that have any access whatsoever to the Relevant Information, including details of sanctions against any employee acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4. Each Party shall provide evidence (further to any reasonable request) that all Personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5. Each Party shall ensure that:

8.5.1. only those employees involved in delivery of the Agreement use or have access to the Relevant Information; and
8.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller. These access controls are set out in the attached Personal Data Agreement; and
8.5.3. specific limitations on the Personnel who may have access to the Information are set out in the attached Personal Data Agreement.

9. Governance: Protection of Personal Data
9.1. At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Sensitive Personal Data.

9.3. Processing of any Personal Data or Sensitive Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis. If either Party:

9.3.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2. becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

9.4. In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1. process the Personal Data (including Sensitive Personal Data) only in accordance with the terms of this Agreement and otherwise only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2. process the Personal Data (including Sensitive Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3. process the Personal Data (including Sensitive Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in
such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4. process the Personal Data in accordance with the eight data protection principles (the "Data Protection Principles") in Schedule 1 to the DPA.

9.5. Each Party shall act generally in accordance with the Seventh Data Protection Principle, and in particular shall implement and maintain appropriate technical and organisational measures to protect the Personal Data (and Sensitive Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Sensitive Personal Data) and having regard to the nature of the Personal Data (and Sensitive Personal Data) which is to be protected. In particular, each Data Controller shall:

9.5.1. ensure that only Personnel authorised under this Agreement have access to the Personal Data (and Sensitive Personal Data);

9.5.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.5.3. obtain prior written consent from the originating Data Controller in order to transfer the Relevant Information to any third party;

9.5.4. permit the other Data Controllers or the Data Controllers’ representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable the Data Controllers to verify and/or procure that the other
Data Controller is in full compliance with its obligations under this Agreement; and

9.5.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.5.6. Specific requirements as to information security are set out in the Schedule.

9.5.7. Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Information Governance Toolkit, particularly in relation to Confidentiality and Data Protection Assurance, Information Security Assurance and Clinical Information Assurance.

9.5.8. The Parties’ Single Points of Contact ("SPoC") set out in paragraph 14 (Governance: Single Points of Contact) below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1. This paragraph supplements paragraph 9 (Governance: Protection of Personal Data) of this Schedule.

10.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3. Faxes shall only be used to transmit Personal Data in an emergency.

10.4. Wherever possible, Personal Data should be transmitted in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

10.5. Any other special measures relating to security of transfer are specified in the attached Personal Data Agreement.
10.6. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.7. The Parties’ Single Point of Contact notified pursuant to paragraph 14 (Governance: Single Points of Contact) will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the fourth Data Protection Principle.

11.2. Special measures relating to ensuring quality are set out in the attached Personal Data Agreement.

12. Governance: Retention and Disposal of Shared Information

12.1. The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3. If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 (Governance: Retention and Disposal of Shared Information), it shall
notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4. Retention of any data shall comply with the Fifth Data Protection Principle and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5. Any special retention periods are set out in attached Personal Data Agreement.

12.6. Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8. Electronic records will be considered for deletion once the relevant retention period has ended.

12.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1. Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them (“Subject Access Requests”).

13.2. Complaints about information sharing shall be routed through each Party’s own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 (Governance: Single Points of Contact) below.
13.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4. Basic details of the Agreement shall be included in the appropriate log under each Party’s Publication Scheme.

14. Governance: Single Points of Contact

14.1. The Parties each shall appoint a single point of contact to whom all queries relating to the particular information sharing should be directed in the first instance. Details of the single points of contact shall be set out in the attached Personal Data Agreement.

15. Monitoring and review

15.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements are set out in the attached Personal Data Agreement.
**Template Personal Data Agreement**

**Data flow:** [Description]

*Description of information flow and single points of contact for parties involved*

<table>
<thead>
<tr>
<th>Originating Data Controller</th>
<th>[Insert:]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact details for single point of contact for Originating Data Controller</td>
<td>Name of point of contact</td>
</tr>
<tr>
<td>Recipient Data Controller</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Contact details for single point of contact of Recipient Data Controller</td>
<td>Name of point of contact</td>
</tr>
</tbody>
</table>

*Description of information to be shared*

<table>
<thead>
<tr>
<th>Comprehensive description of Relevant Information to be shared</th>
<th>[Insert:]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anonymised / not information about individual persons</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Strongly pseudonymised</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Weakly pseudonymised</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Person - identifiable data</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Justification for</td>
<td>[Insert or N/A:]</td>
</tr>
</tbody>
</table>
the level of identifiability required

**Legal basis for disclosure and use**

<table>
<thead>
<tr>
<th></th>
<th>[Insert or N/A:]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DPA Schedule 2 condition/s</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DPA Schedule 3 condition/s</strong></td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Explicit consent</td>
</tr>
<tr>
<td>Implied Consent</td>
<td>Yes / No&lt;br&gt;[If yes, how have you implied consent?:]</td>
</tr>
<tr>
<td>Statutory required/permittend disclosure</td>
<td>[Insert statutory basis:]</td>
</tr>
<tr>
<td>Public interest disclosure</td>
<td>[Insert how the public interest favours use/disclosure of the information:]</td>
</tr>
<tr>
<td>Other legal basis</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>s. 13Z3 / 14Z23 NHS Act 2006 justification</td>
<td>S. 13Z3 condition(s) to permit disclosure</td>
</tr>
<tr>
<td></td>
<td>S. 14Z23 condition(s) to permit disclosure</td>
</tr>
<tr>
<td>Other specific legal</td>
<td></td>
</tr>
</tbody>
</table>
considerations

**Restrictions on use of information**

[Insert:]

**Governance arrangements**

<table>
<thead>
<tr>
<th>Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken</th>
<th>[Insert:]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access controls on use of information</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Specific limitations on Personnel who may access information</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Other specific security requirements (transmission)</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Other specific security requirements (general)</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Specific requirements as to ensuring quality of information</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Specific requirements for retention and destruction of information</td>
<td>[Insert:]</td>
</tr>
<tr>
<td>Specific monitoring and review arrangements</td>
<td>[Insert:]</td>
</tr>
</tbody>
</table>
Schedule 5
Financial Provisions and Decision Making Limits

Financial Limits and Approvals

1. The CCG shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

   1.1. by the following persons and/or individuals set out in column 2 of Table 1 below; and

   1.2. following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the CCG of amendments to Table 1.
<table>
<thead>
<tr>
<th>Decision</th>
<th>Person/Individual</th>
<th>NHS England Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000</td>
<td>CCG Accountable Officer or Chief Finance Officer or Chair</td>
<td>NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance</td>
</tr>
<tr>
<td>Any matter in relation to the Delegated Functions which is novel, contentious or repercussive</td>
<td>CCG Accountable Officer or Chief Finance Officer or Chair</td>
<td>Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer</td>
</tr>
<tr>
<td><strong>Revenue Contracts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The entering into of any Primary Medical Services Contract which has or is capable of having a term which exceeds five (5) years</td>
<td>CCG Accountable Officer or Chief Finance Officer or Chair</td>
<td>Local NHS England Team Director or Director of Finance</td>
</tr>
</tbody>
</table>
Capital

Note: As at the date of this Agreement, the CCG will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the CCG may be required to carry out certain administrative services in relation to Capital expenditure under clause 13 (Financial Provisions and Liability).
Schedule 6

Template Variation Agreement

Variation Reference: [insert reference]

Proposed by: [insert party] [Note – only NHS England may propose National Variations]

Date of Proposal: [insert date]

Date of Variation Agreement: [insert date]

Capitalised words and phrases in this Variation Agreement have the meanings given to them in the Agreement referred to above.

1. The Parties have agreed the [National] Variation summarised below:

2. The [National] Variation is reflected in the attached Schedule and the Parties agree that the Agreement is varied accordingly.

3. The Variation takes effect on [insert date].

IN WITNESS OF WHICH the Parties have signed this Variation Agreement on the date(s) shown below

Signed by

NHS England
[Insert name of Authorised Signatory] [for and on behalf of] [ ]

Signed by

[Insert name] Clinical Commissioning Group
[Insert name of Authorised Signatory][for and on behalf of] [ ]
Schedule to Variation Agreement

[Insert details of variation]
Schedule 7
Local Terms

[Note – Local terms may only be agreed between the CCG and NHS England on an exceptional basis and must not derogate from the terms and conditions of this Agreement. Please note that Local Terms may include:

- details of any pooled funds of NHS England and the CCG;
- resourcing arrangements between NHS England and the CCG; and
- details of any particular services that the Assigned Staff will provide to the CCG under Schedule 8.

If there are no Local Terms, state “There are no Local Terms” in this Schedule 7.]
1. Introduction

1.1. The purpose of this Schedule 8 (Assignment of NHS England Staff to the CCG) is to give clarity to the CCG and NHS England, in circumstances where NHS England staff are assigned to the CCG under Model 1 of the Staffing Models.

1.2. In accordance with clause 18 of this Agreement, the Parties have agreed that the CCG may only engage staff to undertake the Delegated Functions under one of the three Staffing Models referred to in that clause.

1.3. The Parties agree and acknowledge that until such time as the CCG’s preferred Staffing Model takes effect, the engagement of staff to undertake the Delegated Functions shall be in accordance with the terms of this Schedule 8 (Assignment of NHS England Staff to the CCG) (the “Arrangements”).

2. Duration

2.1. The Arrangements shall commence on the date of this Agreement and shall continue until the date on which the Parties agree which of the Staffing Models (set out at clauses 18.1.1 to 18.1.3) will be adopted by the CCG and the date on which such Staffing Model shall take effect.

3. Services

3.1. NHS England agrees to make available the Assigned Staff to the CCG to perform administrative and management support services together with such other services specified in Schedule 7 (Local Terms) (the “Services”) so as to facilitate the CCG in undertaking the Delegated Functions pursuant to the terms of this Agreement.

3.2. NHS England shall take all reasonable steps to ensure that the Assigned Staff shall:
3.2.1. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

3.2.2. perform all duties assigned to them pursuant to this Schedule 8 (Assignment of NHS England Staff to the CCG).

3.3. The CCG shall notify NHS England if the CCG becomes aware of any act or omission by any Assigned Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the Assigned Staff.

3.4. NHS England shall be released from its obligations to make the Assigned Staff available for the purposes of this Schedule 8 (Assignment of NHS England Staff to the CCG) whilst the Assigned Staff are absent:

3.4.1. by reason of industrial action taken in contemplation of a trade dispute;

3.4.2. as a result of the suspension or exclusion of employment or secondment of any Assigned Staff by NHS England;

3.4.3. in accordance with the Assigned Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted by Law;

3.4.4. if making the Assigned Staff available would breach or contravene any Law;

3.4.5. as a result of the cessation of employment of any individual Assigned Staff; and/or

3.4.6. at such other times as may be agreed between NHS England and the CCG.

4. **Employment of the Assigned Staff**

4.1. NHS England shall employ the Assigned Staff and shall be responsible for the employment of the Assigned Staff at all times on whatever terms and conditions as NHS England and the Assigned Staff may agree from time to time.
4.2. NHS England shall pay the Assigned Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Assigned Staff’s salaries and other payments.

4.3. The Assigned Staff shall carry out the Services from NHS England’s places of work and may be required to attend the offices of the CCG from time to time in the course of carrying out the Services. Nothing in this Schedule 8 (Assignment of NHS England Staff to the CCG) shall be construed or have effect as constituting any relationship of employer and employee between the CCG and the Assigned Staff.

4.4. NHS England shall not, and shall procure that the Assigned Staff shall not, hold themselves out as employees of the CCG.

5. Management

5.1. NHS England shall have day-to-day control of the activities of the Assigned Staff and deal with any management issues concerning the Assigned Staff including, without limitation, performance appraisal, discipline and leave requests.

5.2. The CCG agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by Assigned Staff and to deal with any disciplinary allegations made against Assigned Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and personnel as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

6. Conduct of Claims

6.1. If the CCG becomes aware of any matter that may give rise to a claim by or against a member of Assigned Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the CCG shall co-operate in relation to the investigation and resolution of any such claims or potential claims.
6.2. No admission of liability shall be made by or on behalf of the CCG and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

7. Confidential Information and Property

7.1. For the avoidance of doubt, this paragraph 8 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

7.2. It is acknowledged that to enable the Assigned Staff to provide the Services, the Parties may share information of a highly confidential nature being information or material which is the property of NHS England or the CCG or which NHS England or the CCG are obliged to hold confidential including, without limitation, all official secrets, information relating to the working of any project carried on or used by the relevant Party, research projects, strategy documents, tenders, financial information, reports, ideas and know-how, employee confidential information and patient confidential information and any proprietary party information (any and all of the foregoing being “Confidential Information”).

7.3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information and that the Parties shall not (save as required by law) disclose the Confidential Information in whole or in part to anyone and agree not to disclose the Confidential Information other than in connection with the provision of the Services.

7.4. The obligations under this Agreement apply to all and any Confidential Information whether the Confidential Information was in or comes into the possession of the relevant person prior to or following this Agreement and such obligations shall continue at all times following the termination of the Arrangements but shall cease to apply to information which may come into the public domain otherwise than through unauthorised disclosure by NHS England or the CCG, as the case may be.
8. **Intellectual Property**

8.1. All Intellectual Property (meaning any invention, idea, improvement, discovery, development, innovation, patent, writing, concept design made, process information discovered, copyright work, trademark, trade name and/or domain name) made, written, designed, discovered or originated by the Assigned Staff shall be the property of NHS England to the fullest extent permitted by law and NHS England shall be the absolute beneficial owner of the copyright in any such Intellectual Property.
Delegation Agreement

1. Particulars

1.1. This Agreement records the particulars of the agreement made between NHS England and the Clinical Commissioning Group named below.

Area                     Stoke-on-Trent
Clinical Commissioning Group  Stoke-on-Trent Clinical Commissioning Group
CCG Representative        Sarah Blenkinsop
CCG Address for Notices   Floor 3, One Smithfield Leonard Coates Way Hanley Stoke-on-Trent ST1 4FA
Date of Agreement         [Leave Blank]
Delegation                means the delegation made by NHS England to the CCG of certain functions relating to primary medical services under section 13Z of the NHS Act and effective from 1 April 2015 (as amended pursuant to the Delegation)
NHS England Representative Rebecca Woods
Local NHS England Team    NHS England North Midlands
NHS England Address for Notices Anglesey House Towers Business Park Wheelhouse Road Rugeley Staffordshire WS15 1UL

1.2. This Agreement comprises:
1.2.1. the Particulars (Clause 1);
1.2.2. the Terms and Conditions (Clauses 2 to 24 and Schedule 1 to Schedule 6 and Schedule 8 to this Agreement); and
1.2.3. the Local Terms (Schedule 7).

Signed by NHS England
Paul Bauman (for and on behalf of NHS England)

Signed by [Insert name] Clinical Commissioning Group
[Insert name of Authorised Signatory] [for and on behalf of] [ ]
Terms and Conditions

A. Introduction

2. Interpretation

2.1. This Agreement is to be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2.2. If there is any conflict or inconsistency between the provisions of this Agreement and the provisions of the Delegation, the provisions of the Delegation will prevail.

2.3. If there is any conflict or inconsistency between the provisions of this Agreement, that conflict or inconsistency must be resolved according to the following order of priority:

   2.3.1. the Particulars and Terms and Conditions (Clauses 1 to 24 and, in particular, clause 8.7);
   2.3.2. Schedule 1 to Schedule 6 and Schedule 8 to this Agreement; and
   2.3.3. Schedule 7 (Local Terms).

2.4. This Agreement and any ancillary agreements it refers to constitute the entire agreement and understanding between the Parties relating to the Delegation and supersedes all previous agreements, promises and understandings between them, whether written or oral, relating to its subject matter.

3. Background

3.1. NHS England has delegated the Delegated Functions to the CCG under section 13Z of the NHS Act and as set out in the Delegation.

3.2. Arrangements made under section 13Z of the NHS Act may be made on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.
3.3. This Agreement sets out the arrangements that apply in relation to the exercise of the Delegated Functions by the CCG.

3.4. For the avoidance of doubt, functions relating to the commissioning of primary care pharmacy, dental and optical contracts are not delegated to the CCG under the Delegation. The Delegation relates only to the delegation and reservation of primary medical services commissioning functions as set out in this Agreement.

4. Term

4.1. This Agreement has effect from the date set out in paragraph 5 of the Delegation and will remain in force unless terminated in accordance with clause 17 (Termination) below.

5. Principles

5.1. In performing their obligations under this Agreement, NHS England and the CCG must:

   5.1.1. at all times act in good faith towards each other;
   5.1.2. at all times exercise functions effectively, efficiently and economically;
   5.1.3. act in a timely manner;
   5.1.4. share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
   5.1.5. at all times observe relevant statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, and Information Law; and
   5.1.6. have regard to the needs and views of the other Party and as far as is lawful and reasonably practicable, take such needs and views into account.

B. Role of the CCG

6. Performance of the Delegated Functions
6.1. The role of the CCG will be to exercise the Delegated Functions in the Area.

6.2. The Delegated Functions are the functions set out in Schedule 1 of the Delegation and being:

6.2.1. decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:

6.2.1.1. decisions in relation to Enhanced Services;
6.2.1.2. decisions in relation to Local Incentive Schemes (including the design of such schemes);
6.2.1.3. decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
6.2.1.4. decisions about ‘discretionary’ payments;
6.2.1.5. decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

6.2.2. the approval of practice mergers;
6.2.3. planning primary medical care services in the Area, including carrying out needs assessments;
6.2.4. undertaking reviews of primary medical care services in the Area;
6.2.5. decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
6.2.6. management of the Delegated Funds in the Area;
6.2.7. Premises Costs Directions Functions;
6.2.8. co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
6.2.9. such other ancillary activities that are necessary in order to exercise the Delegated Functions.
6.3. Schedule 2 (Delegated Functions) sets out further detail in relation to the Delegated Functions and the exercise of such Delegated Functions.

6.4. The CCG agrees that it must perform the Delegated Functions in accordance with:

6.4.1. the Delegation;
6.4.2. the terms of this Agreement;
6.4.3. all applicable Law;
6.4.4. the CCG’s constitution;
6.4.5. Statutory Guidance; and
6.4.6. Good Practice.

6.4A The CCG must have due regard to Guidance and Contractual Notices.

6.5. Without prejudice to clause 6.4, the CCG agrees that it must perform the Delegated Functions in such a manner as to ensure NHS England’s compliance with NHS England’s statutory duties in respect of the Delegated Functions and to enable NHS England to fulfil its Reserved Functions.

6.6. When performing the Delegated Functions, the CCG will not do anything, take any step or make any decision outside of its delegated authority as set out in the Delegation.

6.7. Without prejudice to any other provision in this Agreement, the CCG must comply with the NHS England central finance team’s operational process (as such process is updated from time to time) for the reporting and accounting of the Delegated Funds. In particular, the CCG will be required to permit the NHS England central finance team and/or their agents and contractors authorised by them to have the ability to access the CCG ledger to provide the services required to deliver financial support and assistance to the CCG necessary to enable them to manage the Delegated Funds and exercise the Delegated Functions. NHS England and the CCG will agree any accruals to be made including any adjustments related to the relevant Financial Year expenditure to ensure no net financial impact or gain on the CCG.

6.8. The decisions of the CCG in exercising the Delegated Functions will be binding on the CCG and NHS England.
7. Committee

7.1. The CCG must establish a committee to exercise its Delegated Functions.

7.2. The structure and operation of the committee must be constituted so as to take into account Guidance issued by NHS England including the revised statutory guidance on managing conflicts of interest for CCGs [https://www.england.nhs.uk/commissioning/pc-co-comms/coi/](https://www.england.nhs.uk/commissioning/pc-co-comms/coi/)

C. Functions reserved to NHS England

8. Performance of the Reserved Functions

8.1. The role of NHS England will be to exercise the Reserved Functions.

8.2. Subject to clause 8.3, the Reserved Functions are all of NHS England's functions relating to primary medical services other than the Delegated Functions and including those functions set out in Schedule 2 of the Delegation and being:

8.2.1. management of the national performers list;
8.2.2. management of the revalidation and appraisal process;
8.2.3. administration of payments in circumstances where a performer is suspended and related performers list management activities;
8.2.4. Capital Expenditure Functions;
8.2.5. Section 7A Functions;
8.2.6. functions in relation to complaints management;
8.2.7. decisions in relation to the GP Access Fund; and
8.2.8. such other ancillary activities that are necessary in order to exercise the Reserved Functions.

8.3. For the avoidance of doubt, the Parties acknowledge that the Delegation may be amended and additional functions may be delegated to the CCG, in which event consequential changes to this Agreement...
shall be agreed with the CCG pursuant to clause 22 (Variations) of this Agreement.

8.4. Schedule 3 (Reserved Functions) sets out further detail in relation to the Reserved Functions.

8.5. To support and assist NHS England in carrying out the Reserved Functions, the CCG will share information with NHS England in accordance with section E (Information) below.

8.6. NHS England will work collaboratively with the CCG when exercising the Reserved Functions, including discussing with the CCG how it proposes to address GP performance issues.

8.7. If there is any conflict or inconsistency between functions that are named as Delegated Functions and functions that are named as Reserved Functions then such functions shall be interpreted as Reserved Functions.

8.8. The Parties acknowledge that, as at the date of this Agreement, the CCG shall provide administrative and management services to NHS England in relation to certain Reserved Functions and that such administrative and management services are as follows:

8.8.1. the administrative and management services in relation to the Capital Expenditure Functions and the Capital Expenditure Funds as more particularly set out in clauses 13.13 to 13.16; and

8.8.2. the administrative and management services in relation to the Section 7A Functions and Section 7A Funds as more particularly set out in clauses 13.17 to 13.20.

8.9. The Parties further acknowledge that NHS England may ask the CCG to provide certain administrative and management services to NHS England in relation to other Reserved Functions as more particularly set out in clauses 13.21 to 13.23. Such administrative and management services shall only be provided by the CCG following agreement by the CCG.
8.10. Notwithstanding any arrangement for or provision of administrative or management services in respect of certain Reserved Functions, NHS England shall retain and be accountable for the exercise of such Reserved Functions.

D. Commissioning

9. Monitoring and Reporting – General Requirements

9.1. The CCG must comply with any reporting requirements under:

9.1.1. this Agreement (including, without limitation, as required by clause 9 (Monitoring and Reporting – General Requirements), clause 12 (Public Information and Access Targets), clause 13 (Financial Provisions and Liability), clause 14 (Claims and Litigation) and Schedule 2 Part 1 paragraph 2 (Primary Medical Services Contract Management) and paragraph 5 (Information Sharing with NHS England));

9.1.2. the CCG Assurance Framework; and

9.1.3. the CCG’s constitution.

9.2. NHS England shall monitor the exercise and carrying out of the Delegated Functions by the CCG under the terms of this Agreement and as part of the CCG Assurance Framework.

9.3. The CCG will notify NHS England of all primary medical services commissioning committee meetings at least seven (7) days in advance of such meetings and NHS England will be entitled to attend such meetings at its discretion.

9.4. The CCG must provide to NHS England:

9.4.1. all information in relation to the exercise of the Delegated Functions (including in relation to the Delegation or this Agreement), (and in such form) as requested by NHS England from time to time; and

9.4.2. all such information (and in such form), that may be relevant to NHS England in relation to the exercise by NHS England of its other duties or functions including, without limitation, the Reserved Functions.
9.5. Nothing in this Agreement shall affect NHS England’s power to require information from the CCG under sections 14Z17, 14Z18, 14Z19 and 14Z20 of the NHS Act.

E. Information

10. Information Sharing and Information Governance

10.1. Schedule 4 (Further Information Sharing Provisions) makes further provision about information sharing and information governance.

10.2. NHS England and the CCG will enter into a Personal Data Agreement that will govern the processing of Relevant Information that identifies individuals under this Agreement. A template Personal Data Agreement is set out in Schedule 4 (Further Information Sharing Provisions).

10.3. The Personal Data Agreement:

10.3.1. sets out the relevant Information Law and best practice, including the requirements of the NHS Digital IG Toolkit;
10.3.2. sets out how that law and best practice will be implemented, including responsibilities of the Parties to co-operate properly and fully with each other;
10.3.3. identifies the Relevant Information that may be processed, including what may be shared, under this Agreement;
10.3.4. identifies the purposes for which the Relevant Information may be so processed and states the legal basis for the processing in each case;
10.3.5. states who is/are the data controller/s and, if appropriate, the data processor/s of Personal Data;
10.3.6. sets out what will happen to the Personal Data on the termination of this Agreement (with due regard to clause 17 (Termination) of the Agreement); and
10.3.7. sets out such other provisions as are necessary for the sharing of Relevant Information to be fair, lawful and meet best practice.

10.4. NHS England and the CCG will share all Non-Personal Data in accordance with Information Law and their statutory powers as set out
in section 13Z3 (for NHS England) and section 14Z23 (for the CCG) of the NHS Act.

10.5. The Parties agree that, in relation to information sharing and the processing of Relevant Information under the Delegation and this Agreement, they must comply with:

10.5.1. all relevant Information Law requirements including the common law duty of confidence (unless disapplied by statute) and other legal obligations in relation to information sharing including those set out in the NHS Act and the Human Rights Act 1998;
10.5.2. Good Practice; and
10.5.3. relevant guidance (including guidance given by the Information Commissioner, the Caldicott Principles, the requirements of the NHS Information Governance Toolkit to level 2, and guidance issued further to sections 263 and 265 of the HSCA) and consistent with guidance issued under section 13S of the NHS Act to providers.

11. IT inter-operability

11.1. NHS England and the CCG will work together to ensure that all relevant IT systems operated by NHS England and the CCG in respect of the Delegated Functions and the Reserved Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

11.2. The Parties will use their respective reasonable endeavours to help develop initiatives to further this aim.

12. Public Information and Access Targets

12.1. The CCG must promptly make available to NHS England such information as is required in respect of the Delegated Functions to ensure NHS England’s discharge of its statutory duties.
12.2. The CCG must ensure that all new Primary Medical Services Contracts contain appropriate provisions such that the CCG is able to discharge its obligations in clause 12.1.

12.3. The CCG must ensure that any information provided under this Agreement complies with all relevant national data sets issued by NHS England and NHS Digital.

F. General


Notification of the Delegated Funds and Adjustments to the Delegated Funds

13.1. NHS England will, in respect of each Financial Year, notify the CCG of the proportion of the funds allocated to NHS England by the Secretary of State pursuant to Chapter 6 of the NHS Act and which are to be paid to the CCG for the purpose of meeting expenditure in respect of the Delegated Functions for that Financial Year (the “Delegated Funds”).

13.2. Except in relation to pooled funds and subject to the terms of this clause 13 (Financial Provisions and Liability) and, in particular, clause 13.4, the CCG must use the Delegated Funds to meet expenditure in respect of the exercise of the Delegated Functions. Without prejudice to the generality of the foregoing, the CCG must make:

13.2.1. all payments in relation to the Primary Medical Services Contracts including payments in relation to QOF and implementing financial adjustments or sanctions (including in relation to breaches of provider obligations); and

13.2.2. all payments under the Premises Costs Directions.

13.3. NHS England may, in any Financial Year by sending a notice to the CCG of such increase or decrease, increase or reduce the Delegated Funds:

13.3.1. in order to take into account any monthly adjustments or corrections to the Delegated Funds that NHS England considers appropriate (following discussions with the CCG), including without limitation adjustments following any changes to the Delegation or Delegated Functions (including changes
pursuant to paragraph 6 or paragraph 16 of the Delegation), changes in allocations, changes in contracts or otherwise;

13.3.2. in order to comply with a change in the amount allocated to NHS England by the Secretary of State pursuant to section 223B of the NHS Act;

13.3.3. to take into account any Losses arising under clause 13.35;

13.3.4. to take into account any Claim Losses;

13.3.5. to take into account any adjustments that NHS England considers appropriate (including without limitation in order to make corrections or otherwise to reflect notional budgets) to reflect funds transferred (or that should have been transferred) to the CCG in respect of the Delegated Funds and/or funds transferred (or that should have been transferred) to the CCG and in respect of which the CCG has management or administrative responsibility under clauses 13.13 to 13.23 of this Agreement; or

13.3.6. in order to ensure compliance by NHS England of its obligations under the NHS Act (including without limitation, Chapter 6 of the NHS Act) or the HSCA or any action taken or direction made by the Secretary of State under the NHS Act or the HSCA.

13.3A NHS England acknowledges that the intention of clause 13.3 is to reflect genuine corrections and adjustments to the Delegated Funds and may not be used to change the allocation of the Delegated Funds unless there are significant or exceptional circumstances that would require such corrections or adjustments (including but not limited to a change in the mandate published by the Department of Health or other external factors).

13.4. The CCG acknowledges that it must comply with its statutory financial duties, including those under sections 223H and 223I of the NHS Act to the extent that these sections apply in relation to the receipt of the Delegated Funds.

13.5. The CCG acknowledges its duty under section 14S of the NHS Act to assist and support NHS England in discharging its duty under section 13E so far as relating to securing continuous improvement in the quality of primary medical services and agrees that it shall take this duty into
account in relation to the exercise of the Delegated Functions and the use of the Delegated Funds.

13.6. The CCG must ensure that it uses the Delegated Funds in such a way as to ensure that NHS England is able to fulfil its functions, including without limitation the Reserved Functions, effectively and efficiently in accordance with this Agreement.

13.7. NHS England may in respect of the Delegated Funds:

13.7.1. notify the CCG of the capital resource limit and revenue resource limit that will apply in any Financial Year;
13.7.2. notify the CCG regarding the payment of sums by the CCG to NHS England in respect of charges referable to the valuation or disposal of assets and such conditions as to records, certificates or otherwise;
13.7.3. by notice, require the CCG to take such action or step in respect of the Delegated Funds, in order to ensure compliance by NHS England of its duties or functions under the NHS Act or the HSCA (including without limitation, Chapter 6 of the NHS Act) or any action taken or direction made by the Secretary of State under the NHS Act or the HSCA (including, without limitation, Chapter 6 of the NHS Act).


*Payment and Transfer*

13.9. The CCG acknowledges that the Delegated Funds do not form part of and are separate to the funds allocated annually under section 223G of the NHS Act (the “*Annual Allocation*”).
13.10. NHS England will pay the Delegated Funds to the CCG monthly using the same revenue transfer process as used for the Annual Allocation or using such other process as notified to the CCG from time to time.

13.11. Without prejudice to any other obligation upon the CCG, the CCG agrees that it must deal with the Delegated Funds in accordance with:

13.11.1. the terms and conditions of this Agreement;
13.11.2. the business rules as set out in NHS England’s planning guidance or such other documents issued by NHS England from time to time;
13.11.3. any Capital Investment Guidance or Primary Medical Care Infrastructure Guidance;
13.11.4. any Guidance or Contractual Notice issued by NHS England from time to time in relation to the Delegated Funds (including in relation to the form or contents of any accounts in relation to the Delegated Funds); and

13.12. Without prejudice to any other obligation upon the CCG, the CCG agrees that it must provide all information, assistance and support to NHS England in relation to the audit and/or investigation (whether internal or external and whether under Law or otherwise) in relation to the use of or payment of the Delegated Funds and the discharge of the Delegated Functions.

Administrative and/or Management Services and Funds in relation to the Capital Expenditure Functions

13.13. The Parties acknowledge that the Capital Expenditure Functions are a Reserved Function.

13.14. The Parties further acknowledge that:

13.14.1. accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Capital Expenditure Functions (“Capital Expenditure Funds”); and

13.15. Without prejudice to clause 13.14 above, the CCG will comply with any Guidance issued in relation to the Capital Expenditure Functions and shall (on request from NHS England) provide the following administrative services to NHS England in respect of the Capital Expenditure Funds:

13.15.1. the administration and payment of sums that NHS England has approved as payable in relation to the Capital Expenditure Functions;

13.15.2. if requested by NHS England and taking into account (i) any other support or services provided to NHS England by NHS Property Services Limited or otherwise and (ii) any Guidance issued in respect of the Capital Expenditure Functions, the provision of advice and/or recommendations to NHS England in respect of expenditure to be made under the Capital Expenditure Functions; and

13.15.3. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Capital Expenditure Functions.

13.16. NHS England may, at the same time as it transfers the Delegated Funds to the CCG under clause 13.10, transfer to the CCG such amounts as are necessary to enable the discharge of the CCG’s obligations under this clause 13 (Financial Provisions and Liability) in respect of the Capital Expenditure Functions.

Administrative and/or Management Services and Funds in relation to Section 7A Functions

13.17. The Parties acknowledge that the Section 7A Functions are part of the Reserved Functions.

13.18. The Parties further acknowledge that:
13.18.1. accordingly, the Delegated Funds do not include any funds in respect of amounts payable in relation to the Section 7A Functions (whether such arrangements are included in or under Primary Medical Services Contracts or not) (“Section 7A Funds”); and

13.18.2. NHS England remains responsible and accountable for the discharge of the Section 7A Functions and nothing in this clause 13 (Financial Provisions and Liability) shall be construed as a divestment or delegation of the Section 7A Functions.

13.19. The CCG will provide the following services to NHS England in respect of the Section 7A Funds:

13.19.1. the administration and payment of sums that NHS England has approved as payable under or in respect of arrangements for the Section 7A Functions; and

13.19.2. such other support or administrative assistance to NHS England that NHS England may reasonably request in order to facilitate the discharge by NHS England of its responsibilities under or in respect of the Section 7A Funds.

13.20. NHS England shall, at the same time as it transfers the Delegated Funds to the CCG under clause 13.10, transfer to the CCG such amounts as are necessary to enable the discharge of the CCG’s obligations under this clause 13 (Financial Provisions and Liability) in respect of the Section 7A Funds.

Administrative and/or Management Services and Funds in relation to other Reserved Functions

13.21. NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to:

13.21.1. the carrying out of any of the Reserved Functions; and/or

13.21.2. without prejudice to the generality of clause 13.21.1, the handling and consideration of complaints.
13.22. If NHS England makes such a request to the CCG, then the CCG will, but only if the CCG agrees to provide such services, from the date requested by NHS England, comply with:

13.22.1. provisions equivalent to those set out above in relation to the Capital Expenditure Functions (clauses 13.13 to 13.16) and the Section 7A Functions (clauses 13.17 to 13.20) including in relation to the administration of any funds for such functions but only to the extent that such provisions are relevant to the management or administrative services to be provided; and

13.22.2. such other provisions in respect of the carrying out of such management and administrative services as agreed between NHS England and the CCG.

13.23. If NHS England asks the CCG to provide certain management and administrative services in relation to the handling and consideration of complaints and if the CCG agrees to provide such management and administrative services (with such agreement to be recorded as a variation pursuant to clause 22 (Variations)) then:

13.23.1. NHS England may, in any Contractual Notice issued by NHS England in respect of such service (and as referred to in clause 13.22.2), specify procedures and responsibilities of the CCG and NHS England in relation to such complaints under the Complaints Regulations and all other Law; and

13.23.2. such Contractual Notice may specify procedures in relation to the provision of an annual report to the Chief Executive of NHS England, procedures in relation to the approval of decisions in relation to complaints and/or the appointment of a responsible person by NHS England pursuant to the Complaints Regulations;

13.23.3. such services shall be arrangements made under the provisions of Regulation 3 of the Complaints Regulations; and

13.23.4. provided that any Contractual Notice issued pursuant to this clause shall be discussed and agreed with the CCG prior to the issue of the Contractual Notice by NHS England.
**Pooled Funds**

13.24. The CCG may, for the purposes of exercising the Delegated Functions under this Agreement, establish and maintain a pooled fund in respect of any part of the Delegated Funds with NHS England in accordance with section 13V of the NHS Act except that the CCG may only do so if NHS England (at its absolute discretion) consents in writing to the establishment of the pooled fund (including any terms as to the governance and payments out of such pooled fund).

13.25. At the date of this agreement, details of the pooled funds (including any terms as to the governance and payments out of such pooled fund) of NHS England and the CCG are set out in the Local Terms.

**Business Plan, Commissioning Plan and Annual Report**

13.26. Within two (2) months of the date of the Delegation and thereafter three (3) months before the start of each Financial Year, the CCG must prepare a plan setting out how it proposes to exercise the Delegated Functions in that Financial Year and in each of the next two (2) Financial Years (or over such longer period as NHS England may require).

13.27. The plan must, in particular, explain how the CCG proposes to ensure NHS England’s compliance with its duties in relation to the Delegated Functions under the NHS Act, including without limitation:

13.27.1. sections 223C (expenditure), 223D (controls on total resource use) and 223E (additional controls on resource use) of the NHS Act; and

13.27.2. sections 13E (duty as to improvement in quality of services), 13G (duty as to reducing inequalities) and 13Q (public involvement and consultation) of the NHS Act.

13.28. The plan must include the following:

13.28.1. details of how the CCG proposes to exercise the Delegated Functions in that Financial Year and in each of the next two (2) Financial Years; and
13.28.2. details of how the CCG proposes to ensure NHS England’s compliance with its duties to achieve any objectives and requirements relating to the Delegated Functions which are specified in the mandate published by the Department of Health to NHS England for the first Financial Year to which the plan relates; and

13.28.3. any other information or detail that NHS England considers necessary to ensure NHS England’s compliance with its obligations under section 13T of the NHS Act or any other provision of the NHS Act or other Law.

13.29. The CCG must revise the plan at the request of NHS England and submit a revised plan to NHS England before the date specified by NHS England from time to time.

13.30. As soon as practicable after the end of each Financial Year (and in any event within two (2) months of the end of each Financial Year or such longer period as NHS England may specify), the CCG must provide to NHS England a report on how the CCG has exercised the Delegated Functions during the previous Financial Year.

13.31. The report referred to in clause 13.30 above must include sufficient detail to ensure NHS England’s compliance with its statutory obligations under section 13U of the NHS Act.

13.32. Following receipt of the report referred to in clause 13.30 above, NHS England may (at its absolute discretion) require such further information from the CCG as NHS England considers necessary to ensure NHS England’s compliance with its obligations under section 13U of the NHS Act.

13.33. The CCG shall comply with any Contractual Notices issued from time to time by NHS England in relation to the inclusion of information in relation to the Delegated Functions in any plan prepared by the CCG under section 14Z11 of the NHS Act or in any report prepared under section 14Z15 of the NHS Act.

Risk sharing

13.34A For the avoidance of doubt, NHS England retains liability in respect of any Losses arising in respect of NHS England’s negligence, fraud, recklessness or deliberate breach in respect of the Delegated Functions and, if the CCG suffers any Losses in respect of such actions by NHS England, NHS England shall make such adjustments to the Delegated Funds (or other amounts payable to the CCG) in order to reflect any Losses suffered by the CCG (except to the extent that the CCG is liable for such Loss pursuant to clause 13.35).

13.35. The CCG is liable (and shall pay) to NHS England for any Losses suffered by NHS England that result from or arise out of the CCG’s negligence, fraud, recklessness or deliberate breach of the Delegation (including any actions that are taken that exceed the authority conferred by the Delegation) or this Agreement and, in respect of such Losses, NHS England may, at its discretion and without prejudice to any other rights, either require payment from the CCG or make such adjustments to the Delegated Funds pursuant to clause 13.3. The CCG shall not be liable to the extent that the Losses arose prior to the date of this Agreement.

13.36. Nothing in this clause 13 (Financial Provisions and Liability) or this Agreement shall affect or prejudice NHS England’s right to exercise its rights (whether arising under administrative law, common law or statute) in relation to actions or steps of the CCG, including any actions or steps that exceed the authority conferred by the Delegation or are a breach of the terms and conditions of this Agreement.

14. **Claims and Litigation**

14.1. Schedule 2 (Delegated Functions) sets out further detail in relation to the performance management of the Primary Medical Services Contracts.
14.2. Nothing in this clause 14 (*Claims and Litigation*) shall be interpreted as affecting the reservation to NHS England of the Reserved Functions (including the reservation to NHS England of all functions in relation to the performers list activities).

14.3. Except in the circumstances set out in clause 14.7 and subject always to compliance with this clause 14 (*Claims and Litigation*), the CCG shall be responsible for and shall retain the conduct of any Claim.

14.4. The CCG must:

14.4.1. comply with any policy issued by NHS England from time to time in relation to the conduct of or avoidance of Claims and/or the pro-active management of Claims;

14.4.2. without prejudice to clause 14.4.1, in respect of legal advice or assistance in relation to a Claim, comply with any requirements of NHS England from time to time (whether set out in a policy issued pursuant to clause 14.4.1 or otherwise) in relation to the use of solicitors or barristers and, at the date of this Agreement, NHS England’s requirement is that a CCG must obtain prior approval from NHS England in respect of the firm of solicitors instructed to provide legal advice or assistance in relation to a Claim;

14.4.3. if it receives any correspondence, issue of proceedings, claim document or other document concerning any Claim or potential Claim, immediately notify NHS England and send to NHS England all copies of such correspondence;

14.4.4. co-operate fully with NHS England in relation to such Claim and the conduct of such Claim;

14.4.5. provide, at its own cost, to NHS England all documentation and other correspondence that NHS England requires for the purposes of considering and/or resisting such Claim; and/or

14.4.6. at the request of NHS England, take such action or step or provide such assistance as may in NHS England’s discretion be necessary or desirable having regard to the nature of the Claim and the existence of any time limit in relation to avoiding, disputing, defending, resisting, appealing, seeking a review or compromising such Claim or to comply with the
requirements of the NHSLA or any insurer in relation to such Claim.

14.5. NHS England shall use its reasonable endeavours to keep the CCG informed in respect of the conduct and/or outcome of the Claim except that NHS England shall have no obligation to do so due to any administrative or regulatory requirement, the requirement of any insurer or the NHSLA or for any other reason that NHS England may consider necessary or appropriate, at its absolute discretion, in relation to the conduct of that Claim or related matter.

14.6. Subject to clause 14.4 and Schedule 5 (Financial Provisions and Decision Making Limits) the CCG is entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

**NHS England Stepping into Claims**

14.7. NHS England may, at any time following discussion with the CCG, send a notice to the CCG stating that NHS England will take over the conduct of the Claim and the CCG must immediately take all steps necessary to transfer the conduct of such Claim to NHS England. In such cases, NHS England shall be entitled to conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle any Claim on such terms as it thinks fit.

**NHS England Stepping out of Claims**

14.8. NHS England may, at any time after it has exercised its rights set out in clause 14.7 above and following discussion with the CCG, send a notice to the CCG stating that the CCG will be required to take over the conduct of the Claim from NHS England and NHS England must immediately take all steps necessary to transfer the conduct of such Claim to the CCG. In such cases, the CCG shall be entitled to conduct the Claim in the manner it considers appropriate in accordance with its obligations under this clause 14 (Claims and Litigation) and subject to Schedule 4 (Further Information Sharing Provisions) and Schedule 5 (Financial Provisions and Decision Making Limits).

**Claim Losses**
14.9. The CCG and NHS England shall notify each other within a reasonable time period of becoming aware of any Claim Losses.

14.10. If the CCG considers that, as a result of a Claim Loss, the Delegated Funds will be insufficient to meet the Claim Loss as well as discharge the Delegated Functions, then the CCG shall immediately notify NHS England and the Parties shall meet to discuss and agree any adjustment that may be needed pursuant to clause 13.3 (and taking into account any funds, provisions or other resources retained by NHS England in respect of such Claim Losses).

14.11. The CCG acknowledges that NHS England will pay to the CCG the funds that are attributable to the Delegated Functions. Accordingly, the CCG acknowledges that the Delegated Funds are required to be used to discharge and/or pay any Claim Losses. NHS England may, in respect of any Claim Losses, at its discretion and without prejudice to any other rights, either require payment from the CCG for such Claim Losses or pursuant to clause 13.3 make such adjustments to the Delegated Funds to take into account the amount of any Claim Losses (other than any Claim Losses in respect of which NHS England has retained any funds, provisions or other resources to discharge such Claim Losses). For the avoidance of doubt, in circumstances where NHS England suffers any Claim Losses, then NHS England shall be entitled to recoup such Claim Losses pursuant to clause 13.3. If and to the extent that NHS England has retained any funds, provisions or other resources to discharge such Claim Losses, then NHS England may either use such funds to discharge the Claim Loss or make an upward adjustment to the amounts paid to the CCG pursuant to clause 13.3.

15. Breach

15.1. If the CCG does not comply with the Delegation or the terms of this Agreement, then NHS England may:
   15.1.1. exercise its rights under this Agreement; and/or
   15.1.2. take such steps as it considers appropriate under the CCG Assurance Framework.
15.2. Without prejudice to clause 15.1, if the CCG does not comply with the Delegation or the terms of this Agreement (including if the CCG exceeds its delegated authority under the Delegation), NHS England may (at its sole discretion):

15.2.1. waive such non-compliance in accordance with clause 15.3 and the Delegation;

15.2.2. ratify any decision in accordance with paragraph 15 of the Delegation;

15.2.3. revoke the Delegation and terminate this Agreement in accordance with clause 17 (Termination) below;

15.2.4. exercise the Escalation Rights in accordance with clause 16 (Escalation Rights); and/or

15.2.5. exercise its rights under common law.

15.3. NHS England may waive any non-compliance by the CCG with the terms of this Agreement provided that the CCG provides a written report to NHS England pursuant to clause 15.4 and, after considering the CCG’s written report, NHS England is satisfied that the waiver is justified.

15.4. If:

15.4.1. the CCG does not comply (or the CCG considers that it may not be able to comply) with this Agreement and/or the Delegation; or

15.4.2. NHS England notifies the CCG that it considers the CCG has not complied, or may not be able to comply with, this Agreement and/or the Delegation,

then the CCG must provide a written report to NHS England within ten (10) days of the non-compliance (or the date on which the CCG considers that it may not be able to comply with this Agreement) or such notification pursuant to clause 15.4.2 setting out:

15.4.3. details of and reasons for the non-compliance (or likely non-compliance) with the Agreement and/or the Delegation; and

15.4.4. a plan for how the CCG proposes to remedy the non-compliance.
16. Escalation Rights

16.1. If the CCG does not comply with this Agreement and/or the Delegation, NHS England may exercise the following Escalation Rights:

16.1.1. NHS England may require a suitably senior representative of the CCG to attend a review meeting within ten (10) days of NHS England becoming aware of the non-compliance; and

16.1.2. NHS England may require the CCG to prepare an action plan and report within twenty (20) days of the review meeting (to include details of the non-compliance and a plan for how the CCG proposes to remedy the non-compliance).

16.2. Nothing in clause 16 (Escalation Rights) will affect NHS England’s right to revoke the Delegation and/or terminate this Agreement in accordance with clause 17 (Termination) below.

17. Termination

17.1. The CCG may:

17.1.1. notify NHS England that it requires NHS England to revoke the Delegation; and

17.1.2. terminate this Agreement

with effect from midnight on 31 March in any calendar year, provided that:

17.1.3. on or before 30 September of the previous calendar year, the CCG sends written notice to NHS England of its requirement that NHS England revoke the Delegation and intention to terminate this Agreement; and

17.1.4. the CCG meets with NHS England within ten (10) Operational Days of NHS England receiving the notice set out at clause 17.1.3 above to discuss arrangements for termination and transition of the Delegated Functions to a successor commissioner,
in which case NHS England shall revoke the Delegation and this Agreement shall terminate with effect from midnight on 31 March in the next calendar year.

17.2. NHS England may revoke the Delegation at midnight on 31 March in any year, provided that it gives notice to the CCG of its intention to terminate the Delegation on or before 30 September in the year prior to the year in which the Delegation will terminate, and in which case clause 17.4 will apply.

17.3. The Delegation may be revoked and this Agreement may be terminated by NHS England at any time, including in (but not limited to) the following circumstances:

17.3.1. the CCG acts outside of the scope of its delegated authority;
17.3.2. the CCG fails to perform any material obligation of the CCG owed to NHS England under the Delegation or this Agreement;
17.3.3. the CCG persistently commits non-material breaches of the Delegation or this Agreement;
17.3.4. NHS England is satisfied that its intervention powers under section 14Z21 of the NHS Act apply;
17.3.5. to give effect to legislative changes;
17.3.6. failure to agree to a National Variation in accordance with clause 22 (Variations);
17.3.7. NHS England and the CCG agree in writing that the Delegation shall be revoked and this Agreement shall terminate on such date as is agreed; and/or
17.3.8. the CCG merges with another CCG or other body.

17.4. This Agreement will terminate immediately upon revocation or termination of the Delegation (including revocation and termination in accordance with this clause 17 (Termination)) except that the Survival Clauses will continue in full force and effect. This Agreement shall not terminate immediately if the Delegation is amended by a revocation and re-issue of an amended Delegation.
17.5. Upon revocation or termination of the Delegation and this Agreement (including revocation and termination in accordance with this clause 17 (Termination)), the Parties must:

17.5.1. agree a plan for the transition of the Delegated Functions from the CCG to the successor commissioner, including details of the transition, the Parties’ responsibilities in relation to the transition, the Parties' arrangements in respect of those staff engaged in the Delegated Functions and the date on which the successor commissioner will take responsibility for the Delegated Functions;

17.5.2. implement and comply with their respective obligations under the plan for transition agreed in accordance with clause 17.5.1 above; and

17.5.3. use all reasonable endeavours to minimise any inconvenience or disruption to the commissioning of healthcare in the Area.

17.6. Without prejudice to clause 15.3 and for the avoidance of doubt, NHS England may waive any right to terminate this Agreement under this clause 17 (Termination).

18. Staffing

18.1. The Parties acknowledge and agree that the CCG may only engage staff to undertake the Delegated Functions under one of the following three staffing models:

18.1.1. “Model 1 – Assignment” under the terms of which the staff of NHS England remain in their current roles and locations and provide services to the CCG under a service level agreement;

18.1.2. “Model 2 – Secondment” under the terms of which certain staff of NHS England are seconded to the CCG (and, for the avoidance of doubt, such secondments will terminate on revocation or termination of the Delegation); or

18.1.3. “Model 3 – Employment” under the terms of which the CCG may create new posts within the CCG to undertake the Delegated Functions provided that the CCG may only do so if it first offers to existing staff of NHS England an opportunity to
apply for such posts and such staff must be appointed if they are deemed appointable,

together, the “Staffing Models”.

18.2. The CCG and NHS England, must within six (6) months of the date of this Agreement, agree which of the Staffing Models (set out at clauses 18.1.1 to 18.1.3 above) will be adopted by the CCG and the date on which such Staffing Model shall take effect.

18.3. In the absence of any agreement under clause 18.2, and up until such date as the CCG’s preferred Staffing Model shall take effect (as referred to in clause 18.2 above), Model 1 described in clause 18.1.1 above will apply. The terms on which Model 1 will apply are set out in Schedule 8 (Assignment of NHS England Staff to the CCG).

18.4. The CCG must comply with any Guidance issued by NHS England from time to time in relation to the Staffing Models and such Guidance may make changes to the Staffing Models from time to time.

18.5. For the avoidance of doubt, any breach by the CCG of the terms of this clause 18 (Staffing), including any breach of the Guidance issued in accordance with clause 18.4 above, will be a breach of the terms and conditions of this Agreement for the purposes of clauses 13.3 and 13.35.

18.6. Without prejudice to clause 18.7, it is the understanding of the Parties that the provisions of the Transfer Regulations will not operate to transfer the employment of any staff of NHS England or any other party to the CCG on the commencement of the Delegation and this Agreement.

18.7. The Parties acknowledge that if at any time before or after the revocation or termination of the Delegation and this Agreement the Transfer Regulations do apply, the Parties must co-operate and comply with their obligations under the Transfer Regulations.

19. Disputes
19.1. This clause does not affect NHS England’s right to take action under the CCG Assurance Framework.

19.2. If a dispute arises out of or in connection with this Agreement or the Delegation (“Dispute”) then the Parties must follow the procedure set out in this clause:

19.2.1. either Party must give to the other written notice of the Dispute, setting out its nature and full particulars (“Dispute Notice”), together with relevant supporting documents. On service of the Dispute Notice, the Agreement Representatives must attempt in good faith to resolve the Dispute;

19.2.2. if the Agreement Representatives are, for any reason, unable to resolve the Dispute within twenty (20) days of service of the Dispute Notice, the Dispute must be referred to the Accountable Officer (or equivalent person) of the CCG and a director of or other person nominated by NHS England (and who has authority from NHS England to settle the Dispute) who must attempt in good faith to resolve it; and

19.2.3. if the people referred to in clause 19.2.2 are for any reason unable to resolve the Dispute within twenty (20) days of it being referred to them, the Parties may attempt to settle it by mediation in accordance with the CEDR model mediation procedure. Unless otherwise agreed between the Parties, the mediator must be nominated by CEDR Solve. To initiate the mediation, a Party must serve notice in writing (“ADR notice”) to the other Party to the Dispute, requesting a mediation. A copy of the ADR notice should be sent to CEDR Solve. The mediation will start not later than ten (10) days after the date of the ADR notice.

19.3. If the Dispute is not resolved within thirty (30) days after service of the ADR notice, or either Party fails to participate or to continue to participate in the mediation before the expiration of the period of thirty (30) days, or the mediation terminates before the expiration of the period of thirty (30) days, the Dispute must be referred to the Secretary
of State, who shall resolve the matter and whose decision shall be binding upon the Parties.

20. **Freedom of Information**

20.1. Each Party acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

20.2. Each Party may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

   20.2.1. each Party shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;
   20.2.2. each Party shall consult the other regarding the possible application of exemptions in relation to the information requested; and
   20.2.3. subject only to clause 14 *(Claims and Litigation)*, each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

20.3. NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions. The CCG shall comply with such FOIA or EIR protocols.

21. **Conflicts of Interest**

21.1. The CCG must comply with its statutory duties set out in:

   21.1.1. Chapter A2 of the NHS Act (including those statutory duties relating to the management of conflicts of interest as set out at section 14O of the NHS Act);
   21.1.2. the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500; and
   21.1.3. Regulation 24 of the Public Contracts Regulations 2015/102,
and must perform its obligations under this Agreement in such a way as to ensure NHS England’s compliance with its statutory duties in relation to conflicts of interest.

21.2. The CCG must have regard to all relevant guidance published by NHS England in relation to conflicts of interest in the co-commissioning context.

22. Variations

22.1. The Parties acknowledge that, under paragraph 16 of the Delegation, the Delegation may be reviewed and amended from time to time and that such amendments may be effected by a revocation and re-issue of an amended Delegation.

22.2. The Parties acknowledge that, under paragraph 6 of the Delegation, certain additional functions may be delegated from time to time by NHS England to the CCG on a date or dates to be notified to the CCG by NHS England in accordance with clause 8.3. If NHS England amends the Delegation and/or delegates additional functions to the CCG, then NHS England and the CCG shall agree such consequential changes to this Agreement pursuant to this clause 22 (Variations).

22.3. Subject to clauses 22.4 to 22.10 below, a variation of this Agreement will only be effective if:

22.3.1. it is materially in the form of the template variation agreement set out at Schedule 6 (Template Variation Agreement); and

22.3.2. it is signed by NHS England and the CCG (by their Agreement Representatives or other duly authorised representatives).

22.4. The Parties may not vary any provision of this Agreement if the purported variation would contradict or conflict with the Delegation.

22.5. NHS England may notify the CCG of any proposed National Variation by issuing a National Variation Proposal by whatever means NHS England may consider appropriate from time to time.
22.6. The CCG will be deemed to have received a National Variation Proposal on the date that it is issued by NHS England.

22.7. The National Variation Proposal will set out the National Variation proposed and the date on which NHS England requires the National Variation to take effect.

22.8. The CCG must respond to a National Variation Proposal within thirty (30) Operational Days following the date that it is issued by serving a written notice on NHS England confirming either:

22.8.1. that it accepts the National Variation Proposal; or
22.8.2. that it refuses to accept the National Variation Proposal, and setting out reasonable grounds for that refusal.

22.9. If the CCG accepts the National Variation Proposal in accordance with clause 22.8.1, the CCG agrees (without delay) to take all necessary steps (including executing a variation agreement) in order to give effect to any National Variation by the date on which the proposed National Variation takes effect as set out in the National Variation Proposal.

22.10. If the CCG refuses to accept the National Variation Proposal in accordance with clause 22.8.2 or to take such steps as set out in clause 22.9, NHS England may terminate this Agreement and revoke the Delegation in accordance with clause 17.3.6.

23. Counterparts

23.1. This Agreement may be executed in counterparts, each of which shall be regarded as an original, but all of which together shall constitute one agreement binding on both of the Parties.

24. Notices

24.1. Any notices given under this Agreement must be in writing, must be marked for the appropriate department or person and must be served by hand, post or email to the following address:

24.1.1. in the case of NHS England, to NHS England’s address for notices set out in the Particulars; or
24.1.2. in the case of the CCG, to the CCG’s address for notices set out in the Particulars.

24.2. Notices sent:

24.2.1. by hand will be effective upon delivery;
24.2.2. by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or
24.2.3. by email will be effective when sent (subject to no automated response being received).

24.3. NHS England may, at its discretion, issue Contractual Notices from time to time relating to the manner in which the Delegated Functions should be exercised by the CCG.

24.4. NHS England may, at its discretion, issue Guidance from time to time, including any protocol, policy, guidance or manual relating to the exercise of the Delegated Functions under this Agreement. NHS England acknowledges that in considering the need and/or content of new Guidance it will engage appropriately with CCGs.
Schedule 1
Definitions and Interpretation

In this Agreement, the following words and phrases will bear the following meanings:

Agreement means this agreement between NHS England and the CCG comprising the Particulars, the Terms and Conditions and the Schedules;

Agreement Representatives means the CCG Representative and the NHS England Representative as set out in the Particulars;

APMS Contract means an agreement made in accordance with section 92 of the NHS Act;

Assigned Staff means those NHS England staff as agreed between NHS England and the CCG from time to time;

Caldicott Principles means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – “To Share or Not to Share?”) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;

Capital shall have the meaning set out in the Capital Investment Guidance or such other replacement Guidance as issued by NHS England from time to time;

Capital Expenditure Functions means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);

Capital Investment Guidance means any Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to:

- the expenditure of Capital, or investment in property, infrastructure or information and technology; or
- the revenue consequences for commissioners or
third parties making such investment;

**CCG Assurance Framework** means the assurance framework that applies to CCGs pursuant to the NHS Act;

**Claims** means, for or in relation to the Primary Medical Services Contracts (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;

**Claim Losses** means all Losses arising in relation to any Claim;

**Complaints Regulations** means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;

**Contractual Notice** means a contractual notice issued by NHS England to the CCG or all CCGs (as the case may be) from time to time and relating to the manner in which the Delegated Functions should be exercised by the CCG, in accordance with clause 24.3;

**CQC** means the Care Quality Commission;

**Data Controller** shall have the same meaning as set out in the DPA;

**Data Subject** shall have the same meaning as set out in the DPA;

**Delegated Functions** means the functions delegated by NHS England to the CCG under the Delegation and as set out in detail in this Agreement;

**Delegated Funds** shall have the meaning in clause 13.1;

**DPA** means the Data Protection Act 1998;
Enhanced Services means the nationally defined enhanced services, as set out in the Primary Medical Services (Directed Enhanced Services) Directions 2014 or as amended from time to time, and any other enhanced services schemes locally developed by the CCG in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);

Escalation Rights means the escalation rights as defined in clause 16 (Escalation Rights);

Financial Year shall bear the same meaning as in section 275 of the NHS Act;

GMS Contract means a general medical services contract made under section 84(1) of the NHS Act;

Good Practice means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;

Guidance means any protocol, policy, guidance or manual (issued by NHS England whether under this Agreement or otherwise) and/or any policy or guidance relating to the exercise of the Delegated Functions issued by NHS England from time to time, in accordance with clause 24.4;

HSCA means the Health and Social Care Act 2012;

Information Law the DPA, the EU Data Protection Directive 95/46/EC; regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of
Personal Data and privacy;

Law means any applicable law, statute, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including, for the avoidance of doubt, the Premises Costs Directions, the Statement of Financial Entitlements Directions and the Primary Medical Services (Directed Enhanced Services) Directions 2014 as amended from time to time);

Local Incentive Schemes means an incentive scheme developed by the CCG in the exercise of its Delegated Functions including (without limitation) as an alternative to QOF;

Local Terms means the terms set out in Schedule 7 (Local Terms);

Losses means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges;

National Variation an addition, deletion or amendment to the provisions of this Agreement mandated by NHS England (whether in respect of the CCG or all or some of other Clinical Commissioning Groups) including any addition, deletion or amendment to reflect changes to the Delegation, changes in Law, changes in policy and notified to the CCG in accordance with clause 22 (Variations);

National Variation Proposal a written proposal for a National Variation, which complies with the requirements of clause 22.7;

Need to Know has the meaning set out in paragraph 6.2 of Schedule 4 (Further Information Sharing Provisions);

NHS Act means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>NHS England</td>
<td>means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;</td>
</tr>
<tr>
<td>Non-Personal Data</td>
<td>means data which is not Personal Data;</td>
</tr>
<tr>
<td>Operational Days</td>
<td>a day other than a Saturday, Sunday or bank holiday in England;</td>
</tr>
<tr>
<td>Particulars</td>
<td>means the Particulars of this Agreement as set out in clause 1 (Particulars);</td>
</tr>
<tr>
<td>Party/Parties</td>
<td>means a party or both parties to this Agreement;</td>
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<tr>
<td>Personal Data</td>
<td>shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;</td>
</tr>
<tr>
<td>Personal Data Agreement</td>
<td>means the agreement governing Information Law issues completed further to Schedule 4 (Further Information Sharing Provisions);</td>
</tr>
<tr>
<td>Personnel</td>
<td>means the Parties’ employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors’ and their sub-contractors’ personnel;</td>
</tr>
<tr>
<td>PMS Contract</td>
<td>means an arrangement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);</td>
</tr>
<tr>
<td>Premises Agreements</td>
<td>means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;</td>
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<tr>
<td>Premises Costs</td>
<td>means the National Health Service (General Medical</td>
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Directions means Services Premises Costs Directions 2013, as amended;

Premises Costs Directions Functions means NHS England’s functions in relation to the Premises Costs Directions;

Primary Medical Care Infrastructure Guidance means any Guidance issued by NHS England from time to time in relation to the procurement, development and management of primary medical care infrastructure and which may include principles of best practice;

Primary Medical Services Contracts means:

- PMS Contracts;
- GMS Contracts; and
- APMS Contracts,
in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements;

GP Access Fund Means the former Prime Minister's challenge fund, announced in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services;

Principles of Best Practice means the Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;

QOF means the quality and outcomes framework;

Relevant Information means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, “confidential patient information” (as defined under section 251 of the NHS Act), and “patient confidential information” as defined in the 2013 Report, The Information Governance Review – “To Share or Not to Share?”);
<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Reserved Functions</strong></td>
<td>means the functions relating to the commissioning of primary medical services which are reserved to NHS England (and are therefore not delegated to the CCG under the Delegation) and as set out in detail in clause 8.2 and Schedule 3 (Reserved Functions) of this Agreement;</td>
</tr>
<tr>
<td><strong>Secretary of State</strong></td>
<td>means the Secretary of State for Health from time to time;</td>
</tr>
<tr>
<td><strong>Section 7A Functions</strong></td>
<td>means those functions of NHS England exercised pursuant to section 7A of the NHS Act relating to primary medical services;</td>
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<td><strong>Section 7A Funds</strong></td>
<td>shall have the meaning in clause 13.18.1;</td>
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<td><strong>Sensitive Personal Data</strong></td>
<td>shall have the same meaning as in the DPA;</td>
</tr>
<tr>
<td><strong>Specified Purpose</strong></td>
<td>means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the CCG’s Delegated Functions and NHS England’s Reserved Functions as specified in paragraph 2.1 of Schedule 4 (Further Information Sharing Provisions) to this Agreement;</td>
</tr>
<tr>
<td><strong>Statement of Financial Entitlements Directions</strong></td>
<td>means the General Medical Services Statement of Financial Entitlements Directions 2013, as amended or updated from time to time;</td>
</tr>
<tr>
<td><strong>Statutory Guidance</strong></td>
<td>means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement to which the CCG and/or NHS England have a duty to have regard, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the CCG by NHS England from time to time;</td>
</tr>
<tr>
<td><strong>Survival Clauses</strong></td>
<td>means clauses 10 (Information Sharing and Information Governance), 13 (Financial Provisions and Liability), 14 (Claims and Litigation) 17 (Termination), 18 (Staffing), 19 (Disputes) and 20 (Freedom of Information), together</td>
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with such other provisions as are required to interpret these clauses (including the Schedules to this Agreement); and

**Transfer Regulations** means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended.
Schedule 2
Delegated Functions

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 (Delegated Functions) sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England’s obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;

2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England’s obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;
2.1.6.2. location of provision of services; and
2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 (Financial Provisions and Liability) or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;
2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);
2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;
2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the NHS Digital IG Toolkit SIRI system);
2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

**Enhanced Services**

2.5. The CCG must manage the design and commissioning of Enhanced Services, including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;

2.7.2. support Data Controllers in providing ‘fair processing’ information as required by the DPA;

2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;

2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;

2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;

2.7.6. obtain the appropriate read codes, to be maintained by NHS Digital;

2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and
2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG’s assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.
2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 (Procurement and New Contracts) and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England’s
obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 (Financial Provisions and Decision Making Limits) deals with the sign off requirements for Primary Medical Services Contracts.

4. **Approving GP Practice Mergers and Closures**

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 (Approving GP Practice Mergers and Closures), the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice’s registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 (Approving GP Practice Mergers and Closures), the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 (Procurement and New Contracts), where applicable.
5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 (Information Sharing with NHS England) is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;
5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;
5.1.3. any other data/data sets as required by NHS England; and
5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

   6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
   6.2.2. ensure that any risks identified are managed and escalated where necessary;
   6.2.3. respond to CQC assessments of GP practices where improvement is required;
   6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
   6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

   7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and
   7.2.2. revisions to existing payments being made under the Premises Costs Directions.
7.3. The CCG must comply with any decision-making limits set out in Schedule 5 (*Financial Provisions and Decision Making Limits*) when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.
Schedule 2
Part 2 – Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 (Delegated Functions) sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;
2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and
2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS England from time to time.

3.2. In discharging its responsibilities set out in clause 6 (Performance of the Delegated Functions) of this Agreement and paragraph 1 of this Schedule 2 (Delegated Functions), the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor’s guidance Substantive guidance on the Procurement, Patient Choice and Competition Regulations.
Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. **Integrated working**

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. **Resourcing**

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions).
Schedule 3
Reserved Functions

1. Introduction

1.1. This Schedule 3 (Reserved Functions) sets out further provision regarding the carrying out of the Reserved Functions.

1.2. The CCG will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions.

2. Management of the national performers list

2.1. NHS England will continue to perform its primary medical care functions under the National Health Service (Performers Lists) (England) Regulations 2013.

2.2. NHS England’s functions in relation to the management of the national performers list include:

2.2.1. considering applications and decision-making in relation to inclusion on the national performers list, inclusion with conditions and refusals;
2.2.2. identifying, managing and supporting primary care performers where concerns arise; and
2.2.3. managing suspension, imposition of conditions and removal from the national performers list.

2.3. NHS England may hold local Performance Advisory Group (“PAG”) meetings to consider all complaints or concerns that are reported to NHS England in relation to a named performer and NHS England will determine whether an initial investigation is to be carried out.

2.4. NHS England may notify the CCG of all relevant PAG meetings at least seven (7) days in advance of such meetings. NHS England may require a representative of the CCG to attend such meetings to discuss any performer concerns and/or quality issues that may impact on individual performer cases.
2.5. The CCG must develop a mechanism to ensure that all complaints regarding any named performer are escalated to the Local NHS England Team for review. The CCG will comply with any Guidance issued by NHS England in relation to the escalation of complaints about a named performer.

3. Management of the revalidation and appraisal process

3.1. NHS England will continue to perform its functions under the Medical Profession (Responsible Officers) Regulations 2010 (as amended by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013).

3.2. All functions in relation to GP appraisal and revalidation will remain the responsibility of NHS England, including:

   3.2.1. the funding of GP appraisers;
   3.2.2. quality assurance of the GP appraisal process; and
   3.2.3. the responsible officer network.

3.3. Funding to support the GP appraisal is incorporated within the global sum payment to GP practices.

3.4. The CCG must not remove or restrict the payments made to GP practices in respect of GP appraisal.

4. Administration of payments and related performers list management activities

4.1. NHS England reserves its functions in relation to the administration of payments to individual performers and related performers list management activities under the National Health Service (Performers Lists) (England) Regulations 2013 and other relevant legislation.

4.2. NHS England may continue to pay GPs who are suspended from the national performers list under the Secretary of State’s Determination: Payments to Medical Practitioners Suspended from the Medical Performers List (1 April 2013).
4.3. For the avoidance of doubt, the CCG is responsible for any ad hoc or discretionary payments to GP practices (including those under section 96 of the NHS Act) in accordance with clause 6.2.1.4 and Schedule 2 (Delegated Functions) Part 1 paragraphs 2.13 and 2.14 of this Agreement, including where such payments may be considered a consequence of actions taken under the National Health Service (Performers Lists) (England) Regulations 2013.

5. Section 7A Functions

5.1. In accordance with clauses 13.17 to 13.20, NHS England retains the Section 7A Functions and will be responsible for taking decisions in relation to the Section 7A Functions.

5.2. In accordance with clauses 13.17 to 13.20, the CCG will provide certain management and/or administrative services to NHS England in relation to the Section 7A Functions.

6. Capital Expenditure Functions

6.1. In accordance with clauses 13.13 to 13.16, NHS England retains the Capital Expenditure Functions and will be responsible for taking decisions in relation to the Capital Expenditure Functions.

7. Functions in relation to complaints management

7.1. NHS England retains its functions in relation to complaints management and will be responsible for taking decisions in relation to the management of complaints. Such complaints include (but are not limited to):

7.1.1. complaints about GP practices and individual named performers;
7.1.2. controlled drugs; and
7.1.3. whistleblowing in relation to a GP practice or individual performer.

7.2. The CCG must immediately notify the Local NHS England Team of all complaints received by or notified to the CCG and must send to the Local NHS England Team copies of any relevant correspondence.
7.3. The CCG must co-operate fully with NHS England in relation to any complaint and any response to such complaint.

7.4. In accordance with clauses 13.21 to 13.23, NHS England may ask the CCG to provide certain management and/or administrative services to NHS England (from a date to be notified by NHS England to the CCG) in relation to the handling and consideration of complaints.

8. **Such other ancillary activities that are necessary in order to exercise the Reserved Functions**

8.1. NHS England will carry out such other ancillary activities that are necessary in order for NHS England to exercise the Reserved Functions.

8.2. NHS England will continue to comply with its obligations under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.3. The CCG must assist NHS England’s controlled drug accountable officer (“CDAO”) to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.4. The CCG must nominate a relevant senior individual within the CCG (the “CCG CD Lead”) to liaise with and assist NHS England to carry out its functions under the Controlled Drugs (Supervision of Management and Use) Regulations 2013.

8.5. The CCG CD Lead must, in relation to the Delegated Functions:

8.5.1. on request provide NHS England’s CDAO with all reasonable assistance in any investigation involving primary medical care services;

8.5.2. report all complaints involving controlled drugs to NHS England’s CDAO;

8.5.3. report all incidents or other concerns involving the safe use and management of controlled drugs to NHS England’s CDAO;

8.5.4. analyse the controlled drug prescribing data available; and
8.5.5. on request supply (or ensure organisations from whom the CCG commissions services involving the regular use of controlled drugs supply) periodic self-declaration and/or self-assessments to NHS England’s CDAO.
Schedule 4
Further Information Sharing Provisions

1. Introduction

1.1. The purpose of this Schedule 4 (Further Information Sharing Provisions) and the associated Personal Data Agreement is to set out the scope for the secure and confidential sharing of information between the Parties on a Need To Know basis between individual Personnel in order to enable the Parties to exercise their primary medical care commissioning functions in accordance with the law. This Schedule and the associated Personal Data Agreement is designed to:

1.1.1. inform about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by the organisations involved;
1.1.2. describe the purposes for which the Parties have agreed to share Relevant Information;
1.1.3. set out the lawful basis for the sharing of information between the Parties, and the principles that underpin the exchange of Relevant Information;
1.1.4. describe roles and structures to support the exchange of Relevant Information between the Parties;
1.1.5. apply to the sharing of Relevant Information relating to GPs where necessary;
1.1.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;
1.1.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;
1.1.8. apply to the activities of the Parties' Personnel; and
1.1.9. describe how complaints relating to Personal Data sharing between the Parties will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose
2.1. The Specified Purpose(s) of the data sharing initiative is to facilitate the exercise of the CCG’s Delegated Functions and NHS England’s Reserved Functions:

2.1.1. the management of the primary medical service performers’ list in accordance with section 91 of the NHS Act;
2.1.2. management of GP revalidation and appraisal;
2.1.3. administration of payments and related performers list management activities;
2.1.4. planning and delivering the provision of appropriate care services;
2.1.5. improving the health of the local population;
2.1.6. performance management of GP providers;
2.1.7. investigating and responding to incidents and complaints; and
2.1.8. reducing risk to individuals, service providers and the public as a whole.

2.2. Specific and detailed purposes are set out in the Personal Data Agreement appended to this Schedule.

3. **Benefits of information sharing**

3.1. The benefits of sharing information are the achievement of the Specified Purposes set out above, with benefits for service users and other stakeholders in terms of the improved local delivery of primary healthcare services.

4. **Legal basis for Sharing**

4.1. Each Party shall comply with all relevant Information Law requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The Parties shall identify the lawful basis for sharing Relevant Information for each purpose and data flow, and document these in the attached Personal Data Agreement.
5. Relevant Information to be shared

5.1. The Relevant Information to be shared is set out in the attached Personal Data Agreement.

6. Restrictions on use of the Shared Information

6.1. Each Party shall only process the Relevant Information as is necessary to achieve the Specified Purpose, and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

6.2. Access to, and processing of, the Relevant Information provided by a Party must be the minimum necessary to achieve the Specified Purpose. Information and Sensitive Personal Data will be handled at all times on a restricted basis, in compliance with Information Law requirements, and Personnel should only have access to Personal Data on a justifiable Need to Know basis for the purpose of performing their duties in connection with the services they are there to deliver. The Need to Know requirement means that the Data Controllers’ Personnel will only have access to Personal Data or Sensitive Personal Data if it is lawful for such Personnel to have access to such data for the Specified Purpose and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Sensitive Personal Data specified.

6.3. Having this Agreement in place does not give licence for unrestricted access to data that the other Data Controller may hold. It lays the parameters for the safe and secure sharing and processing of information for a justifiable Need to Know purpose.

6.4. Neither Party shall subcontract any processing of the Relevant Information without the prior written consent of the other Party. Where a Party subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same
obligations as are imposed on the Data Controllers under this Agreement.

6.5. Neither Party shall cause or allow Data to be transferred to any territory outside the European Economic Area without the prior written permission of the responsible Data Controller.

6.6. Any particular restrictions on use of certain Relevant Information are included in the attached Personal Data Agreement.

7. **Ensuring fairness to the Data Subject**

7.1. In addition to having a lawful basis for sharing information, the DPA generally requires that the sharing must be fair. In order to achieve fairness to the Data Subjects, the Parties will put in place the following arrangements:

7.1.1. amendment of internal guidance to improve awareness and understanding among Personnel;

7.1.2. amendment of privacy notices and policies; and

7.1.3. consideration given to further activities to promote public understanding where appropriate.

7.2. Each Party shall procure that its notification to the Information Commissioner’s Office reflects the flows of information under this Agreement.

7.3. Further provision in relation to specific data flows is included in the attached Personal Data Agreement.

8. **Governance: Personnel**

8.1. Each Party must take reasonable steps to ensure the suitability, reliability, training and competence, of any Personnel who have access to the Personal Data (and Sensitive Personal Data) including reasonable background checks and evidence of completeness should be available on request by each Party.
8.2. The Parties agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where the Personnel are not healthcare professionals (for the purposes of the DPA) the employing Parties must procure that its Personnel operate under a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

8.3. Each Party shall ensure that all Personnel required to access the Personal Data (including Sensitive Personal Data) are informed of the confidential nature of the Personal Data and each Party shall include appropriate confidentiality clauses in employment/service contracts of all Personnel that have any access whatsoever to the Relevant Information, including details of sanctions against any employee acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Information Law requirements, or causes damage to or loss of the Relevant Information.

8.4. Each Party shall provide evidence (further to any reasonable request) that all Personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Information Law and this Agreement.

8.5. Each Party shall ensure that:

8.5.1. only those employees involved in delivery of the Agreement use or have access to the Relevant Information; and

8.5.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller. These access controls are set out in the attached Personal Data Agreement; and

8.5.3. specific limitations on the Personnel who may have access to the Information are set out in the attached Personal Data Agreement.

9. Governance: Protection of Personal Data
9.1. At all times, the Parties shall have regard to the requirements of Information Law and the rights of Data Subjects.

9.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by Parties, without the need to share easily identifiable Personal Data. The Parties shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data/Sensitive Personal Data.

9.3. Processing of any Personal Data or Sensitive Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need to Know basis. If either Party:

9.3.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

9.3.2. becomes aware of any security breach,

in respect of the Relevant Information it shall promptly notify the other Party. The Parties shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

9.4. In processing any Relevant Information further to this Agreement, each Party shall:

9.4.1. process the Personal Data (including Sensitive Personal Data) only in accordance with the terms of this Agreement and otherwise only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

9.4.2. process the Personal Data (including Sensitive Personal Data) only to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

9.4.3. process the Personal Data (including Sensitive Personal Data) only in accordance with Information Law requirements and shall not perform its obligations under this Agreement in
such a way as to cause any other Data Controller to breach any of their applicable obligations under Information Law; and

9.4.4. process the Personal Data in accordance with the eight data protection principles (the “Data Protection Principles”) in Schedule 1 to the DPA.

9.5. Each Party shall act generally in accordance with the Seventh Data Protection Principle, and in particular shall implement and maintain appropriate technical and organisational measures to protect the Personal Data (and Sensitive Personal Data) against unauthorised or unlawful processing and against accidental loss, destruction, damage, alteration or disclosure. These measures shall be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data (and Sensitive Personal Data) and having regard to the nature of the Personal Data (and Sensitive Personal Data) which is to be protected. In particular, each Data Controller shall:

9.5.1. ensure that only Personnel authorised under this Agreement have access to the Personal Data (and Sensitive Personal Data);

9.5.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

9.5.3. obtain prior written consent from the originating Data Controller in order to transfer the Relevant Information to any third party;

9.5.4. permit the other Data Controllers or the Data Controllers’ representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable the Data Controllers to verify and/or procure that the other
Data Controller is in full compliance with its obligations under this Agreement; and

9.5.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

9.5.6. Specific requirements as to information security are set out in the Schedule.

9.5.7. Each Party shall use best endeavours to achieve and adhere to the requirements of the NHS Information Governance Toolkit, particularly in relation to Confidentiality and Data Protection Assurance, Information Security Assurance and Clinical Information Assurance.

9.5.8. The Parties’ Single Points of Contact (“SPoC”) set out in paragraph 14 (Governance: Single Points of Contact) below will be the persons who, in the first instance, will have oversight of third party security measures.

10. Governance: Transmission of Information between the Parties

10.1. This paragraph supplements paragraph 9 (Governance: Protection of Personal Data) of this Schedule.

10.2. Transfer of Personal Data between the Parties shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net / gcsx) email.

10.3. Faxes shall only be used to transmit Personal Data in an emergency.

10.4. Wherever possible, Personal Data should be transmitted in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

10.5. Any other special measures relating to security of transfer are specified in the attached Personal Data Agreement.
10.6. Each Party shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

10.7. The Parties’ Single Point of Contact notified pursuant to paragraph 14 (Governance: Single Points of Contact) will be the persons who, in the first instance, will have oversight of the transmission of information between the Parties.

11. Governance: Quality of Information

11.1. The Parties will take steps to ensure the quality of the Relevant Information and to comply with the fourth Data Protection Principle.

11.2. Special measures relating to ensuring quality are set out in the attached Personal Data Agreement.

12. Governance: Retention and Disposal of Shared Information

12.1. The non-originating Party shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically the Relevant Information will be deleted and formal notice of the deletion sent to the Party that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the Party they came from.

12.2. Each Party shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, if requested by the other Party and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

12.3. If either Party is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy under this paragraph 12 (Governance: Retention and Disposal of Shared Information), it shall
notify the other Party in writing of that retention, giving details of the documents or materials that it must retain.

12.4. Retention of any data shall comply with the Fifth Data Protection Principle and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

12.5. Any special retention periods are set out in attached Personal Data Agreement.

12.6. Each Party shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

12.7. Each Party shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

12.8. Electronic records will be considered for deletion once the relevant retention period has ended.

12.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the Party shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

13. Governance: Complaints and Access to Personal Data

13.1. Each Party shall assist the other in responding to any request made under Information Law made by persons who wish to access copies of information held about them (“Subject Access Requests”).

13.2. Complaints about information sharing shall be routed through each Party’s own complaints procedure but reported to the Single Points of Contact set out in paragraph 14 (Governance: Single Points of Contact) below.
13.3. The Parties shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Agreement or any data processing carried out further to it.

13.4. Basic details of the Agreement shall be included in the appropriate log under each Party’s Publication Scheme.

14. Governance: Single Points of Contact

14.1. The Parties each shall appoint a single point of contact to whom all queries relating to the particular information sharing should be directed in the first instance. Details of the single points of contact shall be set out in the attached Personal Data Agreement.

15. Monitoring and review

15.1. The Parties shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Information Law and best practice. Specific monitoring requirements are set out in the attached Personal Data Agreement.
**Template Personal Data Agreement**

Data flow: [Description]

*Description of information flow and single points of contact for parties involved*

<table>
<thead>
<tr>
<th>Originating Data Controller</th>
<th>[Insert:]</th>
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<tbody>
<tr>
<td>Contact details for single point of contact for Originating Data Controller</td>
<td>Name of point of contact</td>
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<tr>
<td>Recipient Data Controller</td>
<td>[Insert:]</td>
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<tr>
<td>Contact details for single point of contact of Recipient Data Controller</td>
<td>Name of point of contact</td>
</tr>
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</table>

*Description of information to be shared*

| Comprehensive description of Relevant Information to be shared | [Insert:] |
| Anonymised / not information about individual persons | Yes / No |
| Strongly pseudonymised | Yes / No |
| Weakly pseudonymised | Yes / No |
| Person - identifiable data | Yes / No |
| Justification for | [Insert or N/A:] |
### Legal basis for disclosure and use

<table>
<thead>
<tr>
<th>DPA Schedule 2 condition/s</th>
<th>[Insert or N/A:]</th>
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<tbody>
<tr>
<td>DPA Schedule 3 condition/s</td>
<td>[Insert or N/A:]</td>
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<tr>
<th>Confidentiality</th>
<th>Explicit consent</th>
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<td>[If yes, how documented?:]</td>
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<table>
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<td>[If yes, how have you implied consent?:]</td>
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<th>[Insert statutory basis:]</th>
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<th>Public interest disclosure</th>
<th>[Insert how the public interest favours use/disclosure of the information:]</th>
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<table>
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<th>Other legal basis</th>
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<tr>
<th>s. 13Z3 / 14Z23 NHS Act 2006 justification</th>
<th>S. 13Z3 condition(s) to permit disclosure</th>
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<tr>
<td></td>
<td>S. 14Z23 condition(s) to permit disclosure</td>
<td>[Insert:]</td>
</tr>
</tbody>
</table>

| Other specific legal | |
|----------------------| |
**Restrictions on use of information**

| [Insert:] |

**Governance arrangements**

| Specific measures to ensure fairness to the Data Subject, including privacy impact assessments undertaken | [Insert:] |
| Access controls on use of information | [Insert:] |
| Specific limitations on Personnel who may access information | [Insert:] |
| Other specific security requirements (transmission) | [Insert:] |
| Other specific security requirements (general) | [Insert:] |
| Specific requirements as to ensuring quality of information | [Insert:] |
| Specific requirements for retention and destruction of information | [Insert:] |
| Specific monitoring and review arrangements | [Insert:] |
Schedule 5

Financial Provisions and Decision Making Limits

Financial Limits and Approvals

1. The CCG shall ensure that any decisions in respect of the Delegated Functions and which exceed the financial limits set out below are only taken:

1.1. by the following persons and/or individuals set out in column 2 of Table 1 below; and

1.2. following the approval of NHS England (if any) as set out in column 3 of the Table 1 below.

2. NHS England may, from time to time, update Table 1 by sending a notice to the CCG of amendments to Table 1.
<table>
<thead>
<tr>
<th>Decision</th>
<th>Person/Individual</th>
<th>NHS England Approval</th>
</tr>
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<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>Taking any step or action in relation to the settlement of a Claim, where the value of the settlement exceeds £100,000</td>
<td>CCG Accountable Officer or Chief Finance Officer or Chair</td>
<td>NHS England Head of Legal Services and Local NHS England Team Director or Director of Finance</td>
</tr>
<tr>
<td>Any matter in relation to the Delegated Functions which is novel, contentious or repercussive</td>
<td>CCG Accountable Officer or Chief Finance Officer or Chair</td>
<td>Local NHS England Team Director or Director of Finance or NHS England Region Director or Director of Finance or NHS England Chief Executive or Chief Financial Officer</td>
</tr>
<tr>
<td>Revenue Contracts</td>
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<tr>
<td>The entering into of any Primary Medical Services Contract which has or is capable of having a term which exceeds five (5) years</td>
<td>CCG Accountable Officer or Chief Finance Officer or Chair</td>
<td>Local NHS England Team Director or Director of Finance</td>
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</tbody>
</table>
Capital

Note: As at the date of this Agreement, the CCG will not have delegated or directed responsibility for decisions in relation to Capital expenditure (and these decisions are retained by NHS England) but the CCG may be required to carry out certain administrative services in relation to Capital expenditure under clause 13 (Financial Provisions and Liability).
Variation Reference: [insert reference]

Proposed by: [insert party] [Note – only NHS England may propose National Variations]

Date of Proposal: [insert date]

Date of Variation Agreement: [insert date]

Capitalised words and phrases in this Variation Agreement have the meanings given to them in the Agreement referred to above.

1. The Parties have agreed the [National] Variation summarised below:

2. The [National] Variation is reflected in the attached Schedule and the Parties agree that the Agreement is varied accordingly.

3. The Variation takes effect on [insert date].

IN WITNESS OF WHICH the Parties have signed this Variation Agreement on the date(s) shown below

Signed by

NHS England
[Insert name of Authorised Signatory] [for and on behalf of] [ ]

Signed by

[Insert name] Clinical Commissioning Group
[Insert name of Authorised Signatory][for and on behalf of] [ ]
Schedule to Variation Agreement

[Insert details of variation]
Schedule 7
Local Terms

[Note – Local terms may only be agreed between the CCG and NHS England on an exceptional basis and must not derogate from the terms and conditions of this Agreement. Please note that Local Terms may include:

- details of any pooled funds of NHS England and the CCG;
- resourcing arrangements between NHS England and the CCG; and
- details of any particular services that the Assigned Staff will provide to the CCG under Schedule 8.

If there are no Local Terms, state “There are no Local Terms” in this Schedule 7.]
1. Introduction

1.1. The purpose of this Schedule 8 (Assignment of NHS England Staff to the CCG) is to give clarity to the CCG and NHS England, in circumstances where NHS England staff are assigned to the CCG under Model 1 of the Staffing Models.

1.2. In accordance with clause 18 of this Agreement, the Parties have agreed that the CCG may only engage staff to undertake the Delegated Functions under one of the three Staffing Models referred to in that clause.

1.3. The Parties agree and acknowledge that until such time as the CCG’s preferred Staffing Model takes effect, the engagement of staff to undertake the Delegated Functions shall be in accordance with the terms of this Schedule 8 (Assignment of NHS England Staff to the CCG) (the “Arrangements”).

2. Duration

2.1. The Arrangements shall commence on the date of this Agreement and shall continue until the date on which the Parties agree which of the Staffing Models (set out at clauses 18.1.1 to 18.1.3) will be adopted by the CCG and the date on which such Staffing Model shall take effect.

3. Services

3.1. NHS England agrees to make available the Assigned Staff to the CCG to perform administrative and management support services together with such other services specified in Schedule 7 (Local Terms) (the “Services”) so as to facilitate the CCG in undertaking the Delegated Functions pursuant to the terms of this Agreement.

3.2. NHS England shall take all reasonable steps to ensure that the Assigned Staff shall:
3.2.1. faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

3.2.2. perform all duties assigned to them pursuant to this Schedule 8 (Assignment of NHS England Staff to the CCG).

3.3. The CCG shall notify NHS England if the CCG becomes aware of any act or omission by any Assigned Staff which may have a material adverse impact on the provision of the Services or constitute a material breach of the terms and conditions of employment of the Assigned Staff.

3.4. NHS England shall be released from its obligations to make the Assigned Staff available for the purposes of this Schedule 8 (Assignment of NHS England Staff to the CCG) whilst the Assigned Staff are absent:

3.4.1. by reason of industrial action taken in contemplation of a trade dispute;

3.4.2. as a result of the suspension or exclusion of employment or secondment of any Assigned Staff by NHS England;

3.4.3. in accordance with the Assigned Staff's respective terms and conditions of employment and policies, including, but not limited to, by reason of training, holidays, sickness, injury, trade union duties, paternity leave or maternity or where absence is permitted by Law;

3.4.4. if making the Assigned Staff available would breach or contravene any Law;

3.4.5. as a result of the cessation of employment of any individual Assigned Staff; and/or

3.4.6. at such other times as may be agreed between NHS England and the CCG.

4. Employment of the Assigned Staff

4.1. NHS England shall employ the Assigned Staff and shall be responsible for the employment of the Assigned Staff at all times on whatever terms and conditions as NHS England and the Assigned Staff may agree from time to time.
4.2. NHS England shall pay the Assigned Staff their salaries and benefits and make any deductions for income tax liability and national insurance or similar contributions it is required to make from the Assigned Staff’s salaries and other payments.

4.3. The Assigned Staff shall carry out the Services from NHS England’s places of work and may be required to attend the offices of the CCG from time to time in the course of carrying out the Services. Nothing in this Schedule 8 (Assignment of NHS England Staff to the CCG) shall be construed or have effect as constituting any relationship of employer and employee between the CCG and the Assigned Staff.

4.4. NHS England shall not, and shall procure that the Assigned Staff shall not, hold themselves out as employees of the CCG.

5. Management

5.1. NHS England shall have day-to-day control of the activities of the Assigned Staff and deal with any management issues concerning the Assigned Staff including, without limitation, performance appraisal, discipline and leave requests.

5.2. The CCG agrees to provide all such assistance and co-operation that NHS England may reasonably request from time to time to resolve grievances raised by Assigned Staff and to deal with any disciplinary allegations made against Assigned Staff arising out of or in connection with the provision of the Services which shall include, without limitation, supplying NHS England with all information and the provision of access to all documentation and personnel as NHS England requires for the purposes of considering and dealing with such issues and participating promptly in any action which may be necessary.

6. Conduct of Claims

6.1. If the CCG becomes aware of any matter that may give rise to a claim by or against a member of Assigned Staff, notice of that fact shall be given as soon as possible to NHS England. NHS England and the CCG shall co-operate in relation to the investigation and resolution of any such claims or potential claims.
6.2. No admission of liability shall be made by or on behalf of the CCG and any such claim shall not be compromised, disposed of or settled without the consent of NHS England.

7. Confidential Information and Property

7.1. For the avoidance of doubt, this paragraph 8 (Confidential Information and Property) is without prejudice to any other provision of this Agreement in relation to confidential information.

7.2. It is acknowledged that to enable the Assigned Staff to provide the Services, the Parties may share information of a highly confidential nature being information or material which is the property of NHS England or the CCG or which NHS England or the CCG are obliged to hold confidential including, without limitation, all official secrets, information relating to the working of any project carried on or used by the relevant Party, research projects, strategy documents, tenders, financial information, reports, ideas and know-how, employee confidential information and patient confidential information and any proprietary party information (any and all of the foregoing being “Confidential Information”).

7.3. The Parties agree to adopt all such procedures as the other party may reasonably require and to keep confidential all Confidential Information and that the Parties shall not (save as required by law) disclose the Confidential Information in whole or in part to anyone and agree not to disclose the Confidential Information other than in connection with the provision of the Services.

7.4. The obligations under this Agreement apply to all and any Confidential Information whether the Confidential Information was in or comes into the possession of the relevant person prior to or following this Agreement and such obligations shall continue at all times following the termination of the Arrangements but shall cease to apply to information which may come into the public domain otherwise than through unauthorised disclosure by NHS England or the CCG, as the case may be.
8. **Intellectual Property**

8.1. All Intellectual Property (meaning any invention, idea, improvement, discovery, development, innovation, patent, writing, concept design made, process information discovered, copyright work, trademark, trade name and/or domain name) made, written, designed, discovered or originated by the Assigned Staff shall be the property of NHS England to the fullest extent permitted by law and NHS England shall be the absolute beneficial owner of the copyright in any such Intellectual Property.
ENCLOSURE: 9.3

<table>
<thead>
<tr>
<th>Sponsor Director</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td>Cheryl Hardisty</td>
</tr>
<tr>
<td><strong>Title</strong></td>
<td>Director of Commissioning</td>
</tr>
</tbody>
</table>

**Report to**
North Staffordshire and Stoke-on-Trent CCG Governing Boards in common

**Title**
Better Care Fund - Update on 17/18 guidance and changes to Drug and Alcohol services in North Staffordshire

**Meeting Date**
7th March 2017

**Which other CCG committee and/or Group has considered this report**

<table>
<thead>
<tr>
<th>Committee/Group</th>
<th>Other agreements</th>
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</thead>
<tbody>
<tr>
<td>Joint Planning Committee 17.01.17</td>
<td></td>
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<tr>
<td>Joint North Staffordshire and Stoke-on-Trent CCG Governing Board 07.02.17</td>
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</table>

**Purpose of the paper, executive summary of key issues, points and outcomes**

The purpose of this report is to:

- Provide an update to the Joint North Staffordshire and Stoke-on-Trent CCG Governing Board on the Better Care Fund
- Provide an update on the changes to the North Staffordshire Drug and Alcohol Service and the work undertaken to date regarding the Quality Impact Assessment

**Action required**

<table>
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<tr>
<th>Decision</th>
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**Recommendation:**

The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to note that:

- The BCF guidance has not yet been published but note the key areas we have been notified of.
- CCGs and Councils will have a limited amount of time to develop and submit the initial plans and accept that plans may need to be produced before formal board sign off but that amendments can be made following on from the first submission.
- The work to undertake the QIA is underway and that further work is required before formal decisions can be made regarding the investment of £389k for North Staffordshire.
Summary of risks relating to the proposal

Summary of risks associated with the changes to drug and alcohol services will be identified as part of the Quality Impact Assessment which is currently being undertaken.

Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications

All areas are required to have a Better Care Fund in place, agreed between CCGs and Local Authorities. As part of this there are national conditions which also need to be met including the protection of social care.

Is a Quality and/or Equality impact assessment required

The CCG has requested that a full Quality Impact Assessment be undertaken in order to fully understand the changes to be made in order to ascertain how we could seek to mitigate against the impact of the decisions made. A completed Quality Impact Assessment is currently being undertaken for across Staffordshire.

Any engagement activity with stakeholders/practices/public and patients

N/A

Strategic objectives supported by this paper
(identify appropriate goals)

<table>
<thead>
<tr>
<th>North Staffordshire CCG</th>
<th>Yes</th>
<th>No</th>
<th>Stoke on Trent CCG</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will commission safe effective and high quality sustainable services</td>
<td>Yes</td>
<td>No</td>
<td>Improve access</td>
<td>No</td>
<td>Yes</td>
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<td>2. We will deliver better patient outcomes through effective federated and collaborative arrangements with key partners</td>
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<td>Improve health outcomes</td>
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<td>3. We will improve patient experience through patient engagement, feedback</td>
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<tr>
<td>5. Governance &amp; Statutory Requirements</td>
<td>Yes</td>
<td>No</td>
<td>Cross cutting /statutory duties (more than one of the above)</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>6. We will achieve all of the above while remaining within financial balance and achieving best value</td>
<td>Yes</td>
<td>No</td>
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ACRONYMS

N/A
1. **Better Care Fund (BCF) – update**

1.1 Guidance and templates for the BCF have been delayed, with no proposed date for release at this stage; however there are a number of key areas which we have been notified of:

- The BCF is expected to be a two year plan for 17/18 and 18/19
- National conditions have been reduced from 8 to 3:
  - A requirement for a jointly agreed plan, approved by the Health and Wellbeing Board
  - Protection of adult social care
  - Requirement to ring-fence a proportion of the CCG minimum to invest in Out of Hospital services
  - **Plans will also need to set out the area’s vision for integrating health and social care by 2020.**
- Metrics will focus on three elements:
  - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
  - Long term support needs of older people (aged 65 and over) by admission to residential / nursing care homes per 100,000 of the population
  - Delayed Transfers of Care per 100,000 population (attributable to NHS, social care or both)

- 2017-2019 BCF is expected to align to wider integration in the HWB health economy and align to the STP within the HWB area (alignment to the STP requirements will be set out in the planning guidance)

- The BCF plan should evolve from the 2016 BCF plans

- CCG minimum contributions to increase by 1.79% in 17/18 and 1.9% in 18/19

- The local area requirements around **social care funding from the CCG minimum** are still to be agreed

- Once released we will have a limited amount of time to produce and submit an initial BCF plan for Staffordshire and Stoke on Trent

1.2 Potential schemes which are being explored to be key components of the BCFs:

- Discharge to assess
- Aligning Intermediate care and Reablement
- Continuing Health Care
2. Drug and alcohol services - update

2.1 Staffordshire County Council have undertaken and published a Community Impact Assessment to understand the impact on people and the community, however, following discussions with pan-Staffordshire CCGs agreed to meet with representatives from North & South CCGs Quality to co-produce a Quality Impact Assessment (QIA) which considers in more detail proposed service changes risks and suitable mitigating actions. The initial meeting to co-produce the QIA took place on Friday 17th February and a follow up meeting is arranged on Friday 3rd March. The completed QIA will then be presented clinicians, both within the services commissioned and including GPSIs, for their input prior to the CCGs QIA Panels on Friday 24th March (North) and Tuesday 28th March (South).

2.2 As a result of the QIA being completed at this point, it has not been possible to be able to articulate the mitigating actions to be undertaken or make recommendations about how the North Staffordshire CCG additional investment to the County Council of £389k could be utilised to support drug and alcohol services for North Staffordshire patients.

3. Recommendations

3.1 To note that the BCF guidance has not yet been published but note the key areas we have been notified of.

3.2 To note that CCGs and Councils will have a limited amount of time to develop and submit the initial plans and accept that plans may need to produced before formal board sign off but that amendments can be made following on from the first submission.

3.3 To note that the work to undertake the QIA is underway and that further work is required before formal decisions can be made regarding the investment of £389k for North Staffordshire.

END
### Purpose of the report, executive summary of key issues, points, and outcomes

This report provides a summary of the business discussed at the Organisational Development Committee held on 21st February 2017.

The Committee considered the items of business outlined in the update report below.

### Action required

<table>
<thead>
<tr>
<th>Decision</th>
<th>Discussion</th>
<th>To note</th>
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#### RECOMMENDATION

The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common asked to:

**Note** the contents of the report and the decisions made by the Organisational Development Committee, as detailed in its Terms of Reference; and

**Ratify** the Annual Equality & Inclusion Publication (Public Sector Equality Duty – specific equality duty requirement on CCGs), the EDS Easy Read summary document from 17 May 2016 public grading event (EDS Goal 2) and the Equality & Inclusion Strategy 2017 onwards (with 3 Appendices), approved at the January 2017 Joint ODC meeting.

### Summary of risks relating to the proposal

N/A

### Any statutory / regulatory / legal / NHS constitution/ NHSE assurance / governance / implications

N/A

### Quality impact assessment and/or equality impact assessment

N/A

### Any engagement activity with stakeholders/practices/public and patients

N/A
Strategic objectives supported by this paper
(identify appropriate goals)

<table>
<thead>
<tr>
<th>NORTH STAFFORDSHIRE CCG</th>
<th>YES</th>
<th>NO</th>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
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</tr>
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<tbody>
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ACRONYMS
Outlined in the main body of the report.
Chair’s Report from the Joint Remuneration Committee Meeting Held on the 21st February 2017

1.0 Purpose of Report
1.1 This report provides a summary of the business discussed at the meeting held on the 21st February 2017 in line with the duties delegated to the Committees by the Governing Board.
1.2 The key items of business are summarised below:

2.0 Organisational Development Committee – 24th January 2017
2.1 The Joint Governing Board are requested to ratify the Annual Equality & Inclusion Publication (Public Sector Equality Duty – specific equality duty requirement on CCGs), the EDS Easy Read summary document from 17 May 2016 public grading event (EDS Goal 2) and the Equality & Inclusion Strategy 2017 onwards (with 3 Appendices), approved at the January 2017 Joint ODC meeting.

3.0 Organisational Development Committee – 21st February 2017
3.1 Draft OD Strategy and Plan
The Committee were presented with a draft OD Strategy and Plan drafted by the Head of HR and OD.
The Committee decided that better links needed to be made with Member Practices and needed to be joined up with ongoing work on the Vision, Values, mission statement and behaviours which are still under consultation. The Committee asked for amendments to be made and to receive the final versions at the meeting in April.

3.2 GB Development Proposals
The Committee were updated on the agreed process to be undertaken as 3 proposals had been received from external providers. The Committee agreed that a short life Task and Finish Group would evaluate the proposals against an agreed assessment with a review to recommending a preferred provider at the next OD meeting in March, with ratification to Governing Board in April.
The Group would consist of a Lay Member, Head of HR and OD, Clinical Chair, Director of Strategy, Performance and Planning, and Associate Director Corporate Services.

3.3 HR Policy Review
The Committee received a revised report and draft policy for Display Screen Equipment. It was outlined that the policy affords consistency of application across both CCGs, however the Head of HR and OD received minor amendments from the CSU Health and Safety Lead regarding clarification of the process, and it was agreed this would be amended and the policy brought back to the OD meeting in March for approval.

3.4 NHS Protect Security Standards – Self Review Tool and Security Management
The Committee received a report detailing the outcome from the Self Review Tool. The Committee requested a further updated Action Plan as a result of discussions, for oversight by the OD Committee including timeframes and leads. The Committee received the Security Strategy acknowledging that this would also be received by Audit Committee in March.

3.5 Staff Engagement Forum
The Committee received the Terms of Reference as agreed by members of the Staff Engagement Forum, and the list of staff representatives. The Committee heard feedback from the SEF representative that the first meeting was positive and would continue to meet on a bi-monthly basis.

Fiona Hamill
Chief Operating Officer 21st February, 2017
Purpose of the paper, executive summary of key issues, points and outcomes

The key points of the report that we would like to highlight to the Board are:

- **Progress towards achieving trajectories.**
  We have now agreed revised trajectories for 2017/18 and 2018/19 with NHS England which are more realistic and achievable for CCG commissioned patients. Staffordshire and Stoke on Trent have been RAG rated as ‘Amber’ in the national escalation process due to not achieving trajectories for 2016/17.

- **Financial Risk Share – negotiation of virtual pool arrangements.**
  The CCG’s and Local Authorities are currently negotiating a virtual pool arrangement to ensure that funding future placements is agreed quickly and does not obstruct the discharge process. Staffordshire County Council have agreed in principle to adopt the Risk Share proposal and this is being worked to.

- **Dynamic Purchasing System (DPS)**
  Commissioners are looking at new ways on how the current local market can be stimulated to attract new skilled providers to offer services in our Transforming Care Partnership (TCP) area. In Staffordshire and Stoke on Trent a Dynamic Purchasing System was formally launched on 23 January 2017. This will be aimed at providers who can work with a range of individuals within the Transforming Care Cohort alongside clients who have complex needs that may not form part of the TCP but require bespoke packages of care to be procured and purchased.

- **Risk Registers**
  In addition to the overall TCP Risk Register, CCGs have individual Risk Registers which are currently being reported and updated on through governance processes on a regular basis.

- **Other Key Developments in Transforming Care**
  - Revised TCP Finance Plan submission to NHS England by 28.02.2017
  - Revised Governance and Workstream Structure implemented following approval by the Transforming Care Partnership Board on 31.01.2017.

- **Learning Disabilities Mortality Mortality Review (LeDeR)**
  The Learning Disabilities Mortality Review (LeDeR) Programme (2015 – 2018) has been commissioned
by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and supported by ADASS in response to the Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD). The target for implementation across NHS Midlands and East is April 2017.

The overall aim of the LeDeR programme is to:
Drive improvement in quality of health care and social care service delivery for people with learning disabilities from the ages of 4 to 74.

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**RECOMMENDATION**
The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to **note** the direction of travel and national requirements to be delivered through the Staffordshire and Stoke on Trent Transforming Care Partnership; and

**Note** the progress being made in respect of the local CCG commissioned cohorts moving towards discharge to appropriate community placements in Northern Staffordshire.

### Strategic objectives supported by this paper
(identify appropriate goals)

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**Summary of risks relating to the proposal**
TCP Programme Board Risk Register in place and updated on a monthly basis.

**Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications**
N/A

**Is a Quality and/or Equality impact assessment required**
N/A

**Any engagement activity with stakeholders/practices/public and patients**
We continue to engage with service users, family/carers and have commissioned ASIST to undertake service user engagement work as part of the Transforming Care Programme plan. This will inform service development and delivery. The advocacy group have also provided support on the wider needs assessment work which has been undertaken with the cohort.
Staffordshire and Stoke-on-Trent Transforming Care Partnership

Briefing for North Staffordshire and Stoke on Trent Governing Body– February 2017

For people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition

1. Staffordshire and Stoke-on-Trent Transforming Care Partnership (TCP)

1.1 Progress towards achieving Trajectories

We have now agreed revised trajectories for 2017/18 and 2018/19 with NHS England which are more realistic and achievable for CCG commissioned patients as detailed in the table below.

<table>
<thead>
<tr>
<th>Final trajectories submitted to DCO teams 12/12/16 and UNIFY 23/12/16</th>
<th>as at 30/06/17</th>
<th>as at 30/09/17</th>
<th>as at 31/12/17</th>
<th>as at 31/03/18</th>
<th>as at 30/06/17</th>
<th>as at 30/09/17</th>
<th>as at 31/12/17</th>
<th>as at 31/03/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS England commissioned inpatients</td>
<td>33</td>
<td>32</td>
<td>29</td>
<td>28</td>
<td>27</td>
<td>25</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Inpatient Rate per Million GP Registered Population NHS England commissioned</td>
<td>36.52</td>
<td>35.41</td>
<td>32.09</td>
<td>30.98</td>
<td>28.88</td>
<td>27.66</td>
<td>25.45</td>
</tr>
<tr>
<td>CCG commissioned inpatients</td>
<td>30</td>
<td>29</td>
<td>28</td>
<td>25</td>
<td>24</td>
<td>21</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Inpatient Rate per Million GP Registered Population CCG commissioned</td>
<td>33.20</td>
<td>32.09</td>
<td>30.98</td>
<td>27.66</td>
<td>26.36</td>
<td>23.24</td>
<td>17.70</td>
</tr>
<tr>
<td>Total No. of Inpatients with learning disabilities and/or autism* (TCP level; and by TCP of origin)</td>
<td>63</td>
<td>61</td>
<td>57</td>
<td>53</td>
<td>51</td>
<td>46</td>
<td>39</td>
<td>35</td>
</tr>
<tr>
<td>Total Inpatient Rate per Million GP Registered Population</td>
<td>69.71</td>
<td>67.50</td>
<td>63.07</td>
<td>58.85</td>
<td>56.43</td>
<td>50.90</td>
<td>43.16</td>
<td>38.73</td>
</tr>
</tbody>
</table>

These have been agreed by the DCO team for Midlands and East and are uploaded onto the UNIFY system. The TCP in the interim is still being held to account to achieve 20 CCG commissioned patients in beds by the end of Q4 (March 2017) before these new trajectories come into play.

Staffordshire and Stoke on Trent TCP are included in the national escalation process as from 7 December 2016 due to not achieving trajectories for Q16/17. We have, led by the CCG’s produced a Recovery Plan with timescales and actions for delivery focusing on key development areas required, progress towards discharge for the cohort due to move by 31.03.17, current issues, blockages and reported against the use of the Transformation Fund in developing new services.

We are meeting with NHSE colleagues regularly and reporting into the NHSE Midlands and East team on progress. We will continue to be assessed by NHSE on a fortnightly basis via conference calls on the progress of our clients towards discharge and monthly meetings unless notified otherwise.

1.2 Financial Risk Share and Transfer of Resources from NHS E

The CCG’s and Local Authorities are currently negotiating a virtual pool arrangement to ensure that funding future placements is agreed quickly and does not obstruct the discharge process. The Risk Share Proposal has now been shared across the partners and Staffordshire County Council have agreed in principle to work with this pending Cabinet approval in March 2017. Further discussions are being undertaken within Stoke City Council for agreement to be reached.

One of the outstanding issues to resolve was the mechanism for transferring resources to Local Authorities/Clinical Commissioning Groups (CCGs) from NHS England, when NHSE-funded beds are closed, and where a pooled budget is not in place. It has now been agreed to transfer funds by adjusting CCG allocations – to cover community support for both dowry and non-dowry-eligible patients.
The Deputy Director of Finance, North Staffordshire and Stoke on Trent CCGs and the Transforming Care Programme Manager are working with the West Midlands Alignment Working Group to model future capacity for secure placements and establish how funds will flow to enable the CCGs to meet costs of step down placements from secure accommodation.

2. Dynamic Purchasing System

A barrier to timely discharge has been a lack of suitable local provision in the TCP area. Whilst Staffordshire and Stoke on Trent do have a number of skilled, good quality providers who can work with the Transforming Care client group more capacity in the local market is required.

Led by Staffordshire County Council, the TCP hosted a Market Development event on 23rd January 2017 with a total of 56 Providers attending. The Dynamic Purchasing System (DPS); a procedure for procuring contracts was formally launched and this will be the approach used for the Transforming Care cohort for Stoke-on-Trent and Staffordshire and could be used for placements for other complex needs clients.

Feedback received from the event has been positive and the Procurement Group (sub group of the TCP Board) are taking this work forward, led by Staffordshire County Council procurement colleagues.

A timetable for delivery of the DPS is outlined below.

3. Learning Disabilities Mortality Review (LeDeR) Programme

The Learning Disabilities Mortality Review (LeDeR) Programme (2015 – 2018) has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and supported by ADASS in response to the Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD). The target for implementation across NHS Midlands and East is April 2017.

The overall aim of the LeDeR programme is to:

- Drive improvement in quality of health care and social care service delivery for people with learning disabilities from the ages of 4 to 74.
The LeDeR programme will support CCG’s to meet their requirements as laid out in the NHS Operational Planning guidance 2017/18 which includes the following must do:

- **Reduce premature mortality by improving access to health services, education and training of staff and my making necessary reasonable adjustments for people with a learning disability and/or autism**

A key part of the LeDeR programme is to facilitate local reviews of deaths of people with learning disabilities aged 4 – 74 (inclusive) registered with a GP in England at the time of their death.

These local reviews are intended to help health and social care professionals and policy makers to:

- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities
- Identify variation and best practice in preventing premature mortality of people with learning disabilities.
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

There are a number of key actions to have in place to prepare for the initiation of the LD mortality review in Staffordshire and Stoke on Trent including:

- Agree the local footprint and governance arrangements – potentially aligned to the Staffordshire and Stoke on Trent STP/TCP footprint.
- Identify Local Area Contact who will be responsible for allocating cases to reviewers, assuring quality of completed cases and providing strategic support to the Local Area Steering Group
- Ensure local governance is in place through establishing a Local Area Steering Group
- Recruit Reviewers and establish the Review Team – training will be provided in conjunction with Bristol University
- Complete Information Governance Memorandum Of Understanding

### 3.1 Next Steps

An options appraisal will be presented to Staffordshire and Stoke on Trent CCG Governing Bodies identifying the key issues for consideration with setting up the LeDeR, resource implications including financial impact, governance arrangements, risk analysis and recommendations for action.

### 4. Key Developments in Transforming Care – January/February 2017

- Other TCP developments include a review of the Northern Intensive Support Team (IST) which will be completed by the end of February 2017. This is looking at the service model being delivered to understand the activity and outcomes, pathways of care and challenges to the service. Findings of the review will be reported shortly.

  Commissioners are working with South Staffordshire and Shropshire Healthcare NHS Foundation Trust to understand the service provided, activity, referral and quality issues. A quarterly report has been requested by Commissioners for the end of March 2017.

- Co-production with service users in the re-design of the service models including emergency respite and forensic services and development of a workforce plan has commenced with the local Advocacy Group, Asist. This is being reviewed as part of the Operational Practitioners Group (sub Group of the TCP Board) which has been established.

- Project planning work has commenced on a key priority identified in the Transforming Care Plan around the development of crisis response/emergency respite services. A site visit was undertaken on 31.01.2017 to “The Meadows” in Stoke on Trent which could be a potential site for the provision
emergency respite services. This is being explored further through the appropriate Governance routes and Operational Practitioner’s Group.

- The CCGs have been awarded funding for three individuals to accelerate their discharge into community residential placements. One client from North Staffordshire CCG has been discharged into the new placement and one individual from Cannock Chase CCG is on track to discharge by 28.2.2017. The final client from North Staffordshire will move into the placement by 30 June 2017. The local provider North Staffordshire Combined Healthcare NHS Trust is supporting the new provider around workforce development and training which is positive.

- A revised TCP Finance Plan has been submitted to NHS England nationally on 24 February 2017 and positive feedback has been received that this will be used as a model of good practice across other TCP areas.

- The Transforming Care Partnership Board on 31.01.2017 approved the revised Governance and Workstream structure. The revised structure is required to support delivery of the programme’s milestone plan with assigned leads accountable for progress in identified areas allowing Commissioning Leads to shape and drive direction of the programme.

- The TCP has put forward bids for national Transformation Funding to fund a Pan-Staffordshire Community Forensic Practitioner and for children’s services, four whole time equivalent case workers embedded in existing community teams to provide a community response to prevent Tier 4 admissions. The Pan Staffordshire Children’s services bid has been rejected however further work has been undertaken on the forensic services element following feedback from the national team and the outcome is awaited.

5. Client Summary – Northern Staffordshire CCGs

The position within the Northern Staffordshire CCGs cohort at the end of February 2017 is as follows:

**North Staffordshire CCG - 4 individuals**

- One individual was reported to have absconded from the unit (20.02.2017). The MDT have discussed and wish to proceed towards discharge as uncertainty may be causing increased anxiety. The MDT have discussed alternative accommodation type (single person) instead of a shared flat which may be available with same proposed provider, Shelton Care.

- One individual is on track to discharge by 30.06.2017 and transition has commenced but client is anxious around change therefore a longer transition period is required to be undertaken for this individual. The MDT agreed to facilitate patient story and visit to proposed property prior to the Section 117 aftercare meeting on 23/2/17.

- One female client in active treatment in an Independent Hospital within Staffordshire having recently stepped down from low secure services in December 2016.

- One individual is on-track to discharge by 30.06.2017 and a residential placement is being actively sought.
Stoke-on-Trent CCG – 10 individuals

- One individual is on-track to discharge to a community placement in South Staffordshire on 31.03.2017 but the family have corresponded to the CCG to state their concerns that the client will be discharged before ready to do so and they suggest that the client is unsettled. The CCG have provided assurance client will be discharged when all involved agree it is appropriate.

- One individual is due for discharge on 30.06.2017 and Providers are currently being scoped for future placement. A referral has been made to Shelton Care in Stoke on Trent for single person accommodation.

- One female individual is due for discharge on 30.06.2017. The CCG visited a Provider with a similar property required for the individual with a representative from the MDT which confirmed that the placement was appropriate. An application will be made for the Complex Case Panel on 9/3/17.

- One individual is due for discharge 30.09.2017. The care specification has been updated and providers are currently being scoped and explored for a potential placement.

- One female individual who stepped down from low secure care in August 2016 has mental health needs and Aspergers Syndrome. A discharge date has been set at the 30.09.2017 and Providers are being explored for future placement.

- One individual is due for discharge on 31.12.2017. The CPA is due in March and will provide 12 week assessment feedback and an indication of the readiness for discharge. A potential provider, Craegmoor will assess once the 12 week assessment has been reported.

- One individual is due for discharge on 31.12.2017. The local Assessment and Treatment (A & T) Unit have requested further information from PICU regarding a number of client incidents. The CCG have requested a response/admission date if agreed for transfer to the A & T Unit. An alternative provider is still available to provide a service if this is required.

- One individual is not due for discharge until March 2018 and continued scoping of placements is underway. A referral has been made to Adderley Green, (a care with nursing) in Stoke on Trent to see if they could offer a placement for the individual.

- One individual is due for discharge in November 2018 and is on a mental health treatment plan. Providers are currently being scoped and explored for a potential future placement.

- One individual is not due for discharge until March 2019 and remains currently in active treatment and may continue to require a hospital bed for care.
6. Risk Registers

In addition to the overall TCP Risk Register, CCGs have individual Risk Registers which are currently being reported and updated on through governance processes on a monthly basis.

The current “At Risk” registers held by the Providers are being reviewed and cross checked with the requirements for a Dynamic Risk Register which is required to be implemented nationally by 31.03.2017. A report on progress has been shared with NHS England on 10th February 2017 and we will be reporting further around how the dynamic register will be implemented on 24th February 2017. The final report will be presented to NHS England by 31 March 2017.

7. Conclusion

In order to transform the system in line with the clear direction set out in ‘Building the Right Support’, the TCP recognises that we need to continue to work with all our stakeholders, family carers and individuals to deliver the agenda.

The TCP through its revised Governance arrangements has ensured that the process for addressing these issues is now in place in order to drive improvement and to provide assurance and commitment that the plans to achieve change are robust and achievable.

Chris Adams, Staffordshire and Stoke on Trent Transforming Care Programme Manager
Laura McGarvie, Project Support Officer
24th February 2017
This paper sets out the summary action plan following a CCG commissioned follow-up review of both CCGs Capability and Capacity progress against the original NHS England (NHSE) commissioned review undertaken in May 2016. The follow-up review was undertaken November – December 2016.

PwC were commissioned by NHSE to undertake the initial review, in response to concerns regarding financial position of both CCGs. Their final report, dated 7 July 2016, set out twenty one recommendations. Nineteen of these recommendations related to leadership capacity, capability and governance and two recommendations related to immediate actions required to address the financial deficit facing the CCGs.

In PWC’s view, the CCGs have given priority to the delivery of improvements from the original recommendations, in accordance with the action plan we developed to monitor delivery. The view was also that strong governance oversight and project management arrangements were established to sustain a focus on governance and leadership improvement.

PwC summarised our progress as follows:

The CCGs have made significant progress with the planning and delivery of improvements to their capacity, capability and governance arrangements. Action has commenced in response to all of the recommendations made in our report, with the majority of recommendations having already been implemented. The CCG will need to continue to monitor the impact of the changes made to ensure they continue to deliver the expected benefits and to ensure changes are sustainable. A number of improvements, as expected, are still in the process of being made. In particular, there is further work to do in relation to Governing Body and Executive team development, which forms part of a broader organisational development programme. The CCGs are conscious of this and whilst there have been some delays in relation to externally contracted support, this is a priority over the coming months. Whilst the Executive team has not commenced a team development programme, it is evident that other mitigating actions taken have improved the effectiveness of team working. This includes holding weekly Executive meetings, clarifying Executive portfolios and identifying any ‘grey areas’ between portfolios, which need additional focus.

PwC indicated that in their view, 10 of the original recommendations had been fully implemented and 9 partially implemented. The remaining 2 recommendations linked to financial recovery were not within the scope of this review.
The enclosed action plan has been developed in response to the eight new recommendations arising from the follow-up review. The action plan indicates the realistic deadlines expected for delivery of the recommendations following review by each lead officer.

Appendix 1 – Summary of new recommendations

<table>
<thead>
<tr>
<th>Reference</th>
<th>Recommendation</th>
<th>Deadline</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lay Members sitting on sub-committees should be given the opportunity to review and input into the planned agenda for each sub-committee meeting prior to circulation, in order to ensure sufficient Lay Executive involvement in dealing with issues.</td>
<td>March 2017</td>
<td>CCG Chairs</td>
</tr>
<tr>
<td>2</td>
<td>Executive portfolio should be reviewed with the newly formed Executive team in January 2017 and responsibilities formally documented and shared with the Joint Commissioning Committee.</td>
<td>January 2017</td>
<td>Sub-Committee Executive Chairs</td>
</tr>
<tr>
<td>3</td>
<td>In our view, the capability of the team is likely to be sufficient to manage the organisation. However, the AO should continue to reflect on team capacity and the newly formed Executive team has been established in 2017, taking into account the level of service management support before Executive.</td>
<td>December 2017</td>
<td>AO</td>
</tr>
<tr>
<td>4</td>
<td>The CCGs may benefit from developing a structured risk rating system to consider schemes at risk are consistently identified and given appropriate opportunities for action.</td>
<td>February 2017</td>
<td>DBP</td>
</tr>
<tr>
<td>5</td>
<td>QIPP schemes are RAG (Red Amber Green) rated based on two risk criteria (deliverables and milestones. RAG ratings are judgemental and there is currently no set threshold for rating a scheme as red).</td>
<td>February 2017</td>
<td>DBP</td>
</tr>
</tbody>
</table>

Action required

<table>
<thead>
<tr>
<th>Action required</th>
<th>Decision</th>
<th>Discussion</th>
<th>To note</th>
<th>For assurance / For information</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECOMMENDATION</td>
<td>The North Staffordshire and Stoke-on-Trent CCG Governing Boards in common are asked to note:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The progress made since the original Capability and Capacity Review</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• The progress against the follow-up actions in the enclosed action plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic objectives supported by this paper
(identify appropriate goals)

<table>
<thead>
<tr>
<th>North Staffordshire CCG</th>
<th>Yes</th>
<th>No</th>
<th>Stoke on Trent CCG</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will commission safe effective and high quality sustainable services</td>
<td>Yes</td>
<td>No</td>
<td>Improve access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. We will deliver better patient outcomes through effective federated and collaborative arrangements with key partners</td>
<td></td>
<td></td>
<td>Improve health outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. We will improve patient experience through patient engagement, feedback</td>
<td></td>
<td></td>
<td>Improve quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. We will reduce health inequalities and inappropriate clinical variation</td>
<td></td>
<td></td>
<td>Reduce health inequalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Governance &amp; Statutory Requirements</td>
<td>X</td>
<td></td>
<td>Cross cutting /statutory duties (more than one of the above)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. We will achieve all of the above while remaining within financial balance and achieving best value</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Summary of risks relating to the proposal</strong></td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Any statutory/ regulatory/legal /NHS constitutional/NHSE assurance / governance implications</strong></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Is a Quality and/or Equality impact assessment required</strong></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Any engagement activity with stakeholders/practices/public and patients</strong></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>ACRONYMS</strong></td>
<td>N/A</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Review of actions taken and improvements made in response to the CCGs Capability and Capacity Review

Updated recommendations and action plan

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>Date for completion</th>
<th>Lead</th>
<th>Progress</th>
<th>Further actions required (what and when by)</th>
</tr>
</thead>
</table>
| 4/21 | **QIPP Monitoring** *(Fully implemented)*  
**New Recommendation** *(December 2016)*  
QIPP schemes are RAG (Red Amber Green) rated based on two risk areas; deliverables (financial variance) and milestones. RAG ratings are judgemental and there is currently no set threshold for rating a scheme as ‘red’. The CCGs may benefit from developing a standardised RAG rating system to ensure all schemes at risk are consistently identified and given appropriate opportunity for scrutiny. | Mar 17 | Director of Strategy, Planning and Performance | The QIPP Monitoring Methodology process document has been reviewed and is being updated to reflect changes for 2017-19. As part of the update a section will be included on scheme delivery and financial tolerances. This will set out the thresholds for applying RAG ratings. A proposal setting out scheme tolerances and the thresholds to be applied for RAG ratings will be discussed at PDSG on 6th March 2017 and presented the Financial Recovery Group (FRG) for approval on 21st March 2017. The process will be fully embedded for the 2017/18 QIPP Programme from 1 April 2017. |
| 6/21 | **Sceptical Mindset** *(In progress)*  
CCGs should ensure the GB development programme incorporates how to provide effective scrutiny of forecasts and action being taken to mitigate risks and issues to ensure the Governing Body continues to refine how scrutiny is applied effectively. | April 17 | Chief Operating Officer | Selection process being undertaken for bids received to undertake the development programme. OD Committee will receive recommendations from Task & Finish Group in April (date TBC). |
| 7/21 | **Leadership Team Capacity** *(Fully implemented)*  
**New Recommendation** *(December 2016)*  
In our view, the capacity of the team is likely to be sufficient to manage the organisations. However, the | Dec 17 | Accountable Officer | To be considered in due course (deadline not reached) |
<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>Date for completion</th>
<th>Lead</th>
<th>Progress</th>
<th>Further actions required (what and when by)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/21</td>
<td><strong>AO should continue to reflect on team capacity once the newly formed Executive team has been established in 2017, taking into account the level of senior management support below Executives.</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Executive Team Portfolios (In progress)</strong></td>
<td></td>
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<tr>
<td></td>
<td>As the newly formed Executive team is established in January 2017, it is important that the portfolios are revisited and responsibilities formally documented and shared with the Establishment Review Group.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>New Recommendation (December 2016)</strong></td>
<td></td>
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<tr>
<td></td>
<td>We note that the Head of Contracting is still managing a contracting team, employed by the CSU and located at the CSU. In our view this arrangement is not sustainable due to the lack of visibility and insufficient managerial control of that team. The CCG should identify and implement alternative arrangements which mitigate these issues.</td>
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<td></td>
<td></td>
<td>March 17</td>
<td>Chief Operating Officer</td>
<td>Draft portfolios in place. Review will be completed by 31/03/17</td>
<td>Head of Contracting meeting with CSU Service Director to finalise by end of April.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>April 17</td>
<td>Chief Finance Officer</td>
<td>Discussion held between CSU and CFO on how best to progress the interface between the CSU contracting function. Clarity reached that the CSU need to manage the contracting team, CSU have strengthened resource and structure in this area and that interface between CCG Head of Contracting and CSU contracting team needs to be redefined.</td>
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<tr>
<td>No.</td>
<td>Recommendation</td>
<td>Date for completion</td>
<td>Lead</td>
<td>Progress</td>
<td>Further actions required (what and when by)</td>
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</tr>
<tr>
<td></td>
<td><strong>Executive Team Working</strong> (<em>In progress</em>)</td>
<td>April 17</td>
<td>Chief Operating Officer</td>
<td>As per 6/21 Exec level coaching being reviewed Exec Away Days being organised which will include external facilitation. GB Development programme, Heads of Leadership being explored, CCG wide development programme</td>
<td></td>
</tr>
<tr>
<td>9/21</td>
<td>The CCGs commissioned an external consultant to support Executive development programme as part of a wider Organisational Development (OD) programme. There have been delays to this programme outside of the CCGs control. However the CCG is currently in the process of procuring additional support and has taken the decision to commence team development once the newly formed Executive team is in position in early 2017. In our view, this is an appropriate approach as it ensures the benefit of the development support is maximised.</td>
<td></td>
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<td></td>
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<tr>
<td>10/21</td>
<td><strong>Individual Executive Development Plans</strong></td>
<td>April 17</td>
<td>Accountable Officer</td>
<td>In-line with recommendation 8/21</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>New Recommendation</strong> (<em>December 2016</em>)</td>
<td></td>
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<tr>
<td></td>
<td>Executive portfolios should be reviewed by the AO in conjunction with the newly formed Executive team in January 2017 and responsibilities formally documented and shared with the Joint Remuneration Committee. Alongside this, the AO should ensure PDPs are developed and agreed with each Executive.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12/21</td>
<td><strong>Governing Body Training and Development</strong></td>
<td>April 17</td>
<td>CCG Chairs</td>
<td>Selection process being undertaken for bids received to undertake the</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>New Recommendation</strong> (<em>December 2016</em>)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The planned Governing Body development programme,</td>
<td></td>
<td></td>
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<tr>
<td>No.</td>
<td>Recommendation</td>
<td>Date for completion</td>
<td>Lead</td>
<td>Progress</td>
<td>Further actions required (what and when by)</td>
</tr>
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<td>14/21</td>
<td>Should prioritise holding effective meetings and Chairing of meetings. This is important as the combined Governing Body is a large meeting with a challenging agenda and the CCG Chairs (who rotate Chairing the meetings on a monthly basis) will need support to ensure they are able to maximise the contributions of Governing Body Members and ensure the agenda is managed effectively.</td>
<td>Jan 17</td>
<td>Sub-committee Chairs</td>
<td>Business cycle reviewed annually and all committee members' opportunity to input. Lay members are able to request for items to be added to future meetings agendas</td>
<td>COMPLETE</td>
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| 16/21 | **Chairing of Committees**  
**New Recommendation** *(December 2016)*  
Lay Members sitting on sub-committees should be given the opportunity to review and input into the planned agenda for each sub-committee meeting prior to circulation, in order to ensure sufficient Non Executive involvement in deciding which issues are discussed. | April 17            | Chief Financial Officer          | Initial discussions held at meetings where finance papers are presented asking for feedback on current reports and if they meet the needs of users. | Review of all reports to be undertaken with revised suite to be prepared by end of April.                    |
| 19/21 | **Reporting of Information**  
**New Recommendation** *(December 2016)*  
Finance reports to committee and governing body should include graphical representations of trend of expenditure vs. planned expenditure in year to allow members greater visibility of whether the year-end forecast are realistic based on performance against forecasts to current month being reported. | July 17             | Accountable Officer              | Risk register/BAF was reviewed during November and December by CCG       | PWC undertook an internal audit review of risk management in December 2016.                                  |
<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>Date for completion</th>
<th>Lead</th>
<th>Progress</th>
<th>Further actions required (what and when by)</th>
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<td></td>
<td>entries are fully populated and up to date (including to ensure that risks are reviewed and updated by the “date of next review”) prior to being presented to committee and Governing Body meetings.</td>
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<td>officers and execs and updates received. Date of next review was updated - manually has to be input and is often missed by updating officers</td>
<td>Draft report received and recommendations accepted. 2016/17 Risk Register to be closed off. New risk register and strategy to be developed by 30th June. Oversight via the Audit Committee</td>
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</table>
| 20/21 | **Organisational Development Plan**  
As detailed in recommendation 12, there have been delays with the external Organisational Development Support. However, the CCGs have requested that the recommendations from this report form part of the OD programme. Therefore this recommendation is still in progress.                                                                                                                  | April 17           | COO  | Recommendations form part of GB development programme to be procured                                                                                                                                                                                                       | OD committee requested CL to work with other local providers in health economy to share training/learning where possible                                                                                                                                                                                                 |
