## 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: John Howard</td>
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<tr>
<td>2</td>
<td>Declarations of Interest</td>
<td>Verbal</td>
<td>To Note</td>
<td>RC 1.30pm</td>
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<td></td>
<td>In accordance with Standing Order 7.3.2 (i) members and non-members are asked to</td>
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<td></td>
<td>declare interests which are relevant and material to this meeting</td>
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<tr>
<td>3</td>
<td>Confirmation of Quoracy (following consideration of interests declared pertaining to the agenda)</td>
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<tr>
<td>4</td>
<td>Minutes from previous meeting held on 2nd February 2015</td>
<td>Enc 4.1 Enc 4.2</td>
<td>To Note / Decision</td>
<td>RC 1.30pm (5 mins)</td>
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<tr>
<td>5</td>
<td>Chairman’s Address</td>
<td>Enc 5</td>
<td>To Note</td>
<td>RC 1.35pm (10 mins)</td>
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<tr>
<td>6</td>
<td>Clinical Accountable Officer’s Report</td>
<td>Enc 6</td>
<td>To Note / Ratify</td>
<td>AB 1.45pm (10 mins)</td>
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<tr>
<td></td>
<td>• Joint Planning Committee Chair’s Report</td>
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<td>• Joint Organisational Development Committee Report</td>
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<td></td>
<td>Dr Andrew Bartlam, CCG Clinical Accountable Officer</td>
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<td>7</td>
<td>Risk Register</td>
<td>Enc 7</td>
<td>To Note</td>
<td>LT 1.55pm (5 mins)</td>
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<tr>
<td>8</td>
<td>Quality Report</td>
<td>Enc 8</td>
<td>Decision</td>
<td>JD 2.00pm (10 mins)</td>
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<tr>
<td>9</td>
<td>Audit Committee Chair’s Report</td>
<td>Enc 9</td>
<td>Decision</td>
<td>MW 2.10pm (10 mins)</td>
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| 10 | Governing Body Finance Report  
Iain Stoddart, CCG Chief Finance Officer | To Follow | To Note |
| 11 | Governing Body Assurance Report  
CCG Clinical Leads | Enc 11 | To Note |
| 12 | Patient and Public Engagement / Patient Congress Update  
Margy Woodhead, CCG Lay Member - PPI | Verbal | To Note |
| 13 | Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan  
Dr Waheed Abbasi, Clinical Director Mental Health and Specialised Services  
Kevin Day, Joint Commissioning Manager, Stoke-on-Trent | Enc 13 | Decision |
| 14 | Patient Transport Services  
Dr Steve Fawcett, Clinical Director Acute Services | Enc 14 | Decision |
Iain Stoddart, Chief Finance Officer / CCG SIRO | Enc 15 | To Note |
| 16 | EDS / WRES Update  
Sandra Chadwick, Chief Operating Officer | Enc 16 | To Note |
| 17 | Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan  
Dr Emma Sutton, Clinical Director Primary Care | Enc 17 | Decision |
|   |   |   |   |
| 18 |   | Verbal | Information |

**DATE/TIME OF NEXT MEETING:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
<th>Chair</th>
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<tbody>
<tr>
<td>Tuesday 7th June 2016</td>
<td>1.30pm</td>
<td>The Minton Room, Stoke-on-Trent CCG, 79 London Road, ST4 7PZ</td>
<td>RC</td>
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Minutes of the Public Meeting of Stoke-on-Trent Clinical Commissioning Group Governing Body
Held on Tuesday 2nd February 2016 at 1.30pm – 4.00pm
The Minton Room, Stoke-on-Trent CCG, Herbert Minton Building, 79 London Road, Stoke-on-Trent
UNCONFIRMED MINUTES

Present:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tr>
<td>Dr Ruth Chambers OBE</td>
<td>(Chair)</td>
<td>CCG Chair</td>
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<tr>
<td>Sandra Chadwick</td>
<td>(SC)</td>
<td>CCG Chief Operating Officer</td>
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<tr>
<td>Iain Stoddart</td>
<td>(IS)</td>
<td>CCG Chief Financial Officer</td>
</tr>
<tr>
<td>John Howard</td>
<td>(JH)</td>
<td>CCG Lay Member – Governance</td>
</tr>
<tr>
<td>Dr Steve Fawcett</td>
<td>(SF)</td>
<td>CCG Clinical Director, Acute Services</td>
</tr>
<tr>
<td>Dr Waheed Abbasi</td>
<td>(WA)</td>
<td>CCG Clinical Director, Mental Health &amp; Specialist Groups</td>
</tr>
<tr>
<td>Dr Simon Mellor</td>
<td>(SM)</td>
<td>CCG Secondary Care Doctor</td>
</tr>
<tr>
<td>Jayne Downey</td>
<td>(JD)</td>
<td>CCG Director of Nursing and Quality</td>
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<tr>
<td>Noreen Dowd</td>
<td>(ND)</td>
<td>Interim Director of Strategy and Planning title</td>
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<tr>
<td>Cheryl Hardisty</td>
<td>(CH)</td>
<td>Interim Director of Commissioning</td>
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<tr>
<td>Zafar Iqbal</td>
<td>(ZI)</td>
<td>Public Health Director</td>
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In attendance:

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<tr>
<th>Name</th>
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<tr>
<td>Rachel Barker</td>
<td>CCG Executive Assistant</td>
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<tr>
<td>Lisa Taylor</td>
<td>CCG Quality and Governance Manager</td>
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<tr>
<td>Filippa St Aubin D’Ancey</td>
<td>Communications and Press Manager</td>
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<tr>
<td>Sally Parkin</td>
<td>Clinical Director for Partnerships and Engagement</td>
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Apologies:

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<tr>
<td>Dr Andrew Bartlam</td>
<td>CCG Clinical Accountable Officer</td>
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<tr>
<td>Margy Woodhead</td>
<td>CCG Lay Member – Patient and Public Involvement</td>
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<tr>
<td>Dr Harald Van Der Linden</td>
<td>LMC Secretary</td>
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<tr>
<td>Val Lewis</td>
<td>Manager, Health Watch</td>
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<tr>
<td>Louise Rees</td>
<td>Interim Director of Adult Social Care and Protection, Stoke City Council</td>
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Members of the Public:

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<th>Name</th>
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<tr>
<td>Ian Syme</td>
<td>Member of the Public</td>
</tr>
<tr>
<td>Dave Blackhurst</td>
<td>Member of the Press</td>
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<td>4 members of the public</td>
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Action

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

   RC welcomed members to the Governing Body meeting and introduced Noreen Dowd and Cheryl Hardisty in their capacity as Joint Directors across Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups.

   Apologies of absence were noted as above.

2. **Members’ Declaration of Interest**

   There were no Declaration of Interests declared.

   The Declaration of Interest Register was available for review at the meeting.

3. **Confirmation of Quoracy**

   The meeting was confirmed as quorate.
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4. Minutes from previous meeting held on 2\textsuperscript{nd} December 2015

The minutes of the meeting held on the 2\textsuperscript{nd} December 2015 were \textit{noted} and \textit{agreed} as a true and accurate record of the meeting.

5. Chair’s Address

RC presented the report to the Governing Body to provide an address to the meeting of Stoke-on-Trent Clinical Commissioning Group Governing Body. Details as follows:

\textbf{Introduction}

RC thanked all of the teams both within the CCG and the frontline staff across the health economy for their continued hard work.

\textbf{Update on Executive Staffing}

RC advised that Marcus Warnes was successfully appointed and commenced the role of Accountable Officer for North Staffordshire CCG on 10th December. The appointment was subject to confirmation by NHS England, which had been received.

RC welcomed Noreen Dowd, Interim Director of Strategy and Planning title and Cheryl Hardisty Interim Director of Commissioning, shared appointments with North Staffordshire CCG to the meeting.

\textbf{Collaborative Working}

RC highlighted the further progress made on collaborative working with North Staffordshire CCG in moving towards an integrated executive and management structure. The revised structure included an expanded executive management function shared with North Staffordshire CCG whilst ensuring there was no dilution of clinical leadership at executive level.

It was reiterated that whilst the executive, clinical and managerial workforce along with the committee structure would be joint, this was not a merger. Both CCGs would remain sovereign bodies with their own Governing Bodies and Accountable Officers.

\textbf{Stoke-on-Trent CCG Constitution}

RC advised that the CCG submitted proposed changes to its Constitution to NHS England in October 2015. These reflected the revised Governing Body structure as a consequence of working more collaboratively with North Staffordshire CCG, whilst still retaining individual sovereignty. NHS England had confirmed approval of the proposed changes to the constitution in line with section 14 of the NHS Act 2006 with effect from the 2\textsuperscript{nd} February 2016. The revised Constitution would be published on the CCG website.

The Governing Body duly \textit{received} and \textit{noted} the Chair’s Report.

6. Clinical Accountable Officer’s Report

SF presented the report on behalf of Dr Andrew Bartlam to provide the Governing Body with an update of issues and items of business discussed at sub-committees of the Governing Body. Details as follows:

\textbf{DIRECTION}

\textbf{Primary Care}

SF confirmed that Primary Care remained a priority area for the CCG. The CCG continued to support the North Staffordshire GP Federation, whilst it developed its vision and plans.

Stoke-on-Trent and North Staffordshire CCGs were making good progress on developing a Primary Care Strategy which would sit within a broader pan Staffordshire Primary Care Strategy. The strategy would
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provide a clear vision for primary care and co-commissioning and the role that the Federation and primary care professions would play in the development and delivery of new models of care across Staffordshire.

Referral To Treatment (RTT)
Both 18 Weeks RTT and Cancer performance remained areas of concern. The focus for 18 weeks RTT was around the incomplete pathways, with performance in November being 90.7% and year to date performance of 90.5%, against the 92% target.

The CCG was applying contractual sanctions. As the Remedial Action Plan (RAP) had not been delivered, a request for a further improvement plan and RAP had been requested. The CCG was working with the TDA and NHS England to agree timelines for agreeing both the improvement plan and the RAP.

Cancer
In November the CCG failed to achieve the 2 week wait, 2 week wait (breast), 62 day from GP referral and 62 day from screening standards. Remedial action plans were in place for 31 day (overall and surgery) and 62 day from GP referral target. A performance notice has been raised for the 2 week wait breast target.

DEVELOPMENT
CCG Chair
SF reiterated that Dr Prasad Rao’s tenure as Chair of Stoke-on-Trent CCG ended in early 2016 and Dr Ruth Chambers OBE was appointed from the CCG Membership as Chair and commenced in post on the 4th January 2016.

SF thanked Prasad for the fantastic work and commitment shown in leading the CCG from authorisation to where it is today.

DIRECTION
Chairs Reports
Organisational Development Committee
The Governing Body noted the items of business discussed at the meeting on the 19th January 2016 which included (1) Management of Change Update; (2) Staff Side Partnership Forum HR policies Updates; (3) OD Programme Update; (4) Equality and Inclusion Targeted Training; (5) EPRR Update; and (6) EDS Update.

The CCG Suspension and Removal Policy
SF advised that the policy aimed to ensure that where removal from office was being considered, it was dealt with reasonably and in line with the CCG constitution.

IS clarified that the ‘Office Holder’ term was the CCG definition and not the HMRC definition. This was duly noted by members.

The Governing Body duly ratified the CCG Suspension and Removal Policy.

Executive Forum
The Governing Body noted the items of business discussed at the meeting on the 24th November 2015 which included (1) Joint Integrated Finance and Performance Report; (2) Quality Report Open; (3) CCG Corporate Risk Register; (4) Cancer And End Of Life Report; (5) Transforming Care; and (6) Continuing Health Care Adoption of a Dynamic Purchasing System.
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The Governing Body noted the items of business discussed at the meeting on the 29th December 2015 which included (1) Joint Integrated Finance and Performance Report; (2) Quality Report Open; (3) CCG Corporate Risk Register; (4) Cancer And End Of Life Report; (5) Transforming Care; (6) Learning Development Procurement Frameworks; (7) Developing a Joint Strategic Commissioning Board; (8) Joint Committee Proposals; and (9) a Voluntary Sector Grant Programme Update - Revival Intensive Home Support Service.

Planning Committee

The Governing Body noted the items of business discussed at the meeting on the November 2015 which included (1) Terms of Reference; (2) Finance Update; (3) Joint Strategy Update; (4) Care Act; (5) Mental Health Implementation Plan; (6) CAMHS Implementation Plan; (7) Approach To Managing Service Developments; (8) Update on Contracts; and (9) Children’s Emergency Care Centre (CECC) – Pathway Redesign.

The Governing Body noted the items of business discussed at the meeting on the December 2015 which included (1) Terms of Reference; (2) Finance Update; (3) Contracting Update; (4) Contract Matrix 15/16; (5) Commissioning Intentions UHNM; (6) Pan Staffordshire Update; (7) Draft Joint Strategy; (8) Draft Primary Care Strategy; (9) Mental Health Implementation Plan; (10) Keele Research Institute; (11) CAMHS Implementation Plan / Governance Structure; and (12) Commissioning Timelines.

The Governing Body duly received and noted the Clinical Accountable Officer’s Report and ratified the decisions made at the Sub Committee’s as detailed as above.

7. CCG Corporate Risk Register

LT presented the report. Details as follows:

LT advised that during 2015, the CCG had been working with North Staffordshire CCG to review the contents of each Risk Register and to align those risks that are applicable to both CCGs to enable one risk register to be maintained. Following this process a new Risk Register was constructed by the Informatics Team which allowed staff across Stoke-on-Trent and North Staffordshire CCGs to access one Risk Register, to add and review risks ‘live’. The system had been streamlined to allow risks to be applicable to one, or both CCGs, and allowed risks to be allocated to each CCG’s strategic objectives. This reduced the workload for staff members who may lead on the same risk for each organisation, allowing them to review and update their risks once where possible. This maintained the clear link to each CCG’s own objectives and ensured sovereignty to each Governing Body.

LT confirmed that (1) risk owners had reviewed the risk descriptions for their risks and updated where appropriate; (2) risks scoring 12+ were reviewed at the Joint Finance and Performance Committee on a monthly basis; (3) clinical risks were also reviewed at the Joint Quality Committee bi monthly; (4) the principle risks to the organisation were monitored on a quarterly basis at the Audit Committee; and (5) alert notices were now set up to notify the Head of Governance at North Staffordshire CCG and the Governance Manager at Stoke-on-Trent CCG when new risks were added to the system to allow early monitoring and review.

The Governing Body duly noted the contents of the Corporate Risk Register for risks scoring 15 and above; and noted that a training session was held on the 18th January 2016 across North Staffordshire and Stoke-on-Trent CCG’s to officially launch the Joint Risk Register to all staff across both CCGs.

8. Finance Report

IS presented the finance report to highlight the month financial monitoring position. Details as follows:
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IS advised that (1) the CCG’s month 9 position was a £2.692m surplus which was an improvement from the planned surplus of £2.652m up to period 9 by £40k; (2) the CCG’s forecast outturn position is held at a planned surplus of £3.731m in line with the control total; (3) to achieve the planned surplus position of £3.731m the CCG must continue to deliver on its QIPP programme of £10.57m; (4) the current and forecast performance against the original QIPP programme levels, together with risk scenarios could impact on the out-turn performance; (5) the CCG needs to mitigate the current level of risk and fully deliver to QIPP programme levels in the last 3 months of the financial year, (delivery of £5.425m between January to March); (6) net risks of £1m are un-mitigated, but the forecast surplus was held at plan on the basis of satisfactory agreement of final contract values with providers around performance and contract levers; and (7) further actions were being taken through the internal turnaround regime to deliver against plan in line with the gross level of assessed risks.

IS advised that taking the latest spending projections into account and recognising that acute contracts were over-performing at a gross level (before assumptions for fines and MRET) there were now considered to be net risks of £1m not mitigated with identified actions. The divergence from plan could be largely attributed to four factors (1) Acute over-performance; (2) delayed delivery of QIPP assumptions in Q3; (3) no specific alignment of BCF performance element to cover NEL general over-performance; and (4) differences arising from assumptions and forecasts relating to appropriate charging of specialised commissioning activity between the CCG and NHS England.

IS advised that discussions were taking place with UHNM and other providers to reassess and agree expected year-end financial positions and would include all outstanding matters relating to system resilience claims, sanctions and contract levers applied and other matters including 18 week backlog clearance.

The contract variations with the Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP) are still to be signed for the transfer of Step Down and Long Term conditions activity to UHNM, and the final values are still to be agreed. In the interim, contract payments to SSOTP have been adjusted to reflect the transfer of responsibility.

A discussion took place around (1) the Better Care Fund and the dialogue with the Local Authority around investment in domiciliary care; (2) the need for the counting structure to be clear and unambiguous; and (3) that the granular detail is reported to the Joint Finance and Performance Committee each month.

The Governing Body duly received and noted the Finance Report.


The report was presented to provide assurance to the Governing Body on the CCGs performance against quality metrics, NHS Constitution targets and NHS Outcomes Framework indicators. Details as follows:

**A&E** – SF advised that the 95% target had not been achieved but highlighted the ongoing work to improve the situation with ECIP (Emergency Care Improvement Programme).

**Front of House** – The number of service users had increased to 58 a day.

**Referral to Treatment (RTT)** – Performance remained below target. The CCGs were following the contractual process for failure to agree a Recovery Action Plan and continued to work with the Trust to create a robust and assured plan for delivery.
**SC advised that a Board to Board meeting with UHNM was being arranged in order for the CCG to gain reassurance on UHNM’s Trust Board assurance against planned quality and safety improvement measures against constitutional targets.**

**Cancer – SF advised that in November the CCG failed to achieve the 2 week wait, 2 week wait (breast), 62 day from GP referral and 62 day from screening standards. The rising referral rates were noted; however conversion rates suggest that GP referrals were comparable to other areas of the country.**

SC advised that a robust action plan was in place and there was continuing work with IST. However improvement actions were needed, these would be raised through the Planned Care and CQRM meetings for escalation. **ACTION: SF to raise at the meetings.**

A discussion took place around (1) capacity and demand; (2) the need to clearly understand where the issues are; (3) the need to support UHNM to achieve the targets; (4) the need to identify how to move forward; and (5) the need to ensure that quality remained a priority.

**Mental Health**

**IAPT - WA highlighted the gradual improvement that had been sustained but that the 50% Recovery target had not been met. There was confidence that this could be achieved in quarter 4 although risks remain. The two additional mental health targets would be included within the report to the next meeting. **ACTION: WA to include in the next report.**

The Governing Body received and noted the Assurance Report.

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ND presented the report to update members of the Joint Planning Committee on Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 which was issued on 22 December 2015. Details as follows:

ND advised that (1) the NHS Planning Guidance set out steps to deliver a sustainable, transformed health service and included key system priorities, agreed by all national health and care bodies, which related to the Government Mandate to NHSE; (2) this included business rules and incentives that would support delivery; (3) the document would set the programme of work for the next year; (4) all NHS organisations would produce two separate but interconnected plans – a Local health and care system ‘Sustainability and Transformation Plan’ (STP), and a 2016/17 Operational Plan by organisation; (5) The STP would cover October 2016 to March 2021; (6) STPs were due in June 2016 and were linked to accessing transformation funding from 2017/18 onwards; (7) the 2016/17 Operational Plan would count as year one of the Sustainability and Transformation plan; and (8) the geographies involved in ‘Success Regime’ would determine the STP ‘transformation footprint’, therefore the CCGs were part of the Staffordshire footprint.

ND highlighted the National ‘must dos’ for 2016/17 which included (1) advancement in spread of seven day working; (2) producing a high quality and agreed STP; (3) returning the system to aggregate financial balance; (4) developing plans to address sustainability and quality of general practice; (5) meet access standards across all NHS Constitution targets including new mental health access targets; (6) deliver actions set out in local plans to transform care for people with learning disabilities; (7) develop and implement an affordable plan to make improvements in quality, and; (8) development of new care models to feature prominently within STPs.

The Operational Plans would be agreed in April and would need to cover activity, capacity and finance
and needed to demonstrate (1) how we reconcile finance with activity; (2) planned contribution to efficiency savings; (3) plans to deliver key must dos; (4) how quality and safety will be maintained and improved for patients; (5) how risks across local healthy economy plans have been jointly identified and mitigated through an agreed contingency plan, and; (6) how plans link with and support with local emerging STPs.

ND highlighted that CCGs had been set firm three year allocations, followed by two indicative years; real terms element of growth in CCG allocations for 17/18 onwards would be contingent upon development and sign off of a robust STP during 16/17. CCGs and councils would need to agree a joint plan to deliver requirements of Better Care Fund (BCF) in 16/17 and CCGs would be advised on minimum amounts required to pool as part of notification of wider allocations.

A discussion took place around Primary Care (1) the need to shift resource from Acute to Primary Care; (2) the work the local federation was undertaking; (3) the capacity and capability of the federation; (4) the Primary Care strategy; and (5) the need to develop the infrastructure to release capacity.

IS highlighted the need to be better aligned and unified as there was a 10% over target allocation for Specialised Commissioning but a 3% under for Primary Care. There were monies available that the health economy could bid against.

The Governing Body duly noted the update on Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 and noted that the Planning Submission would be signed off by the Governing Bodies of Stoke-on-Trent and North Staffordshire CCGs at the Joint Extraordinary Meeting on the 8th March 2016.

11. **Quality Open Report**

JD presented the report to support the delivery of the CCG vision of ensuring consistent high quality and safe care; and to provide assurance that the structures and processes are in place for sustaining and improving all three domains of quality; positive patient experience, safety and clinical effectiveness. Details as follows:

JD advised that following the meeting of the Joint Quality Committee held in January 2016 the Terms of Reference had been updated and would be presented for review and approval at the next meeting of the Quality Committee prior to ratification by the Governing Body.

**Healthcare Associated Infections (HCAI) Presentation**

At the Joint Quality Committee, members received a detailed presentation in respect of the current position in relation to MRSA and C Difficile within the CCG and its main providers, along with comparative information for other CCGs within the West Midlands. Members received assurance of the range of actions being undertaken in relation to HCAIs and the key areas currently being addressed through the Infection Prevention and Control Strategy.

**Non Urgent Patient Transport Service (NSL)**

The Joint Quality Committee was advised that the 3 year contract with NSL Care Services terminates on the 31st July 2016. NSL has made a strategic business decision to withdraw from the Patient Transport Service market. The CCG was appraising various options to ensure continuity of service delivery post 1st August 2016 on a Staffordshire-wide basis. The CCG would undertake market engagement events with providers ensuring there was robust patient involvement.
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North Staffordshire Combined Healthcare NHS Trust (NSCHT)
Following the Comprehensive Inspection, the Trust were awaiting the final report from the Care Quality Commission (CQC) which would be presented and discussed at the Quality Summit, the CCGs Director of Nursing and Quality would be attending. Members were advised of work being undertaken by the Trust to improve the waiting times within the Child and Adolescent Mental Health Service (CAMHS).

Staffordshire Doctors Urgent Care (SDUC)
Workforce assurance continued to be an area of focus and discussion at the Clinical Quality Review Meetings with SDUC. Whilst the service continued to have above the minimum safe staffing levels on duty there were high volumes of patients using the service.

Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP)
Members received assurance that community hospitals safe staffing had been maintained during October / November 2015 across the community hospital in-patient wards. In addition, members noted that an announced visit was carried out by the CCG on the 17th December 2015 to the inpatient wards at Bradwell Hospital. There were no concerns requiring escalation at the time of the visit.

University Hospital of North Midlands (UHNM)
The Quality Committee received assurance that the 12 hour breach (quality) framework had been re-enacted from last year. Patient safety visits to Accident and Emergency with UHNM and the CCG were undertaken to seek assurances with regards to the safety of care delivered in A&E and to provide constructive recommendations and support for improvement. The Committee received assurance that there were no immediate concerns and a range of good practice was evident and noted.

The Governing Body duly received and noted the Quality Open Report.

12.1 Update on Patient and Public Involvement

SP presented the report to provide a summary of progress in relation to the Patient and Public Involvement. Details as follows:

Patient Congress Update
SP advised that the Patient Congress met in November 2015 and in January 2016. November’s Congress discussed the GP Out of Hours and Front of House Design programme and was asked what they would like to see considered in the Northern Staffordshire Five Year Strategy proposals. January’s Congress had an update on the My Care My Way consultation and gave feedback on how future consultations could be improved. The next Patient Congress meeting would be a joint meeting with North Staffordshire Patient Congress, looking at the Voluntary and Community sector.

Patient and Public Involvement Steering Group Update
A review of both the PPI Steering Group and Patient Congress would be undertaken in line with the new committee structure.

CCG Membership Scheme
SP confirmed that there were currently 1,939 people in the CCG membership scheme. Work was ongoing with CSU colleagues during Q4 to focus recruitment, to ensure that there was adequate representation of the local population and demographics.

Wide scale engagement
A second large scale engagement event took place on 27th January entitled ‘Our Plans for Your NHS: a Community Conversation’.
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<td><strong>Working with the Local Authority</strong></td>
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<td>SP advised that the ‘Better Together’ (formally ‘My City, My Say’) campaign concluded with more than 500 local citizens engaging in conversations about services in their City. The exercise has enabled the CCG to engage on a wider footprint across the City, asking the same questions which were posed at the engagement event on 30th June.</td>
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| **Recruitment to the Head of Communication and Engagement** |
| SP advised that as part of the Management of Change process, a new Head of Communication and Engagement would be recruited to support and work across both Stoke-on-Trent and North Staffordshire CCGs. |

| **The Governing Body duly noted the contents of the report.** |

| **12.2 Second Citizens Jury** |
| SP presented the report to summarise the benefit of a Citizens Jury to the CCG as a commissioning organisation and to the patients it serves. The first jury focusing on diabetes generated several practical recommendations to improve the quality of the CCGs commissioned services which have been accepted and are being acted on. Details as follows: |

| SP advised that (1) the first Citizens Jury, convened by North Staffordshire CCG in September 2014 examined the services and experiences of people with diabetes, and resulted in a report which was published in March 2015; (2) the Citizens Jury comprised patients and interested members of the public with Lay leadership. It agreed the scope of the investigation and works over a short period of time, and engaged collaboratively with patients, carers, clinical commissioners, service managers and healthcare professionals. It was sponsored by, but independent to, the CCGs; (3) the approach puts patients, carers and the interested public at the heart of healthcare commissioning, and provided a real opportunity for patients to lead in the shaping of future services. It demonstrated the effectiveness of lay wisdom in identifying strengths, weaknesses and opportunities for improvement of healthcare services. |

| SP highlighted the objective perspective from patients and members of the public which challenge assumptions and identify potential blind spots. It also reinforces the CCG’s culture of openness and inclusion and is based on the NHS constitutional tenet that the NHS belongs to the people. |

| SP advised that the North Staffordshire and Stoke-on-Trent Patient Congresses had proposed that a second jury should be convened. The proposals from NS CCG Patient Congress were discussed with the Stoke-on-Trent CCG Patient Congress on 5th January and it had been agreed that Mental Health should be the next topic. This was subsequently supported by North Staffordshire CCG Governing Board. |

| A discussion took place around (1) the need to the the wider engagement plan; (2) the benefits of the process and the need to ensure that value is being added; and (3) the learning from the last Citizens Jury which was available within the report on the website. |

| SP advised that the Citizens Jury costs would be met by the patient engagement budgets across North Staffordshire and Stoke-on-Trent CCGs. |

| The Governing Body duly considered the options for a second Citizens Jury proposed by the Patient Congress and supported a second Citizens Jury investigation; agreed the broad topic for the next Citizens Jury as Mental Health; and agreed that the next Citizens Jury will be jointly sponsored by both North Staffordshire and Stoke-on -Trent Governing Bodies’. |
### Agenda Item 4.1

#### 13. Transforming Care Update

WA presented the report to update the Stoke-on-Trent CCG Governing Body on the CCGs current position with regard to the progress against NHSE trajectory for reduction of the learning disability inpatient cohort for delivery in 15/16; and the Transforming Care work programme and next set of key milestones, in respect of implementing the national plan – ‘Building the Right Support’. Details as follows:

WA advised that there were 16 patients on the Stoke-on-Trent Transforming Care Register. The NHSE Trajectory stated that by the end of March 2016 there should be 10 patients on the Stoke-on-Trent Transforming Care Register. Projections indicated that the CCG was not in-line to meet this target. An action plan had been produced which identified the key risks and how the CCG would mitigate against these.

**Transforming Care Partnership**

Transforming Care planning and commissioning is now taking place on a Transforming Care Partnership basis across both Stoke-on-Trent and Staffordshire. The first meeting of the Transforming Care Partnership Board tasked with overseeing this work programme was held on 28th January. The role of the Board was to develop new models of care.

A discussion took place around (1) specialised services and the impact on the target; (2) the new patients within the systems; (3) the need to be sure that Providers were able to support the discharge; (4) the weekly meetings with NHS England; and (5) the need for the risk of not achieving the target to be included on the CCGs Risk Register. **ACTION:** LT to include if required and to discuss with IS the governance risks outside of the meeting.

SC noted the significant number of patients in Stoke-on-Trent and the need to ensure that there was sufficient grip and representation at the Board meetings.

IS highlighted the need to ensure that the financial risk to Stoke-on-Trent CCG was included within the Action tracker due to the large number of patients in the area. This should be reported to the CCG. **ACTION:** Action plan and reports to be submitted to the Joint Planning Meetings for assurance.

The Governing Body duly noted the Transforming Care Update; and noted that there are risks to achieving some of the planned discharges by March 2016 which may impact on delivery of the targets set by NHS England.

#### 14. Equality & Inclusion (standing agenda) updates for (1) EDS and (2) WRES

SC presented the report to inform the Governing Body of progress on the equality performance of Stoke-on-Trent Clinical Commissioning Group including delivery against meeting the Public Sector Equality Duty (PSED 2011). Details as follows:

SC advised that (1) a joint CCG EDS Action Plan 2015-17 had been developed to progress the recommendations detailed within the EDS Public Grading Report. This was reviewed on a regular basis at the Joint Organisational Development Committee; (2) The Equality & Inclusion Strategy 2015-17 would go out to electronic engagement, taking place with local communities of interest until April 2016; (3) Equality and Inclusion (E&I) what been delegated to the Joint Organisational Development Committee who reviewed and monitored progress on a regular basis; (4) Equality Impact & Risks Assessments (EI&RAs) were a primary source for demonstrating how the CCG had considered legal duties under the Human Rights Act 1998, The Equality Act 2010 and the Public Sector Equality Duty 2011; and (5) the next joint EDS public grading (held with North Staffordshire CCG) on the 17th May
### Agenda Item 4.1

2016 would focus on EDS Goal 2: Improved patient access and experience.

SP advised that at the Public Grading Event the CCGs had received either good or requires some improvement across the goals. Helpful recommendations had been received from the panel and workstreams had been created to embed these through the process. There was acknowledgement from the panel that it was evident that both CCGs were trying to ensure the process was correct and wanted to fulfil their obligations fully.

The Governing Body duly noted (1) A joint CCG EDS Action Plan 2015-17 had been developed and reviewed on a regular basis at the Joint ODC; (2) The Equality & Inclusion Strategy 2015-17 would go out to electronic engagement early January until April 2016; (3) Equality and Inclusion (E&I) was delegated to the Joint ODC; (4) Equality Impact & Risks Assessments (EIRAs) were a primary source for demonstrating how CCG have considered legal duties under the Human Rights Act 1998, The Equality Act 2010 and the Public Sector Equality Duty 2011; and (5) The RAG status of EDS & WRES website display ‘compliance with NHS England’ of our larger providers.

#### 15. Consultation: Draft Stoke-on-Trent Joint Health and Wellbeing Strategy & the Adults’ and Children and Young People’s Strategic Plans 2016-20

SC presented the draft strategies. Details as follows:

SC advised that she was now a member of the Health and WellBeing Board and the additional place for the CCG on this Board was welcomed.

The two strategies were currently out for consultation and were available on the Stoke-on-Trent City Council website. There was a deadline of the 21st February for any comments and a link would be included on the CCG website. **ACTION:** FsaD to add the link to the strategies.

SC advised that the strategy and plans had been developed in line with national guidance and local needs, and were aimed at improving health and wellbeing outcomes for the people of Stoke-on-Trent. The views of young people, adults, carers, families, staff, professionals and the wider community had been gathered as a result of a series of stakeholder engagement events and public consultation that took place during Autumn 2015, and had been integral to the development of these documents. It was important that the CCG Governing Body supported these areas through the plans.

It was agreed that key commissioning areas would provide responses. **ACTION:** RB to circulate documents to commissioners. CH to coordinate CCG response.

The Governing Body duly received and noted the Consultation: Draft Stoke-on-Trent Joint Health and Wellbeing Strategy & the Adults’ and Children and Young People’s Strategic Plans 2016-20.

#### 16. Questions From The Public

Ian Syme raised concerns around the poor performance compared to other similar areas for Cancer and questioned how the CCG was planning to ensure that the targets were met.

SF highlighted the contractual levers that had been implemented and the work with UHNM to improve the performance. There was ongoing work with Primary Care to ensure that the pathways worked quickly and efficiently. Once patients were in the pathways the service was quick as UHNM operated a ‘one stop shop’.

SC highlighted the capacity and workforce issues and the national issue in relation to recruitment. The
CCG was not complacent and an update would be included within the next report to the Governing Body.

Ian Syme questioned how the contract lever penalties being returned to the Department of Health would impact the CCG. Previously these could be reinvested.

IS advised that there had been no effect this year. The question had been asked to NHS England following the recent notification. The impact for the following year was unclear. Full understanding would be available from April.

Ian Syme queried if the CCG had received concerns in relation to safeguarding referrals, following soft soft intelligence received from Social Workers.

JD advised that no concerns had been raised to the CCG or to the CCG Adult or Child Safeguarding Nurses but this would be investigated. Both had close contact and daily communication with the Local Authority and Providers, and were members of the Safeguarding Boards.

Dave Blackhurst questioned if audits had been undertaken to check the welfare of patients who had breached the two week referral target. If referrals were too high for Royal Stoke had other Providers been explored.

SF advised that assurance would be sought from the Provider, however it was unlikely to impact on the outcome as even patients who have breached the two week deadline would be very unlikely to breach much beyond seven days of the target. Alternative Providers had not been sought as it was recognised that the NHS provided the best service for Multi-Disciplinary Teams.

Dave Blackhurst queried the Joint Investigation undertaken.

SF advised that the Joint Investigation was instigated following a lack of clarity around the issues. It provided an opportunity for the Provider and Commissioner to work together to understand the issues. This then formed part of the Remedial Action Plan. Once the Joint Investigations were completed an Improvement Plan would be agreed. However actions would be identified and implemented prior to this process being completed to improve the performance.

FsaD advised that following the recent termination of the Uniting Care contract in Cambridge and Peterborough, NHS England had commissioned an independent review to find the key facts and causes behind the collapse of the contract. Lessons learned from the review would be used to make sure that the cancer and end of life contracts were robust and sustainable. Commissioners would continue with the work on both procurements but would not enter into any contractual commitments until the learning had been identified.

18. Date, time and venue of next meeting

Tuesday 5th April 2016 at 1.30pm in The Minton Room, Stoke-on-Trent CCG, Herbert Minton Building, 79 London Road, Stoke-on-Trent.

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.
### Action Tracker 5th April 2016 (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>
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<tbody>
<tr>
<td>2nd February 2016</td>
<td>9.</td>
<td>Governing Body Assurance Report</td>
<td>Cancer SC advised that a robust action plan was in place and there was continuing work with IST. However improvement actions were needed, these would be raised through the Planned Care and CQRM meetings for escalation.</td>
<td>Dr Steve Fawcett</td>
<td>Completed</td>
</tr>
<tr>
<td>2nd February 2016</td>
<td>9.</td>
<td>Governing Body Assurance Report</td>
<td>Mental Health The two additional mental health targets to be included within the report to the next meeting.</td>
<td>Dr Waheed Abbasi</td>
<td>These will be included once the data is available after April.</td>
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| 2nd February 2016  | 13.       | Transforming Care Update              | The risk of not achieving the target to be included on the CCGs Risk Register.  
Discuss with IS the governance risks outside of the meeting.  
To ensure that the financial risk to Stoke-on-Trent CCG was included within the Transforming Care Action Tracker. Action plan and reports to be submitted to the Joint Planning Meetings for assurance. | Lisa Taylor, Dr Waheed Abbasi | Dr Waheed Abassi reviewing this risk and the request for consideration on the CCG Risk Register. Full action plan to be submitted to April Governing Body meeting, where further discussion will take place. Completed - Action tracker included within the Governing Body agenda. |
| 2nd February 2016  | 15.       | Consultation: Draft Stoke-on-Trent Joint Health and Wellbeing Strategy | To add a link to the strategies from the CCG website.  
To circulate the documents to commissioners. CH to coordinate CCG response. | Filippa St Aubin D’ancey, Rachel Barker, Cheryl Hardisty | Completed. Response provided to the Local Authority. |
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<th>AUTHOR</th>
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<tr>
<td>Name</td>
<td>Rachel Barker</td>
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<td>Title</td>
<td>Executive Assistant</td>
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<td>Name</td>
<td>Dr Ruth Chambers OBE</td>
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<td>CCG Chair</td>
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**REPORT TO**  
Stoke-on-Trent CCG Governing Body

**TITLE OF REPORT**  
Chair’s Report

**DATE OF THE MEETING**  
5th April 2016

**WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?**

<table>
<thead>
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**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD**

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<th>Approve</th>
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**RECOMMENDATION**

The Governing Body is requested to note the Chair’s Report.

**STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER**

*(identify appropriate goals)*

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
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<tbody>
<tr>
<td>1. Improve access</td>
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<tr>
<td>Purpose of the Report, Key Points, Outcomes, Executive Summary</td>
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<td>---------------------------------------------------------------</td>
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<td>This report will provide an update to the Governing Body around the current environment that the CCG has been operating in.</td>
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<th>Summary of Risks Relating to the Proposal</th>
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<th>Quality Impact Assessment and/or Equality Impact Assessment</th>
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<th>Any Related Work with Stakeholders/Practices/Public and Patient Engagement</th>
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<th>Acronyms</th>
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Introduction
The CCG continues to work closely and effectively with its system partners during this nationally difficult time across both the health and social care economy and I would like to acknowledge the outstanding efforts across the CCG and in collaboration with our partners.

The key priorities remain around the pressures in urgent care, the NHS constitutional standards, the financial position and the financial recovery plan and the Pan Staffordshire Transformation Programme.

I am, 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.

Collaborative Working
Further progress has been made on collaborative working with North Staffordshire CCG in moving towards an integrated executive and management structure. Staff have transitioned into the new structure and organisational arrangements form the 1st April 2016 following the conclusion of the Management of Change process. The CCGs are exploring co-location options.

Whilst the executive, clinical and managerial workforce; and the committee structure will be shared by both CCGs, this is not a merger and both CCGs will remain sovereign bodies with their own Governing Bodies, Chair’s and Accountable Officers.

Executive Staffing
Following a robust interview process I am pleased to announce that Becky Scullian has been appointed as Interim Deputy Director of Commissioning. Becky commenced in this role in March.

The recruitment of the Director of Commissioning and Director of Strategy, Planning and Performance posts commenced in January, with final interviews scheduled for 22 / 30 March 2016.

Cheryl Hardisty has previously been appointed to the Director of Commissioning post on an interim basis until a substantive appointment is made.

Noreen Dowd will continue as Interim Director of Strategy, Planning and Performance until a substantive appointment has been made. This will ensure that we have the required senior leadership through the forthcoming annual planning round.

Following the Management of Change process Stoke-on-Trent CCG has one Clinical Director vacancy and North Staffordshire CCG has one Clinical Director vacancy, posts which will sit on each respective Governing Body, as well as forming part of the single executive team across both CCGs. The recruitment process has commenced with interviews scheduled to take place on the 13th April 2016.

NSL
I wish to inform you that on the 9 February 2016 Midlands and Lancashire CSU issued an exception report on behalf of Commissioners to NSL Limited. The exception report was issued to NSL Limited as the remedial action plan agreed following the issue of performance notice (PN05) was breached and not rectified within the last five operational days.

The exception report informed NSL Limited that 1% of the actual monthly contract value would be withheld as per general condition 9 and that commissioners would allow a period of 25 operational days (until 15 March 2016) for NSL Limited to rectify the breach of the remedial action plan. If they were unable to rectify
the breach within the time period a second exception report would be issued informing them that money would be withheld permanently.

On the 23rd March 2016, Midlands and Lancashire CSU on behalf of Commissioners issued a second exception letter to NSL Limited in relation to PN05 informing them that as the breach was not remedied, in accordance with general condition 9.4, the money will now be permanently retained. The sums within the agreed Remedial Action Plan will continue to be deducted from the actual monthly contract value until the breach is rectified. Copies of exception letters issued are enclosed (Appendix 1).

**Staffordshire Transformation Programme**

I am pleased to confirm that John MacDonald, has been appointed to the role of Chair of the Staffordshire Transformation Programme. John will undertake this role in addition to his role as Chair of University Hospitals of North Midlands and will start his new role with immediate effect and will be chairing the Transformation Board meetings. Penny Harris will also be joining the Transformation Programme Team on 4 April as Director of Transformation. I am sure you will all join me in welcoming both John and Penny and the CCG looks forward to working with them both.

**Healthwatch**

Val Lewis has announced her resignation as Manager of Healthwatch Stoke-on-Trent and will leave on 29th April 2016. The Governing Body would like to take this opportunity to thank Val, for her continued support and commitment shown to the Governing Body and the local population. Val has been in attendance as an observer at our Governing Body meetings and has always provided positive contributions to the meetings providing local focus and impartial, impactful and measured responses on behalf of patients and service users.

We would like to wish Val success in her future endeavours.
23rd March 2015

Dear Mr Raisbeck

Outcome of Exception Report relating to Performance Notice Ref: PN05

This letter is issued by NHS Midlands and Lancashire CSU acting on behalf of the Commissioners to NSL Limited (the "Provider") under General Condition 9 (Contract Management) of the Contract for the provision of Services between the Provider and the Commissioners (the "Contract").

The Exception Report was issued because the remedial action plan agreed following issue of contract query ref: PN05 had been breached.

As this breach has not been remedied, in accordance with General Condition 9.24, the withheld money will now be permanently retained. The sums within the agreed Remedial Action Plan will continue to be deducted from the actual monthly contract value until the breach is rectified.

Yours sincerely

Elizabeth Johnson
Contract Officer
9th February 2016

Dear Mr Raisbeck

Exception Report Re: Performance Notice: PN05

Please see the enclosed exception notice for your attention.

Yours sincerely

Elizabeth Johnson
Contract Officer
Exception Report re Performance Notice ref: PN05

This Exception Report is issued by NHS Midlands and Lancashire CSU acting on behalf of the Commissioners to NSL Limited (the “Provider”) under General Condition 9 (Contract Management) of the Contract for the provision of Services between the Provider and the Commissioners (the “Contract”).

This Exception Report has been issued because the remedial action plan agreed following issue of Performance Notice ref: PN05 has been breached and this breach has not been rectified within the last 5 operational days. Commissioners consider that the Provider has breached the remedial action plan because submissions relating to the contract performance for December 2015 did not meet the targets within the agreed remedial action plan.

The consequence for failure against this action plan is that Commissioners shall withhold 1% of actual monthly contract value with immediate effect. (General Condition 9.23)

In line with General Condition 9, Commissioners shall allow a period of 25 operational days (until 15th March 2016) for NSL Limited to rectify the breach of the remedial action plan. Should NSL Limited be unable to rectify the breach within this period, Commissioners shall issue a second exception report.

Date 09th February 2016

Signed

Elizabeth Johnson
Contract Officer
NHS Staffordshire and Lancashire CSU
ENCLOSURE: 6

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<td>Dr Andrew Bartlam</td>
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REPORT TO: Stoke-on-Trent CCG Governing Body

TITLE OF REPORT: Clinical Accountable Officer’s Report

DATE OF THE MEETING: 5th April 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

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RECOMMENDATION

The Governing Body is requested to note the Clinical Accountable Officer’s Report and ratify the decisions made at the Sub Committees in particular the ratification of the Voluntary Care Strategy (attached at Appendix 1).

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER

(identify appropriate goals)

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### PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY

This report will provide an update to the Governing Body around the current environment that the CCG has been operating in and an update of the business undertaken at the Sub-Committees Chaired / Vice Chaired by Andrew Bartlam.

### SUMMARY OF RISKS RELATING TO THE PROPOSAL

None

### ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS

None

### QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

Date completed, please highlight any direct or indirect implications

None

### ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT

Provide further information, including dates if applicable

None

### ACRONYMS

If not listed in the report, please list

N/A
DIRECTION
Health and WellBeing Board
Stoke-on-Trent Health and Wellbeing Board brings together key health and care organisations to improve the health of local people and ensure fair access to services and is managed by Stoke-on-Trent City Council. The board meets to understand local needs, agree priorities and ensure that NHS organisations and the council work more closely, this includes commissioning services together where possible.

The Board’s key functions are:
• To undertake a Joint Strategic Needs Assessment (JSNA);
• To develop a Joint Health and Wellbeing Strategy;
• To ensure that the commissioning plans and activities of Clinical Commissioning Groups and the City Council are consistent with JSNA and the Health and Wellbeing Strategy;
• To support development of Joint Commissioning, Integrated Delivery and Pooled Budgets;
• To assess needs for pharmaceutical services in its area, and publish a statement of its first assessment and of any revised assessment; and
• To encourage integrated working under the Health and Social Care Act.

I am pleased to advise that both myself and Sandra Chadwick, CCG Chief Operating Officer are now voting members of the Health and WellBeing Board. The additional seat is welcomed by the CCG Governing Body to ensure that we have the right representation at meetings.

The Joint Health and Wellbeing Strategy 2016-20 and plans and the Staffordshire And Stoke-On-Trent Adult Safeguarding Partnership Board 2014-15 Annual Report were presented at the December meeting of the Health and WellBeing Board. The Joint Health and Wellbeing Strategy 2016-20 and plans have been developed in line with national guidance and local needs, and are aimed at improving health and wellbeing outcomes for the people of Stoke-on-Trent. The views of young people, adults, carers, families, staff, professionals and the wider community had been gathered a result of a series of stakeholder engagement events and public consultation that took place during Autumn 2015, and had been integral to the development of these documents. The draft Strategy was available for public consultation and comments on the Stoke-on-Trent City Council website. The draft strategy was also presented at the February meeting of the Stoke-on-Trent CCG Governing Body for review and discussion by members and following the meeting feedback was collated and provided. Following approval at the Health and WellBeing Board the strategy will be published on the Stoke-on-Trent CCG City Council website:


Nominated strategic leads will take responsibility for the progress and performance of each priority working with partnership groups to deliver the actions set out in this strategy. The Health and Wellbeing Board will monitor progress against defined indicators and measures for each priority through its performance management framework.

An annual report will be produced showing performance and identifying any areas that need to be reviewed or further action is required.

My Care, My Way – Home First
The formal consultation exercise on My Care, My Way – Home First ended on 17 January 2016. The public consultation and continuing engagement will run in parallel with the continued implementation of new services and care pathways. Feedback from the public, staff, external advisory and scrutiny bodies will be incorporated into final proposals and will help to shape services going forward. Following the close of the
consultation and the review of the findings a report has been presented to the Executive Management Team at both Stoke-on-Trent and North Staffordshire CCG’s. External validation will now be undertaken with recommendations provided to both Stoke-on-Trent CCG and North Staffordshire CCG Governing Bodies following consideration by commissioners. There will be further specific consultation prior to any changes to existing services or bed provision. The report will also go to the local authority scrutiny committees. Following the close of the consultation and the review of the findings a report will be published.

**Pan Staffordshire Transformation Programme – ‘We’re Better Together’**
Feedback has been received from NHS England and NHS Improvement on the Case for Change and further work is required in a number of areas to provide the required level of assurance. The system response over the coming weeks and months is critically important and there will be some refocusing on key areas of improvement and strengthening of governance arrangements.

There needs to be a clearer vision for the programme and detail about what will be different, and greater provider involvement in the work streams and programme leadership, with an explicit focus on the urgent care system, more detailed finance and activity modelling and strengthened programme management arrangements.

A general concern is about pace and that we deliver real change next year. There is a renewed emphasis on identifying some key priorities that we can demonstrate we can deliver. One such area is an enhanced community offer across health and social care that builds on the new models of care set out in the Five Year Forward View. A very tangible demonstration of our ability as a system to change would be the agreement and implementation of a single overarching model for Staffordshire and Stoke on Trent with localised roll out covering our population next year.

As the case for change will inform the Staffordshire and Stoke on Trent Sustainability and Transformation Plan (STP), there is a lot of work to do to get us to a credible STP by the end of June. There is significant support from outside of the NHS to help us deliver a credible STP, which is critical to secure the national transformational monies that will come with a signed off STP.

**DELIVERY**

**A&E**
The urgent care system continues to attract local and national attention due to the continued non-attainment of the 95% 4 hour quality metric. Contractual processes have been followed, with the issuing of a contract performance notice and the formation of a remedial action plan. The CCGs have withheld 1% of the contract line, as 95% was not attained for October 2015 and 1% of the contract line, as 90% was not attained for November and December 2015 and January 2016 (as per the remedial action plan).

You will note from the Integrated Performance Report, that performance has deteriorated since August 2015 and the January 2016 performance (77%) is the worst position year to date.

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<tr>
<th>A&amp;E waiting time - total time in the A&amp;E department</th>
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<td>Fee hour wait</td>
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<td>Percentage of patients who spent 4 hours in A&amp;E</td>
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Resultantly, the CCGs have refreshed the structure of the Urgent Care PMO and facilitated the construction of the Local Health Economy Emergency Care Improvement Plan (LHE ECIP). The LHE ECIP Plan is managed by the Unscheduled Care Delivery Group (UCDG) and reports progress and impact through a robust governance process, ultimately to the Systems Resilience Group (SRG). The diagnostic of the system has been completed.
and the ECIP Concordat has been agreed and signed off. The vision for the system has been agreed and the high impact changes defined (Assess before Admission, Todays work today, Discharge to assess). The high impact actions within these areas are: Exemplar Front Door, Ambulatory Emergency Care, Frailty, Step Up, Therapies, Exemplar Ward, Home First and Step Down. ECIP continue to support the system with each of the high impact changes.

**Referral to Treatment (RTT)**

18 Weeks performance remains an area of concern. The focus for 18 Weeks RTT is on incomplete pathways, which means that 92% of patients on all waiting lists must have waited less than 18 weeks. Performance falls short of the required standard. An improvement plan was submitted to NHS England on 19 February 2016, with a number of key actions and an improvement trajectory to achieve the target. The CCGs will continue to work with UHNM and our other providers to ensure this it is successfully implemented and delivers the required improvements.

The diagnosis of the problems faced at University Hospitals North Midlands highlights the impact of trauma activity on the trauma and orthopaedics specialty, theatre and critical care capacity and workforce, and specialty demand in a number of areas. The improvement plan focusses on capacity (capacity modelling, increased use of the County Hospital, use of alternative providers), workforce (critical care and theatre workforce plan) and pathway redesign, e.g. colorectal.

As a system we have established a new, robust governance framework and have sought external support from the National Improvement Support Team, to, for example, carry out a utilisation review of theatres. Additionally, the CCGs are implementing Map of Medicine (a decision making and referral tool) in primary care to help manage demand.

**Cancer**

Cancer RTT standards remain a continued cause for concern, although at the time of writing this report we are on trajectory to deliver all standards by the end of March 2016, further detail is included within the Assurance Report. A cancer Remedial Action Plan (RAP) is in place with clear actions, trajectories and targets for improvement detailed. This is being monitored through the contract management arrangements with UHNM.

Key actions set out in the RAP include continued review of pathways, increased capacity for challenged pathways, e.g. colorectal, urology and lung, a separate cancer activity plan in the contract with the Trust and a primary care led improvement programme, incorporating education and peer review.

**Financial Recovery**

The CCG continues to maintain a tight grip on its financial position albeit it has faced significant challenges throughout the course of the financial year. A fortnightly Financial Recovery Group, held jointly with North Staffordshire CCG actively reviews these challenges and the risks that they pose in delivering to the CCGs financial control total. The close scrutiny of performance against the CCG’s Financial Recovery Plan (FRP) allows for closer scrutiny and ‘deep dive’ into specific areas of concern.

In addition, Alistair Mulvey, our internal Turnaround Director, provides the CCGs with the required grip both on the achievement of this year’s FRP and the development of robust plans for 2016/17 and 2017/18. Alistair chairs the Performance and Delivery Steering Group, which meets weekly to both support and hold to account the leads for the schemes that constitute the FRP.

One of the main issues that the FRG and the CCG has grappled with over the course of this financial year is in terms of financially transacting the implications of the step up and step down services. Whilst significant mitigation has been undertaken to date there still remains a financial gap which is likely to impact on the CCG’s delivery to its financial control total.
A comprehensive review of this year’s financial position and indication of the plan for next year is contained within the Chief Finance Officer’s Report.

Planning Round
The CCG is in the final stages of the 2016/17 planning. We have met all NHS England submission deadlines and have been in regular correspondence to ensure that the final submission on April 11th is of robust quality and meets all the necessary requirements.

DEVELOPMENT

Chairs Reports
The recommendations captured in this report provide the key highlights of the business undertaken since the last Governing Body at two of the Governing Body’s sub-committees chaired / vice chaired by myself as the Clinical Accountable Officer, namely:

- Joint Planning Committee
- Joint Organisational Development Committee

Joint Planning Committee Meeting on the 12th January 2016
The Governing Body is asked to note the items of business discussed at the meeting on the 12th January 2016
(1) Draft Joint Strategy Update; (2) Inequalities and Healthcare; (3) FRP / QIPP; (4) Pan Staffordshire Update (Case for Change); (5) Finance Update; (6) Contracting Update; (7) Planning Guidance 2016/17; and (8) Primary Care Prescribing Budget Report 2016/17.

Inequalities and Healthcare
Reducing health inequalities is a legal duty for the NHS as defined in the NHS Health and Social Care Act 2012. The NHS Five Year Forward View emphasised the importance of the role of the NHS in the prevention and reduction of health inequalities. The document noted that whilst the NHS has dramatically improved over the past 15 years, the quality of care that people receive can be changeable, preventable illness is widespread and health inequalities are deep-rooted. More than half the inequality in life expectancy is linked to higher rates of smoking in deprived populations.

Whilst it is clear that the NHS has a role in prevention and reducing health inequalities the biggest impact will be achieved through tackling the root causes of health. The Health and Wellbeing Strategy for Stoke-on-Trent aims to improve health in its widest sense and address the social determinants of health through all partners. This document is a supportive document for the wider Health and Wellbeing Strategy.

The Joint Planning Committee duly received and noted the proposed targets and recommendations for reducing health inequalities.

Joint Planning Committee Meeting on the 9th February 2016
The Governing Body is asked to note the items of business discussed at the meeting on the 9th February 2016
(1) Finance Update and Planning Guidance 2016/17; (2) Contracting Update; (3) Pan Staffordshire Update (Case for Change); (4) Primary Care Strategy; (5) Voluntary Sector Strategy; (6) Personal Health Budgets; (7) Walk In Centre Review; (8) QIF (Quality Improvement Framework) /QOF (Quality and Outcomes Framework) XL 2016/17; and (9) CCG LIS Scheme.

Primary Care Strategy Update
The Northern Staffordshire Primary Care Strategy sets out Stoke on Trent and North Staffordshire CCG’s vision for Primary Care for 2015-2020. It is aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire, supported the Staffordshire
Transformation Programme, ‘Together We’re Better’ and built on the new opportunities provided through primary care co-commissioning.

The Joint Planning Committee duly approved the Primary Care Strategy update.

Voluntary Sector Strategy (VCS)
CCG commissioning of the VCS has been fragmented with differential investment strategies and inequity in the level of support and engagement. The strategy seeks to establish a clearly aligned direction of travel for the future to enable the CCGs to commission collaboratively to achieve parity and efficiency and maximise value for money, impact and outcomes delivered.

The co-produced strategy, developed by the CCGs with Voluntary Action Stoke on Trent (VAST) and Support Staffordshire, sets out a new relationship with the sector with a commitment to work collaboratively and in an integrated and co-ordinated manner to improve access and outcomes for patients and local people.

The full strategy is enclosed as Appendix 1 for members review.

The Joint Planning Committee duly accepted the Voluntary Sector strategy proposal subject to comments from members.

The Governing Body is therefore requested to ratify the decision of the Planning Committee.

Walk In Centre Review
A review was undertaken to understand the effectiveness of the services in both North Staffordshire and Stoke on Trent CCG, specifically looking at two key elements (1) registered patients at both sites. As commissioners with NHS England we have to provide core medical services to this cohort of patients on a long term basis, an aim of the review will be to scope out potential alternative solutions to ensure patients’ needs are met; and (2) the walk-in element of service and the impact this service has on A&E admissions, whether access to the service meets needs and if in the long term this service is sustainable and the service is in the right area.

The Joint Planning Committee duly noted the progress on the Walk in Centre Review.

QIF (Quality Improvement Framework) /QOF (Quality and Outcomes Framework) XL 2016/17
The Quality Improvement Framework (QIF) has been developed as a continuation of the previous schemes of QIF in Stoke-on-Trent and QOF XL in North Staffordshire. Both schemes have historically focused on improving health outcomes and addressing health inequalities within the Clinical Commissioning Groups (CCG) respective populations. The 2016-2019 scheme aligns the QIF and QOFXL from the two Clinical Commissioning Groups to provide a consistent approach across northern Staffordshire.

The Committee was asked to approve the scheme presented for 2016-17 and to note the intention to review the indicators 2017-19 once the uncertainties about the future of QOF (Quality and Outcomes Framework) were resolved. The payment structure for the scheme would also be reviewed annually to ensure payments remained within the financial envelope.

The Joint Planning Committee duly accepted the proposal which would be passed to the NHS England Area Team for approval and be revisited next year.

Organisational Development (OD) Committee
The Governing Body is asked to note that no meetings have been held since the last meeting of the Governing Body. The next meeting is scheduled on the 31st May. An update will therefore be included within June’s CAO Report.
Investing in Healthy Communities

A Strategy for Effective, Sustainable and Successful Commissioning by the Local NHS of the VCSE Sector in North Staffordshire

Dec 2015 v12
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Introduction
In early 2015, the Clinical Commissioning Groups (CCGs) in both Stoke-on-Trent and North Staffordshire (Newcastle-under-Lyme and Staffordshire Moorlands) in dialogue with Support Staffordshire and VAST initiated a review of its investment in non-NHS provided services to the local community. This included investments in voluntary, community and social enterprise (VCSE) organisations engaged in a wide range of service delivery.

Some of this investment was in the form of relatively traditional grants, whilst others were contracts or service level agreements. The degree of service specification varied significantly, as did reporting against those specifications. Over £5.5 million is currently invested with over £2.5 million being invested in End of Life and Palliative care and support. The remainder is a mix of contracts and grants focused around, Mental Health, Older people and specialist interest groups. Currently contracts vary in size from £9,000 to over £800,000 across 29 different providers, with the majority of investment in single organisations. Investments are largely in organisations with a local track record and have been in existence for a number of years and may not reflect current or emerging needs and priorities. There is a need for clarity about outcomes with appropriate measures and reporting. The current reporting systems prevent true values being reported and this is lost to commissioners. There is a need for contract efficiency moving forward.

The aim of this document is to outline a clearer, transparent and consistent approach to future investment in communities and neighbourhoods.

We seek to also influence key strategic partners in NHS provider bodies, other health and social care agencies, and related services such as local policing and independent investors/funders. This is not to constrain or reduce the diversity of funding available, but to encourage where possible, an approach that reduces duplication, maximises efficiency, minimises repetition and makes more effective use of what are shrinking funds for most public service investors.

The Five Year Forward View sets a clear direction of travel that includes the VCSE sector. It describes an environment of co-commissioning that underpins the Better Care Fund and a direct shift from the acute medical model to an anticipatory, social, preventative model, one which the sector has much experience in delivering. Integration of Health & Social care offers huge potential opportunities for the sector but one where the sector needs to respond proactively in order to reap the benefits of the changing environment.

Sheila Crosbie, North Staffordshire CCG         Garry Jones, Support Staffordshire
Dave Sanzeri, Stoke CCG                        Lorien Barber, VAST
Strategic direction and policy drivers

Two key national perspectives have emerged in recent months that have a significant bearing on this strategy.

1. NHS Five Year Forward View: Stronger partnerships with charitable and voluntary sector organisations

*When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.*

*With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self management educational courses, as well as encouraging independent peer-to-peer communities to emerge.*


The challenge to the local Health Economy and VCSE is to enable this market for services that meet current and future needs. Currently the majority of spend relates to rolling grants or contracts with repeated delays in confirmation of roll forward and release of funds that puts services and organisations at risk and makes it difficult to plan and participate in planning, both internally and with the local health economy.

The VCSE is clearly referenced in other local strategies which recognise the role that the VCSE can play in delivering education for specific needs and navigation and care co-ordination roles to support individuals to personalise the care that they need with the access that allows them to maximise the effectiveness of health & social care interventions in their health and wellbeing; however, although well referenced, there are currently no clear mechanisms for investing in the sector and it is not clear how this will be enabled.
2. In the current Joint Review of Investment being carried out by DoH, NHS England and Public Health England, their interim findings show that:

Integrated personal health and care budgets have an important role to play in driving resources towards holistic, locally-rooted and personalised approaches, providing they allow real choice, are introduced alongside a provider market development programme and comprehensive information system and as part of the wider culture shift towards collaborative care. They also therefore have the potential to be an important driver for resources towards the VCSE sector, where VCSE organisations are genuinely coproduced, have strong community relationships and have access to local marketplaces. It is not always necessary to expand individual organisations in order to achieve scale: personal budgets have demonstrated it is possible to create systems which enable personalised and small-scale approaches to become widespread rather than needing necessarily to grow individually.

Independent brokerage and advocacy to support personal budgets is imperative to market development and choice for the individual, as are clear and co-ordinated referral and signposting routes into services.

A programme of delivery for Personal Health Budgets is required across the local health economy by the end of March 2016.

North Staffordshire and Stoke-on-Trent CCG Priorities for Healthy Communities

The two CCGs have established their visions for local communities independently, however 5 shared themes emerge:

- Support people to live independently
- Give people the best support when they need it most
- Help people to stay well
- Work better together for the people who we serve
- Use our resources to maximum benefit.

The commitment in the local health economy is to move a significant amount of service taking place within the acute sector to be provided within the community and the focus of that activity will be to support people to remain living independently in their homes for as long as safely possible. Home First, Reablement and assessment at the lowest
level of dependency and Integrated Local Care are all clear directions of travel, in which the VCSE is expected to play a full and active role to enable delivery.

People will be supported to acquire the knowledge and capability to take best care of themselves, and to make the most of their health and improve their wellbeing. If, however, people become unwell and/or their needs became complex, they will be supported in the community to make sense of their physical and mental health needs, and to improve their circumstances. If a person requires acute hospital care for a period of time, the first objective of those that support them in the acute setting, would be to help them to return home.

The commissioning of services must be joined up. Innovative new commissioning methods must be adopted to ensure that providers work together to provide integrated, coordinated services that offer consistent support for people on their journey to good health and independence, regardless of whether they require an acute or community response. This also applies equally to the local VCSE.

The range of services that combine to form the local health economy; including the VCSE, will be properly coordinated to ensure that they work well together, provide best value for money, and deliver excellent outcomes for the people that use them, even under circumstances of high pressure.

The CCGs in conjunction with Public Health and with active engagement in the Health and Wellbeing Boards are committed to ensuring health outcomes are continually improved, health inequalities are reduced and to shift care and resources from treatment to prevention. CCG's are not the direct commissioners of public health or prevention services but acknowledge prevention is the key to better outcomes for the local population.

“A greater focus on prevention, improved coordination and integration will require a major shift in the way that organisations represented on the Board operate. It will also require commitment and support from other organisations - health trusts, local businesses, service providers and the community and voluntary sectors - if we are to achieve the best possible services and outcomes for the residents of Stoke-on-Trent.”  Stoke on Trent Joint Health & Wellbeing Strategy 2013-15

“….. we will always look for the best person or organisation for the job. In some cases, this will mean delivering services ourselves and in others, it may mean other organisations delivering services on our behalf – particularly those in the voluntary sector.

The (Community Care) strategy will outline how local organisations will work together to meet the needs and expectations of local people. It will ensure that the services developed and delivered in partnership are modern, innovative, creative and make a real improvement to the lives of people with long term conditions.”  Staffordshire County Council Health & Wellbeing Strategy 2013 - 18
New Model of Care

The new model of care aligns with the vision for integrated health, mental health and social care, and agreed strategic priorities detailed within better care fund (BCF) plans across the Local Health Authority. BCF and other associated strategic plans (Stoke and Staffordshire) seek to deliver a whole system approach to care and support where all elements of the system work together to proactively deliver a “continuum of care” that is efficient, effective, local and personalised and “helps people to help themselves to stay healthy and well”. It requires an integrated delivery system from community and voluntary sector support through to empowering self-care and education.

The voluntary sector has a role to play in offering training, access and supporting fellow Health & Social Care professionals at all levels within the new model of care, be it palliative and end of life care; providing help at home to enable early discharge; advice, information and guidance on diagnosis; maximizing income and economic wellbeing, peer support, increasing social inclusion and reducing isolation, education and healthy lifestyle promotion for those with long term conditions and those at greatest risk of developing them. The voluntary sector is also critical to engaging those with physical and mental health conditions in meaningful activity, which is often a key method of supporting individuals back into employment and maintaining social inclusion.

The VCSE are being called on to support the Health & Wellbeing Boards and the Better Care Fund in implementing interventions addressing wider determinants of health aimed at improving life expectancy; as there is an acknowledgement that the VCSE has a large role to play in this locally. The mechanisms to shift the investment of resources to enable this are not yet clear.

To date the commissioning of the sector has largely been needs led and responsive but uncoordinated and lacking in strategic oversight and direction. This has potentially hindered the local market and not capitalised on the local skill, talent and endeavour of the vibrant local VCSE to find solutions and help drive the change toward prevention and early intervention.

The challenge to commissioners is to look for the opportunities to co-design, co-commission and coordinate for local health needs. The challenge to the sector is to offer a consistent and coherent response and be seen as a trusted service deliverer that offers more than other providers and yet can also deliver the desired outcomes of improved health for the population of North Staffordshire.
Proposal

The Local VCSE will commit to developing services that deliver:

1. **Fit & Well**
   - Healthy lifestyle information, advice & guidance
   - Social Prescribing
   - Improved access to mainstream services, reduce inequality,
   - Improved mental health and wellbeing, increase social inclusion

2. **High Risk but Independent**
   - Improved health literacy and self care
   - Prevent avoidable hospital admissions
   - Support people to live independently, including support for carers
   - Appropriate community and self-help services including peer support
   - Care Co-ordination or Care Facilitation
   - Improved access to services, reduced inequality
   - Improved mental health and wellbeing

3. **Receiving Care**
   - Prevent avoidable hospital admissions
   - Support discharge and enhance community care
   - Care Co-ordination or Care Facilitation
   - Improved access to services, reduced inequality
   - Improve mental health and wellbeing
   - Enabling people to die in the place of their choosing
   - Enhance support responses over the winter period
**Recommendations:**

1. Continue to commit to a ring-fenced small grant scheme to enable local market testing and to respond to needs led gap analysis and social prescribing.

2. Develop multipurpose vehicle / lead consortia models managed by the sector for the sector around geographic and/or thematic basis with an offer of service provision and voluntary contribution.

3. Seek to integrate current VCSE services into consortia / prime provider models for delivery.

4. Commit to a minimum of 3 year contracts to achieve measurable and sustainable outcomes.

5. Develop a social value measure and outcome framework that is evidenced based and needs led.

6. Coproduce quality standards for VCSE providers, to embed good practice and increase confidence.

7. Clinical Services delivered by VCSE organisations to be identified and fully integrated into service delivery systems in health pathways.

8. Ensure representation of the VCSE at the Health & Wellbeing Boards.

9. Ensure that the VCSE is represented at the Pan Staffordshire Commissioning Congress.

10. Develop measures and analysis of needs to inform health economy commissioning.

11. Maintain a mixed funding economy to support market development, choice and support the reduction in inequality by reaching those with poorest health outcomes.
Appendix 1

Getting the most from investing in the VCSE sector for health outcomes

Key principles of sector investment:

VCSE providers have maximum impact where commissioners:

- Value their role in understanding the needs of users – engaging with VCSE organisations as advocates for marginalised groups in addition to their provider role. Pre-procurement timetables should be sufficient to co-design outcomes for patients
- Value VCSE organisations to support community participation in addition to their provider role
- Consult with potential provider VCSE organisations well in advance of specification design to help determine clear priority outcomes for new services.
- Put outcomes for services users at the heart of the planning process. Map the full range of potential providers to gain a full understanding of the potential role that each organisation could play in delivering outcomes.
- Allow opportunities, whilst respecting intellectual property and competitive markets, for providers to market place potential solutions to difficult areas.
- Share local data regarding difficult issues widely to enable the sector to respond
- VCSE organisations are engaged in mapping communities’ needs and assets
- Recognise the value of market diversity and promote market development to meet local needs and avoid unintentional market monopolies
- Commission for outcomes and allow providers to develop new and innovative ways to deliver the outcomes.
- Invest in the capacity of the provider base, particularly those working with hard to reach groups. Approaches should be built on a comprehensive understanding of all sections of the community and in particular groups which are often overlooked or which experience health and wellbeing inequalities
- Ensure contracting processes are transparent and fair.
- Consider requiring cooperative, co productive approaches, including an expectation to work in partnership where such an approach would enhance outcomes, add social value and/or support the new model of care, where the person is placed at the centre of the care.
• Build social value into procurement to promote longevity, sustainability and broadly progressive, positive social outcomes, even where beyond the scope of the specific commission in question.

• Allow extra time and resource for building partnerships and consortia where the long term outcome will offset this upfront investment.

• Commit to longer term contracts and risk sharing as ways of achieving efficiency and effectiveness.

• Ensure paperwork & monitoring arrangements are proportionate to contract size.

• Seek feedback from service users and communities, and providers on the effectiveness of new services in meeting local needs.

• **Key Principles for the Sector to respond to:**
  
  • evidence the needs of users in all proposals
  
  • Demonstrate community participation and reach
  
  • provide evidence of coproduced outcome measures with service users
  
  • promote the variety in the sector and seek to partner with complimentary services to capacity build within the sector, both thematically and/or geographically, in a spirit of cooperation and collaboration, not competition
  
  • develop and test new innovations / ways of working
  
  • establish evidence based practices in support of commissionable activity
  
  • provide options that allow / enable commissioners to identify where social value & health economic returns exist.

  • identify and demonstrate the added value of voluntary sector service provision

  • seek to lever in additional investment to add resource and value to local commissioning for the benefit of service users and their identified health and wellbeing needs.

**Benefits of investing in Communities through the VCSE sector:**

VCSE Organisations have a track record in providing services that:

• Are designed to meet identified need locally, where people live and work, through a collaborative approach to designing services with the service users.
• are holistic and person centred, solving whole lifestyle issues, rather than just treating through individual clinical interventions resulting in long term, sustainable solutions.

• reach individuals who would otherwise remain unsupported, untreated and ultimately become more unhealthy and costly in clinical terms

• are fair and inclusive

• empower individuals to make decisions about their own health and wellbeing, encouraging independence and sustainable outcomes

• are outcome focused irrespective of short term targets

• are innovative, willing to try new ways of working and learn and share experience

• people trust and are willing to invest their own time and effort into

• are efficient and good value for money

• involve local volunteers, families, friends and carers, increasing social value in the local area

• are accountable to the people they serve locally

• maximise collaborative advantage and minimise competition, duplication and wasted effort
**Strengths of the voluntary sector in shaping and delivering public services**

Many voluntary organisations have pioneered the services they provide – by being the first to identify and meet a need and then persuading the state to take responsibility for making the necessary services universally available. Charities are also often founded by people with direct experience as service users, or have services users on their trustee board.

**By being close to their users and communities, voluntary organisations often have a unique perspective on needs and how to improve services. This includes identifying where earlier intervention could have prevented crisis.**

**Often based within the communities they work with, charities bring a local expertise to public service delivery and are able to reach and provide a voice for some of the most marginalised and isolated people**

**Charities are also able to use their advocacy role to apply the knowledge and expertise gained through working with service users to influence service improvement.**

https://www.ncvo.org.uk/policy-and-research/public-services/what-we-believe#strengths

**NHS England on the role of Grants:**

There is a recognition that grant funding remains an effective tool in the toolbox of investment not only because it works for VCSE organisations, but because it enables commissioners to work with VCSE organisations of all sizes, to respond to the needs of patients and the public and to target health inequalities in innovative ways where contracts can be overly prescriptive and constraining.

Many VCSE organisations do not have the scale and capacity to compete or to deliver large scale public sector contracts but, with a grant, can make significant contributions to improving health outcomes. The Health and Social Care Act 2012 gives Clinical Commissioning Groups (CCGs) the power to use grant funding to support VCSE activities at national, regional and local levels. This relates specifically to section 14z5 of the NHS Act 2006, amended by the Health and Social Care Act 2012 which enables CCGs to award grants to voluntary organisations which provide or arrange for the provision of services which are similar to the functions of the CCG. It is continued recognition that grant funding plays a powerful role in the local health and care economy and the role that grants can play a vital role in helping commissioners fulfill their commitments to their population and improve health outcomes for all.

There is a distinction between awarding a grant and awarding a contract for services. Grant funding is not subject to European Union procurement rules, although in making arrangements for large grants CCGs should demonstrate a transparent process.
equivalent to that required by EU procurement rules for contracts, and non-competition should be justified

(NHS England 05: A bite Size guide to: Grants for the Voluntary Sector)

A group of trusts and foundations have also made the following arguments to the independent review in favour of increased use of grant funding:

- Provision of person centred holistic approaches
- Local solutions to local problems
- Enabling greater customer focus and direct user engagement
- Encouraging collaboration between organisations which need to work together rather than compete.

They recognise grants are not right for all service provision but believe that they are particularly well suited to addressing the complex needs faced by many high needs – and high demand / cost – service users. They also recognise the commissioning challenge of needing to work with a larger number of smaller, often local organisations, but see this arising from the misapplication of a contractual model (best suited for larger standardised provision) to holistic person centred services.

(Joint review of investment – DoH, NHS England & Public Health)

Possible funding models:

1. **Micro-investment: Healthy Ideas - up to £10,000**

   Investing relatively small amounts of money to let people try things out or to get their ideas off the ground. The main driver here is to support people with good ideas but no funds and to de-risk investment that could turn into something much bigger. One off, proof of concept funding

   This would largely be suited to a Grant Framework and a ring fenced innovation fund.

   Such an approach could be managed by a third party grant management body that is familiar with the local VCSE sector and experienced in such an approach, rather than directly by the CCG.
2. Small Investment: Health Innovation and Change - up to £99,000

Investing modest amounts of money in developing projects and services that clearly meet current needs and reduce demand on mainstream services, now and in the future. This builds on good ideas and puts them into action over a year or more to develop local evidence bases and relationships on which to further develop larger scale business cases where relevant. Small investment can also help to bridge gaps or maintain niche / geographic services where demand is small but outcomes more difficult to sustain without local responses.

This could suit a grant or contract approach depending on how prescriptive the outcomes and activities were. Up to 3 years in term, flexible to reflect evidence and track record.

This could be managed by a third party grant management body or directly by the CCG. This could be well suited to a partnership approach.

3. Medium Investment: Community Health and Wellbeing - £100,000 +

Investing through a commissioned and contracted service in something that we are clear works, meets identified needs, with clear evidence base and identifiable outcomes and is sustainable or reduces need in the long term. Investors give confidence to the provider by committing to services for up to 3 to 5 years.

This would warrant formal contracts with procurement and monitoring proportionate to the size of the contract awards. Likely to be made up of established service provision within care pathways.

This could be managed by a third party contract management body or directly by the CCG. This could be well suited to a partnership approach.

4. Large Investment: Future Health and Wealth - £100,000 +

As a local community, we must identify the small number of intractable problems and priorities we want to address over a longer period of time; and then do it. These will be issues with complex and long term causes.

This would warrant formal contracts with procurement and monitoring proportionate to the size of the contract awards.

This is most likely to be managed directly by commissioners, given the level of risk involved, but in order to prevent large scale investment excluding small, effective providers, such investment should consider appropriate partnership models, sub-contracting arrangements and lead-provider models.

Larger investment is also likely to involve greater competition and contracts being put out to tender.
Such investment should also look to capture the entire patient pathway from universal to specialist / acute. With joint funding mechanisms brought into play to ensure all needs are met.

Social value should always be recognised as part of any procurement process to ensure local sustainability.

This method is likely to involve pooled budgets or co-commissioning and integrated service design. The potential here is for capitated funds and outcome rewards.
## Author and Reporting Officer/Director

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>REPORTING OFFICER /DIRECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Lisa Taylor</td>
</tr>
<tr>
<td>Title</td>
<td>Quality and Governance Manager</td>
</tr>
</tbody>
</table>

### Report To
Stoke-on-Trent CCG Governing Body

### Title of Report
CCG Corporate Risk Register

### Date of the Meeting
5th April 2016

### What Other CCG Committee/Group/Individual Has Considered This Report?

<table>
<thead>
<tr>
<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Committee February 2016 (Clinical risks)</td>
<td>CCG Risk Owners</td>
</tr>
<tr>
<td>Finance &amp; Performance Cttee March 2016 (All risks)</td>
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</table>

### Action Required From Committee/Group/Governing Body

<table>
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<tr>
<th></th>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
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<tbody>
<tr>
<td>Stoke-on-Trent CCG</td>
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<td>X</td>
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### Recommendation
The Governing Body is asked to:
- **Note** the contents of the Corporate Risk Register for risks scoring 15 and above (enclosed at appendix 1)

### Strategic Objectives Supported by This Paper

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access</td>
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<td>4. Reduce health inequalities</td>
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<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
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During 2015, the CCG has been working with North Staffordshire CCG to review the contents of each Risk Register and to align those risks that are applicable to both CCGs to enable one risk register to be maintained.

A new Risk Register has now been constructed by the Informatics Team which will allow staff across North Staffordshire and Stoke-on-Trent CCGs to access one Risk Register to add and review risks ‘live’. This system has been streamlined to allow risks to be applicable to one, or both CCGs, and allows risks to be allocated to each CCG’s strategic objectives. This maintains the clear link to each CCG’s own objectives and ensures sovereignty to its Governing Body.

The contents of the Corporate Risk Register for risks scoring 15 and above are enclosed at appendix 1. Since the last meeting all clinical risks have been reviewed by the CCG’s Quality Committee at its meeting in February 2016, and all risks reviewed by the Finance and Performance Committee at its meeting in March 2016.

### SUMMARY OF RISKS RELATING TO THE PROPOSAL

The CCG Risk Register captures identified financial, reputational and clinical risks to the organisation and the actions being taken to mitigate these risks. These risks link to the CCGs Board Assurance Framework which details the principle risks which if not mitigated against, may threaten the delivery of the CCGC’s strategic objectives.

### ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS

Delivery of NHS Constitutional Targets; delivery of statutory duties.

### QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

N/A

### ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT

N/A

### ACRONYMS

Detailed within main body of report.
<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Date Added</th>
<th>Description of Risk</th>
<th>Initial Risk Score</th>
<th>Current Risk Score</th>
<th>Assurance Framework</th>
<th>Operational Lead</th>
<th>Exec Lead</th>
<th>Date of Next Review</th>
<th>Last Controls to Mitigate</th>
<th>Last Action Comment</th>
<th>Target Risk Score</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td>12/10/2015</td>
<td>There is a risk of the CCG failing to achieve one or more of the NHS Constitution waiting time targets, leading to NHS England not being assured, and the CCG receiving an overall rating of 'not assured'.</td>
<td>20</td>
<td>15</td>
<td>Yes</td>
<td>Jolley Paul (5PJ)</td>
<td>Stoke On Trent PCT</td>
<td>31/03/2016</td>
<td>Feb 2016 - On-going use of contract levers and service improvement plans, continued scrutiny at SRG, assurance that operational plans for 2016/17 meet demand and address underperformance in key NHS Constitution areas. Cancer: Performance monitoring though Planned Care Board which reports to SRG. Quality Issues picked up at CQRM</td>
<td>Feb 2016 - Cancer Further to the letter of 14 July 2015 (Gateway Reference: 03614) setting out the requirement to confirm the local position against eight key priorities and the development of Action Plan to improve cancer 62 day performance, additional guidance has been received on 29 October 2015 (NHS England Publications Gateway Reference: 04235). The Cancer Improvement Plan has been updated to reflect these additional requirements. UHMN has achieved the performance trajectories overall and at pathway level for both the Remedial Action Plans and Cancer Improvement Plan for November 2015. A contract performance notice was raised on 15th January 2016 for consistent failure to achieve the 2ww systematic breast target. On 28th January commissioners met with UHMN to agree the next steps, with the preferred outcome for commissioners to agree a RAP and for UHMN that commissioners to withdraw the performance notice; the outcome being that a JI will be completed (terms of reference</td>
<td>Monthly SRG Meetings. PMO in place. Regular Performance Reports to Sub-Committee and Governing Board / Body, detailing actual performance against targets and actions to mitigate.</td>
<td>0</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31/03/2016</td>
<td></td>
<td>North Staffs AND Stoke</td>
<td>6</td>
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</table>
The Cancer Local Implementation Team met on 26th January 2016. The group agreed the new 2ww referral forms which will be implemented in February 2016. The group reviewed commissioner activity planning assumptions and the operational plan related to cancer for 2016/17. The Cancer LIT work plan was updated to reflect local priority work streams. Risk score reviewed and remains unchanged.

<table>
<thead>
<tr>
<th>No</th>
<th>Date</th>
<th>Name</th>
<th>Title</th>
<th>Action</th>
<th>Line of Business</th>
<th>Score</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>17/11/2015</td>
<td>Smith Gemma (CCG) NSCCG</td>
<td>Clinical Director</td>
<td>Feb 16- Still continued failure to achieve 18 week target, UHNM not provided RAP or date for recovery. Monthly fine of 2% of contract value invoked IMAS (improvement team) to support capacity and demand model. Work stream set up jointly with UHNM and CCG lead commissioners to tackle backlog and to achieve sustainability moving forward. Risk increased from 12 to 15</td>
<td></td>
<td></td>
<td>Target date for RTT is January 2016, follow up backlog is to be confirmed. Reduction of backlog to deliver RTT target, transfers out to other providers,</td>
</tr>
<tr>
<td>92</td>
<td>17/11/2015</td>
<td>Scullion Becky (CCG) NSCCG</td>
<td>Clinical Director</td>
<td>Feb 16- Actions still ongoing and being picked up via BCF. Bigger issue for Stoke than N. S Stoke - AMG still picking up a large number of domiciliary patients</td>
<td></td>
<td></td>
<td>SRG is in place with Executive level representation.</td>
</tr>
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</table>
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Lorraine Cook</th>
</tr>
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<tbody>
<tr>
<td>Title</td>
<td>Head of Quality</td>
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</table>

REPORTING OFFICER / DIRECTOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Jayne Downey</th>
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<tr>
<td>Title</td>
<td>Director of Nursing and Quality</td>
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</table>

REPORT TO

Stoke-on-Trent CCG Governing Body

TITLE OF REPORT

Quality Report

DATE OF THE MEETING

5th April 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

- COMMITTEE/GROUP
  - Joint Quality Committee – February and March 2016
- INDIVIDUAL
  - N/A

ACTION REQUIRED FROM COMMITTEE / GROUP / GOVERNING BODY

<table>
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<tr>
<td>X</td>
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RECOMMENDATION

The Governing Body is asked to note the contents of the report and request further information as required, and in particular:

- Ratify the Terms of Reference for the Quality Committee (Appendix 1) for adoption from April 2016.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER (identify appropriate goals)

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PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY

This report aims to provide Stoke-on-Trent CCG Governing Body with assurance that structures and processes are in place to promote, monitor and ensure safe, high quality health services for the people of Stoke-on-Trent. This report focuses on items of business discussed at the Quality Committee meetings held in February and March 2016.

SUMMARY OF RISKS RELATING TO THE PROPOSAL

Detailed within the main body of the report.

ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION / ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS

N/A

QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

N/A

ANY RELATED WORK WITH STAKEHOLDERS / PRACTICES / PUBLIC AND PATIENT ENGAGEMENT

N/A

ACRONYMS

Detailed within the body of the report.
Quality Committee

(Report of business and activities considered during the February and March 2016 Committee meetings)

1. Patient Story
At the March 2016 Quality Committee meeting, members received a patient story personally presented from a gentleman who is profoundly deaf. He is the founder of an organisation called ‘Deafinitequality’ and he has just won a small lottery grant to deliver a programme aimed at improving the health of deaf people through activity programmes and health advice. The Quality Committee heard his experiences of using local health services to inform how we might be able to improve things for people who are deaf.

The Committee heard of difficulties experienced in the following areas:
- Making appointments and being reliant on Textdirect/Typetalk telephone system.
- Communication difficulties at the GP Surgery
- Difficulties in receiving general information such as travel vaccines and the procedures and processes which support this information.
- Attending hospital appointments where there is often a lack of professional sign language support available

The Committee heard of the patient’s experience throughout his journey through many NHS Services which often left him feeling frustrated, scared and not fully informed.

Members agreed to seek assurance from each of its main providers on the support available for patients who are deaf or hard of hearing, and the CCG’s Director of Nursing and Quality agreed to discuss this with Director of Nursing colleagues across Staffordshire to explore the possibilities of undertaking a Staffordshire-wide piece of work in this area. In addition it was agreed that this would be discussed with the Primary Care Team to explore the possibilities of including this within face-to-face training programmes to raise awareness within GP Surgeries to GPs and their staff, and on-line through work planned via pod casts available to all GP Practices.

Healthwatch Stoke-on-Trent supported the experiences expressed through this patient story advising that their research provided supporting evidence of the limited support available.

2. Patient Experience
The Quality Committee received a presentation and Insight (Patient Experience & Membership Feedback) Report 2015/16 Quarter 3 (October – December); the report covered both North Staffordshire CCG and Stoke-on-Trent CCG enabling triangulation of information and analysis of themes on a wider scale. There were 279 feedback contacts recorded in the quarter by the following methods: Soft Intelligence – patient based (89), PALS (81), Media (54), MP Letters (28) and Complaints (27).

Stoke-on-Trent CCG directly received 14 complaints; this in line when compared with the previous quarter (13). The services the complaints were about include: Continuing Healthcare (5), Out of Hours (2), Royal Stoke (2) and a further 5 relating to separate services and all have differing themes.

The CCG is not aware of any complainants contacting the Parliamentary and Health Service Ombudsmen requesting an independent review of their complaints.

The most common reason for patient feedback (154) is within the patient experience domain of ‘access and waiting’ which is consistent with previous quarters. Members noted that the services with the highest number of feedback related to access to appointments in both Orthopaedics and Ophthalmology and access to the Anti-Coagulation Service, all at Royal Stoke University Hospital. These areas are known to the CCG and
are areas of ongoing dialogue with the Trust. The Trust’s Directorate Management teams are currently working with the Clinicians to validate all waiting lists and to provide additional clinic sessions in order to bring waiting times down for patients. There are planned changes in how the Anti-Coagulation Service is commissioned from 1st April 2016 and communication was sent to patients, however on review the letter was unclear on what the changes would mean for individuals; this has now been rectified.

Quarter 3 saw 292 events submitted for both North Staffordshire CCG and Stoke-on-Trent CCG. 170 of the events recorded were regarding ‘safe, high quality co-ordinated care’; which is consistent with previous quarters. The top themes under the domains of patient experience are: ‘discharge issues’, ‘medication issues; and ‘clinical care/treatment’.

The joint Datix Newsletter is circulated to all GP Practices and uses a ‘you said, we listened, we did’ style to provide additional feedback, highlighting themes and what outcomes have been achieved in direct response to the concerns practices are raising.

### 3. Primary Care Assurance Report

At the February 2016 Quality Committee, members received the Primary Care Assurance Report which included an update in respect of the Pan Staffordshire Primary Care Strategy and the Northern Staffordshire Primary Care Strategic Delivery Plan which was discussed with member practices in February to gain their valuable input.

**Northern Staffordshire Primary Care Strategic Delivery Plan**
The Strategic Delivery Plan highlights the need to change, driven by the significant strain General Practice finds itself under. There are areas within Northern Staffordshire where remedial action is needed quickly. The aim of the delivery plan is to improve the quality, capacity and capability of primary care services across both CCGs. It describes a system where general practice is at the heart of a more integrated system, delivering a wider range of primary and community care services. The focus will be on ensuring more patients are managed in the community to avoid unnecessary admissions to hospital and reducing GP generated demand. It will enhance patient experience and outcomes by improving clinical and service quality.

**Care Quality Commission GP Practice Visits**
Members noted that the Care Quality Commission are continuing to visit a number of GP Practices in the area with three recent reports issued receiving ‘good’ (2) and ‘requiring improvement’ (1). The reports are available on the CQC website and the Primary Care Team will continue to work with these practices and NHS England to support improvement.

**Primary Care Joint Commissioning**
The Staffordshire Clinical Commissioning Groups are at ‘level 2’ which means we have joint commissioning responsibilities shared with the Area Team. It is anticipated that we will move to full delegation and hold primary care contracts from April 2017. This will be completed as ‘Pan Staffordshire’ with all 6 CCGs taking on full delegation at the same time. However it should be noted that there is the potential that we will be asked to move to Level 3 full delegation by the Department of Health prior to that date. Pan-Staffordshire meetings are held on a regular basis to discuss a range of primary care issues including quality, workforce, Personal Medical Services (PMS), estates and strategy.

### 4. Nursing Home Strategy and Implementation Plan

In September 2015, North Staffordshire and Stoke-on-Trent CCGs approved a Care Home Strategy to improve the quality of care for local care home residents. The Strategy identified 4 key priority areas:
Priority 1: Develop, support and improve quality of care within care home settings ensuring that the sector is able to manage the increasing complexity of residents needs in the future.

Priority 2: Ensure access to healthcare services that are responsive and can meet the holistic needs of this vulnerable group of patients.

Priority 3: Ensure robust quality monitoring and assurance framework for all nursing homes.

Priority 4: Reduce avoidable admissions to hospital, ensuring the care home resident receives safe, high quality care in an environment that is most appropriate.

The implementation of the strategy will be delivered by a small task and finish group led by the Director of Nursing and Quality, with representation from quality, safeguarding, health and social care commissioners.

Leads have been identified for the priority areas and good progress is being made across all areas, including the award of £63k from NHS England following a successful bid application which will be used to recruit a senior frailty specialist nurse for 12 months to support up to 20 care homes with high admission rates and provide education and leadership to care home staff. In addition, success is being seen in the rapid access to intermediate care CQUIN where 40 homes, both residential and nursing, are now able to directly refer to the Hub / intermediate care teams. These homes represent 49% of the care home bed base for older people.

5. Infection Prevention and Control

The Quality Committee continues to receive assurance on the actions being taken in relation to infection prevention and control across the local health economy. A Staffordshire wide assurance / good practice event was recently held involving commissioners, providers, NHS England, Public Health England and the Trust Development Authority, which was extremely successful with an annual update planned. Providers from across Staffordshire presented information on how each organisation is managing HCAI and taking active measures to improve services and to protect their patients. The aim of the event was to share intelligence and good practice and to receive assurance in relation to practice, systems and processes and IPC related improvement initiatives within each provider trust.

Members noted that as at the end of December 2015, the CCG is over trajectory for Clostridium difficile although work continues through the Infection Prevention and Control Group to implement and monitor the areas detailed within the C Difficile Action Plan.

Further assurance was provided in relation to the key areas currently being addressed through the IPC Strategy which include:

- Prevention of avoidable infection
  - Short life working group to address the high incidence of CDI across the health economy but particularly in the north of the county
- Improvement in standards of IPC in the Care Home setting
- Reduction in the incidence of catheter associated infection in the care home setting
- Support improvement of IPC in Primary Care
- Reduction in Antimicrobial Prescribing across the Health Economy

6. Quality Reports

Members received Quality Reports in respect of its main providers covering the three domains of quality; patient experience, safety and clinical effectiveness. Below are the key areas to bring to the Governing Body’s attention at this time::.

6.1 NSL Non Urgent Patient Transport Service

Members received the quality report for NSL, key highlights to note are:

- The Quality Committee was advised that the 3 year contract with NSL Care Services terminates on the 31st July 2016 and that NSL has made a strategic business decision to withdraw from the PTS market. The CCG has commenced a robust procurement exercise to commission a new service provider to ensure
continuity of service delivery post 1st August 2016. As part of this process, patients are being consulted and engaged with, to help inform the future delivery of the service.

- The CCG and NSL continue to focus on performance and quality and NSL has a range of initiatives underway to improve performance and patient experience focussing on:
  - Recruitment of additional staff
  - Increasing the number of patient feedbacks with the use of friends and family forms available on vehicles, at NSL Ambulance Liaison Departments as well as telephone patient surveys.
  - Extension of the Renal Liaison post to cover out of hours which has been well received by both patients and staff.

- Assurance continues to be received that the focus on quality will continue right through to the end of the contract.
6.2 North Staffordshire Combined Healthcare NHS Trust (NSCHT)
Members received the quality report for NSCHT, key highlights to note are:

- Following the Comprehensive Inspection, the Trust are awaiting the final report from the Care Quality Commission (CQC) which will be presented and discussed at the Quality Summit provisionally planned for the 16th March 2016. The CCG’s Director of Nursing and Quality and Head of Quality will be attending.
- Members were advised of work being undertaken by the Trust to improve the waiting times within the Child and Adolescent Mental Health Service (CAMHS). It was noted that waiting time levels have developed over a period of time due to demand and the level of resource available. Members noted that work is ongoing to understand the current position whilst a range of initiatives are being implemented as a priority. In addition, following approval by NHS England of a CAMHS Action Plan, further investment will be received from the CCG for utilisation in this area.
- Members noted that the Trust are looking to promote an open and learning culture to ensure that lessons are learnt and a weekly review group is in place to review complaint activity and safeguarding data to identify and respond to any areas of particular concern in a timely way. In addition, the Trust has established a Patient Council with an elected chair who will attend both the open and closed Trust Board sessions.

6.3 Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP)
Members received the quality report for Staffordshire and Stoke-on-Trent Partnership Trust, key highlights to note are:

- The Care Quality Commission carried out a comprehensive inspection which included an announced inspection visit week commencing the 3rd November 2015. Following the comprehensive inspection the Trust were issued a warning notice and a steering group has been set up to monitor the actions in the improvement plan which needs to be completed by 29th February 2016. These have been discussed at the CQRM and in meetings with the Trust’s Director of Nursing & Quality. The CQC have not yet issued draft reports and publication dates are awaited.
- The Trust continues to report to their Board that safe staffing has been maintained across community hospital inpatient wards. During January 2016, pressure was placed on clinical teams when due to the health economy being under extreme pressure, a decision was made to open winter escalation capacity on Cheadle Community Hospital on 6th January. This escalation capacity closed on the 5th February 2016.
- Members noted that the Clostridium Difficile target for the year is 10 and therefore is currently over target by 7 cases. Fourteen of the CDI cases during the year were deemed unavoidable, (no lapses in care identified) following a robust RCA process.
- SSOTP receive very good patient and carer feedback with the national benchmark for the friends and family test of 95% being exceeded all year.

6.4 University Hospitals of North Midlands NHS Trust (UHNM)
Members received the quality report for UHNM, key highlights to note are:

- As members will be aware, the local health system has been under varying degrees of pressure during December 2015 and into January 2016 sustaining EMS level 4 and 12 hour trolley breaches. The Quality Committee continues to receive assurance that the 12 hour breach (quality) framework has been re-enacted from last year which includes:
  - Each patient experiencing a 12 hour breach is interviewed
  - An A&E breach report is received weekly and is submitted to the Clinical Quality Review Meeting for UHNM on a monthly basis
  - UHNM hold a 12 hour Breach Panel to review the Root Cause Analysis’, which the CCG, as the Commissioner attends.
  - The CCG has undertaken unannounced visits to the outlier wards have been undertaken to try and better understand the main issues with patient flow and medically fit for discharge within the hospital. Members received assurance that there continues to be no major issues to highlight following these visits. In addition, a quality visit to the County Site A&E Department has also been undertaken.
A Board to Board meeting has been scheduled between UHNM, Stoke-on-Trent CCG as lead commissioner and representatives from North Staffordshire and Stafford and Surrounds CCGs invited to attend to discuss the failure of the constitutional targets along with assurance around patient safety and quality.

7. **Joint Quality Committee Terms of Reference and Business Cycle**

In order to reduce duplication and make most effective use of time and expertise available, the decision was taken in 2014 to align the work of North Staffordshire CCG and Stoke-on-Trent CCG Quality Committees with a view to merging this function. It was recognised that the new joint Quality Committee would include elements of, and members from, both CCG’s committees, which it would replace, but would have a new identity.

Although the Joint Quality Committee has operated as one entity since April 2015, it has operated with the two existing separate Terms of Reference for each organisation with two different sets of quoracy. In December 2015 committee members views were sought to gauge the effectiveness of the Joint Quality Committee via a questionnaire.

The self-assessment identified many common areas which were grouped into three themes: 1) the size of the membership – with agreement that the committee is too big for optimal performance 2) members seeking clarity of their individual and collective role 3) request from the membership to refocus the reports to ensure they are consistent, outcome focused and quality impact focused.

Analysis of the self-assessment findings, updated terms of reference and a business cycle were presented at the Committee in January 2016 for consideration. The terms of reference were discussed and concerns were raised that representation from patient and public involvement colleagues (CCG non-executives, Healthwatch organisation representatives and Patient Congress representatives) had been reduced when looking to streamline representation. It was also felt that as each CCG has a separate Patient Congress it was important that they are represented on the committee.

The CCGs listened to concerns and reflected changes with updated terms of reference and business cycle presented at the Committee in February 2016 for consideration.

The key changes include reduction in the size of the committee and an invitation to Clinical Directors to attend when receiving reports aligned to their portfolio areas. In addition, presenters will now be required to attend in line with the business cycle with Healthwatch organisations having a more formal role presenting/sharing information and intelligence that they hold. In response to members concerns about reducing patient and public involvement colleagues representation it has been agreed that this will remain unchanged whilst the review of patient and public involvement meetings/information flows in being undertaken. However, the terms of reference will be reviewed by the Committee at its meeting in September 2016 following the conclusion of the review to ensure an even representation of members from all work streams.

The committee **approved** the terms of reference enclosed at appendix 1 at its meeting on 10th February, for submission to Governing Body for **ratification** for adoption from April 2016.
Joint Quality Committee
Terms of Reference

1. Constitution

i. The Clinical Commissioning Group’s Governing Body/Board hereby resolve to establish a Committee of the Governing Body/Board known as the Quality Committee. The Committee is established in accordance with North Staffordshire Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation and Stoke-on-Trent Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation.

ii. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into each CCG’s constitution and standing orders.

iii. As per the CCG’s constitution, in the interest of partnership working, this Committee will operate as a ‘Committee in common’ with representatives from both CCG’s as per each CCG constitution, the accountability and decision making of the Committee shall remain the responsibility of the individual CCG and its Governing Body/Board.

2. Accountability

The Committee is accountable to the Governing Body/Board of each CCG. Any changes to these terms of reference must be approved by the Governing Body/Board of each CCG.

3. Purpose

i. The Quality Committee aims to provide assurance on the quality of the services the CCG commissions and promote a culture of continuous quality improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. The Committee will ensure appropriate challenge, intervention and escalation when required to ensure commissioned services are safe and of high quality.

ii. The Committee will support the Governing Board/Body to fulfil its statutory functions in terms of quality:
   - To secure continuous improvement in the quality of services and health outcomes including effectiveness, safety and patient experience.
   - Assisting and supporting NHS England in securing continuous improvement in the quality of primary medical services.

iii. The Committee will bring together information from a variety of sources about the quality of the care commissioned and triangulate or critically review this for action by the CCGs or providers from whom the CCG commissions. In doing so the Committee will support the Governing Board/Body by providing assurance and information on quality, so as to enable the Governing Board/Body to fulfil its role and responsibility.

4. Membership and Attendees

i. The Quality Committee comprises the following voting members:
   - GP Board Member Non-Executive, North Staffordshire CCG (Chair)
   - Lay Member – Patient & Public Engagement, North Staffordshire CCG
   - Lay Member – Patient & Public Engagement, Stoke-on-Trent CCG
   - Director of Nursing & Quality
   - Clinical Director(s)
   - Head of Quality
• Head of Quality

ii. The following representatives are invited to the Quality Committee ‘in attendance’:
   • Designated patient representative from Patient Congress(es)

iii. The Committee may also extend invitations to other personnel with relevant skills, experience or expertise as necessary to enable it to address matters before the Committee or as part of the Committee’s cycle of business. These representatives will be noted in the minutes as ‘in attendance’.

iv. Due to the potential confidential nature of some issues discussed at the Committee, external personnel will be asked to sign a Confidentiality Agreement prior to attending or becoming a member of the Committee.

v. Should a conflict of interest arise for an individual or as Chair of another Committee i.e. Audit Committee Chair, the individual concerned will be recorded as being an attendee, rather than a member.

vi. In the event of the Chair of the Committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

vii. Membership will be reviewed regularly to adjust for changes as required by the purpose of the Committee.

5. QUORUM
   i. A minimum of three members of the Committee will constitute quorum, so long as this includes one Non-Executive/Lay Member, one Clinical Director and either the Director of Nursing & Quality or a Head of Quality.

   ii. The Chair will confirm that the quoracy has been met at the start of the meeting and this will be recorded in the minutes.

6. MEETINGS
   i. The Quality Committee will meet on a monthly basis, but no less than nine times per year.

   ii. Other meetings may be convened as appropriate to deal with relevant business including meetings via telephone or video conference.

   iii. The CCG will nominate a member of staff to act as Secretary to the Committee. Their responsibility will be to assist the Chair in convening meetings, preparing agendas and papers and keeping the minutes of the meeting and generally ensuring that the administrative arrangements for the Committee comply with the standards set by the CCG for the conduct of all meetings.

7. AUTHORITY
   i. The Committee is authorised to:
      a) Investigate any activity within its terms of reference and produce an annual work programme to discharge its responsibilities.
      b) Seek any information it requires from any employee, or interim and temporary members of staff, who are directed to co-operate with any requests by the Committee.
      c) Obtain legal or other independent professional advice and secure the attendance of personnel with relevant experience and expertise as it considers necessary.
      d) Establish and approve the terms of reference of such sub-reporting groups, or task and finish groups, as it believes are necessary to fulfil its terms of reference.

8. DUTIES
   i. To provide the Governing Body/Board with assurance that there are robust systems in place for monitoring, measuring and improving quality throughout the CCGs to enable them to meet their
responsibilities for the quality of health care, subsequently reported in the Annual Governance statement, in the following areas:

ii. **Patient Experience**
   - To provide a strategic link between patient and public engagement and the delivery of high quality, safe health care and improved outcome for patients.
   - To review the findings of national and local surveys, complaints, PALS enquiries, claims, serious incidents, soft intelligence and other forms of feedback about the experience of patients of local health services highlighting trends and advising appropriate actions and outcomes for patients.
   - To review the events entered by General Practice / CCG via the Insight DATIX system, highlighting trends and advising appropriate actions and learning.

iii. **Quality Assurance of Local Providers**
   - To receive, scrutinise and challenge the quality assurance reports from local providers, via Clinical Quality Review Meetings, highlighting any areas of concern in relation to quality within the health economy with particular reference to clinical performance and directing appropriate action.
   - To review items of concern or exception which are being considered within the Clinical Quality Review Meetings. Taking an active role in reviewing and advising on appropriate actions.
   - To scrutinise, challenge and review the systems in place within the CCGs to ensure, monitor and improve the quality of health care delivered to the patient.
   - To seek assurance that the quality of service commissioned is appropriate and delivered, including confirmation of quality reports developed, discussed and actioned, escalating issues where appropriate.
   - To review the registration status of providers against the requirements of the Care Quality Commission and highlight any concerns.
   - To receive an overview in relation to Workforce Assurance (whilst noting that reports will be submitted to the Clinical Quality Review Meetings).
   - To identify items that should be escalated to the Governing Body/Board or where themes or trends are evident across the wider health economy. In this, the Committee may explore issues in advance of discussion by the Governing Board/Body and will provide an oversight of the decision making processes for the various groups that monitor safety and quality on behalf of the CCGs.
   - To ensure the engagement of appropriate external bodies on areas of concern.
   - To ensure that quality assurance information is used to inform commissioning decisions and drive quality improvement.

iv. **Clinical Risk Management**
   - To ensure that a robust strategy for clinical risk management is in place to manage the whole spectrum of risks associated with the CCGs business, that: identifies and prioritises risks, describes action to be taken to mitigate each risk, identifies how risk is measured, challenges and moderates risk rating scores, identifies leaning outcomes.
   - To review the clinical aspects of the CCG’s Corporate Risk Registers.

v. **Safeguarding**
   - To receive regular Safeguarding reports enabling the Quality Committee to oversee the governance arrangements for safeguarding children and vulnerable adults and monitor the implementation of health care related aspects in action plans following Serious Case Reviews, Domestic Homicide Reviews and Adult Protection Investigations.

vi. **Infection Control**
   - To review and monitor progress with reducing/eliminating healthcare associated infections.

vii. **National Publications / External Reports**
    - To provide a forum for the review & discussion of national/independent reports regarding quality, reports from the Department of Health arm’s length bodies or regulators/inspectors, professional and accreditation bodies, for local interpretation and ensure relevant actions are completed.
o To monitor and scrutinise the progress being taken by the CCGs in response to key national publications and highlight any risks/slippages to the Governing Body/Board as appropriate.

viii. **Quality Related Strategies & Policies**

o To receive quality related strategies & policies for expert view and approval prior to submission to the Governing Body/Board for ratification.

ix. **Quality Impact Assessments**

o To ensure that all service development and redesign, evaluation of services and decommissioning of services are subject to Quality Impact Assessment (QIA).

o To ensure that Quality Impact Assessments are undertaken for all Quality Innovation Productivity and Prevention (QIPP) schemes.

o To scrutinise and challenge the efficiency of the CCG’s QIA of QIPP schemes and provider’s QIA of Cost Improvement Programmes (CIP). This will be provided through a task and finish group with the results presented to the Committee.

o To receive a full copy of the Quality Impact Assessment for any scheme identified as high risk, either at the outset or during the delivery of the service, and further detail on how the mitigating actions being taken to manage the risks.

x. **Feedback / Assurance from Sub Groups and Wider Networks**

o To receive regular assurance and exception reports from groups aligned to the Committee.

o To receive feedback from the Quality Surveillance Group on local health economy quality related issues to ensure swift action is taken where risks have been identified or there is a reality of poor patient care.

o To receive an assurance and exception reports on the quality of primary care.

o To review and agree terms of reference for all subgroups that report directly into the Committee to ensure that membership and functions are satisfactory.

9. **REPORTING**

The Committee will have the following reporting responsibilities:

i) To ensure that the minutes of the Quality Committee are formally recorded and submitted to each CCG Governing Body/Board. If there is commercially sensitive or sensitive information then a closed session of the Committee would need to be agreed with the Committee Chair.

ii) The Quality Committee will produce a bi-monthly report for each CCG Governing Body/Board.

iii) To ensure that conflicts and/or interests are managed in accordance with the CCG’s policies and procedures.

iv) To bring to the attention of each Governing Body/Board in a separate report, any items of specific concern which require Governing Body/Board’s approval to act.

v) To provide exception reports to the Governing Body/Board, highlighting any key developments /achievements or potential risks/ issues.

vi) To provide assurance to the Audit Committee as a minimum annually that clinical risks are being adequately managed by the CCGs.

10. **RESPONSIBILITY OF COMMITTEE MEMBERS AND ATTENDEES**

Members of the Committee have a responsibility to:

i) Prioritise attendance at meetings, with a minimum attendance of two thirds of the meetings, having read all papers beforehand.

ii) Act as ‘champions’, disseminating information and good practice as appropriate.

iii) Identify agenda items to the secretary ten working days before the meeting.

iv) Submit papers for distribution at least five working days before the meeting.

11. **ADMINISTRATIVE ARRANGEMENTS**

The Secretary to the Committee will ensure:

a) Correct minutes are taken, and once agreed by the Chair; ensure distribution of the minutes to the members of the Committee.
b) Conflicts of interest are recorded along with the arrangements for managing those conflicts.
c) A record of matters arising is produced with issues to be carried forward.
d) An action list is produced following each meeting and distributed to members.
e) Ensuring any outstanding action is carried forward on the action list until complete.
f) They provide appropriate support to the chair and Committee members.
g) The agenda is agreed with the chair prior to sending papers to members no later than five working days before the meeting.
h) The annual programme of work of the Committee is up to date and agreed by the Committee.
i) The minutes of the meeting are distributed within five working days of the meeting taking place.
j) The papers of the Committee are filed in accordance with each CCG’s policies and procedures.

12. REVIEW

a) The Committee shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles and the Conflict of Interest policy.
b) The Committee will review its own performance, membership and terms of reference annually or sooner if required.
c) An annual report of its performance, membership and terms of reference with recommendations will be submitted to each Governing Body/Board for agreement and approval.

Date Agreed by Committee: February 2016
Date Approved at North Staffordshire CCG Governing Board: March 2016
Date Approved at Stoke-on-Trent CCG Governing Body: Proposed April 2016
Review Date: September 2016
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Lisa Taylor</th>
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<tbody>
<tr>
<td>Title</td>
<td>Quality and Governance Manager</td>
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REPORTING OFFICER /DIRECTOR

<table>
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<tr>
<th>Name</th>
<th>John Howard</th>
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<tr>
<td>Title</td>
<td>Lay Member for Governance / Chair of the Audit Committee</td>
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REPORT TO

Stoke-on-Trent CCG Governing Body

TITLE OF REPORT

Audit Committee – Chair’s Report

DATE OF THE MEETING

5th April 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

<table>
<thead>
<tr>
<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
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<tbody>
<tr>
<td>Audit Committee – 16th February 2016 (considered the items summarised within this report)</td>
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ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD

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<thead>
<tr>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
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<tr>
<td>X</td>
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RECOMMENDATION

The Governing Body is asked to note the contents of the Audit Committee Chair’s report of the meeting held on the 16th February 2016, and in particular:

- Ratify the revised Information Governance Handbook for circulation to all staff.
- Ratify the revised Audit Committee Terms of Reference for implementation with effect from April 2016.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER

(identify appropriate goals)

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<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
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<tbody>
<tr>
<td>1. Improve access</td>
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<td>2. Improve health outcomes</td>
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<td>3. Improve quality</td>
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<td>4. Reduce health inequalities</td>
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<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
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PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY

This written report from the Chair of the Audit Committee aims to highlight to the Governing Body the key issues discussed at each meeting, in line with its Terms of Reference and key responsibilities. It aims to provide the Governing Body with formal assurance on the CCGs, systems and processes reviewed by the Audit Committee, to highlight any areas of concern and support the preparation of the Annual Governance Statement for inclusion in the Annual Report and Accounts.

The attached report provides a summary of items discussed at its last meeting held on the 16th February 2016, as follows:

- External Audit Plan
- External Audit Appointments for NHS Stoke-on-Trent CCG
- Draft Head of Internal Audit opinion 2015 / 2016
- Counter Fraud
- Information Governance
- Declarations of Interest Quarterly Update
- Hospitality and Gifts Register
- Audit Committee Terms of Reference
- Audit Committee Self-Assessment
- Assurance Framework and Risk Register (including exception reports; Better Care Fund & QIPP)
- Waivers

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<thead>
<tr>
<th>SUMMARY OF RISKS RELATING TO THE PROPOSAL</th>
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<td>Exception reports relating to Better Care Fund and QIPP; HMRC Review (within main body of report)</td>
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<td>Information Governance Toolkit; Constitution; Prime Financial Policies; Freedom of Information Act;</td>
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<th>ACRONYMS</th>
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1. **External Audit Plan**

   Members received the Audit Plan for Stoke-on-Trent CCG for the year ending 31st March 2016 which set out an overview of the planned scope and timing of the audit, as required by the International Standard on Auditing 260. The Audit Plan detailed the challenges and opportunities the CCG is facing relating to financial pressures and delivery of QIPP; primary healthcare; achievement of constitutional targets and Better Care Fund and how the auditors will consider these areas during the audit, along with taking into account national audit requirements as set out in the Code of Audit Practice and associated guidance.

   In addition, members were appraised of the concept of ‘materiality’ and how this will be applied during the audit. As is usual in public sector entities, materiality has been determined as a whole as a proportion of the gross revenue expenditure of the CCG. For the purposes of planning, our auditors have determined overall materiality to be £7.457m being 2% of gross revenue expenditure. The application of materiality is significant to ensure a clean opinion is given by our auditors and the achievement of this is not without risk to the CCG.

2. **External Audit Appointments for NHS Stoke-on-Trent CCG**

   From 2017 / 2018 onwards, CCGs and NHS Trusts must have an ‘auditor panel’ to advise on the appointment of their external auditors. As the 2017 / 2018 appointment must be made by the end of the preceding year (i.e. by 31st December 2016), panels need to be in place early in 2016. It was noted that existing Audit Committees can be used to act as the nominated panel for this process.

   The Governing Body can be assured that arrangements are in hand to adhere to these requirements by the establishment of a ‘Northern’ Auditor Panel for North Staffordshire and Stoke-on-Trent CCGs with a joint procurement exercise undertaken Staffordshire-wide. A detailed timeline will be received at the next Audit Committee meeting.

3. **Internal Audit Progress Report**

   Members received a progress report against the Internal Audit Plan for 2015 / 2016 of which a summary of the findings of the finalised reports is detailed below to provide assurance to the Governing Body where appropriate, and in addition to highlight areas of risk:

   - **Key Financial Systems 2015 / 2016 (General Ledger, Cash Management, Debtors, Creditors and Payroll)**
     
     The Governing Body can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied. However, the review has identified issues that need to be addressed in order to ensure that the control framework is effective in managing this area.

   - **Delivery of the CCG Financial Recovery Plan – Phase 2 (Joint Report with North Staffordshire CCG)**
     
     The Governing Body can take substantial assurance that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively.

   - **Board Assurance Framework and Risk Management (Joint Report with North Staffordshire CCG)**
     
     The Governing Body can be assured that the CCGs have developed their Assurance Framework and Corporate Risk Register to include both risks identified for North Staffordshire and Stoke-on-Trent CCGs, and includes the required components to support the CCG’s Annual Governance Statement. The Internal Audit report confirmed that there has been continued work by the CCGs to further embed a risk management culture across the organisation with further work now required to fully populate the controls, gaps and assurances for all risks.
Follow Up of High, Medium and Low Priority Management Actions – Phase 2

The Governing Body can be assured that the CCG has demonstrated good progress in implementing the agreed management actions.

Information Governance Toolkit (Version 13)

The Governing Body can be assured that at the time of the review (October 2015) sufficient evidence had been uploaded onto the Information Governance Toolkit to support the standards with detailed action plans to obtain the required refreshed evidence to achieve the scores by the final submission in March 2016, which concluded that appropriate governance arrangements are in place at the CCG.

4. Draft Head of Internal Audit opinion 2015 / 2016

Members received the draft Head of Internal Audit Opinion (as at the 9th February 2016) for 2015 / 2016 in order to assist the CCG in preparing its Annual Governance Statement, and to give the CCG advance warning of the opinion and the issues that have been flagged that will impact on the opinion too. It should be noted that the Opinion will be finalised in the formal Internal Audit Report to the next Audit Committee meeting in April 2016 once the CCG has received and responded to all internal audit reports, to complete the Internal Audit Programme for 2015 / 2016.

The Governing Body can be assured, that as at the 9th February 2016, the draft opinion provided by the CCG’s Internal Auditors states:

‘The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.’

Members were advised that the descriptions of the annual opinions utilised by Internal Audit have been recently reviewed and reworded nationally to bring these in line with the Public Sector Standards around risk management, governance and internal control. Therefore, whilst this wording may look different to opinions received in previous years, the Governing Body can be assured that this is a positive draft opinion. The Audit Committee noted that factors and findings which have informed the draft opinion which will need to be referred to within the CCG’s Annual Governance Statement relate to the following two reports, which have been brought to the Governing Body’s attention in previous Audit Committee Chair’s Report:

- Delivery of the CCG Financial Recovery Plan (FRP) – Phase One 4.15/16 (Advisory)
- Better Care Fund - Governance 5.15/16 (Partial Assurance)

In the remainder of the work completed by Internal Audit, all areas received either substantial or reasonable assurance. Where weaknesses have arisen, these have been incorporated within the CCGs management action tracker and as part of Internal Audit follow up reviews will be subject to validation once confirmed as implemented and then presented to the Audit Committee.

5. Counter Fraud

Members received a progress report on the anti-fraud work undertaken to date against the NHS Protect Generic areas of Fraud Work, namely Strategic Governance; Inform and Involve; Prevent and Deter; and Hold to Account (Investigations, Sanctions and Redress). Key areas to note are:

- Activities in line with work plan covering the areas above remain on target with the main area of under delivery relating to the ‘hold to account / contingency’ category. This reflects the fact that there have only been two referrals (with no cases to answer) for the year to date and it is therefore likely that the plan will under deliver against this area of the workplan.
- NHS protect have issued an intelligence report outlining the number of ‘commissioner based referrals received by NHS protect during the first three quarters of 2015 / 2016. The aim of the report is to inform NHS commissioners and Anti-Fraud Specialists of the national economic crime risks, so that
targeted awareness and preventative work can be undertaken. Audit Committee members noted the contents of this report.

- Following the publication of the NHS Protect Standards for Commissioners, there is a requirement for the commissioning body to review the anti-fraud, bribery and corruption arrangements of providers where the CCG is the lead commissioner, the value is in excess of £200k p/a and the NHS Standard Contract is used. This review is undertaken by examination of the Self-Assessment Toolkit that providers are required to complete. Members therefore received the review of the Self Review Toolkit (SRT) completed and returned to NHS Protect from:
  - North Staffordshire Combined Healthcare NHS Trust
  - Staffordshire and Stoke-on-Trent Partnership Trust
  - University Hospital of North Midlands

For all three providers, the Governing Body can be assured that there were no high level concerns following the review of the SRT from the provider, and therefore the Anti-Fraud Specialists had no concerns to bring to the attention of the Chief Finance Officer or Audit Committee.

The Audit Committee noted that a Self Review Toolkit had not been completed by Nuffield Health as they currently do not have an individual within their Trust who is recognised as appropriately trained and qualified in this field to undertake this return. Nuffield Health has raised this with NHS Protect and it is understood that this situation has arisen elsewhere nationally and feedback and a way forward is awaited.

6. Information Governance (IG)
   Members received the IG Report, of which key areas to note are:
   - There have been no IG related incidents reported to date during 2015 / 2016.
   - The CCG’s Information Governance Toolkit score stands at 71% (as at the 8th February 2016) with a proposed target score of 91% to be achieved by the 31st March 2016. Significant progress continues to be made in this area and the CCG is on target to achieve the target score.
   - The CCG has achieved the 95% compliance of staff who have completed their Information Governance training during 2015 / 2016.
   - Progress continues to be made against the Improvement Plan for 2015 / 2016 in readiness for the submission of the Information Governance Toolkit. As the Audit Committee does not meet again prior to the 31st March 2016 submission deadline, the Audit Committee approved for the Senior Information Risk Owner (SIRO) to review and approve the Annual Report and Toolkit Submission no later than this date.
   - The Audit Committee approved the Fair Processing Notice which had been reviewed and updated in-year, prior to circulation.
   - 1 issue has been recorded on the Caldicott Issues Log since the last meeting.
   - The Audit Committee received the revised Information Governance Handbook which is reviewed on an annual basis to ensure this remains accurate and up to date in line with the requirements of legislation, the toolkit and the CCG. Minor amendments have been made and the Audit Committee approved this revised Handbook for submission to Governing Body for ratification.

The Governing Body is asked to ratify the revised Information Governance Handbook for circulation to all staff. Staff will be asked to confirm that they are bound by a duty of confidentiality and agree to adhere to the Handbook at all times.
7. **Declarations of Interest (DOI) Quarterly Update**

The DOI register had been reviewed and updated by Governing Body members since the last meeting as is standard practice within the CCG, noting interests registered by new members appointed to the Governing Body over recent months. A comparison of any new or amended interests against information contained within Companies House continues to be undertaken on a quarterly basis or as declared. This revised register is available on the CCG website. In addition, members noted that a review of the ‘all CCG staff’ register had been undertaken during January 2016 in line with its policies and procedures. The Audit Committee continues to receive assurance of the internal controls in place in relation to Conflicts of Interest.

8. **Hospitality and Gifts Register**

Assurance was received that processes are in place within the CCG to capture and record appropriately any declarations of hospitality or gifts received by staff within the CCG. Members noted that there have been two declarations entered onto the register to date which had been appropriately and accurately recorded. In addition, to further strengthen controls in this area, Governing Body members will be requested to complete a quarterly return, at the same time as reviewing their declarations of interest, to confirm that no hospitality has been received, or complete a form as required.


Members received the Freedom of Information Report for the period 1st October 2015 – 31 January 2016 noting 83 requests were received. Members noted that whilst the complexity of FOIs is increasing performance in relation to response times remains lower than expected.

Members will recall that this issue was expedited from the Chair of the Audit Committee to the Midlands and Lancashire Commissioning Support Unit (CSU) in October 2015, to seek assurance on the proposals and actions to improve this service along with the associated timeframe for implementation.

During December 2015, a formal complaint was brought to the attention of the CCG relating to a FOI which had not been responded to within timescales. The Governing Body can be assured that an investigation has taken place and a meeting held with the individual, the Chief Operating Officer and Chief Finance Officer along with representatives of the CCG and CSU. This complaint is now resolved with the complainant confirming that they are assured on the actions being taken to resolve this.

However whilst the CCG was aware of issues relating to performance and response times and had begun to take steps to address this, this has highlighted further gaps in controls and assurances for this service with a backlog of FOIs not responded to within statutory timeframe. An action plan has been developed to strengthen this area with urgency. Assurances have been received from the CSU in relation to a new electronic system to manage this process along with weekly SITREP reports to the CCG to monitor this more closely. The Audit Committee will continue to monitor this area closely at future meetings and will ensure the Governing Body is informed appropriately.

10. **Audit Committee Terms of Reference**

All Sub-Committees of the Governing Body are required to review their Terms of Reference as a minimum on an annual basis. Minor amendments were proposed by the CCG’s Governance Manager to strengthen the Audit Committee’s responsibilities in respect of information governance, and to include reference to holding meetings ‘in common’ with North Staffordshire CCG Audit Committee, as and when required. This supports the increased collaborative working across the two CCGs and the agreement that all meetings should be held together where necessary, and separately, by exception. In addition, following the appointment of Jayne Downey, Director of Nursing and Quality across the two CCGs, the terms of reference have been amended to include this post (or deputy) in attendance.

*The Governing Body is asked to ratify the revised Audit Committee Terms of Reference for implementation with effect from April 2016.*
11. **Audit Committee Self-Assessment**

The Audit Committee confirmed its process and timeline for undertaking its self-assessment for 2015 / 2016. The Committee will utilise the checklists detailed within the NHS Audit Committee Handbook, which will help to formulate the contents of the Committee’s Annual Report on activities and areas for development. The Committee will receive and review its draft Audit Committee Annual Report at its next meeting prior to submission to the Governing Body, to offer assurance on the work undertaken on its behalf during the last 12 months and its development and areas of focus moving into 2016 / 2017.


Members were pleased to receive the CCG’s full Assurance Framework and Risk Register for review following the work undertaken to join these processes across North Staffordshire and Stoke-on-Trent CCGs. The Governing Body can be assured that this revised electronic system is now live across the two CCGs following a training session to launch this on the 18th January 2016. Processes are now confirmed to review the Risk Register within the CCG’s Sub Committee structure in line with business cycles which will be reflected in the revision of the CCG’s Risk Management Strategy shortly.

The Audit Committee was assured that the process to join these two systems was robust, which was reflected in the recent Internal Audit review, along with evidence of work undertaken with risk owners since the launch of the revised system to further populate the register with any controls, assurances or gaps. This greater detail and population was also recognised by Internal Audit.

At the last meeting, members requested exception reports relating to two principle risks detailed on the CCG’s Assurance Framework; Better Care Fund and QIPP, which follows the receipt of two Internal Audit reports where recommendations were proposed to strengthen internal controls in these areas also.

12.1 **Better Care Fund**

Members received assurance on the steps taken to strengthen this area including the signing of the Section 75 Agreement, and the implementation of a Section 75 Board which has been in operation since January 2015 with executive level representation from the CCG. Members noted that the Health and Wellbeing Board has overall responsibility for the delivery of the BCF and is required to submit quarterly monitoring to NHS England.

12.2 **QIPP**

Members received assurance on the range of actions being implemented to further strengthen this area, noting that whilst systems were in place previously they are now more consistently applied, with improved key performance indicators. The Audit Committee requested assurance around sustainability when the increased resource within this area is removed, and it was noted that this will always be a challenge; the focus now is on ensuring staff have the required skills to ensure this is embedded. Whilst risks will always remain, the improved systems should ensure that warning signs will become apparent earlier to allow steps to be taken where necessary.


Members noted that strong progress has been made on both the implementation of recommendations for the 2014 / 2015 and 2015 / 2016 internal audit reports, which was evidenced by the follow-up testing undertaken by Internal Audit over recent months.

Moving into 2016 / 2017, work will be undertaken to align this process across the two CCGs to ease reporting and strengthen monitoring in this area.
14. **Waivers**

One waiver has been authorised since the last meeting by the Chief Financial Officer in line with the CCG’s Standing Financial Instructions for the Pan Staffordshire Prioritisation and Efficiency Workstream, approved by North Staffordshire CCG as the lead. The Committee noted that the waiver allowed for the continuation of the service until March 2016, whilst the Business Case awaits final approval from NHS England.

**John Howard**

Lay Member for Governance / Chair of the Audit Committee
1. Introduction
The Audit Committee (the Committee) is established in accordance with Stoke-on-Trent Clinical Commissioning Group’s constitution, Standing Orders and Scheme of Delegation. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Clinical Commissioning Group’s Constitution and Standing Orders.

2. Purpose
The purpose of the Audit Committee is to assist Stoke-on-Trent CCG to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards;
- Public money is safeguarded and properly accounted for;
- Financial Statements are prepared in a timely fashion, and give a true and fair view of the financial position of Stoke-on-Trent CCG for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources; and
- Reasonable steps are taken to prevent and detect fraud and other irregularities

The Committee is authorised by the CCG Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, or interim and temporary members of staff, who are directed to co-operate with any request made by the Committee. The Committee is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

To support the collaborative working across Stoke-on-Trent and North Staffordshire CCGs, the Audit Committee may wish to hold meetings ‘in common’, where appropriate, with North Staffordshire CCG Audit Committee to discuss items of common interest. This will be agreed in advance with the Chair of each Audit Committee and a Chair’s Report submitted to each CCG Governing Body in line with normal processes.

3. Membership
The lay member on the Governing Body, with a lead role in overseeing key elements of governance, will chair the Audit Committee.

Voting members:
- Lay Member Governance (Chair)
- 2 members of the Governing Body
  - Lay Member PPI
  - Secondary Care Consultant

Other attendees required (non-voting):
- External Audit
- Internal Audit
- Chief Finance Officer and/or Deputy CFO
- Director of Nursing and Quality (Or Deputy)
- Governance Manager
• Local Counter Fraud Specialist (LCFS)

The Audit Committee would have the flexibility to be able to invite any CCG Manager or Clinical Director to be held to account if it was felt appropriate by the Committee.

Other individuals may attend by invitation of the Committee to provide advice or expertise. These need to be noted in the minutes as ‘in attendance’.

Confidentiality
Due to the potential confidential nature of some issues discussed at the Committee, external members will be asked to sign a Confidentiality Agreement prior to becoming a member of the Committee.

4. Conflicts of Interest
It is the responsibility of all Members and all individuals in attendance to declare any conflicts of interest pertaining to the agenda.

Conflicts of interest are recorded at the beginning of each meeting. The nature of the conflict of interest and the Chairs decision based on consideration of this information will be formally minuted.

If a conflict of interest arises, then the Chair may request members or those in attendance to withdraw at the appropriate discussion/voting point.

When more than 50% of the voting members of the Committee are required to withdraw from a meeting or part of it than the remaining Chair will consider whether the meeting is quorate. Where the meeting is not quorate the discussion will be deferred until quorum can be convened.

Where a quorum cannot be convened from the membership of the Committee the Chair may invite on the temporary basis one or more of the following so the group can progress the item of business:
• A member of the Governing body who is not a current member of the Committee
• A representative from the CCG membership
• A member of the Health and Wellbeing Board
• A member of the a Governing of another CCG

5. Voting
• Voting will be by consensus
• Where consensus is not reached, each voting member will be allowed one vote
• The Chair (or vice Chair) will retain the casting vote

The outcome of the voting should be clearly recorded in the minutes.

6. Quoracy
No business will be transacted unless two voting members are present, one of which should be the Chair.

7. Frequency and notice of meetings
The Committee will meet not less than four times a year. The External Auditor(s) or Head of Internal Audit may request additional meetings if they consider it necessary. Further meetings may be scheduled by the CCG exception if required. The Audit Committee may also request on occasions to meet with Internal Audit and External Audit, prior to the formal Committee meeting(s) taking place. At least once a year, the Committee shall meet privately with the External Auditor and Internal Auditor without any senior officers present.
A schedule of meeting dates will be set and circulated to members for each calendar year. A calendar of business will reflect the business to be considered by the Committee throughout the year.

8. Secretary
The Committee will be formally minuted. Agendas and papers will be available five working days before the meeting is scheduled to take place. A formal action sheet will be held and reported to each meeting.

9. Reporting arrangements
The minutes of each Governing Body Subcommittee will be reported to the Governing Body for information when agreed as accurate by the Committee.

The Committee Chair will provide a written report to the Governing Body following each meeting on Committee business. This should highlight:

- Issues
- Risks
- Assurance
- Recommendations

If there is commercially sensitive or sensitive information than a closed session of the Committee would need to be agreed with the Committee Chair.

It is the Committee Chairs responsibility to highlight to the CCG Governance Manager areas of their report which may need to be considered in the closed section of the Governing Body.

10. Remit and responsibilities of the Committee
The Committee shall critically review the Clinical Commissioning Group’s financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

The focus of the Committee will be driven by the priorities identified by the Clinical Commissioning Group, and the associated risks. It will operate to a programme of business that will also be flexible to new and emerging priorities and risks.

The key duties of the Audit Committee are as follows:

10.1 Integrated governance, risk management and internal control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group’s activities that support the achievement of the Clinical Commissioning Group’s defined objectives.

Its work will complement that of the Quality Committee. In particular, the Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Governing Body of Clinical Commissioning Group.
- The underlying assurance processes that indicate the degree of achievement of Clinical Commissioning Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
• Compliance with Information Governance legislation. In particular the Committee will review the adequacy and effectiveness of the annual self-assessment against the information governance toolkit prior to endorsement by the CCG Governing Body.

• The Governing Body Assurance Framework, through review and monitoring on a quarterly basis, requesting exception reports for any principle risks as deemed appropriate.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee’s use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

10.2 Internal Audit
The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and the CCG.

This will be achieved by:
• Consideration of the provision of the internal audit service, the cost of the audit and any questions of review and possible termination of contract.
• Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.
• Considering the major findings of internal audit work (and management’s response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.
• Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Clinical Commissioning Group.
• An annual review of the effectiveness of internal audit.

10.3 External Audit
The Committee shall review the work and findings of the external auditors and consider the implications and management’s responses to their work.

This will be achieved by:
• Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
• Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
• Discussion with the external auditors of their local evaluation of audit risks and assessment of the Clinical Commissioning Group and associated impact on the audit fee.
• Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Clinical Commissioning Group and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

10.4 Other assurance functions
The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.
These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

10.5 Counter fraud
The Committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

10.6 Management
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the Clinical Commissioning Group as they may be appropriate to the overall arrangements.

10.7 Financial reporting
The Audit Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group’s financial performance.

The Committee shall ensure that the systems for financial reporting to the Clinical Commissioning Group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Clinical Commissioning Group.

The Audit Committee shall exercise the Governing Body’s delegated authority in signing off the annual report and final accounts. This will be formally reported to the Governing Body at its next public meeting.

The Audit Committee shall also focus particularly on:
- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and qualitative aspects of financial reporting.

The Audit Committee shall approve key financial and governance policies prior to recommendation for ratification by the Governing Body. Addendums to Standing Orders shall be reported to the Committee.

The Committee shall also receive regular reports detailing items including single tender waivers and Losses and Compensations.

11. Conduct of the Committee
The conduct of the Committee should reflect the Code of Accountability and Code of Conduct for NHS Boards and the seven principles of public life promulgated by the Nolan Committee. These include:
- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
12. Review of Terms of Reference
The Committee will review its Terms of Reference annually. Changes in the Terms of Reference need to be approved by the Governing Body and reflected in the appropriate Schedule of the CCGs Constitution.

The Audit Committee shall carry out an annual self-assessment to review its own performance, membership and terms of reference. The outcome of which will be shared with the Governing Body.

Date Agreed by Committee: 16th February 2016
Date Approved at Governing Body: Proposed April 2016
Review Date: January / February 2017
### ENCLOSURE: 11

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>REPORTING OFFICER /DIRECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Laura Janda</td>
<td>Noreen Dowd</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
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</thead>
<tbody>
<tr>
<td>Noreen Dowd</td>
<td>Laura Janda</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Planning and Development Manager</td>
<td>Interim Director or Strategy and Performance</td>
</tr>
</tbody>
</table>

### REPORT TO
Stoke-on-Trent CCG Governing Body

### TITLE OF REPORT
Governing Body Assurance Report

### DATE OF THE MEETING
5th April 2016

### WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

<table>
<thead>
<tr>
<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance is considered at the Joint Finance and Performance Committee.</td>
<td>Business Intelligence and Commissioner colleagues have considered and provided input into the CCG Assurance Report.</td>
</tr>
</tbody>
</table>

### ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD

<table>
<thead>
<tr>
<th>ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD</th>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approve</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### RECOMMENDATION
The Stoke-on-Trent CCG Governing Body is asked to **consider** and **receive** the CCG Assurance Report.

### STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER
(identify appropriate goals)

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>2. Improve health outcomes</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3. Improve quality</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>4. Reduce health inequalities</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>TABLE: PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To provide assurance to the Governing Body on the CCGs performance against quality metrics, NHS Constitution targets and NHS Outcomes Framework indicators.</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE: SUMMARY OF RISKS RELATING TO THE PROPOSAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The attached report offers assurance to the Governing Body on the CCGs performance against key performance indicators. The report is by exception and includes only those indicators that are currently at risk or failing. Narrative on key risks, actions and assurance is provided. NHS Constitution targets feature on the CCG Risk Register. For the April 2016 assurance report the following indicators are included as at risk:</td>
</tr>
<tr>
<td>• A&amp;E four hour wait</td>
</tr>
<tr>
<td>• 18 weeks (RTT) indicators</td>
</tr>
<tr>
<td>• Referral to treatment non-admitted pathway</td>
</tr>
<tr>
<td>• Cancer 2 week target</td>
</tr>
<tr>
<td>• Cancer 31 day target</td>
</tr>
<tr>
<td>• Cancer 62 day target</td>
</tr>
<tr>
<td>We are achieving against all other Constitutional targets.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE: ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NHS Constitution targets outlined in the attached report are a statutory duty for the Clinical Commissioning Group as outlined in the NHS Constitution, the NHS Mandate, and the CCGs Membership Constitution.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE: QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE: ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE: ACRONYMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
Stoke-on-Trent Governing Body Assurance report

Referral to Treatment

<table>
<thead>
<tr>
<th>RTT Non-admitted</th>
<th>Standard 95%</th>
<th>Current 94.7%</th>
<th>YTD 94.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period. (E.B.2)</td>
<td>Month Jan-16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RTT Incomplete

<table>
<thead>
<tr>
<th>RTT Incomplete</th>
<th>Standard 92%</th>
<th>Current 90.5%</th>
<th>YTD 90.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period. (E.B.3)</td>
<td>Month Jan-16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: Commissioners raised a contract performance notice (CPN) with University Hospital North Midlands (UHNM) relating to the failure to deliver the incomplete target and agreed the trajectory which indicated overarching delivery of the 92% standard by the end of October 2015. The Trust failed to achieve against this and as a result, the CCGs withheld 2% of the contractual value for a period of one month. However, the CCGs made the decision to close the CPN to enable us to submit a further contract performance notice with the intention of the Trust providing remedial action plan (RAP) with overarching actions at a specialty level to deliver the constitutional target of 92%. This RAP was received by the CCGs on the 20th December 2015 and was not agreed due to a number of terms and conditions requested by the Trust. The CCGs followed the contractual process outlined under GC9 of the contract for failure to agree a RAP and are currently withholding 2% of the monthly contract which will be permanently withheld should the target not be met before the end of this contract year. UHNM have now submitted a further trajectory outlining that performance will be back on track by the end of July 2016.

A&E Waiting Time - Total time in the A&E Department

<table>
<thead>
<tr>
<th>Four hour wait</th>
<th>Standard 95%</th>
<th>Current 76.7%</th>
<th>YTD 84.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who spent 4 hours or less in A&amp;E. (E.B.5)</td>
<td>Month Jan-16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: Performance has deteriorated since August 2015 and the January 2016 performance (77%), is the worst position year to date. The urgent care system continues to attract local and national attention due to the non-attainment of the 95% 4 hour quality metric. Contractual processes have been followed, with the issuing of a contract performance notice (CPN) and the formation of a remedial action plan (RAP). The CCG’s have withheld 1% of the contract line, as 95% was not attained for October 15 and 1% of the contract line as 90% was not attained for November and December 2015 and January 2016 (as per the remedial action plan).

The CCG’s have refreshed the structure of the urgent care team and facilitated the construction of the local health economy emergency care improvement plan (LHE ECIP). The LHE ECIP plan is managed by the Unscheduled Care Delivery Group (UCDG) and reports progress and impact through a robust governance process, ultimately to the system resilience group (SRG). The diagnostic of the system has been completed and the ECIP concordat has been agreed and signed off. The vision for the system has also been agreed and the high impact changes defined (access before admission, today’s work today, discharge to assess). The high impact actions within these areas are: Exemplar Front Door, Ambulatory Emergency Care, Frailty, Step Up, Therapies, Exemplar Ward, Home First and Step Down. ECIP will continue to support the system with each of the high impact changes.
# Stoke-on-Trent Governing Body Assurance report

## Cancer - 2 Week Waits

<table>
<thead>
<tr>
<th>Urgent GP Referrals</th>
<th>Standard</th>
<th>93%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. (E.B.6)</td>
<td>Current</td>
<td>92.1%</td>
</tr>
<tr>
<td></td>
<td>YTD</td>
<td>92.5%</td>
</tr>
<tr>
<td></td>
<td>Month</td>
<td>Jan-16</td>
</tr>
</tbody>
</table>

**Comments:** With regards to breast two week standard, a contract performance notice (CPN) was issued to University Hospital North Midlands (UHNM) on 15 January 2016 and we have agreement to complete a joint investigation. The review is on track to be completed by 28 March 16. Provisional data from UHNM indicates that the target will be achieved in February (97.8%).

## Cancer - 31 Days

### First Definitive Treatment

<table>
<thead>
<tr>
<th>Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis. (E.B.8)</th>
<th>Standard</th>
<th>96%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>97.2%</td>
<td></td>
</tr>
<tr>
<td>YTD</td>
<td>95.0%</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Jan-16</td>
<td></td>
</tr>
</tbody>
</table>

### Subsequent surgery

<table>
<thead>
<tr>
<th>Percentage of patients receiving subsequent treatment for cancer within 31 days, where that treatment is Surgery. (E.B.9)</th>
<th>Standard</th>
<th>94%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>75.0%</td>
<td></td>
</tr>
<tr>
<td>YTD</td>
<td>91.4%</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Jan-16</td>
<td></td>
</tr>
</tbody>
</table>

### Drug Treatments

<table>
<thead>
<tr>
<th>Percentage of patients receiving subsequent treatment for cancer within 31 days, where that treatment is an Anti-Cancer Drug Regimen. (E.B.10)</th>
<th>Standard</th>
<th>98%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>97.3%</td>
<td></td>
</tr>
<tr>
<td>YTD</td>
<td>99.0%</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Jan-16</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

Provisional data from University Hospital of North Midlands (UHNM) indicates that all 31 day targets will be achieved in February:

- 31 day first treatment: 96.8%
- 31 day subsequent treatment (anti cancer drug): 100.0%
- 31 day subsequent treatment (surgery): 94.4%
- 31 day subsequent treatment (radiotherapy) 100.0%
Section 1: NHS Constitution Reporting (Exceptions)

Stoke-on-Trent Governing Body Assurance report

Cancer - 62 Days

<table>
<thead>
<tr>
<th>Month</th>
<th>Current</th>
<th>YTD</th>
<th>18 months annualised trend to Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>72%</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>Feb</td>
<td>73%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td>79%</td>
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Comments:
University Hospital of North Midlands (UHNM) have revised their trajectory and are now predicting achievement of the 62 day treatment standard from GP referral target by March 2016. The guidance received on 29 October 2015 (NHS England Publications Gateway Reference: 04235) describes that good progress has been made in delivering the Action Plan and sets out an update on key areas, communicates decisions and highlights further development in the following five areas: Backstop policy of 104 days, Demand and Capacity Planning, Inter-provider transfers and breach allocation, PTL management, Good Practice. In response to this, commissioners and UHNM have commenced the process of updating the local position against the eight key priorities and the further development of the Action Plan to improve cancer 62 day performance to reflect the additional requirements.

A remedial action plan (RAP) is in place for 62 days from urgent GP referral for first definitive treatment. The RAP includes trajectories for the overall standard and specific trajectories for the 3 most challenged pathways (lung, colorectal, urology). All trajectories have not been achieved therefore contract levers have been applied.
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Christine Adams</th>
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<tbody>
<tr>
<td>Title</td>
<td>Senior Commissioning Manager, Staffordshire CCGs</td>
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REPORTING OFFICER /DIRECTOR

<table>
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<tr>
<th>Name</th>
<th>Dr Waheed Abbasi</th>
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<tr>
<td>Title</td>
<td>Clinical Director, Mental Health Services, SOT CCG</td>
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REPORT TO

Stoke-on-Trent CCG Governing Body

TITLE OF REPORT

Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan

DATE OF THE MEETING

29th March 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

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<thead>
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ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD (please identify all applicable and provide details below)

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RECOMMENDATION

The Governing Body is asked to:

Formally sign-off and approve the Staffordshire and Stoke-on-Trent Transforming Care Partnership Joint Transformation Plan (attached) for people with learning disabilities and/or autism who display behaviours that challenge, including those with a mental health condition.

To note the progress being made in respect of the local cohort around the work programme and the next set of key milestones for the Staffordshire and Stoke-on-Trent Transforming Care Partnership.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER (identify appropriate goals)

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<td><strong>(supporting information to be included, if applicable)</strong></td>
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<td>To seek approval from the Governing Body for sign-off of the Staffordshire and Stoke-on-Trent Transforming Care Partnership Joint Transformation Plan for people with Learning Disabilities and/or Autism who display behaviours that challenge, including those with a mental health condition.</td>
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<td>To inform the Board about the work programmes and next set of key milestones for the Staffordshire and Stoke-on-Trent Transforming Care Partnership.</td>
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**Background**

The Transforming Care Programme is a national programme to change how we deliver and commission services to children, young people and adults with learning disabilities and/or autism, including those with challenging behaviours and a mental health condition.

Following a response to the Winterbourne View scandal, NHS England and Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) set up six fast track partnerships bringing together commissioners across health and social care. Their experience has shaped the national programme, outlined in “Building the Right Support” (published October 2015), that is driving service redesign across England. The two main elements of the programme are the delivery of a:

- New national service model to provide support to live in the community.
- National resettlement programme to move service users out of hospital/care home settings into more appropriate local accommodation. The programme aims to reduce reliance on in-patient beds, which result in the closure of some facilities.

The ultimate aim for people with a learning disability and/or autism is to be able to lead active lives within the community and live independently within their own home just as other citizens expect to. There is a strong emphasis on engaging service users and their families/carers to co-produce transformation plans, and for these to give people more choice as well as control over their own health and care services.

**Staffordshire and Stoke-on-Trent Transforming Care Partnership**

In November 2015, local areas were requested to establish Transforming Care Partnerships across the CCGs, Local Authorities and include Specialised Commissioners with effect from 1st January 2016.

The Staffordshire and Stoke-on-Trent Transforming Care Partnership Board was set-up in January 2016 to transform, drive forward re-design and achieve whole system change for people with learning disabilities and/or autism over the next 3 years in line with the national plan and service model released in October 2015.

Andrew Donald is the Senior Responsible Officer (SRO) for the programme with Simon Robson, Interim Director of Commissioning, Stoke City Council acting as the Deputy SRO. Membership of the Board includes senior personnel from across the health and social care economies, NHS England Area Team, NHS Specialised Commissioning and third sector organisations including REACH who support people with learning disabilities. The board will meet on a bi-monthly basis with an operational working group led by local Commissioners and two project workstreams feeding into the work programme focussing on:

- Integrated commissioning and
- Integrated care and support.

The purpose of the Board is to drive forward re-design and system wide change to improve services for
people with learning disabilities and/or autism who display behaviours that challenge, including those with a mental health condition.

**Joint Transformation Plan**
The key focus to date has been the completion and sign-off of the 3 year Joint Transformational Plan which is a requirement of NHS England, Local Government and the Associate Directors of Adult Social Services (ADASS).

Submission of the first iteration of the Staffordshire and Stoke-on-Trent Transforming Care Plan was made on 8th February 2016 and the final plan is due for submission by 11th April 2016.

Staffordshire and Stoke-on-Trent received very positive feedback for the first iteration of the plan which achieved a score of 68% and Green on the ratings scaled and the second iteration was forwarded on 14th March 2016 in-line with national schedule for revised plans. The plan is now being reviewed nationally and processed locally through Governing Bodies and Local Councils to ensure full sign-off by key stakeholders.

A Communications and Engagement strategy in support of the plan has been developed and an ‘Easy read’ version will be co-produced with people with learning disabilities and/or autism.

**Conclusion**
May 2016 will mark the 5th anniversary of the Panorama programme which exposed abuse and neglect at the Winterbourne View Hospital. In the last year progress has been made with a step change in the approach nationally and locally. The agenda in Staffordshire and Stoke-on-Trent is deliverable with much more of a focus on prevention required, workforce development, housing and the development of community based services with people with learning disabilities and family carers at the centre of this design. Staffordshire is embracing the challenge with an emphasis in pace and innovation.

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**
Highlight any implications, including finance, quality, reputation, governance, strategic workforce, clinical, medicines optimisation, equality related or other

Strategy and Risk log attached to the implementation plan.

**ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS**
Finance and Activity planning schedules completed. There are financial implications relating to the remodelling of services.

**QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT**
Date completed, please highlight any direct or indirect implications

The programme will drive continuous improvement in quality.

**ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT**
Provide further information, including dates if applicable

Patient Engagement and person centred planning is at the heart of the programme. A Communications and Engagement Plan has been developed
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Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan

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1. Mobilise Communities

Governance and Stakeholder Arrangements

1.1 Describe the Health and Care Economy Covered by the Plan

About Us

The Staffordshire area covers the populations of the City of Stoke-on-Trent and Staffordshire County.

The estimated resident population for Staffordshire and Stoke-on-Trent is 1,111,200 covering a large geographical area of 1,048 square miles.

The area is made up from a mixture of cities, towns and villages.

Key public sector Commissioners of health, care and wellbeing include the six Clinical Commissioning Groups (CCGs):

- Cannock Chase
- East Staffordshire
- North Staffordshire
- South East Staffordshire and Seisdon Peninsula
- Stafford and Surrounds
- Stoke-on-Trent

and two upper-tier local government organisations:

- Staffordshire County Council
- Stoke-on-Trent Unitary Authority

Staffordshire also has 8 District Councils:

- Cannock Chase
- East Staffordshire
- Lichfield
- Newcastle-under-Lyme
- South Staffordshire
- Stafford
- Staffordshire Moorlands
- Tamworth
Population of People with a Learning Disability

Learning Disability is one of the most common forms of disability and is a lifelong condition with a wide spectrum of need. It can be acquired before, during or soon after birth and affects an individual’s ability to learn.

There are no official statistics reporting the population with a learning disability. Various sources have been used to estimate the numbers of people with learning disabilities across Staffordshire and Stoke-on-Trent:

- The numbers of pupils in Staffordshire and Stoke-on-Trent with their primary type of need being a learning disability were: 2,210 (specific), 6,420 (moderate), 670 (severe) and 200 (profound and multiple) making up around 6% of all pupils. Around 1,170 pupils (1.1%) also have autistic spectrum disorder (January 2015).

- The number of people on GP registers for learning disabilities was 5,300 (0.5%) (2014/15). Research suggests that this underestimates the true value of the learning disabilities population across Staffordshire and Stoke-on-Trent which is estimated to be around 20,800 for adults aged 18 and over.

- The number of adults known to local authority services was circa 3000 (2014/15)

The number of people with a learning disability and/or autism aged 55 or over is estimated to increase by 26% by 2030, with a 90% increase for those aged 85+ and a 51% increase for those aged 75-84. These changes will present challenges across the health care economy as people...
with learning disabilities are more likely to experience age related health conditions at an earlier stage. Meanwhile the number of people with a learning disability and/or autism aged 45-54 declines by 720 or 13%, and for those aged 25-34 by 0.4%.

The number of people with a moderate or severe learning disability is estimated to increase overall by **6% from 2015 to 2030**. Again this masks an ageing population of those with a moderate or severe learning disability - numbers aged 55 or over increase by **59%**, with an 85% increase in those aged 85+ and a 47% increase for those aged 75-84.

**Appendix 1: What is the Population of Staffordshire and Stoke-on-Trent (Office for National Statistics).**

**Commissioning Arrangements in Staffordshire**

**Children’s Services**

In respect of collaborative commissioning arrangements and arrangements with Providers, the Staffordshire CCGs have Block Contracts for Children and Adolescent Mental Health Services (CAMHS) Tier 3 (community services). Tier 4 Assessment and Treatment inpatient beds are commissioned by NHS England from North Staffordshire Combined Healthcare NHS Trust within Staffordshire and other providers outside of Staffordshire.

Out of area placements are currently commissioned on a case by case basis using variable contract arrangements. Commissioners have commenced commissioning by open tender with individual packages of care commissioned through a mini-selection process which is open to existing or new providers. Work is well underway to upskill and develop the local market so that it is able to provide more specialist care and support on a consistent basis across the county.

Local, medium secure and CAMHS beds are commissioned through NHS England Specialised Commissioning (Midlands and East).

**Adult Services**

Block contracts are in place with South Staffordshire and Shropshire Healthcare NHS Foundation Trust and North Staffordshire Combined Healthcare NHS Trust for the provision of Community Learning Disability teams and Intensive Support Team (IST).

Local Authorities commission supported living services and social care services from a range of domiciliary and residential based providers. Placements can be jointly funded through a ‘split’ arrangement. The Provider market is diverse and changing with voluntary, private sector and charitable organisations in the mix.

**1.2 Describe Governance Arrangements for this Transformation Programme**

The Staffordshire and Stoke-on-Trent Transforming Care Partnership encompasses the County of Staffordshire and City of Stoke on Trent. The key partners are:

- Staffordshire County Council
- Stoke-on-Trent City Council
- Stafford and Surrounds Clinical Commissioning Group (CCG)
- Cannock Chase CCG
- South East Staffordshire and Seisdon Peninsula CCG
- North Staffordshire CCG
- East Staffordshire CCG
- Stoke-on-Trent CCG
- NHS England Specialised Commissioning Teams / Hubs
- Representatives from people with learning disabilities, families and carers
- NHS England Local Area Team (Midlands and East)
- Lead GP Clinician for Learning Disabilities and Mental Health

In line with the revised commissioning footprints, a Staffordshire and Stoke-on-Trent Transforming Care Partnership Board has been established with the Accountable Officer from Stafford and Surrounds CCG, Cannock Chase CCG and South East Staffordshire and Seisdon Peninsula CCG appointed as the Senior Responsible Officer (SRO) - Andrew Donald. The Deputy SRO, Simon Robson is the Interim Associate Director of Commissioning, Commissioning and People Directorate, Stoke-on-Trent City Council. The Partnership has been endorsed by the Chief Officers of all CCGs and Local Authorities.

The Board i.e. the Leadership Team for the programme will oversee the delivery of key objectives and the achievement of outcomes as detailed in the Joint Transformation Plan and monitor the progress, risks and issues of the associated workstreams over the next three years.

The Governance structure as per the diagram has been agreed along with the Terms of Reference for the Transforming Care Partnership Board. The Terms of Reference for the Transforming Care Partnership Board are attached as "Appendix 2".

1.3 Describe Stakeholder Engagement Arrangements

Involvement with people with complex needs and/or challenging behaviour is paramount and has always been at the heart of any development within Learning Disabilities across Health and Social Care.
Effective engagement is fundamental to the success of the Staffordshire and Stoke-on-Trent Transforming Care programme and will be achieved through a comprehensive Communications and Engagement plan aligned to the local vision and the programme plan.

Throughout the duration of the programme to date, people with complex needs and challenging behaviour have been at the centre of developments and work has been focused with stakeholders around the current cohort to develop clear care service specifications and pen profiles to support the commissioning of appropriate community placements. A significant number of stakeholders have been involved to date on both an individual person centred and operational programme level which include:

- CCGs (local, boundary and out of area CCGs)
- Local Authorities
- NHS Specialised Commissioning
- NHS England Transforming Care Local Area Team and other area Leads
- Mental Health NHS Providers in the local area and Independent and Third Sector
- Community Providers
- NHS Acute Trusts
- Police, Probation and other criminal justice systems
- Advocacy and Peer Support Organisations
- Health Scrutiny Committees
- Carer and service user representatives/Experts by Experience
- Learning Disability Partnership Boards

The Stakeholder Communications and Engagement Plan (Appendix 6) has been developed depicting who the Stakeholder groups are to be involved, their motivations, what degree of involvement they need with the programme, and what outcomes are required for the Stakeholders as a result of the engagement.

A mapping exercise will also identify existing communications channels, networks and media that can be used to deliver the engagement. Co-production with people with learning disabilities and family carers will be routine business with information provided in Easy Read where appropriate (See Appendix 7 – Co-production Stakeholder and Engagement Model).

Local Authority Commissioners have developed robust Market Position Statements and are engaging with NHS Commissioners around the development of these and taking them forward into commissioning plans and the development of provider capability.

Other key stakeholders will include Housing, Criminal Justice and Education providers.

Individual patient engagement will at all times continue and particularly within the operational case management process.

1.4 Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The Transforming Care Partnership is committed to the principle of co-production and co-design (see Appendix 7 - – High Level Co-production and Stakeholder Model / Framework) will make use of the “Think Local Act Personal” tools referenced in guidance to measure success in doing so as this work progresses.
Partner organisations have carried out several pieces of work in recent years which have involved people with a learning disability and their carers in developing local strategy and services. This plan has been produced using the vision set out in these strategies namely:

- Staffordshire County Council’s All Age Disability Strategy 2013–18 was developed through a thorough consultation and engagement process.
- Stoke on Trent City Council’s Learning Disability Strategy 2010–15 was developed in partnership with people with a learning disability, closely involving self-advocates and experts by experience in setting the Strategy’s priorities and principles.
- In 2015, the City Council commissioned Staffordshire University’s Faculty of Arts and Creative Technologies to devise an innovative consultation exercise to gather views on the future design of day services within the City. Using craft activities, video logs, strong visual aids and a mixture of large scale events, small “pop up” and one to one sessions this consultation programme was able to gather a wealth of information and ideas from people who use services and their carers.
- The Staffordshire and Stoke on Trent strategies for Emotional Wellbeing and Mental Health 0-18 includes recommendations in relation to vulnerable groups, including young people with learning disabilities. The strategy was subject to stakeholder engagement and consultation with children and young people.

Both Staffordshire and Stoke on Trent commission the REACH self-advocacy service as one way of ensuring that people with a learning disability are supported to speak up. REACH run regular Parliament meetings to discuss topics of interest and share information. REACH MPs then form a conduit to disseminate information to their communities. REACH workers also support a number of members to have roles as Experts by Experience and these Experts attend the Learning Disability Partnership Boards (one stakeholder co-chairs the Stoke Board) and have also been involved in Care & Treatment Reviews as panel members.

REACH will be active members in the TCP development and workstream programmes.

**What Have People Told Us**

A cross section of customers and their families have told us they would like the following:

- Individualised community support and more flexibility of support, to learn, enjoy and achieve in life and make *genuine* friends.
- Reassurance that support will be made available for carers when they need a break.
- *Genuine* choice and control in everyday life, just like everyone else.
- Better information around the support they may be able to access.
- Individuals and families want to be *genuinely* involved and listened to.
- People are *genuinely* supported by the Council and Providers during the shift towards self-directed support.
- To have well paid work opportunities (with support where required), as opposed to minimum wage or voluntary work, with an increased disposable income.
- Support to make friends, be part of group activities and to do things together as a family.
- Support to live an ordinary life, playing and learning alongside friends within their communities.
- Support in making a smooth transition to adult life.
- Families want opportunities to carry on or return to work.
• Flexible support to respond to the fluctuating needs of illness and impairment.
• Access to personal assistants to help support with day opportunities, through personal budgets and direct payments.
• Transparency and greater understanding of what services and support cost.
• More opportunity for support during the 24 hour day including at evening time, centred around an individual's needs and preferences e.g. cinema, drama class, go to the pub, etc.
• Opportunities to try things and see what works best, with simple solutions where possible.
• Ultimate Choice and Control over how the money allocated to them is spent, and ability to choose their care and support provider and staff.
• People do not want to lose touch with their peers where building based services are re-provided and would like local opportunities to meet and socialise with others.
• Individuals wish to feel safe, free from abuse, harassment and crime and included within their community e.g. Citizenship Watch Scheme, Changing Places, increased wheelchair access and with less people abusing disabled facilities.
• Customers and their families want a voice, to be valued, to be supported in developing their confidence, self-esteem and to be seen in a positive light.
• Opportunities to make genuine connections with their communities.

A cross section of recent views has told us thus far that they would like the following specifically in relation to accommodation:

• Choice and control in respect of where they live and increased options in respect of the types of accommodation available.
• Genuine Choice and control over whom they live with and whether they live alone or in friendship groups, with a more reasonable amount of time to make the transition from existing accommodation setting to new.
• Support and security in respect of their accommodation choice i.e. secure tenure, with help managing money and paying bills in relation to their accommodation.
• Repairs done well and in a timely fashion by professional people.
• Accommodation that is big enough and flexible enough so they have their own space when they wish, but also access to communal space if they so wish.
• The speed of finding suitable accommodation needs to be improved with less “red tape” and fewer professionals involved in the move.
• Accommodation is accessible and adaptable so as customers age they can remain in their existing setting.
Staffordshire County Council works with the following framework for involvement with users and carers.

Key Themes from the Feedback from Parents and Carers include:

**A Child Centred Approach to Understanding Needs** -
- The needs of children, disabled children and those with long term medical conditions, needs more recognition.
- The need to consider social and communication ability as well as academic progress
- All Teachers and Support Staff working with the child need to be aware of their needs and provide consistent support
- Behaviour needs to have more recognition

**Clarity and Consistency of Support, Monitoring and Progress** -
- What support will be available to those children and young people without a Statement or Education Health & Care (EHC) Plan? Clarify “Special Educational Needs (SEN) Support” – in a clear framework, or “standard” of the support that can be expected.
- Be clear and transparent about what must be done
- Monitoring, early identification, clear funding arrangements should be clarified in the Code of Practice. Monitor progress - regularly and early action if no progress.
- Individual Education Plans are vital, parents must be central to this. Meetings focus on needs of the child, not funding.

**Parent/Carer Involvement** -
- A framework is needed to identify that parents must be involved at every stage
- Parent/carer forums need to have a stronger and more strategic voice – in LA, NHS and CCGs.
- Co-produce the changes with parents in real partnership
Information, Advice and Guidance -
- A “single point of access” is important but people need to know what support is available – work with Parent Partnership Service and Parents to design this.
- Factual, impartial advice and appropriate legal expertise will be needed. It is not just about a web based service – face to face is important.
- Think about expanding PPS to act as a “hub” for the Local Offer – parent trust it
- Some parents don’t know where to start to get information whereas sometimes there is information overload

Person-Centred Integrated Education, Health and Care Plans -
- Face to face is vital, need to trust the co-ordination, real people to speak to
- Could parent advocates be trained and commissioned to support other parents
- Need more local decision making, consistent working across all Districts
- Team around the child, work as equals with shared goals – consistent support

Moving Forward through Co-Production

We will only get this right if we listen to and act upon the views and experiences of the experts, the Children and Young People, their parents and professionals who support them. Children and Young People and their parents have given a very clear message. They want to work with us as partners, they want good information to empower them to have real choice and control over how their needs are met, and robust monitoring to pick up when things aren’t improving so that prompt action can be taken to put things right.

We will work together to take this forward in partnership, we will do things differently by developing a new approach that works for the Children and Young People of Staffordshire.

A full Communication and Engagement plan for the Transforming Care Partnership’s work has been developed to ensure that the Partnership achieves its goal of co-producing future commissioning intentions and service models. This plan will make use of existing links that commissioners have with stakeholders including:

- Learning Disability Partnership Boards (LDPBs) in Staffordshire and Stoke on Trent
- The REACH self-advocacy groups and People’s Parliaments that are already established in the Transforming Care Partnership (TCP) area
- Existing parent carer and young people’s forums across the area.
2. Understanding the Status Quo
Baseline Assessment of Needs and Services

2.1 Provide Detail of the Population / Demographics

The following information has been drawn from a number of data sources.

There are currently 14,500 people living in Staffordshire with a diagnosis of LD and 6,600 with ASD. It is estimated that 3-5,000 have a dual diagnosis.

These individuals are living longer and therefore require input from “traditional services” and may have other conditions with which they may require support.

Children and Young People with Learning Disabilities

The school census collects data on young people with special educational needs and disability (SEND). Based on the latest data (January 2015):

- 14% of pupils in schools in Staffordshire and Stoke-on-Trent have identified special educational needs (equating to 23,200 pupils).
- 3% of pupils in schools in Staffordshire and Stoke-on-Trent have statements or education, health and care (EHC) plan (equating to 4,800 pupils).
- The numbers of pupils with their primary type of need being a learning disability were: 2,210 (specific), 6,420 (moderate), 670 (severe) and 200 (profound and multiple). The total makes up around 6% of all pupils across Staffordshire and Stoke-on-Trent which is higher than the national average of 5%. Around 1,170 pupils (1.1%) also have autistic spectrum disorder which is similar to the England average (also 1.1%).

Adults with Learning Disabilities

The number of people recorded on a disease register (Quality Outcomes Framework register) as having a learning disability was around 5,300 in 2014/15 with the recorded prevalence (0.5%) being slightly higher than the national average (0.4%) (Table 1).

Estimated numbers and projections of Staffordshire and Stoke-on-Trent residents with learning disabilities are shown in Table 2. These expected numbers suggest that there are significant numbers of people undiagnosed or unrecorded on GP disease registers across Staffordshire and Stoke-on-Trent.

Table 1: Recorded prevalence of learning disabilities by CCG, 2014/15

<table>
<thead>
<tr>
<th>CCG</th>
<th>Number on register</th>
<th>Recorded prevalence</th>
<th>Statistical difference to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannock Chase</td>
<td>638</td>
<td>0.5%</td>
<td>Higher</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>671</td>
<td>0.5%</td>
<td>Higher</td>
</tr>
<tr>
<td>North Staffordshire</td>
<td>888</td>
<td>0.4%</td>
<td>Lower</td>
</tr>
<tr>
<td>South East Staffordshire and Seisdon Peninsula</td>
<td>863</td>
<td>0.4%</td>
<td>Lower</td>
</tr>
<tr>
<td>Stafford and Surrounds</td>
<td>444</td>
<td>0.3%</td>
<td>Lower</td>
</tr>
<tr>
<td>Stoke-on-Trent</td>
<td>1,820</td>
<td>0.6%</td>
<td>Higher</td>
</tr>
<tr>
<td>Staffordshire and Stoke-on-Trent CCGs</td>
<td>5,324</td>
<td>0.5%</td>
<td>Higher</td>
</tr>
<tr>
<td>West Midlands</td>
<td>28,408</td>
<td>0.5%</td>
<td>Higher</td>
</tr>
<tr>
<td>England</td>
<td>252,446</td>
<td>0.4%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Quality and Outcomes Framework (QOF) for April 2014 - March 2015, GPES and CQRS database - 2014/15 data extracted 10th July 2015. Copyright © 2015, Health and Social Care Information Centre. All rights reserved.
The number of people known to adult social care was circa 3000 across Staffordshire and Stoke-on-Trent which is slightly lower than the numbers of people estimated with moderate or severe learning disability and likely to be in receipt of services (4,320 people).

Table 2: Estimates of Adults with Learning Disabilities, 2015-2030

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
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<tbody>
<tr>
<td><strong>Staffordshire</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>16,160</td>
<td>16,470</td>
<td>16,740</td>
<td>17,060</td>
</tr>
<tr>
<td>Moderate or severe</td>
<td>3,340</td>
<td>3,350</td>
<td>3,370</td>
<td>3,400</td>
</tr>
<tr>
<td>Learning disability</td>
<td>740</td>
<td>730</td>
<td>730</td>
<td>730</td>
</tr>
<tr>
<td>Moderate or severe</td>
<td>1,010</td>
<td>980</td>
<td>970</td>
<td>980</td>
</tr>
<tr>
<td>Learning disability</td>
<td>230</td>
<td>230</td>
<td>230</td>
<td>220</td>
</tr>
<tr>
<td>Down’s syndrome</td>
<td>330</td>
<td>320</td>
<td>320</td>
<td>320</td>
</tr>
<tr>
<td>Autistic spectrum</td>
<td>6,830</td>
<td>6,990</td>
<td>7,130</td>
<td>7,290</td>
</tr>
<tr>
<td><strong>Stoke-on-Trent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>4,650</td>
<td>4,690</td>
<td>4,740</td>
<td>4,830</td>
</tr>
<tr>
<td>Moderate or severe</td>
<td>980</td>
<td>980</td>
<td>980</td>
<td>1,000</td>
</tr>
<tr>
<td>Learning disability</td>
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<td>230</td>
<td>230</td>
<td>230</td>
</tr>
<tr>
<td>Moderate or severe</td>
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<tr>
<td>Learning disability</td>
<td>70</td>
<td>70</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Down’s syndrome</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Autistic spectrum</td>
<td>1,960</td>
<td>1,980</td>
<td>2,010</td>
<td>2,050</td>
</tr>
<tr>
<td><strong>Staffordshire and</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stoke-on-Trent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>20,810</td>
<td>21,160</td>
<td>21,480</td>
<td>21,890</td>
</tr>
<tr>
<td>Moderate or severe</td>
<td>4,320</td>
<td>4,330</td>
<td>4,350</td>
<td>4,400</td>
</tr>
<tr>
<td>Learning disability</td>
<td>970</td>
<td>960</td>
<td>950</td>
<td>960</td>
</tr>
<tr>
<td>Moderate or severe</td>
<td>1,350</td>
<td>1,310</td>
<td>1,290</td>
<td>1,310</td>
</tr>
<tr>
<td>Learning disability</td>
<td>300</td>
<td>300</td>
<td>290</td>
<td>290</td>
</tr>
<tr>
<td>Down’s syndrome</td>
<td>420</td>
<td>420</td>
<td>420</td>
<td>410</td>
</tr>
<tr>
<td>Autistic spectrum</td>
<td>8,790</td>
<td>8,970</td>
<td>9,210</td>
<td>9,340</td>
</tr>
</tbody>
</table>

Note: Numbers may not add up due to rounding
Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI)

**Health and Wellbeing Outcomes**

People with learning disabilities face challenges and prejudice every day, for example research suggests:

- National estimates suggest 7% of adults with a learning disability are parents. Half of all families with children with a learning disability live in poverty.

- Less than one in five people with a learning disability work, although at least 65% of people with a learning disability want to work. Of those people with a learning disability that do work, most only work part time and are low paid. Based on 2014/15 data the proportion who were in paid employment in Staffordshire was 3% which is lower than the England average of 6%. The proportion of adults...
with learning disabilities in paid employment in Stoke-on-Trent was similar to the national figure at 6.3%.

- Just one in three people with a learning disability take part in some form of education or training.

- The nature of accommodation for people with a learning disability has a strong impact on their safety and overall quality of life and the risk of social exclusion. Fewer adults with learning disabilities in Staffordshire and Stoke-on-Trent live in their own home or with their family (52% and 67% respectively compared to national average of 73%).

- At least half of all adults with a learning disability live in the family home - meaning that many don't get the same chances as other people to gain independence, learn key skills and make choices about their own lives.

- Less than a third of people with a learning disability have some choice of who they live with, and less than half have some choice over where they live.

- People with a learning disability are 58 times more likely to die aged under 50 than other people.

- Around seven in ten families caring for someone with profound and multiple learning disabilities have reached or come close to ‘breaking point’ because of a lack of short break services

**What Else Do We Know?**

In Staffordshire we have the following:

- 13,079 Children on SEN support
- 2,586 Children in a special school/pupil referral unit
- 316 Other local authority pupils in our special schools
- 3,469 Children with a statement of educational needs
- 350 Children with an education health and care plan and of those we have 135 children in an out of county independent and non-maintained placement which is an 11% increase.
- 199 Children in receipt of Direct Payments with a Learning disability or Autism;

The National Service Model is about the following groups of people:

- Children, young people or adults with a learning disability and/or autism who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.

- Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.

- Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

- Children, young people or adults with a learning disability and/or autism, often with lower
level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.

- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

This is not an exhaustive list. These groupings cannot cover the complexities of every individual, nor all the causes of certain behaviours. Individuals do not 'slot neatly' into any single grouping – they overlap, people’s needs change over time, and often a large part of the challenge for local services will be to understand what combination of factors lies behind an individual’s behaviour.

These groupings are a means of demonstrating the range and complexity of the group described within the service model and some common themes and needs that will require consideration by commissioners.

We have outlined in the next sections of the plan the mix of services we have within the County and out of area for these Cohorts.

### 2.2 Analysis of Inpatient Usage by People from Transforming Care Partnership

#### Patient Flows

At the time of this report there are 36 adult in patient learning disability and/or autism inpatient beds commissioned by the Transforming Care Partnership area. This includes locked rehabilitation and assessment and treatment beds commissioned by CCGs. There are 17 individuals in low and medium secure beds which are commissioned by NHS England.

There are 15 CAMHS Tier 4 beds at the Darwin Unit in North Staffordshire although these are not specifically for individuals with a Learning Disability (LD).

Specialist in patient services for young people with a learning disability is provided by Birmingham and Solihull Mental Health Trust. There are also units in Staffordshire including Huntercombe which provide Tier 4 CAMHS beds but these are not specifically for LD patients.

#### Commissioning Challenges

As Staffordshire is a large county, there are a number of cross boundary issues with commissioning challenges which complicate the patient flows notably:

- Staffordshire has significant patient flows into the Birmingham and the Black Country area from South Staffordshire
- There are patients who are registered out of area but live in Staffordshire and vice versa
- There are no inpatient services provided by the local NHS Foundation Trust for patients with learning disabilities in South Staffordshire.
- There are 3 significant Independent Hospitals in Staffordshire (Ashley House, Market Drayton; The Woodhouse, Cheadle; John Munroe, Leek. Two of these have historically been an importer of patients from other areas.
• There is not an integrated Health and Social Care team managing the flow of patients across Staffordshire and the cohort are managed in separate ways across North and South Staffordshire.
• The North Staffordshire CCGs are working with the Provider in North Staffordshire to reduce the inpatient Assessment and Treatment bed base by 5 from 11 to 6. In line with Commissioner requirements the proposals to change the service are being developed and reviewed.
• Some patient flows have been caused by lack of suitable services within the area for patients with complex needs.

2.3 Describe the Current System

NHS Service Provision

The four South Staffordshire CCGs (East Staffordshire CCG, Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula and Stafford and Surrounds CCG) commission from the local NHS Foundation Trust – South Staffordshire and Shropshire Healthcare NHS Foundation Trust. This is a very large provider of acute mental health, community mental health and learning disability services. The Trust has an Intensive Support team and Community Learning Disability Teams, Children’s Learning Disability provision and CAMHS services.

North Staffordshire and Stoke on Trent CCGs commission services from North Staffordshire Combined Healthcare NHS Trust including Intensive Support Team, Community Teams and Assessment and Treatment inpatient beds for the population of North Staffordshire and Stoke on Trent CCGs. There is a CAMHS disability and nursing team, specialist ASD diagnostic service and 6 beds for respite care at Dragon Square learning disability unit.

Both local NHS Providers have been actively engaged in the use of the Health Equalities Framework (HEF) and are exploring the options of developing this further with social care colleagues. The HEF provides a clear and transparent overarching framework to look at planning around social, behavioural, communication and service related factors on a person centred basis.

CCGs also commission individual “spot placements” for people with learning disabilities, complex needs and challenging behaviours from Independent Hospital Providers the main ones being from: Lighthouse; Huntercombe; Cambian Care; Ashley House.

Local Authority Service Provision

Within Staffordshire County Council Independent Futures is the commissioned social work service and there is a single point of access for people aged 16 and over, called ‘Staffordshire Cares’ which refers into a Supporting Independence Service (SIS) and to meet eligible need. A range of supports are currently commissioned by Staffordshire County Council and these include:- Residential and Nursing Care, supported living arrangements, day opportunities, domiciliary care, shared lives, respite care, advocacy and carers hub.

For people aged under 16 years Staffordshire County Council commission Families First social work function and undertakes early help assessments to determine appropriate subsequent interventions and care pathway. The range of services commissioned include: residential placements, specialist fostering and adoption placements, aiming high activities and a range of specialist support services for children and young people with special educational needs and disability.
Staffordshire County Council has a Section 75 contractual arrangement with North Staffordshire Combined Healthcare NHS Trust and South Staffordshire and Shropshire Foundation Trust for adult mental health social care. Stoke on Trent City Council also has a Section 75 Agreement with North Staffordshire Combined Healthcare NHS Trust for the delivery of adult mental health social care.

The Local Authority has three Disability Resource Centres that offer respite and crisis accommodation for families with children with disabilities and challenging behaviour. In addition to this, bed based Respite/Crisis intervention is also available at Woodland View (10 beds), Silverbirch (5 beds). There is also a resource available in the North of the County for those 18 years and over.

Staffordshire County Council has a countywide All Age Disability Strategy, ‘Living My Life My Way’ 2013 – 2018, which sets out the vision for housing for disabled residents. However, while this does outline the strategy for those with lower level needs via supporting housing arrangements, it does require further development to include housing options for the Transforming Care Cohort; therefore this will be reviewed and integrated into the TCP plan.

Local Authorities commission supported living services and social care services from a range of domiciliary and residential based providers. Placements can be jointly funded through a ‘split’ arrangement. The Provider market is diverse and changing with voluntary, private sector and charitable organisations in the mix.

Local Authorities are currently implementing a fully operational Countywide assessment and diagnostic service for adults with Autism, and will use 2016 as a learning phase to accurately develop data regarding demand and onward referral to inform future commissioning and service provision.

For young people who have mental health autism or behavioural issues that are either causal to or result from low level offending behaviour, we have a Staffordshire County wide (excluding Stoke on Trent) specialist treatment and therapeutic service “known as 10-19”, which is delivered by Midlands Psychology, who are specialists in conditions that relate to offending behaviour.

In relation to short breaks for disabled children, all services have been reviewed under the Aiming High Programme and are currently out to tender and provision will be finalised under the revised model of support for April 2017 onwards and in line with the TCP plan.

**Generic Provision**

CCGs commission advocacy services from ASIST, and Staffordshire County Council and Stoke on Trent City Council have jointly commissioned advocacy services from National Youth Advocacy Services, for the following cohorts: Looked After Children, Children with emotional wellbeing/mental health issues (Staffordshire only), children subject to a child protection plan, children & young people with learning disabilities, children and young people with Special Educational Needs and Disabilities (SEND; up to 25 years).

An All Age Carers Hub model has been commissioned by Stoke on Trent City Council, Staffordshire County Council and all CCGs to meet the needs of both young and adult carers. This service was implemented on the 1st April 2015, and is delivered by People Plus.

**Commissioning Arrangements**

In addition to the assurances already in plan, Staffordshire is working towards the development of integrated commissioning and pooled budgets for people with learning disabilities and/or autism. We are actively jointly working to influence the Independent
Sector market to develop appropriate and timely services for this cohort rather than on a population basis.

The current system is not being monitored against the national outcome measures however, the TCP plan will be in-line with the new guidance more robust and aligned to new objectives.

**Self-Directed Support**

By 1st April 2016 Personal Health Budgets (PHBs) will be available to those with learning disability and/or autism, and personal budgets are already on offer for social care spend.

Work is underway to develop the local offer across the CCGs.

Children in receipt of Direct Payments with a Learning disability or Autism;

<table>
<thead>
<tr>
<th>Age Today</th>
<th>Children/YP</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
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<td>17</td>
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</tr>
<tr>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>199</strong></td>
</tr>
</tbody>
</table>

2.4 What Does the Current Estate Look Like? What Are The Key Estates Challenges, Including in Relation to Housing for Individuals?

**Council's**

Staffordshire County Council estate currently consists of:

- **Adults:**
  - 7 Complex needs day opportunities services
  - 1 Respite Unit
  - 2 In house residential care homes

- **Children’s:**
  - 2 in house residential care units
  - 1 respite unit

Stoke on Trent City Council’s estate currently consists of:

- **Adults:**
  - 1 Respite/Short Break Unit
  - 2 day opportunity services for people with complex needs
  - 1 building housing an Employment and Training Service and Person Centred Planning (PCP) Suite
• 2 day opportunity services for people with moderate needs

Children’s:
• 10 small group homes for 20 children in care.
• 6 bedded internal weekend respite home ‘Wood View’ with a mix of complex, behaviour and physical needs. This respite unit offers respite for up to 24 Children and Young People (CYP) on rota.

CCG’s

Following transfers of commissioning responsibility for a range of LD provision from the NHS to social care and closure of services such as NHS Campus schemes there is very little NHS controlled estate used to provide services for people with a learning disability in this area.

CCGs in North Staffordshire and Stoke on Trent jointly commission an 11 bedded in-patient service provided by our local NHS Provider Trust. 5 beds are designated as Assessment & Treatment beds and 6 as medium stay beds with a focus on rehabilitation. The two units are next door to each other and located in the grounds of the Harplands Hospital, which is the mental health hospital for the area.

It is planned to redesign this building in 2016 in order to provide a more flexible environment which will support a revised service specification issued by local commissioners for future assessment and treatment services. Building changes will:

• Reduce beds provided from 11 to 6.
• Provide each patient with more individual space and their own facilities.
• Reduce risks to patients that may currently arise from patients having to share much of the communal space at the service.
• Aid staff in managing and supporting patients with differing needs within the Unit, enabling a more personalised support programme to be implemented for each patient.
• Provide an environment that is more conducive to a patient’s recovery and rehabilitation.
• North Staffordshire and Stoke CCGs jointly commission a 6 bedded in-patient respite service for children with disabilities. It is a community based facility located at Dragon Square in Chesterton.

Challenges With The Current Estate

Most placements for people with a learning disability and complex needs are provided through accommodation owned by independent providers or landlords. Although generally there is an adequate supply of accommodation in the TCP area, there are a number of challenges with the current situation:

• Both Stoke on Trent and Staffordshire have a large number of people with a learning disability living in “Group Supported Living” schemes where 3 – 5 people share a house. Whilst this can work well for some people, the model does rely heavily on finding potential tenants who are compatible to live together and then who have made a positive choice to do so. It can also tie the provision of support to particular properties which limits the choice offered to individuals and means that the accommodation offer lacks the flexibility that commissioners would want.

• A number of independent providers have either undertaken new developments in the TCP area recently or have expressed interest in doing so. Whilst this investment and expansion of the choice available is welcome, there have been difficulties in co-
ordinating these approaches and ensuring that what is being built matches the needs of the LD population locally. For example some companies have built new accommodation without any reference to commissioners resulting in buildings that do not really meet local requirements. There have also been cases where several new services have opened in close geographical proximity which has then posed a challenge to existing community support such as CLDTs and District Nursing teams where capacity can become stretched.

- Commissioners are aware that a number of potential housing models and solutions are not fully developed across the TCP area. For example, not all parts of the area have Adult Placement Schemes, Keyring schemes of Hub and Spoke models of accommodation available.

- A further challenge is that people with a learning disability and their carers do not have knowledge of the various housing options that might be available and so do not always make use of things that might be available such as existing mainstream Extra Care services.

**The Way Forward to 2019**

The Transforming Care Partnership recognises that there are gaps in the existing estate. From CTR’s Commissioners have identified the following gaps:

- Short term and crisis accommodation
- Step down accommodation for people with a forensic history
- Accommodation designed to be autism friendly
- Accommodation suitable for young people coming through transition with complex needs.

The Communications and Engagement plan (Appendix 6) includes plans which will engage with health and social care providers. It is acknowledged that existing local housing strategies do not always reference the needs of the learning disability population and work will be undertaken through the Transforming Care Partnership Board to ensure that District and Unitary Authorities will incorporate these needs in to future strategies.

The key to meeting these challenges is to work with people with a learning disability and their carers to co-produce future models of care offered to them where estates and where people live is a key component. Commissioners are also committed to further market engagement work as part of the work of the Partnership and this needs to include providers of accommodation as well as those who offer care and support services.

**2.5 What is the Case for Change? How Can the Current Model of Care be Improved?**


*National Must Do’s for 2016/17 – 2020/21:*

- “Deliver” actions set out in local plans to transform care for people with learning disabilities including implementing enhanced community provision, reducing inpatient capacity and rolling out care and treatment reviews in line with published policy.

- As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out dated in-patient beds and reinvesting in continuing learning disability support.

Mental health, learning disabilities and autism:
Overall 20:20 goal: to close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole.

2016/17 Deliverables

Increase in people with learning disabilities / autism being cared for by community not inpatient services, including implementing the 2016/17 actions for transforming care.

The Case for Change across Stoke-on-Trent and Staffordshire reflects the content of these national documents and the work to remodel care and support for those with learning disabilities commenced locally in 2011 with the publication of reports by the National Development Team for Inclusion (NTDi) on local provision.

There is further work to be undertaken to improve the current model of services including the implementation of Personal Health Budgets. Every CCG is required to develop a wider local offer for Personal Health Budgets by April 2016 as outlined in the NHS Mandate and Five Year Forward View.

The newly established Staffordshire and Stoke-on-Trent Transforming Care Partnership provides an opportunity to enable a consistent Staffordshire wide approach to addressing the needs of the learning disability and autism population across the whole life course. Adopting early identification, integrated case management, individualised person centred planning, early intervention, positive behavioural support approached, community based support services, short term intensive support and respite care facilities will enhance the overall approach.

The case for change is closely aligned to the principles set out within the new model of care.

Specialist Health Review Report (NDTi)

The case for change commenced four years ago in Staffordshire when the health and social care economies of Staffordshire and Stoke commissioned a review of specialist health adult learning disability services (with a specific focus on people with complex needs and challenging behaviour) from the National Development Team for Inclusion (NDTi). Commissioners recognised the need for a review of the strategic approach to these services. The brief was to review current services against policy and best practice models and provide recommendations for future services to previous Primary Care Trusts, now CCGs.

The NDTi Report’s Recommendations included points about future integration of health and social care services and that ‘a substantial and medium term programme of organisational change’ was essential if local services were to deliver policy expectations and avoid increasing costs, ensuring high quality services for the future.

The review and subsequent report also identified three major issues to be addressed as a priority:

- strategic vision and direction;
- evidence based practice;
- Service model.

Since publication of the report a significant development programme has been put in place with new services commissioned including the development of Intensive Support Services, monitoring and reporting processes implemented and in South Staffordshire dramatically
reducing the number of hospital beds 8 to nil.

There are still a number of challenges in the system which are:

- Transitions – can be problematic i.e. from children's services to adults; hospitals to community and from one Provider to another
- Lack of integration in systems, partnerships and funding leading to delayed decisions and people getting stuck in the system
- Sometimes a lack of networking across the system to wrap care around people and reports of arguments between agencies and refusals to accept cases e.g. Autism.
- Widespread recognition that those with a learning disability and/or autism and challenging behaviours are not best served by long term hospitalisation
- Population increases will put pressure on in patient capacity
- The ageing population of those with a learning disability and/or autism requires more proactive support in later life. Their care needs to focus on keeping people healthy and well in the community, and maintain their independence.
- Current commissioning activity is undertaken in silos and is often reactive which therefore means that we lose the whole system efficiency.
- The Care Act has introduced new duties and responsibilities for local authorities around information, advice and support for those with learning disabilities and/or autism. Existing capability needs to be built on to ensure that people receive the right information at the right time, and the information and advice is able to be understood.
- As for nationally there is a lack of whole system awareness and working – whether a service is forensic or not is a real dividing line, as it is across the country.
- There is no current ability to influence inpatient beds being commissioned in Staffordshire and Stoke on Trent residents.

Appendix 3 provides a high level gap analysis of the assessment against the national learning disability service model.

Independent Advocacy and Support to Communicate

One of our key ambitions is to ensure Commissioners and Providers fully conform to the Accessible Information Standard, and this will be monitored through procurement and contract management.

Advocacy will become a much more important part of the support provided to those with a learning disability and/or autism, focusing on outcomes which are how advocacy services are already commissioned.

Going Forward to 2019

The Staffordshire and Stoke-on-Trent Transforming Care Partnership is on the journey to develop further services, embed processes, shape the provider market and ensure sustainability for the future.

To achieve the right model of care the Partnership recognises that there is more work needed to be put into place to develop:

- A system wide approach across specialised and CCG commissioning, health and social care and other services e.g. housing, for those in Staffordshire and Stoke on Trent with a learning disability and/or autism and challenging behaviours.
• Care and support services need to be redesigned to minimise inpatient care to when it is the best place for the person concerned e.g. crisis prevention, respite or assessment when community provision not possible, or when it is mandated by the courts.

• A ‘whole life’ preventative approach needed for care and support with a much greater emphasis of addressing or reducing the impact of challenging behaviours from a young age.

• Greater collaborative working is needed at a national level to influence the use of beds in Staffordshire and Stoke on Trent.

• Significant market development and provider liaison is required to achieve the changes required by building the skills and capacity in the market, and to avoid destabilisation.

• Reduce the reliance on inpatient care through person centred care

• Transfer care into a community setting that offers high quality and safe services.

• Develop the right workforce who have the necessary skills and knowledge across patient pathways to support clients in the community.

• Improve integration and communication across the system and for organisations, professionals and teams to work better together to ensure that the care that is commissioned and provided is centred around the individual but also that consideration is given to the families and carers who provide a vital service to support people keeping and staying well.
3. Develop Your Vision For The Future

3.1 Vision, Strategy and Outcomes

Our **vision** is that people living in the right place with the appropriate support to maximise their independence at the right cost underpinned by a local housing offer that prevents, reduces or delays needs and costs.

This will be achieved by:
- Developing an integrated commissioning model
- Creating a menu of options to enable and create choice and control
- Ensuring a whole life approach
- A fundamental shift in the market
- Linking in national models of good practice.

3.2 Describe Your Aspirations For 2018/19.

**Vision**

The **vision** for this TCP area identifies how we wish to commission and provide services in future to ensure people with learning disabilities and/or autism are supported and their needs are met in their local community wherever possible.

**Ambition**

Our **ambition** is to shift away from the historical focus on meeting current Health and Social Care needs to the creation of a system that builds personal independence and resilience from birth onwards through the use of resources across Education, Housing, Health and Social Care.

As Commissioners of services for the most vulnerable we will utilise funding effectively to provide the right support, in the right place at the right time:

- **The Best Start in Life** – we will work with parents and carers to make sure that each child is safe, supported and cared for whilst being able to take managed risks, develop a positive self-image and become physically healthy and emotionally resilient. We want to make sure that there is early help for parents with a disabled baby or toddler. We want to make sure the right help is available, for example good quality child care that is stimulating, safe and encourages development of early milestones.

- **Lifelong Learning** – we will ensure that education, lifelong learning and skills development is purposeful and results in meaningful opportunities for disabled people that enable them to take their place as full citizens.

- **Choice and Control** – we will ensure that disabled people of all ages are able to control the way in which they are supported to live fulfilling lives.
- **Community Opportunities** – we will ensure that disabled people of all ages have equal access to the whole range of universal services and community opportunities.

- **Good Health** – we will improve health outcomes (both physical and emotional wellbeing) and reduce health inequalities for disabled people of all ages.

- **A strong voice for disabled people & their families** – we will move from listening to disabled people and their families to valuing and supporting their right to be in charge of how their support is planned and delivered.

- **Staying Safe** – we will enable all disabled people to live safer lives and will protect the most vulnerable.

Promoting prevention and early intervention with reduced admissions to hospital, care and support will:

- Improve quality of care
- Improve quality of life
- Reduce reliance on in patient services
- Aim to be closer to home
- In line with best practices of care
- Personal and responsive to individual needs
- Ensure value for money

### 3.3 How Will Improvement Against Each of These Domains be Measured?

**Outcomes**

The expected **outcomes** for services as a result of the Transformation programme are:

- More people with learning disability will be supported to live in the community at home
- The frequency of people displaying behaviours that challenge will be reduced as will the severity of episodes
- People with a learning disability and/or autism who display challenging behaviours will be kept safe in their communities wherever possible
- Fewer people will be admitted to secure hospitals and inpatient beds
- Delayed discharges will be minimised
- People with a learning disability and/or autism will have a projected length of stay recorded when they are initially admitted to hospital
- Any hospital stays will be closer to the individual’s home and support networks
- There will be fewer inpatient beds commissioned for Staffordshire population
- People with a learning disability and/or autism who display challenging behaviours will enjoy an improved quality of care and improved quality of life.
- People will be encouraged where eligible to have a personal budget and self-direct their care and support.

**Monitoring and Review**

To **measure** progress against the domains the Transforming care Partnership will use the following:

- Health Equality Framework (HEF) to monitor the quality of life indicators.
- National Assuring Transformation Data Set to monitor reduced reliance on patient services.
• The basket of quality indicators to monitor the quality of care covering hospital and community services.
• Quality assurance checker schemes for Providers.
• Key performance indicators to measure the outcomes from the commissioned service from the local NHS Provider Trusts.
• Uptake of personal health budgets and personal budgets.

3.4 Describe any Principles You Are Adopting in How You Offer Care and Support To People With a Learning Disability and/or Autism Who Display Behaviour That Challenges.

In Staffordshire the organisations involved in the Transforming Care Partnership will work to a set of **overarching Good Commissioning Principles** which are:

- Understanding that people using services, and their carers and communities, are experts in their own lives and are therefore essential partners in the design and development of services. Good commissioning creates meaningful opportunities for the leadership and engagement of people, including carers and the wider community, in decisions that impact on the use of resources and the shape of local services.

- Convenes and leads a whole system approach to ensure the best use of all resources in a local area through joint approaches between the public, voluntary and private sectors.

- Achieve through leadership, values and behaviour of elected members, senior leaders and commissioners of services and is underpinned by the principles of coproduction, personalisation, integration and the promotion of health and wellbeing for all.

- Ensure a vibrant, diverse and sustainable market to deliver positive outcomes for local people and communities. It is concerned with sustainability, including the financial stability of providers.

- Evidence what works; it uses a wide range of information to promote quality outcomes for people, their carers and communities, and to support innovation

- Provide value for money by identifying solutions that ensure a good balance of quality and cost to make the best use of resources and achieve positive outcomes for people and their communities.
Our aim is to reduce the number of inpatient beds commissioned for the Staffordshire population. To deliver this we will use the following approaches:

- Service users and their families will be at the heart of decisions about their care, providing them with more choice and control over their care including promoting a culture of positive risk taking.
- We will assume a person has the mental capacity to make decisions about their care, unless it is established that they lack capacity for that specific decision – and all practicable steps will be taken to support them to make their own decisions.
- We will establish the extent of a person’s mental capacity as soon as there is any doubt as to whether the person has the mental capacity to make decisions.
- Services will be commissioned which promote prevention, early intervention and wellbeing to support people of all ages, including children, who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital, including from the Criminal Justice System.
- We will encourage the use of mainstream services as the starting point for care and support, available and accessible for those with a learning disability and/or autism.
- Where mainstream services are insufficient to meet a person’s needs then we will provide access to specialist multi-disciplinary community based housing and support expertise.
- We will work in partnership across health and social care commissioners to ensure people’s homes are in the community.
- Commissioners and providers of care and support across the Staffordshire region will collaborate and share knowledge and experience to achieve the best outcomes for service users, including collaborating regionally across the wider West Midlands and with NHS England specialised commissioners where appropriate.
- People involved in implementing the plan will use a problem solving ‘can do’ approach.
- We will develop cost effective services which promote individuals independence

If they were able to put into words, the individual would be able to state in relation to the care and support they receive that:

- My care is planned, proactive, and co-ordinated
- I am involved in deciding how my health and care needs are met
- I live in the community with support from and for my family and paid carers
- I am involved in deciding where I live and who I live with
- I have a fulfilling and purposeful everyday life
- I get good care from mainstream NHS services
- I can access specialist health and social care support in the community
- I am supported to stay out of trouble
- If I need assessment and treatment in a hospital setting because my health needs can’t be met in the community, it is high-quality and I don’t stay there longer than I need to
- If I need to be in hospital, then I only stay as short a time as is necessary
- We will provide support in the least restrictive setting possible that is therapeutic and safe for all. Where restrictive interventions are required they should be for the shortest time possible.
- We will proactively use intelligence from a range of sources to identify and respond to commissioning gaps and to facilitate and shape the local health, social care and housing market.
- We will protect those with a learning disability and/or autism from abuse and neglect wherever possible, and address safeguarding concerns as soon as they arise.
4. Implementation Planning

Proposed Service Changes (incl. pathway redesign and resettlement plans for long stay patients)

4.1 Overview of your New Model of Care

Services for people with a learning disability and/or autism in Staffordshire have been going through radical change over the last few years, with the closure of learning disability hospitals and changes in social care provision. This has not only been driven by the events at Winterbourne View; which highlighted the importance of good quality commissioning for supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition and those with complex needs; but also driven by feedback from people with a learning disability and family carers about the need for these services to be transformed.

The Staffordshire and Stoke-on-Trent model is based on the principle that people with a learning disability and/or autism should lead as fulfilling lives as possible in the community supported by universal services and focuses on a number of key strands:

- Access to mainstream healthcare services
- Effective prevention and early intervention
- Person centred care and planning
- Consistently highly skilled, confident and value driven workforce
- Planned, proactive and co-ordinated care in the community
- Choice and control at the heart of all service provision and planning

Two workstream groups will be established to further develop the model and proposals in relation to these areas including:

- Integrated Commissioning
- Integrate Care and Support
How is the new model different?

The emphasis on community provision over inpatient settings will mean that the size and extent of community provision relative to inpatient provision will be further enhanced. Community provision will be focused on three cohorts:

- **The current in-patient cohort, including those in forensic settings**
  The community provision will need to accommodate those previously served by inpatient settings, so people can improve their quality of life, be safe and improve the quality of their care and support so that where possible they can stay in their own home and any in-patient admissions are minimised.

- **The current community cohort**
  The community provision will need to keep people with a learning disability and/or autism living well in communities, preventing deterioration in their wellbeing and crises so that their need for in-patient services is reduced to when they are the best option.

- **The wider learning disability and autism population**
  This is the cohort that is less well known to services, with the exception of Primary Care. Mainstream services and community networks will need to support people with a learning disability and/or autism living well in the community without the need for specialist services for those with learning disabilities and/or autism where at all possible.

This will require community provision to be proactive, intervening early to reduce need, including addressing the underlying causes of behaviours so that the frequency and severity of challenging and offending behaviour is reduced. This will be helped by effective risk stratification of the population, with the newly developed registers of those at risk of admission being the key tool to do this.

The role of mainstream services and community networks are an important partner in achieving this. There will need to be much more of a focus, on making sure that people with learning disabilities and/or autism can access all the relevant mainstream services, and have the ability to be supported by their peers, and to contribute to the support of others in this way as well.

In addition, there will be a consistent approach to challenging behaviours across all teams so that the right interventions are delivered to change behaviours, and therefore reduce the severity and frequency of challenging behaviour and consequently the needs that need to be addressed. The UK Positive Behavioural Support Competence Framework lists the competencies that define best practice, and this framework will be used to create this consistent approach to challenging behaviour across the system. The framework has a number of key themes:

- Creating high quality care and support environments
- Functional, contextual and skills based assessment
- Developing and implementing a Behaviour Support Plan (BSP)

What does good look like?

People with a learning disability and their carers tell us what they think good looks like and they will continue to tell us throughout the Transforming Care process. Therefore the new model of care in the TCP area will be based upon the national model published by NHS England in October 2015 and upon the results of co-production and
consultation/engagement work (see Appendix 6 and 7).

We have also within Staffordshire and Stoke-on-Trent worked collaboratively with Prisons to help identify and manage patients with Autistic Spectrum Conditions.

Key Pillars

At this stage of the process we can identify a number of key pillars that need to be in place to enable us to fully implement the national model. A number of these are either in place or in development.

- **Minimal use of Hospital Beds.** Commissioners are reducing the number of directly commissioned Assessment & Treatment beds in the TCP area from 11 to 6 from April 2016. Through the Care & Treatment Review and other processes other hospital placements are being challenged and discharge sought where this is appropriate for the person.

- **Early Intervention.** Providing just enough support in a timely fashion to ensure that people with complex needs can remain in the community wherever possible whilst encouraging people to form their own network of support, making use of community assets and facilities and ensuring that people do not become dependent on statutory services where alternatives exist.

- **Enhanced Specialist Community Based Support.** There are 2 strands to this element; early intervention/admission prevention and the provision of short term accommodation options for people in crisis. The TCP area has already commissioned Intensive Support Teams with a remit to provide intensive time limited interventions to prevent placement breakdown (whether with a family or a paid for service) and to support discharge of patients into the community. A gap that has been identified in current service provision has been a lack of alternatives to hospital beds for somebody who is in crisis – short term respite of “crisis space” type services.

- **Access to Mainstream Services.** Part of the model will be that somebody with a learning disability and an additional need will be able to access the most appropriate service for that need, be it a physical health need or a mental health issue. For example we will ensure that somebody with a primary mental health need can be treated through mental health services (community or inpatient) rather than be placed into a learning disability service. Tools such as the “Green Light Toolkit” will be used to measure whether this is happening.

- **Primary Care Clinical Nurse Specialist Service (Health Facilitation)** Staffordshire CCGs commission a small team of Primary Care Clinical Nurse Specialists. They provide a case management service which offers support, education and awareness to mainstream healthcare providers enabling improved access to care and service delivery to patients who have a learning disability. The key focus of the work is within primary care supporting GP practices to develop and maintain registers, deliver annual health checks and develop health action plans.

The service is really well respected and established and supports people with learning disabilities through the mainstream healthcare pathways including acute care. The ambition for the Clinical Nurse Specialist Service is to engage in strategic development work that supports better universal access to mainstream services and positive outcomes practically reducing known health inequalities.

In Stoke-on-Trent the service will be delivered through the local Mental Health
Provider.

- **Co-ordinated and Integrated Care and Support.** Making a person’s journey through support services as smooth as possible and preventing a person being referred and re-referred amongst services. Health and Social Care teams in Stoke on Trent are trialling a joint management structure. Adults and Children’s social workers are coming together to work in a “Pod” system to discuss cases and share learning and experiences. The Transforming Care risk register is jointly managed and updated by health and social care staff. We will ensure that Care Co-ordination is an effective tool to support people subject to the CPA process and use this methodology to support discharge and ensure the success of community placements.

- **Developing the Market.** We need to ensure that there is a greater choice of providers in the TCP area with the range of skills and competencies to successfully support people with a learning disability and other complex needs. Commissioners have already held several market engagement events to explain future intentions and stimulate interest from providers in coming to the area. A new LD Framework is currently out to tender to ensure that we have a range of quality providers in the area to develop the necessary capacity to support people in the community. This framework covers people with mental health needs, with autism, with a personality disorder, who have an offending or forensic history and who may be coming through transition into adult services.

- **A Competent Workforce.** Obviously the success of a new community based model of care depends on having the right staff in place with the necessary skills, training and competencies. We are working with providers to explain what will be required in future placements to safely support people with complex needs and are also linked to West Midlands regional work on workforce development.

- **Criminal Justice System.** Better links with the seven (7) prisons in the TCP area and better links with the mental health criminal justice teams (CJTs) in the community. The newly established framework contract includes a provider list of providers experienced in working with those of offending histories.

- **Personal Budgets/Personal Health Budgets (PHBs).** We will encourage greater take up of PHB’s to provide more flexibility for people with a learning disability to design and control their own package of support.

- **All Age Approach.** We will ensure that transitions between services for young people and their families is as seamless as possible, integrating work between children’s and adult’s services well before the age of 18 to allow joint panning for the future support for that young person. Similarly, consideration will be given to the aging population of people with a learning disability and ensuring that age appropriate services can be provided for those at the upper end of the age range.

### 4.2 What New Services will you Commission?

A number of new services have already been commissioned or are planned as part of the TCP area’s response to the published Model of Care. A local gap analysis has also informed future commissioning plans.

It is planned to commission:

- **A revised Assessment & Treatment Unit** which will offer 6 beds in the TCP area (reduced from the current provision of 11) with a tight service specification to ensure...
a length of stay of no longer than 12 weeks with discharge back to family homes or to a community based service.

- **Crisis and short break accommodation** for people with a learning disability and complex needs to provide an alternative to hospital admission

- **A provider framework** is being established across the TCP area to ensure that providers are attracted to the area to offer capacity in residential or supported living placements for people with a learning disability and additional needs. The framework will offer placements for people with mental health issues, are on the autistic spectrum, with a personality disorder, with a forensic or offending history or for young people going through transition to adult services.

- **Enhanced community based services** to work with people with forensic or offending behaviours.

- **Provision of advocacy services** to this group with be reviewed (including Independent Mental Capacity Advocate (IMCA)/Independent Mental Health Advocacy (IMHA) services) to ensure that people with the most complex needs, and their carers, have sufficient support to have a voice.

As we plan to commission new services the Partnership will look to align and pool budgets; explore capitated budgets with providers in the area and commission a range of supports for people using personal budgets and personal health budgets i.e. brokerage and individual service funds.

### 4.3 What Services Will You Stop Commissioning, or Commission Less Of?

Historically, the commissioned provision for people with a learning disability has relied heavily on use of in-patient beds (both directly commissioned with local NHS Provider Trusts and independent hospitals) and block contracts for community based provision.

Over a number of years commissioners in both Staffordshire and Stoke on Trent have begun work to re-shape provision for this group, for example decommissioning bed based services known as Chebsey Close (North Staffordshire) and Milford Unit (South Staffordshire) and re-investing these resources in community based Intensive Support Teams. In-patient beds (Milford Unit) operated by the Provider Trust in South Staffordshire were closed in 2012 and Chebsey Close in 2013.

Services that Commissioners will cease commissioning or commission less of include:

- In-patient beds operated by NHS Provider Trusts (Assessment & Treatment beds)
- In-patient beds operated by independent hospital providers
- In-patient beds to provide respite services
- Block contracted supported living services which tie provision of support to specified premises
- Supported Living services provided in shared houses – i.e. where a tenant’s only private space is a bedroom with all other facilities shared.
- Continue the shift of resources away from larger scale residential and specialist building based day services provision to community support.
- Continue the shift from in-house provision to provision within the independent sector.

### 4.4 What Existing Services Will Change or Operate in a Different Way?

To ensure the success of the new model of care across Stoke on Trent and Staffordshire a number of existing services will need to make reasonable adjustments to the way in which
they have been operating.

- In-patient beds provided by NHS Trusts in the area will change. From April 2016 the bed numbers will reduce from 11 to 6 across the TCP area. A new service specification will be in force which ensures that the in-patient beds will provide a short term A&T service with a maximum 12 week stay. Positive Behavioural Support techniques will be expanded and ratios of qualified staffing increased to provide a more intensive intervention for patients ensuring a timely discharge either back to family homes or to community placements.

- Commissioners will review the operation of existing Community Learning Disability Teams to ensure that sufficient attention is given to reviewing capacity and care co-ordination, supporting people to move into community settings and to linking with social care and other involved teams/professionals.

- Intensive Support Teams have been established across Staffordshire and Stoke on Trent and a full service review will be carried out in 2016 after each service has been operational for 12 months to assess the effectiveness of the service and make adjustments to the service specification and operational policies as required.

- There will be closer working between learning disability and mental health commissioners and providers to ensure that people with a learning disability who have a primary mental health need receive support and/or treatment from mainstream mental health services where-ever possible and so avoid the situation where somebody is admitted into a learning disability bed principally because of a mental health issue.

- A range of health and social care provision needs to be more autism aware to ensure that people on the autistic spectrum (with and without a learning disability) receive timely support/interventions/treatment to prevent a crisis situation occurring with the associated risk of hospital admission.

- Existing respite/short break provision will be reviewed to ensure that there is capacity created to provide emergency short stay accommodation in the community as part of the local crisis response offer and to provide an alternative to hospital admission.

- We will seek to further integrate community health and social work teams across the TCP area, building on integration of management structures already begun in Stoke on Trent in 2015.

- Health services in Stoke on Trent and Staffordshire have introduced the Health Equalities Framework to provide a baseline against which to measure a patient’s progress against desired outcomes and we will look to expand use of this tool into social care commissioned and provided services.

**For Staffordshire County Council:**

Whilst progress has been made in shaping the Independent Sector market for All Age Disabilities, there are a number of areas that need addressing further in order to ensure a diverse and quality marketplace, shaped by the demands of customers and their families. These are broadly summarised below:

- Improve capacity in Staffordshire in meeting a diversity of accommodation and care and support needs of those with Challenging and or/Complex Needs i.e. those often going into Out of County specialist residential provision or currently in “Winterbourne”
type accommodation i.e. Transforming Care.

- Increase in a diversity of high quality local accommodation to support those who wish to live as individuals or in friendship groups in a supported living environment i.e. improve Local Housing Offer.

- Increase in expedient and quality accommodation solutions for those with a lower level of need and those living with parents.

- Increase in the availability of accommodation and care and support options for those between the ages of 18 and 21, often coming from Out of County specialist residential education.

- Increase in accommodation and support options for those with Learning Disability and or Autism and Dementia.

- Increased opportunities for support during the 24 hour day as opposed to traditional “9 to 5”.

- Increase in the provision of preventative services which help prevent or delay the development of care and support needs or reduce care and support needs (including carer support needs), that builds on individual and community assets.

- Increase in day opportunities, especially for those with more complex needs.

- Strengthen support and signposting for individuals who wish to gain and improve everyday life skills, to enable them to live as safely and independently as possible.

- Strengthen universal services and general signposting for individuals and their carers, thus reducing the numbers relying on crisis support.

- Improve quality and cost effectiveness of support and genuine involvement of individuals and families in judging quality of support.

- Increased genuine opportunity for real employment.

- Increase support (local offer) for those people up to the age of 25 with special educational needs and disabilities (SEND).

- Development of new opportunities for short breaks and activities for disabled children and young people that help develop the skills needed to live as independently as possible, whilst providing parents/carers with a genuine break from the caring role.

- Increase in the availability of foster placements as an alternative to residential care for disabled children and young people who are able to have their needs met in community settings.

- Increase in Providers in the Staffordshire marketplace able to offer price competitive residential care for disabled children who have complex needs, as we currently place over 50% of our disabled children “Out of County”.

- Increase in Providers who can provide accessible information and advice, including via social media, to all not just those with eligible care needs.
4.5 Describe How Areas Will Encourage The Uptake of More Personalised Support Packages

In order to continue the shift towards personalisation and community based support, Commissioners and Providers need to work together to ensure person centred approaches and co-production in commissioning and market development, thinking locally and acting personally.

Delivering cost effective, personalised and community based support in the current financial environment requires an ambition, willingness and commitment from everyone involved to think and act differently. Stimulating markets and developing new models of care and support, needs all parties to be open to new ideas. Market intelligence and systems of communicating information to individuals and their families need to be improved. Communication, information and interaction between Commissioners and Providers and also needs to be enhanced.

This means wider responsibility to ensure that sufficient provision is in place across the market. Care markets will need to become more diverse, with high quality and sustainable providers that can meet the needs of those who wish to self-direct their own support. As individuals have greater control, commissioners will need to change the approach from one of market control to one of market facilitation, and ensure the mechanisms and processes for people to self-direct their care and support is made as easy as possible and bureaucracy free.

By 1st April 2016 Personal Health Budgets will be available to those with learning disability and/or autism, and personal budgets are already on offer for social care spend.

- During the course of the delivery of the transformation, personal budgets and personal health budgets will be brought together, such that by 2020 they will be integrated personal budgets for all those with a learning disability and/or autism.

- Currently we do not have integrated commissioning arrangement’s in place for those with a learning disability/autism. There will be a move to pooled or at least aligned budgets for health and social care spend for the population concerned during the course of the Transforming Care Plan.

There is a Personal Health Budget (PHB) work stream in progress with the PHB Manager, who works across the TCP and a local offer is being developed.

The TCP will embed a culture of personalised care and work across organisational boundaries to support patient pathways including work to further develop the personalisation agenda. The work programme will be across both children and adult services.
4.6 What Will Care Pathways Look Like?

Individual needs through integrated Care and Treatment Reviews (CTRs), development of the Provider market based on feedback from CTRs, and the development of personalised care packages that make the best use of personal health budgets and personal budgets. Packages of care will be spot purchased to ensure that the individual needs of people are understood and provided but to do this effectively, significant work will be undertaken to develop the Provider market to ensure care is cost effective. The model focuses on:

1. Prevention.
2. Developing suitable post discharge support and community provision to keep people out of hospital;
3. Reducing the reliance on inpatient facilities.

Staffordshire and Stoke-on-Trent TCP will through a whole system approach be placing the individual at the centre of the care pathway journey. The individualised pathway approach may continue throughout a person’s life with input from services where required. In patient care is only a small part of some individual's journey and all efforts will continue to be made to reduce in-patient admissions and lengths of stay in line with national directives.

Hospital admission will be integrated into a broader care pathway, working closely with community-based mental health and learning disability services including Clinical Nurse Specialists in Primary Care who will have a major role to play in supporting people with complex needs and challenging behaviour to access mainstream services. Hospital-based specialist services will only be used where community settings cannot deliver. The enhanced and crisis support team use inpatient settings as part of a continuum of care, and will work with hospital staff from the day of admission to the day discharge, to make sure an estimated date of discharge is determined when the person is admitted and discharge planning and preparations begin from the day of admission this is in-line with national policy.

There will also be an improved offender pathway to minimise in-patient admissions. An admission of a person with a learning disability onto the offender pathway (specialised commissioning commissioned services) will only occur for people who are detained under Part
III of the Mental Health Act 1983 (Patients Concerned in Criminal Proceedings or Under Sentence). An admission of a person with a learning disability detained under Part II of the Mental Health Act 1983 (Compulsory Admission to Hospital and Guardianship) will only occur if the referral for an admission is via the courts as part of the diverting offenders with mental health problems and/or learning disabilities within the National Conditional Cautioning Framework. Treatment pathways will range between 2/3 years for low secure and 4/5 maximum for medium secure. This improved offender pathway will include:

- Community forensic support to policy custody areas and magistrates courts
- The use of Care and Treatment Reviews (CTRs) before an admission
- Intensive community inpatient support services (non secure)
- Short break/crisis intervention support and facilities

Partnership working wrapping around the individual is essential across all services and relevant stakeholders. Individuals and families themselves will see:

- More flexible and accessible services
- Choice and control as people with challenging behaviour themselves will be involved in developing pathways
- Improved information at the right time
- Strengthened advocacy services
- Greater focus on personalisation

Each person will have different experiences but their care pathway journeys should be consistent with defined outcomes. Care pathways will be evidenced based subject to reasonable adjustments and take into account best practice to ensure the right care in the right place at the right time.

4.7 How Will People be Fully Supported to Make the Transition from Children’s Services to Adult Services?

The “Living My Way, My Life Strategy (2014-18)”, will be utilised as part of the TCP plan setting out a vision for the delivery and planning of services for all ages. Where transition between children’s and adults services is required then early joint working between professionals to effectively plan services will be adopted to make that transition possible.

We believe the following aspects should be in place in all circumstances to manage transition to Adults Services effectively:

- Identification of likely future adult needs as early as possible. Whilst in some cases this should be from the age of 14 onwards (see guidance below; ‘When a Transition Assessment must be carried out’) it should be undertaken in any event at the most appropriate time for the Young Person where this is of ‘significant benefit’
- Young people (and their parents/carers) should not be left suddenly without support or services on their 18th birthday and then required to wait for reassessment for eligible Adult Services
- Children, young people and families should have access to good quality Information, Advice and Guidance (IAG) before point of transition, in a variety of formats as required to meet their needs
- Any assessments or reassessments and changes to care arising from these, should take into account the development and mental capacity of the Young Person and/or their parents & carers.
- Safeguarding considerations must be paramount at all times
- Where possible, named ‘lead practitioners’ for transition should support ‘pre-transition’
activity (including visits & meetings) throughout the transition phase

- A whole-family approach to assessment of need should be taken that considers not just the needs of the child/Young Person but also their parents/carers as they approach transition
- (Where possible) greater independence should be empowered and self-reliance encouraged, to reduce lifelong service dependency
- Transition arrangements should reflect the areas young people and families have told us are important to them – they should help them maintain a healthy body and mind, allow them to pursue education, employment or training if they wish to, stay safe, and have enough money to access the support they require.
- Cooperation between providers of Children’s/Young People’s and Adult’s Services with a focus on joint working before, during and after the point of transition to ensure any changes to care and support are implemented smoothly and concerns and worries are addressed

Outcomes

For an individual and their parents/carers at transition these are:

- **Information and Advice**: I have the knowledge, information and skills I need to enable me to manage my health (or that of the person I care for), plan for the future, and cope with emergencies.
- **Physical Health**: I have good health and am able to look after my own health and wellbeing.
- **Safe Environment**: Our home and the surrounding area (or the person’s I care for) is well maintained, safe, and suitable for us to manage day to day activities, have enough space to play or study. I feel safe, comfortable and happy there.
- **Life Outside of Caring**: (applicable to young carers & parent carers): I am able to have a life outside of caring, that includes breaks, social networks, activities and connections to others who can help me.
- **Emotional Wellbeing**: I feel emotionally well, healthy and happy. I know who I can talk to if I need someone to listen.
- **Money**: I am happy with what I have and I don’t worry about money. I am able to enjoy my hobbies and activities with friends.
- **Employment, Education & Training**: I am able to work towards what I want to achieve and know how to access support if I need help to get me there.
- **Choices and Behaviour**: I feel involved in decisions about me and my family and the support we get. I am asked my views and feel they are listened to.

### 4.8 How Will You Commission Services Differently?

**Key messages: Children, young people and families commissioning**

**The mandate for change:**
- Most children and young people in Staffordshire are safe and happy, but some do not get the support and protection they need from their families to thrive.
- When we asked them, children said they still wanted to be supported by their families and friends to cope with the day-to-day problems they face.
- Providing children are safe, we want them to thrive within their families and communities. The evidence says that their lives will be better as a result.
- Yet the way we support children in Staffordshire is currently based on referral to and dependency on professional services.
- The challenge is to enable Staffordshire’s children to thrive in their own families and
communities, whilst continuing to keep the most vulnerable children safe

- It’s what children want, it gives them a better chance in life and it’s the right thing to do

**Articulating the solution – (to be confirmed as co-production with partners advances)**

- Families not just children: enabling us to address the root cause of a child’s problem (which often lies with the parents) instead of repeatedly treating the symptoms
- Empowerment not dependency: thinking less about referral routes and more about equipping families with information, advice or strategies to successfully work through their problems
- Prevention and early help: it’s better for the family and a better use of resources to get in before crisis point
- Working in partnership: we can’t do this in isolation. Everyone has a role in supporting the families they know to recognise their problems and know how to go about solving them
- Continuing to safeguard the most vulnerable

In line with the current trend care settings will move from in patient provision to community settings. We will look to as priority areas commission crisis support services and admission prevention (crisis) accommodation.

Local Commissioners across the health and social care economy are committed to work with the Independent and third sector to shape and secure a vibrant and quality care and support market for people with complex needs and challenging behaviour. We are looking to drive new provision and will de-commission where appropriate.

The inclusion of children and people with autism into the cohort requires a greater understanding of the population and market development is key in these areas for the local economy. Lack of local services means that frequently individuals within these cohorts are placed out of area.

Both Local Councils have developed robust market position statements and are working jointly with NHS organisations on securing additional providers and services. The increase in complexity of needs and age range means that more providers will be required to support individuals in a niche market. Locally we are working to ensure procurement and contracting mechanisms must not be too time consuming or to discriminate against small providers.

As a larger commissioning footprint commissioning of services will be on a wider footprint and in some cases on a regional basis. There will be more collaborative commissioning and continued risk sharing arrangements with other CCGs. Further work needs to be undertaken at national and local level around aligning budgets with NHS England Specialised Commissioners. NHS England will be required to support local negotiations to ensure that funding is allocated appropriately.

**Outcomes Based Commissioning**

Outcomes based and person centred commissioning is becoming the norm with a focus on results rather than activities and processes. The personalisation agenda has been prioritised at a national level and so locally it is essential we react in a person centred way in future. Commissioning has been run with traditional models of delivery and our ambition is to shift this to individually based service design that state clearly what people want and outcomes people expect from their services and support. To this end service specifications will be based on evidence and best practice, be outcome based and address quality issue.
Working Towards Integrated Commissioning

Services will be commissioned in alignment with the nine (9) principles:

- Principle 1: a good and meaningful life
- Principle 2 & 3: person and family / carers at the centre
- Principle 4: support to my family and paid staff
- Principle 5: where I live and who I live with
- Principle 6: mainstream health services
- Principle 7 & 8: specialist multi-disciplinary health and social care support in the community
- Principle 9: hospital

Staffordshire through the All Ages Disability Board (and explore capitated budgets with Providers in the area) is working towards integrated commissioning and developing pooled budget arrangements. This will:

- Enable whole system leadership
- Enable the delivery of integrated packages of care for individuals moving away from the current ‘firefighting’ approach and bring together the total resource across the whole pathway from prevention to intensive support
- Secure the best value for money for placements
- Support financial savings across the health and social care economy
- Increase efficiency releasing resources to enable provision of services not currently provided;
- Improve access to services and increase the self-directed support offer
- Shift the balance of resources upstream and prevent the need for more expensive/complex packages of care
- Reduction in micro-management and increase trust between organisations based on jointly agreed outcomes and monitoring delivery (quality, safety and finances)

In Staffordshire County Council, whilst progress has been made in shaping the Independent Sector market for All Age Disabilities, there are a number of areas that need addressing further in order to ensure a diverse and quality marketplace, shaped by the demands of customers and their families. These are broadly summarised below:

- Improve capacity in Staffordshire in meeting a diversity of accommodation and care and support needs of those with Challenging and or/Complex Needs i.e. those often going into Out of County specialist residential provision or currently in “Winterbourne” type accommodation i.e. Transforming Care.
- Increase in a diversity of high quality local accommodation to support those who wish to live as individuals or in friendship groups in a supported living environment i.e. improve Local Housing Offer.
- Increase in expedient and quality accommodation solutions for those with a lower level of need and those living with parents.
- Increase in the availability of accommodation and care and support options for those between the ages of 18 and 21, often coming from Out of County specialist residential education.
- Increase in accommodation and support options for those with Learning Disability and or
Autism and Dementia.

- Increased opportunities for support during the 24 hour day as opposed to traditional “9 to 5”.
- Increase in the provision of preventative services which help prevent or delay the development of care and support needs or reduce care and support needs (including carer support needs), that builds on individual and community assets.
- Increase in day opportunities, especially for those with more complex needs.
- Strengthen support and signposting for individuals who wish to gain and improve everyday life skills, to enable them to live as safely and independently as possible.
- Strengthen universal services and general signposting for individuals and their carers, thus reducing the numbers relying on crisis support.
- Improve quality and cost effectiveness of support and genuine involvement of individuals and families in judging quality of support.
- Increased genuine opportunity for real employment.
- Increase support (local offer) for those people up to the age of 25 with special educational needs and disabilities (SEND).
- Development of new opportunities for short breaks and activities for disabled children and young people that help develop the skills needed to live as independently as possible, whilst providing parents/carers with a genuine break from the caring role.
- Increase in the availability of foster placements as an alternative to residential care for disabled children and young people who are able to have their needs met in community settings.
- Increase in Providers in the Staffordshire marketplace able to offer price competitive residential care for disabled children who have complex needs, as we currently place over 50% of our disabled children “Out of County”.
- Increase in Providers who can provide accessible information and advice, including via social media, to all not just those with eligible care needs.

4.9 How Will Your Local Estate/Housing Base Need to Change?

Following transfers of commissioning responsibility for a range of LD provision from the NHS to social care and closure of services such as NHS Campus schemes there is very little NHS controlled estate used to provide services for people with a learning disability in this area.

CCGs in North Staffordshire and Stoke on Trent jointly commission an 11 bedded in-patient service provided by our local NHS Provider Trust. 5 beds are designated as Assessment & Treatment beds and 6 as medium stay beds with a focus on rehabilitation. The two units are next door to each other and located in the grounds of the Harplands Hospital, which is the mental health hospital for the area.

It is planned to redesign this building in 2016 in order to provide a more flexible environment which will support a revised service specification issued by local commissioners for future assessment and treatment services. Building changes will:
• Reduce beds provided from 11 to 6.
• Provide each patient with more individual space and their own facilities.
• Reduce risks to patients that may currently arise from patients having to share much of the communal space at the service.
• Aid staff in managing and supporting patients with differing needs within the Unit, enabling a more personalised support programme to be implemented for each patient.
• Provide an environment that is more conducive to a patient’s recovery and rehabilitation.

4.10 Alongside Service Redesign (e.g. investing in prevention/early intervention/community services); Transformation in Some Areas Will Involve ‘Resettling’ People Who Have Been in Hospital for Many Years. What Will This Look Like and How Will it be Managed?

People currently in hospital placements may have a range of complex needs in addition to their learning disability, therefore it is vital that the TCP area engages with providers of both care and support and accommodation to ensure a choice of suitable service to support them upon discharge, Important factors will be:
• Ensuring providers have a competent workforce.
• Ensuring the choice of provision within the community
• Ensuring the choice of quality accommodation within the community
• Ensuring that specialist community health teams are resourced to work with higher caseloads and independent providers,
• That each individual has a thorough transition plan of appropriate length to ensure a successful discharge,

In the TCP area a number of clients require settling into the community from hospital placements. Each person has an individual discharge plan overseen by their multi-disciplinary team. These plans include input from all persons involved in the client’s care along with carers and families and independent advocates.

Factors that are taken into account to ensure a successful transition include:
• Comprehensive need analysis
• Comprehensive risk assessment
• Excellent information sharing between providers
• Consideration of the environmental factors
• Detailed service specification of the client needs
• Allowing sufficient time for familiarisation within the new service.

Our local housing market needs to be developed and shaped in order to meet the needs of the current and future cohort of individuals. Further guidance is awaited on the establishment of NHS dowries for people who have been in hospital for five years or more.

Alongside the service re-design we need to be aware of the impact of the welfare reforms in regards to specialist housing and exempt accommodation which could destabilise the housing market for people with a learning disability.

Criminal Justice System

A close working relationship is required with health and social care providers to ensure that they
are able to respond to changing commissioning intentions, and play a full part in the work to build skills and capabilities in the workforce around positive behavioural support and also the management of complex cases who have been involved with the Criminal Justice System.

**What principles will be adopted?**

Services will be commissioned which promote prevention, early intervention and wellbeing to support people of all ages, including children, who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital, including the Criminal Justice System.

**4.11 How Does This Transformation Plan Fit With Other Plans and Models to Form a Collective System Response?**

- We will link this plan in with existing plans in Staffordshire including the recently produced CAMHS Local Transformation Plans for Children and Young People where priorities are identified which include reduction in in-patient beds;

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**Local Priorities**

**North Staffordshire priorities**

<table>
<thead>
<tr>
<th>Description of Scheme</th>
<th>Proposed Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Referral Hub Choice Apointments &amp; increased capacity at Tier 3</td>
<td>93% of choice appointments within 4 weeks by June 2018</td>
</tr>
<tr>
<td>- Single point of access for Tier 2 &amp; 3 services</td>
<td>Increased partnership/intervention capacity due to delivery of choice within 4 weeks</td>
</tr>
<tr>
<td>- Triage and signposting, telephone advice, short term interventions</td>
<td>Multi-agency/partnership working with 3rd sector providers ensures CYP have their needs met by the most appropriate services to meet their needs</td>
</tr>
<tr>
<td>- Choice and partnership delivered within timescales</td>
<td>Telephone access to advice and signposting for referrers</td>
</tr>
</tbody>
</table>

**South Staffordshire priorities**

<table>
<thead>
<tr>
<th>Description of Scheme</th>
<th>Proposed Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropsychiatry service</td>
<td>Improved case management</td>
</tr>
<tr>
<td>- Deliver support to CYP with co-morbidities at risk of admission</td>
<td>Reduction in inpatient admissions</td>
</tr>
<tr>
<td>- Provide early intervention/local support</td>
<td>Reduction in out of area placements</td>
</tr>
<tr>
<td>Children and Young People with co-morbidities</td>
<td>All CYP with comorbidity of CAMHS/ASD to receive medication &amp; multi-disciplinary review</td>
</tr>
<tr>
<td>- Improve joint working &amp; support for CYP with co-morbidities— particularly those with ASD</td>
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</tbody>
</table>
South Staffordshire:

- Neuropsychiatry service to deliver support to children and young people with co-morbidities at risk of admission and provide early intervention and support
- Improved joint working and support for children and young people with co-morbidities, particularly those with Autistic Spectrum Disorder (ASD).

North Staffordshire:

- Learning Disability Psychiatrist to provide dedicated medical leadership and improved management of children with complex needs.

Mental Health Crisis Concordat:

- Mental Health Concordat, action plan and strategic priorities including the Better Together Mental Health workstream;

Local Offer for Personal Health Budgets:

- Local offer for Personal Health Budgets this is being developed and a workstream implemented led by the PHB Manager.

Autism Strategy:

- Delivering with Partners the objectives of the National Autism Strategy at local level.
5. Delivery

Plans need to include key milestone dates and a risk register

5.1 What are the Programmes of Change/Work Streams Needed to Implement this Plan?

The Transforming Care Partnership Board has agreed a governance and project structure to support delivery of the vision set out in the national plan ‘Building the right support’. The Board recognises that effective project management is essential to be able to deliver the aspirations of Staffordshire’s Transforming Care Partnership Plan including the Resettlement Programme and the transformational change required in Staffordshire to deliver the National Service Model.

The key focus of this programme will be to drive the necessary transformation and development of services in Staffordshire to ensure that children, young people and adults with a learning disability and/or autism have the same opportunities as anyone else. The governance structure has therefore been established to drive the design and implementation of the new service model and to deliver the resettlement strategy.

The approved governance structure is set out below.

Further detail on the key programmes of work for each group is set out below.

<table>
<thead>
<tr>
<th>GROUP</th>
<th>RESPONSIBLE FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transforming Care Partnership Board</td>
<td>Overall accountability for the development and delivery of Staffordshire’s Transforming Care Partnership Plan. Decision-making, direction and oversight.</td>
</tr>
<tr>
<td>Transforming Care Operational Group</td>
<td>Drives delivery of the plan and work streams. Ensures programme critical success factors are delivered. Stakeholder Engagement Plan Risk Management Plan</td>
</tr>
</tbody>
</table>
| Integrated Commissioning Work Stream | Needs assessment including confirmation of numbers and needs by cohort and current accommodation status and placement in and out of area  
Review of existing services, provision and pathways  
Market Development Plan (including community capacity)  
Procurement and contracting. Development of a Local Crisis Service  
Review of personalisation proposals  
Workforce Development Plan  
Development of proposals for integrated teams  
Culture change  
Data management  
Finance and performance  
Quality  
Communication and consultation  
Stakeholder engagement |
| Integrated Care & Support Work Stream | Development of personalisation proposals  
Development of new pathways  
Resettlement programme  
Risk assessment  
Care and Treatment Reviews  
Individual Patient Planning  
De-commissioning of in-patient beds  
Culture change  
Performance indicators  
Communication and Consultation Strategy  
Case Management  
Organisational Development |

The Board recognises that as the programme is scoped more fully that the structure and focus of activity may need to be reviewed to ensure it remains fit for purpose and able to deliver our vision with more focussed groups to deliver key activity.

5.2 Who is Leading the Delivery of Each of These Programmes, and what is the Supporting Team.

Overall accountability for delivery of the programme sits with the Transforming Care Partnership Board, which brings together senior representation from all CCGs within Staffordshire, Staffordshire County Council, Stoke-on-Trent City Council, NHS England, Healthwatch and Clinical representation. Further consideration will be given to ensure appropriate input from the Local Government Association (LGA) and Adult Directors of Social Services (ADASS).

This group acts as the key decision-maker for all programme related decisions. It is anticipated that representatives ensure appropriate placement of the programme within their respective organisations taking forward recommendations for implementation.

Further consideration will be given to ensure appropriate engagement and representation from Borough Councils, Registered Social Landlords and private sector providers within the Partnership and programme as part of project initiation.

Delivery of the programme will be achieved through strong project management overseen by the Programme Board and managed on a day to day basis by the Steering Group with escalation as required. This group will be responsible for ensuring stakeholder engagement
throughout the programme and in all work streams.

The programme will also provide regular updates to Staffordshire's Commissioning Congress.

Membership of the two key groups – the Transforming Care Partnership Board and the Steering Group - is set out below.

Identified leads for each work stream is shown below. Each group brings together representation from both Council and CCGs to ensure the programme is fully embedded. Links with Mental Health commissioning colleagues will also be drawn in.
5.3 What are the Key Milestones – Including Milestones for when Particular Services will Open/Close?

An outline plan has been produced showing key milestones. This is being reviewed and updated as part of project initiation and will further evolve once the scale and scope of the programme are confirmed. A high level milestone plan is set out below to show the overall development and delivery milestones.

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Direction</strong></td>
<td><strong>Design – As is Evaluation</strong></td>
<td><strong>Design – To Be Development</strong></td>
<td><strong>Delivery</strong></td>
<td><strong>D-Day</strong></td>
<td></td>
</tr>
<tr>
<td>Establish governance</td>
<td>Needs assessment</td>
<td>Market development</td>
<td>Deliver Positive Behavioral Support Area Wide</td>
<td>New Models of Care in place</td>
<td></td>
</tr>
<tr>
<td>Transforming Care Plan – Draft 08/02; Final 11/02</td>
<td>Provider mapping</td>
<td>Workforce development</td>
<td>New Contracting Framework</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gap analysis</td>
<td>Pathway Redesign</td>
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</tbody>
</table>

A more detailed delivery plan sits below this, set out in *Appendix 4*, which will be used to manage the initiation and design phases of the project. More detailed stage and work stream plans will be produced after the visioning sessions to support the design and implementation of service changes.

5.4 What are the Risks, Assumptions, Issues and Dependencies?

Risk management will be integral to delivery of this programme. The risk management process will reflect the Council and CCG corporate approaches. These policies ensure that Risks, Assumptions, Issues and Dependencies (RAID) are proactively identified, understood, documented and managed.

Management of RAID is a specific responsibility of the Transforming Care Partnership Board and Steering Group. As part of project initiation, a risk workshop was held on 23 February with the Steering Group to identify, document and rate risks to the programme, which are set out in the risk log. Further sessions are planned in March to agree risk owners and review the mitigation approaches. Risks will be reviewed and managed on an on-going basis at Programme Board, Steering Group and in Work Stream and escalated where necessary. At the time of this submission, the key risks to the programme are:
• Ensuring appropriate placement of the programme within individual organisations to ensure effective decision-making to support the development and delivery. The governance structure ensures appropriate representation of key stakeholders from health and care who are senior enough to make recommendations to their own decision-making bodies.

• Ensuring common understanding, agreement and buy-in of the vision and objectives amongst all organisations. The governance structure builds on current effective working relationships within health and care drawing in appropriate representation. The Partnership Board’s aspirations to use this programme to transform health and care services for Staffordshire residents with a learning disability and/or autism and acknowledges the scale of the transformation programme. A series of visioning workshops are scheduled with health and care professionals and service users to confirm our common vision and support co-production of the services. (see Appendix 7 – High Level Co-production and Stakeholder Model / Framework)

• Ensuring appropriate resourcing to the development and delivery of the programme. All parties acknowledge the scale of the required transformation within Staffordshire and have put forward appropriate resourcing in terms of capacity and capability to establish and design the programme. However, the anticipated scope of the programme will mean that the capacity will need to be reviewed regularly particularly to ensure that we maximise the transformation opportunity.

• That there is poor quality information on the numbers and needs of children, young people and adults with a learning disability and/or autism in Staffordshire, where they live and services available. The project plan includes an initial needs assessment to identify this from various sources to ensure that we know. This will be underpinning Individual Patient Planning, the Market Development Strategy and the Estates Strategy.

• That analysis of existing provision within Staffordshire identifies that there are significant gaps in services which are greater than anticipated as well as insufficient suitable accommodation locally. The first phase of the project therefore includes a detailed needs assessment and provider mapping so that we confirm the gap in capacity and capability and address this in the Market Development and Estate Plans.

• That the resettlement programme will cause stress to the individuals from what is effectively their current home. Individual patient planning is given a high priority within the project with an emphasis that the moves are appropriate, are supported by the right package of care and are carefully managed according to individuals needs to minimise the associated stress.

The Programme’s Risk Management Strategy and the latest version of the Risk Log are set out in Appendix 5.

5.5 What Risk Mitigations Do You Have in Place?

Risk mitigations for all identified risks to the programme is set out in Appendix 5 together with their anticipated proximity. Further detail on the mitigation strategies for immediate risks to the programme is set out below.
<table>
<thead>
<tr>
<th>Category</th>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reputational</td>
<td>Partner organisations may not have the capacity or capability to deliver the required changes, with the result that outcomes are compromised and timescales are not achieved.</td>
<td>Initial programme plan identifies resource requirements. More detailed work stream plans are being developed and will include an assessment of required resource and whether this is currently available so that Partnership Board are able to identify additional resources or free up capacity or re-scope work stream plans to minimise the impact.</td>
</tr>
<tr>
<td>Financial</td>
<td>The transformation funding requires match funding by CCGs.</td>
<td>Work being undertaken to fully understand how to test and revise existing services.</td>
</tr>
<tr>
<td>Financial</td>
<td>Available resources in the local health and social care economy are extremely challenging and therefore there is no new money to support Transformation Plans.</td>
<td>Key partners will work across organisational boundaries in order to deliver the best care possible within available resource envelope. Shared working, resources and paperwork will reduce the cost burden across the City. An assumption has been made that funding will follow the client and therefore will be sustainable in the longer term.</td>
</tr>
<tr>
<td>Legal / Procurement</td>
<td>There is a need to fully engage current providers in the development phase however this poses a risk regarding any future procurement that might be required at a later stage.</td>
<td>Current providers are excluded from the TCP Board and a multi-disciplinary Clinical Reference Group is being developed to support the clinical input into the programme. Legal advice has been sought.</td>
</tr>
<tr>
<td>Benefits</td>
<td>The time needed to develop a common understanding, secure agreement and buy-in and agree outcomes is not taken, with the result that the programme fails to set a vision, define scope and prioritise and agree objectives and that as a result the programme fails to meet the needs of stakeholders (including service users), benefits are not realised and resource is wasted.</td>
<td>The governance structure builds on current effective working relationships between the Councils and CCGs. All commissioning bodies are committed to the same vision to use the programme as a way to transform the model of care for service users with a LD and/or autism. A series of visioning workshops with health and care commissioners and providers are scheduled to confirm our common understanding (including ‘perceived as is’) and service users, their families and carers to identify improvements and co-design the solution. Further detail is set out in Co-Production and Engagement Strategy and Action Plan.</td>
</tr>
<tr>
<td>Safety</td>
<td>Poor quality, and potentially inconsistent, information (including NHS England Specialised Commissioning data) on the numbers and needs of each cohort of service users, there is a risk that service re-design is based on an under representation of need meaning that the support offer developed is insufficient or inappropriate.</td>
<td>The initial project plan includes an early activity to conduct a needs assessment and review of existing provision, services and pathways so we have a better understanding of need and what is currently available. The validation process on numbers and needs of cohort, including inpatient numbers, will be iterative and on-going throughout the programme to deliver accurate sources of information on need of each cohort and individual service users.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Details</td>
</tr>
<tr>
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</tr>
<tr>
<td>Reputational</td>
<td>If there is insufficient engagement and co-production with service users, their families and carers, that the designed solution does not meet desired objectives, represents a missed opportunity or the programme is subject to a Judicial Review (which impacts on the reputation of the organisations and the programme).</td>
<td>The programme has developed a Co-Production and Engagement Strategy to support the design and delivery of the vision and new service model. This includes innovative ways to engage and consult service users with LD and/or autism and their families and carers. This is supported by ASSIST, a voluntary organisation to ensure the engagement of service users. The framework provides the overarching structure for our visioning and engagement proposals set out in the supporting Action Plan.</td>
</tr>
<tr>
<td>Quality</td>
<td>Insufficient, inappropriate provision developed locally to ensure that service users are moved to accommodation that fully meets their needs or the vision and aspiration of the programme.</td>
<td>Once the plan is finalised and the proposals for service redesign are developed during the initial stages of the project, the financial plan for delivery will be confirmed and prioritised by the TCP Partnership Board and relevant governing bodies of each commissioner. Development of the proposals will include consideration of the most efficient ways of delivering and, where necessary, include redistribution of funding to meet the aims and aspirations of the programme. Where there is a shortfall of appropriate accommodation, the Partnership Board will consider ways of developing this including seeking additional funding to support development.</td>
</tr>
<tr>
<td>Quality</td>
<td>There is a risk that the timescales for the resettlement programme and data quality on patients provided by NHS England means there is a risk that individual patients may initially be moved to inappropriate accommodation resulting in additional stress, risks to patient safety and need for further moves.</td>
<td>The plan for the resettlement programme will be in line with national requirements/timescales and will include significant focus on individual patient planning with the service user, their families and carers.</td>
</tr>
<tr>
<td>Strategic</td>
<td>The opportunities to maximise benefits and economies of scale by working in partnership with Shropshire and Telford are missed as they don't want to engage.</td>
<td>The SRO for Staffordshire and Stoke-on-Trent Transforming Care Partnership has had discussions with Shropshire about the opportunities, however, Shropshire do not wish to progress this at the current time. The Partnership Board will continue to look at strategic opportunities and dependencies throughout the programme.</td>
</tr>
</tbody>
</table>

Further detail on risks including strategic operational, delivery, programme, financial, legal and reputational ones are set out in the Risk Log.
Appendix 1 – Population of Staffordshire and Stoke-on-Trent.

Appendix 2 – Terms of Reference for the Transforming Care Partnership Board

Appendix 3 – Transforming Care Gap Analysis

Appendix 4 – Project Planning Documentation
  • Seven Steps and Plan on a Page
  • Milestones
  • Commissioning plan.

Appendix 5 – Risk Management Strategy and Risk Register

Appendix 6 – Communications and Engagement Strategy
  • Communications and Engagement Plan

Appendix 7 – High Level Co-production and Stakeholder Model / Framework
Appendix 1:

What is the population of Staffordshire and Stoke-on-Trent like?

Population Structure
The estimated resident population for Staffordshire and Stoke-on-Trent is 1,111,200 covering a large geographical area of 1,048 square miles.

Overall Staffordshire and Stoke-on-Trent has a relatively high concentration of people in the older age groups. The proportion of people aged 65 and over in Staffordshire and Stoke-on-Trent is higher than the England figure (20% compared with 18%). At a district level this ranges from 17% in Stoke-on-Trent to over 23% in Lichfield and Staffordshire Moorlands.

An Ageing Population
Similar to global trends, Staffordshire and Stoke-on-Trent has experienced a significant ageing of its population and there are now 61,800 more people over 65 than there were 20 years ago.

This trend is predicted to continue with Staffordshire and Stoke-on-Trent seeing its older population grows faster than average (Figure 1).

Between 2014 and 2019, the overall population for Staffordshire and Stoke-on-Trent is expected to rise by 2% (Figure 2). However during this period the numbers of older people are projected to increase more rapidly:

- the number of people aged over 65 is expected to increase by 11% (equating to 23,800 people)
- the number of people aged 75 and over by 18% (17,300 additional people)
- the number of people aged 85 and over by 22% (5,600 people)

At the same time the numbers of working age people (16-64) is projected to decline. The impact of these demographic changes means there will be an increase in the dependency ratio of older people to working age people across Staffordshire and Stoke-on-Trent. There are currently about three residents of working age for every older person. By 2034 this will reduce to two people of working age for every older person (Figure 3). In terms of health and care, this has implications for the economy and workforce.
Figure 1: Population projections, 2014-2034

Source: 2012-based population projections, Office for National Statistics, Crown copyright
Figure 2: Projected population change between 2014 and 2019

Source: 2012-based population projections, Office for National Statistics, Crown copyright
Rurality

Living in a rural area has a positive association with people's satisfaction. However it can also present difficulties in accessing services. In addition the structural demographic change towards an older population is the single most significant factor in an increasing prevalence of rural isolation.

Based on the 2011 Rural and Urban Classification 19% of Staffordshire and Stoke CCG’s population live in rural areas, which is higher than the national average of 17%. South Staffordshire (40%), Stafford (32%), Staffordshire Moorlands (30%) and Lichfield (30%) are particularly rural whilst Stoke-on-Trent and Tamworth populations are classified as urban.

Deprivation

Based on the Index of Multiple Deprivation 2015, Staffordshire is a relatively affluent area but has notable pockets of high deprivation in some urban areas with 9% of its population living in the most deprived fifth of areas nationally. However some of the remote rural areas in Staffordshire do have issues with hidden deprivation and in particular around access to services.

In contrast Stoke-on-Trent is ranked as the 14th most deprived local authority area in England (of 326) and the third most deprived area in the West Midlands Region. Almost three in ten people in the City live in the most deprived tenth of areas nationally with another fifth of the population falling in the second most deprived decile nationally.

Ethnicity

Overall there is little ethnic diversity across Staffordshire with the population being predominantly White British. According to the 2011 Census around 8.1% of Staffordshire and Stoke-on-Trent’s population were from a minority ethnic background concentrated mainly within East Staffordshire (13.8%) and Stoke-on-Trent (13.6%)
Transforming Care Partnership’s Board

Terms of Reference

Amendment History:

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<th>Date</th>
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</tr>
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<td>18.01.2016</td>
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<td>1.1</td>
<td>04.02.2016</td>
<td>TSU recommendations</td>
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<td>1.2</td>
<td>08.02.2016</td>
<td>Steering Group updates</td>
</tr>
<tr>
<td>1.3</td>
<td>26.02.2016</td>
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Background

The Transforming Care Programmes objectives are to deliver the actions and commitments in Transforming Care and the Concordat Programme of Action to the timescales set out in those documents.

The national programme aims to transform the way services are commissioned and delivered to stop people being referred to hospital inappropriately, provide the right model of care, and drive up the quality of care and support for people with learning disabilities and/or autism.

Purpose

The purpose of the Board is to provide vision, sponsorship, strategic direction, ownership for the Transforming Care Programme to transform services for individuals with learning disabilities and/or autism within Staffordshire and Stoke-on-Trent.

Terms of Reference

- To provide vision and system leadership for the Transforming Care Partnership
- To ensure effective governance for the Transforming Care Programme.
- To ensure clear placement of the Transforming Care Programme within the our respective organisations
- To ensure the interfaces and dependencies with other major projects and programmes being delivered are identified and managed effectively.
- To ensure that quality is central to the Transforming Care Partnership
- To provide overall direction on the development and implementation of the Transforming Care Programme and ensure that it meets National Guidance Frameworks.
- To act as the key decision making body for major programme decisions subject to agreement of our respective governance structures where appropriate.
- To develop, agree and sign off the Staffordshire Learning Disabilities Transformation plan including the critical success factors, benefits and resource implications.
- To be responsible and accountable for the successful delivery of the outcomes specified.
- To review the progress of the Staffordshire Transformation Plan and oversee implementation.
- To ensure that the Programme adopts an effective approach to benefit realisation and risk and issues management.
- To ensure that the Programme is used to drive transformation of health and care services to meet the needs of the people with learning disability and/or autism in Staffordshire and Stoke-on-Trent including review of pathways of care.
- To ensure that the Programme draws in relevant partners to support the implementation of the wider aims of the programme including where appropriate Borough Councils, Registered Social Landlords and private sector providers.
- To explore the opportunity to engage with partners in Shropshire and Telford to maximise benefits of the programme.
- To ensure affordability and value for money of the final proposals.
- To develop and agree the Communications Strategy and Plan.
- To oversee the review and reassessment of all people on the Transforming Care Cohort and delivery of the resettlement programme.
- To ensure that the programme engages stakeholder views including residents with learning disabilities and/or autism, their families and carers.
- To produce regular reports on progress as required to the CCG Governing Bodies, Council Cabinets, and NHS England Area Team(s).

**Governance Structure**

The governance structure showing key groups together with memberships is set out below.

**Quoracy**

The following members require being present for the meeting to be quorate:

- One member from each of the following organisations should be present at each meeting:
  - Cannock Chase CCG
  - East Staffs CCG
  - North Staffs CCG
  - South East Staffs/Seisdon Peninsula CCG
  - Stafford & Surrounds CCG
  - Stoke on Trent CCG
  - Staffordshire County Council
  - NHS England
Where a meeting is not quorate, arrangements for dealing with this should be clearly set out in the minutes.

Frequency of Meetings

The meetings will convene on a monthly basis and will be reviewed periodically.

These Terms of Reference will be subject to annual review.

8th February 2016
APPENDIX 3

Transforming Care – Gap Analysis

A recent Gap Analysis on the Assessment Against the LD Service Model has been undertaken by the organisations included in the Partnership Board. Once the vision is agreed further work will be undertaken to refine this but as a draft situation, the following gaps exist:-

<table>
<thead>
<tr>
<th>Principle 1 - I have a good and meaningful everyday life</th>
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</thead>
<tbody>
<tr>
<td><strong>Gaps</strong></td>
</tr>
<tr>
<td>• how the Supporting Independence Service (SIS) offer can be extended to under 16’s, principally in a brokerage function to support those with additional needs to access short breaks;</td>
</tr>
<tr>
<td>• Engagement of wider partners;</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 2 - My care and support is person-centred, planned, proactive and coordinated.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gaps</strong></td>
</tr>
<tr>
<td>• The Local Authority acknowledges that local health and care services should develop a dynamic register based on sophisticated risk stratification of their local area and are endeavouring to do so with the front line Social Work function Independent Futures;</td>
</tr>
<tr>
<td>• Case file evidence to demonstrate both for EHCP's and Adult Care &amp; support plans that individuals and their families have been fully involved in the planning process. It should be noted that whilst individuals and families are involved in the planning process, for those over the age of 18 assessments or support plans are not currently available in an easy read format; this is an area for development;</td>
</tr>
<tr>
<td>• Need common definition of what constitutes a person centred plan to ensure consistent standards;</td>
</tr>
<tr>
<td>• Audit of person centred plans;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 3 - I have choice and control over how my health and care needs are met.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gaps</strong></td>
</tr>
<tr>
<td>• Our ambition is to ensure commissioners and providers fully conform to the Accessible Information Standard by 31st July 2016;</td>
</tr>
<tr>
<td>• Within continuing care we do have over 100 packages of support that is jointly funded with health and social care however these are predominantly through invoice arrangements as opposed to joint personal budgets, so this would be the next logical phase in development;</td>
</tr>
<tr>
<td>• Advocacy services - Anecdotal evidence would suggest there is an extensive waiting list for this service however so capacity in this area is a potential issue;</td>
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<tr>
<td>• Review against new Accessible Information Standard;</td>
</tr>
<tr>
<td>• Easy read/pictorial not available for all Plans;</td>
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<tr>
<td>• No easy read Care Programme Approach (CPA);</td>
</tr>
<tr>
<td>• PHB’s need to be developed further for people with LD;</td>
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<tr>
<td>• Joined up, systematic process offering integrated budget across health &amp; social care;</td>
</tr>
</tbody>
</table>

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<tr>
<th>Principle 4 - My family and paid support and care staff get the help they need to support me to live in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gaps</strong></td>
</tr>
<tr>
<td>• How effectively we utilise crisis beds also requires review as there is potential to use our resources more effectively;</td>
</tr>
<tr>
<td>• The Local Authority is currently in the process of revising its Market Position Statement which will clearly identify areas that need strengthening for Learning Disability and/or Autism;</td>
</tr>
<tr>
<td>• Emergency respite availability;</td>
</tr>
<tr>
<td>• Opportunities to explore this with changes in respite provision in Stoke and North Staffs;</td>
</tr>
<tr>
<td>• Lack of skilled staff;</td>
</tr>
<tr>
<td>•Providers struggle to recruit staff with the necessary skills;</td>
</tr>
<tr>
<td>• MPS needs to be reviewed;</td>
</tr>
</tbody>
</table>
**Principle 5 - I have a choice about where I live and who I live with.**

<table>
<thead>
<tr>
<th>Gaps</th>
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</thead>
<tbody>
<tr>
<td>• There is currently a variety of differing housing solutions however there is recognition that this range needs to develop;</td>
</tr>
<tr>
<td>• Exploration will be taken in respect of whether there is a need to establish a supported living framework agreement for complex people with significant health needs. This engagement work will be undertaken in conjunction with a range of local housing providers;</td>
</tr>
<tr>
<td>• Housing strategy does not cover LD;</td>
</tr>
<tr>
<td>• Few people interested in home ownership;</td>
</tr>
<tr>
<td>• Low uptake for Extra Care;</td>
</tr>
</tbody>
</table>

**Principle 6 - I get good care and support from mainstream health services.**

<table>
<thead>
<tr>
<th>Gaps</th>
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</thead>
<tbody>
<tr>
<td>• There is a gap in secondary health care for adults with autism;</td>
</tr>
<tr>
<td>• There is a gap in relation to 16 plus with autism who find themselves in contact with the criminal justice system. Currently no forensic joined up response;</td>
</tr>
<tr>
<td>• Longer term commissioning of Health Facilitation service in SOT;</td>
</tr>
<tr>
<td>• Hospital passports;</td>
</tr>
<tr>
<td>• Consistency of liaison staff;</td>
</tr>
<tr>
<td>• A Quality Checker’ scheme is not currently in place;</td>
</tr>
<tr>
<td>• Stoke and North Staffs – Green Light Toolkit not in place;</td>
</tr>
</tbody>
</table>

**Principle 7 - I can access specialist health and social care support in the community.**

<table>
<thead>
<tr>
<th>Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Room for improvement remains in joint working arrangements between Mental Health and Autism services (through for example the development, implementation and testing of joint working protocols) and in structured support for those with Autism post-diagnosis;</td>
</tr>
<tr>
<td>• We are only now (January 2016) implementing a fully operational Countywide assessment and diagnostic service for Adults with Autism, and will use 2016 as a learning phase to accurately develop data on demand and onward referral to inform what gaps there are for future commissioning and service provision;</td>
</tr>
<tr>
<td>• Links with Staffordshire;</td>
</tr>
<tr>
<td>• Project Plan to be developed;</td>
</tr>
<tr>
<td>• Workshops to gain views of staff, service users and carers to be run;</td>
</tr>
<tr>
<td>• Intensive 24/7 multi-disciplinary health and social care support not in place in Children’s services;</td>
</tr>
</tbody>
</table>

**Principle 8 - If I need it, I get support to stay out of trouble**

No gaps identified at this point.

**Principle 9 - If I am admitted for assessment and treatment in a hospital setting because my health needs can’t be met in the community, it is high quality and I don’t stay there longer than I need to.**

<table>
<thead>
<tr>
<th>Gaps</th>
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</thead>
<tbody>
<tr>
<td>• Young people under 18 who become mentally unwell struggle to get a joined up response should they require inpatient services no local resources. IST / ISS newly formed early intervention and prevention teams from the NHS work alongside Douglas Road / Resource Centres (Social Care) as there are no health respite facilities should the person be unable to remain in their home but do not require inpatient setting under the mental health act;</td>
</tr>
<tr>
<td>• There are no respite facilities in the south;</td>
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<tr>
<td>• Green Light Toolkit;</td>
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<tr>
<td>• Raise awareness of Model of Care with mental health services;</td>
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<tr>
<td>• New service specification;</td>
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<tr>
<td>• Contract variation;</td>
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<tr>
<td>• Transition to new model;</td>
</tr>
<tr>
<td>• Environmental changes;</td>
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<tr>
<td>• Framework agreement in place;</td>
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<tr>
<td>• Mini competitions;</td>
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</table>
Appendix 4

7 Step Plan

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<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
<th>Step 6</th>
<th>Step 7</th>
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</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Situation Description</td>
<td>Situation Analysis</td>
<td>Option Generation</td>
<td>Option Evaluation</td>
<td>Business Case/ Proposal</td>
<td>Implementation</td>
</tr>
<tr>
<td>Confirm the route and process for decision making and ‘sign offs’</td>
<td>Execute Market Research and Define ‘As Is’ processes</td>
<td>Confirm/ Validate the Situation Description and identify the issues to be addressed/ resolved</td>
<td>Generate approaches and potential solutions</td>
<td>Assess the various alternatives to address the issues identifying benefits &amp; dis-benefits</td>
<td>Construct a structured business proposal addressing the key components of the Treasury 5 Case Model</td>
<td>Launch Project Plan</td>
</tr>
</tbody>
</table>

| Confirm the key dates of meetings and report lead in’s | | | | | | Monitor and Report |
| Deliver the change through planned implementation | | | | | | |
# Transforming Care Programme - Plan on a Page (Project Initiation Stage)

<table>
<thead>
<tr>
<th>Staffordshire &amp; Stoke TCP Plan</th>
<th>Project Initiation</th>
<th>Co-Production and Stakeholder Engagement</th>
<th>Integrated Commissioning</th>
<th>Integrated Care and Support</th>
</tr>
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<tbody>
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<td><strong>February</strong></td>
<td>TCP Partnership Board established</td>
<td>Review of existing evidence</td>
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<td>TORs and governance</td>
<td>Document ‘As l’d pathways</td>
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<tr>
<td>NHS England feedback</td>
<td>Work streams established</td>
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### Progress/Update

- **Staffordshire & Stoke TCP Plan**
  - Draft plan submitted to deadline of 8/2. Currently awaiting feedback from NHS England to confirm necessary amendments for final plan. This is expected 19/2 and are anticipated to include updates on finance and performance data. Timetable for drafting and approvals is currently being developed based on a revised plan submission date of 14/3/16.

- **Project Initiation**
  - First meeting of the Transforming Care Partnership Board held on 28 January. Terms of reference and governance structures agreed at Partnership Board on 25 February. High level project planning has commenced and will be developed further as the work streams are initiated. This will be supported by a number of Visoning Workshops and engagements in April and May 2016. This session will help us to develop our new model of care and identify the changes that are needed to support delivery of our vision. These blueprints will support development of detailed project plans. Other key project documentation will be produced alongside this.
  - The blueprints, RAID log and PID will be brought to Programme Board on 22 March for review together with an update on how the engagement strategy is progressing.

- **Co-Production and Stakeholder Engagement**
  - The programme has developed a Co-Production and Engagement Strategy to support development of the vision and solution design. The Partnership is working with REACH, a local project set up to support adults with LD and/or autism to deliver a programme of engagement sessions with service users. Other sessions with health and care professionals and providers, including LA housing departments and RSLs, the Criminal Justice Service and education are currently being scheduled. The findings from these will be used to develop the blueprint for the new service with these forming the basis of project plans for each workstream.

- **Integrated Commissioning**
  - Detailed work stream plan to be developed in May following initial engagements.

- **Integrated Care and Support**
  - Detailed work stream plan to be developed in May following initial engagements.

---

### Key to symbols
- Original Milestone
- Milestone on target
- Latest Forecast
- Date at risk, but plan in place to resolve
- Completed
- Milestone missed/ no plan to resolve/ no information

### Key to RAG states
- Green (G): On track
- Yellow (Y): Concerns/ outstanding issues
- Red (R): Milestone missed/ no plan to resolve/ no information
<table>
<thead>
<tr>
<th>Management and Control</th>
<th>Current RAG</th>
<th>Comments</th>
<th>Action Owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Purpose, objective and scope are clear and visible</td>
<td>Green</td>
<td>Vision workshop set for 28/01/2016. Final Plan to be approved by 31/03/2016 and submitted by 11.04.2016.</td>
<td>SRO</td>
</tr>
<tr>
<td>2. Roles, lines of accountability and decision-making are clear and in place</td>
<td>Green</td>
<td>Roles and Responsibilities to be agreed by Partnership Board by 29/02/2016.</td>
<td>TCP</td>
</tr>
<tr>
<td>3. Suitable governance meetings are taking place at appropriate intervals with the right representation and actions being taken</td>
<td>Green</td>
<td>Partnership Board Meetings agreed monthly.</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>4. The relationships and partnerships needed to deliver the objective are in place and working effectively</td>
<td>Green</td>
<td>All Partners identified and included on the partnership board.</td>
<td>TCP</td>
</tr>
<tr>
<td>5. Stakeholders needs and expectations are understood and being addressed or managed appropriately</td>
<td>Green</td>
<td>A separate task and finish group will be responsible for Communications and Engagement. Action Plan expected by 31/05/2016</td>
<td>Comms Lead</td>
</tr>
<tr>
<td>6. Existing risks, issues and barriers known, visible and being appropriately addressed (including culture and leadership)</td>
<td>Green</td>
<td>A risk workshop will be held once the vision is agreed by the Partnership Board and feedback on the plan has been received by NHS E</td>
<td>Project Team</td>
</tr>
<tr>
<td>7. Finances (costs, savings and pressures) are understood, robust enough and are being managed effectively</td>
<td>Green</td>
<td>Current costs have been requested.</td>
<td>Commissioners</td>
</tr>
<tr>
<td>8. Inter-dependencies are known, visible and are being managed</td>
<td>Green</td>
<td>Dependencies will be managed by the project team and reported to the Partnership Board.</td>
<td>SRO</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. A delivery plan, relevant to the complexity of the project or business activity and current phase, exists; with clear milestones, linked to benefits and dependencies, and an understanding of any sequencing required.</td>
<td>Green</td>
<td>Delivery Plan is currently in draft stage and will be submitted to NHS E for quality assurance</td>
<td>Operational Group</td>
</tr>
<tr>
<td>10. Forecast delivery timescales are deemed to be achievable</td>
<td>Green</td>
<td></td>
<td>Operational Group</td>
</tr>
<tr>
<td>11. Current delivery performance against plan is good (on track)</td>
<td>Green</td>
<td></td>
<td>Operational Group</td>
</tr>
<tr>
<td>12. SCC business resource is appropriate (capability, capacity, fit)</td>
<td>Green</td>
<td></td>
<td>SRO</td>
</tr>
<tr>
<td>13. Benefits (financial) on track to be delivered</td>
<td>Green</td>
<td></td>
<td>Finance Lead</td>
</tr>
<tr>
<td>14. Benefits (non-financial) on track to be delivered</td>
<td>Green</td>
<td></td>
<td>Finance Lead</td>
</tr>
</tbody>
</table>
Staffordshire and Stoke-on-Trent Transforming Care Partnership Risk Register

Please see full risk log as attached spreadsheet.
Appendix 5

STAFFORDSHIRE AND STOKE TRANSFORMING CARE PARTNERSHIP

Risk Management Strategy
2nd March 2016

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Transforming Care Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version Control No.</td>
<td>V 1.0</td>
</tr>
<tr>
<td>Author / Project Manager</td>
<td>Kirsty Alldread</td>
</tr>
<tr>
<td>Date Submitted</td>
<td>03/03/2016</td>
</tr>
</tbody>
</table>

Section 1: Introduction

Purpose
The purpose of this Risk Management Strategy is to describe the risk management techniques and standards to be applied on the Transforming Care Programme for Staffordshire and Stoke and the responsibilities for achieving an effective risk management procedure.

Objective
The objective of this Risk Management Strategy is to detail a systematic application of procedures for identifying and assessing risks, and then planning and implementing risk responses. This will provide a disciplined environment for proactive decision making to assess and control uncertainty and, as a result, improve the ability of the project to succeed.

Scope
This Risk Management Strategy applies to the overall conduct of the Transforming Care Programme. Work streams and delivery partners may operate different risk management approaches, but any significant variances from this strategy are to be assessed and accepted by the Steering Group.

Responsibility
The Project Manager is responsible for the creation and updating of this Risk Management Strategy.

Section 2: Risk Management Procedure

Overview
This section provides a description of the risk management procedure to be used for the project. The project is to apply five steps to risk management: identify, assess, plan and implement, supported by communication.

Identify
The primary goal of the ‘Identify’ step is to recognise the threats and opportunities that may affect the project’s objectives. Risks will be identified using a combination of techniques, including reviewing the lessons of comparable projects (for example, Better Care Fund), risk prompts lists and brainstorming in formal risk workshops. These will be supplemented by ad hoc recognition of risks during project planning and delivery. All identified threats and opportunities will be captured in a Risk Register. In addition, Early Warning Indicators will be used to monitor critical aspects of the project and provide information on potential sources of risk (see Section 12.0). The risks will be shared with key stakeholders to confirm that they reflect any major concerns stakeholders may have.
<table>
<thead>
<tr>
<th>Assess</th>
<th>The primary goal of the ‘Assess’ step is to estimate each risk in terms of estimated likelihood (probability), impact and immediacy (proximity), and evaluate the overall level of risk associated with the project and expected monetary value of that risk (see Section 3.0).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>The primary goal of the ‘Plan’ step is to prepare specific management responses to the threats and opportunities identified, ideally to remove or reduce the threats and to maximise the opportunities. The Plan step involves identifying and evaluating a range of options for responding to threats and opportunities. It is important that the risk response is proportional to the risk and that it offers value for money. A key factor in the selection of responses will be balancing the cost of implementing the responses against the probability and impact of allowing the risk to occur. Any chosen responses should be built into the appropriate level of plan, with provision made for any fall-back plans. Mitigation actions are also to be recorded, in summary, in the project Risk Register. The various types of responses for threats and opportunities are summarised in Section 11.0.</td>
</tr>
<tr>
<td>Implement</td>
<td>The primary goal of the ‘Implement’ step is to ensure that the planned risk responses are actioned, their effectiveness monitored, and corrective action taken where responses do not match expectations. This is to be achieved by nominating risk owners and risk actionees for each risk.</td>
</tr>
</tbody>
</table>
| Communication | The primary goal of the ‘Communicate’ step is to ensure that information related to the threats and opportunities faced by the project is communicated continually, both within the project and externally to stakeholders. Risks are to be communicated as part of the following management products:  
  - Status (Highlight) Reports  
  - Work stream (Checkpoint) Report (when produced)  
  - End Stage Reports  
  - End Project Reports  
  - Lessons Reports  
  Further direction on the communication of risks is contained within the project’s Communication Management Strategy. |

| Section 3: Tools and Techniques |
| The following specific risk management techniques will be used on this project |
| Probability-impact calculations | The project will use a probability-impact calculation to assess the overall severity of each risk, enabling each risk to be ranked so that management time and effort can be prioritised. The value of the risk will be determined by multiplying the probability by the impact. |
| Expected monetary value | Where monetary values have been attributed to individual risks, expected monetary values will be calculated by combining the cost of the risk impact with the probability of the risk occurring. For example, if the cost of a risk was £160,000 and its likelihood of occurrence was estimated at 25%, then the expected value would be £40,000. The aggregated expected value of all costed risks will inform the amount of risk budget required for the project. |

| Section 4: Records |
| Overview | The project will use a Risk Register to provide a record of identified risks (threats and opportunities) relating to the project, including their status and history. |
| Format | The Risk Register will be maintained as a live list on the project’s SharePoint site once established. The most up-to-date version of the Risk Register (dated 2 March 2016) is appended to this Strategy. |
For each entry in the Risk Register, the following should be recorded

<table>
<thead>
<tr>
<th><strong>Composition</strong></th>
<th><strong>For each entry in the Risk Register, the following should be recorded</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Identifier</strong></td>
<td>Provides a unique reference for every risk entered into the Risk Register. This will be a numeric value auto-generated by SharePoint.</td>
</tr>
<tr>
<td><strong>Risk Category</strong></td>
<td>The type of risk in terms of the project’s chosen categories (e.g. civils, planning, legal, etc.). See Section 10.0.</td>
</tr>
<tr>
<td><strong>Risk Description</strong></td>
<td>A description of the risk cause and event (threat or opportunity).</td>
</tr>
<tr>
<td><strong>Risk Effect (narrative)</strong></td>
<td>A description of the risk effect (impact).</td>
</tr>
<tr>
<td><strong>Proximity</strong></td>
<td>The time factor of risk, i.e. when the risk may occur. The impact of a risk may vary in severity depending on when the risk occurs. This would typically state how close to the present time the risk event is anticipated to happen (e.g. imminent, within stage, within project, beyond project). Proximity should be recorded in accordance with the project’s chosen scales. See Section 9.0</td>
</tr>
<tr>
<td><strong>Probability, impact and expected value</strong></td>
<td>It is helpful to estimate the <em>inherent</em>(^1) values (pre-response action) and <em>residual</em>(^2) values (post-response action). These should be recorded in accordance with the project’s chosen scales. See Section 8.0</td>
</tr>
<tr>
<td><strong>Risk Score</strong></td>
<td>A score calculated from probability multiplied by impact. See Section 8.3.</td>
</tr>
<tr>
<td><strong>Risk level</strong></td>
<td>‘High’, ‘Medium’ or ‘Low’. See Section 8.3.</td>
</tr>
<tr>
<td><strong>Risk Response Categories</strong></td>
<td>How the project will treat the risk in terms of the project’s chosen categories. See Section 11.0.</td>
</tr>
<tr>
<td><strong>Risk Response</strong></td>
<td>Actions to resolve the risk and these actions should be aligned to the chosen response category. Note that more than one risk response may apply to a risk.</td>
</tr>
<tr>
<td><strong>Risk Status</strong></td>
<td>Described in terms of whether the risk is pending (i.e. not yet accepted by the Project Team), active, resolved (i.e. pending closure by the Project Team) or closed.</td>
</tr>
<tr>
<td><strong>Risk Owner</strong></td>
<td>The person responsible for the management, monitoring and control of all aspects of a particular risk assigned to them, including the implementation of the selected responses to address the threats or to maximise the opportunities. (There can only be one risk owner per risk.)</td>
</tr>
<tr>
<td><strong>Risk Actionee</strong></td>
<td>The person(s) who will implement the action(s) described in the risk response. This may or may not be the same person as the risk owner.</td>
</tr>
<tr>
<td><strong>Risk Author</strong></td>
<td>The person who raised the risk.</td>
</tr>
<tr>
<td><strong>Date Registered</strong></td>
<td>The date the risk was identified.</td>
</tr>
<tr>
<td><strong>Review Date</strong></td>
<td>The date the risk is due to be reviewed.</td>
</tr>
</tbody>
</table>

---

\(^1\) The exposure arising from a specific risk before any action has been taken to manage it.  
\(^2\) The risk remaining after the risk has been applied.
Section 5: Reporting

Risks will all be captured in a Risk Register, available to view by all of the Partnership Board, Steering Group and Workstream Groups. Risks are typically to report using the communication methods detailed in Section 2.6. In addition, risks and risk responses will be reviewed in summary at each programme meeting and in detail at regular risk workshops. Project-level risks deriving from workstreams are to be reported to the Project Manager during regular work stream catch-up meetings and incorporated within the Risk Register. Where risk tolerance exceeds the threshold levels of risk exposure, an Exception Report will be submitted to the Project Board.

Section 6: Timing of Risk Management Activities

Risk management is a process that will occur continuously throughout the project cycle in accordance with the details directed within this strategy. Specific risk workshops will be conducted on a quarterly basis.

Section 7: Roles and Responsibilities

<table>
<thead>
<tr>
<th>Roles</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate / Programme Management</td>
<td>Provide the corporate risk management policy and risk management process guide.</td>
</tr>
<tr>
<td>Executive</td>
<td>Be accountable for all aspects of risk management and, in particular, ensure a project Risk Management Strategy exists.</td>
</tr>
<tr>
<td></td>
<td>Ensure that risks associated with the Business Case are identified, assessed and controlled.</td>
</tr>
<tr>
<td></td>
<td>Escalate risks to corporate or programme management as necessary.</td>
</tr>
<tr>
<td>Senior Users</td>
<td>Ensure that risks to the users are identified, assessed and controlled.</td>
</tr>
<tr>
<td>Senior Supplier</td>
<td>Ensure that risks relating to the supplier aspects are identified, assessed and controlled. At this stage, the Programme does not have an identified Supplier on the Programme Board due to the stage of the programme.</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Create the Risk Management Strategy.</td>
</tr>
<tr>
<td></td>
<td>Create and maintain the Risk Register.</td>
</tr>
<tr>
<td></td>
<td>Ensure that project risks are being identified, assessed and controlled throughout the project lifecycle.</td>
</tr>
<tr>
<td>Workstream Managers</td>
<td>Participate in the identification, assessment and control of risks.</td>
</tr>
<tr>
<td>Project Assurance</td>
<td>Review risk management practices to ensure that they are performed in line with the project’s Risk Management Strategy.</td>
</tr>
<tr>
<td>Project Support</td>
<td>Assist the Project Manager in maintaining the project’s Risk Register.</td>
</tr>
</tbody>
</table>

Section 8: Scales

This section defines the scales for estimating probability and impact for project’s risks

**Probability**

*Probability is to be assessed and rated using these criteria*

<table>
<thead>
<tr>
<th>Score</th>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>Unlikely to occur during the project / Up to a 10% chance of occurrence</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>11-30% chance of occurrence</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>31-50% chance of occurrence</td>
</tr>
</tbody>
</table>
## Impact

*Impact is to be assessed and rated using these criteria:*

<table>
<thead>
<tr>
<th>Score</th>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Low</td>
<td>Unlikely to occur during the project / Up to a 10% chance of occurrence</td>
</tr>
<tr>
<td>2</td>
<td>Reasonable</td>
<td>11-30% chance of occurrence</td>
</tr>
<tr>
<td>3</td>
<td>Major</td>
<td>31-50% chance of occurrence</td>
</tr>
<tr>
<td>4</td>
<td>Severe</td>
<td>51-70% chance of occurrence</td>
</tr>
<tr>
<td>5</td>
<td>Catastrophic</td>
<td>71-99% chance of occurrence</td>
</tr>
</tbody>
</table>

### Risk (probability-impact) score / level

*Each risk will have an overall score derived from a probability-impact calculation. These scores will translate into risk levels ('High', 'Medium' or 'Low') using these criteria:*

<table>
<thead>
<tr>
<th>Score</th>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;15</td>
<td>High</td>
<td>Proactive response, monitor closely</td>
</tr>
<tr>
<td>6 to 14</td>
<td>Medium</td>
<td>Proactive response, monitor regularly</td>
</tr>
<tr>
<td>0 to 5</td>
<td>Low</td>
<td>Monitor infrequently</td>
</tr>
</tbody>
</table>

### Section 9: Proximity

Proximity reflects the fact that risks will occur at particular times and the severity of their impact will vary according to when they occur. This section defines the scales to be used for estimating risk proximity:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imminent</td>
<td>If occurs, likely to be within 3 months</td>
</tr>
<tr>
<td>Within stage</td>
<td>If occurs, likely to be within current project stage</td>
</tr>
<tr>
<td>Within project</td>
<td>If occurs, likely to be within future project stages</td>
</tr>
<tr>
<td>Beyond project</td>
<td>If occurs, likely to be after project(s) end</td>
</tr>
</tbody>
</table>

### Section 10: Risk Categories

The project will use the following risk categories:

- Financial Schedule
- Quality
- Benefits
- Resource
- Interdependency
- Strategic
- Reputational
- Legal
Section 11: Risk Response Categories

The project is to use the following risk response categories:

<table>
<thead>
<tr>
<th>Response (threat)</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid (threat)</td>
<td>A risk response where the threat either can no longer have an impact or can no longer happen.</td>
</tr>
<tr>
<td>Reduce (threat)</td>
<td>Proactive actions are taken to reduce the probability of the event occurring by performing some form of control, and/or to reduce the impact of the event should it occur.</td>
</tr>
<tr>
<td>Fallback (threat)</td>
<td>Putting in place a fallback plan for the actions that will be taken to reduce the impact of the threat should the risk occur. This is a reactive form of the ‘reduce’ response which has no impact on likelihood.</td>
</tr>
<tr>
<td>Transfer (threat)</td>
<td>A third party takes on responsibility for some aspect of the financial impact of the threat (e.g. through insurance or contractual clauses). This is a form of the ‘reduce’ response which only reduces the financial impact of the threat.</td>
</tr>
<tr>
<td>Accept (threat)</td>
<td>A conscious and deliberate decision is taken to retain the threat, having discerned that it is more economical to do so that to attempt a risk response action. The threat should continue to be monitored to ensure that it remains tolerable.</td>
</tr>
<tr>
<td>Share (threat or opportunity)</td>
<td>Through the application of a pain/gain formula, both parties share the gain (within pre-agreed limits) if the cost is less than the cost plan, and both parties share the pain (again within pre-agreed limits) if the cost plan is exceeded.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response (opportunity)</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance (opportunity)</td>
<td>Proactive actions are taken to enhance both the probability of the event occurring and the impact of the event should it occur.</td>
</tr>
<tr>
<td>Exploit (opportunity)</td>
<td>Seizing an opportunity to ensure that the opportunity will happen and that the impact will be realised.</td>
</tr>
<tr>
<td>Reject (opportunity)</td>
<td>A conscious and deliberate decision is taken not to exploit or enhance an opportunity, having discerned that it is more economical to do so than to attempt a risk response action. The opportunity should continue to be monitored.</td>
</tr>
</tbody>
</table>

Section 12: Early-Warning Indicators

Risk management needs to be proactive to anticipate potential problems. Early warning indicators can be used to provide information on the potential sources of risk, or as a way of tracking sensitive risks, triggering further corrective actions if predefined levels are reached. The project will use the following early warning indicators:

- Forecast outturn exceeds planned spend profile / total budget.
- Requests to change the approved highways improvement designs.
- Delays in the delivery of planned outputs / objectives.
- Reductions in the expected project benefits.

Section 13: Risk Tolerances

Risk tolerance describes the threshold levels of risk expose which, when exceeded, will trigger an Exception Report to bring the situation to the attention of the Partnership Board. For this project, any risk that exceeds a score of 15 (i.e. with a risk level of ‘High’) will be referred to the Partnership Board. These risks may subsequently referred onto corporate or programme management. Additionally, the Partnership Board will be informed when the aggregated expected monetary value of the risks exceeds 10% of the project’s budget. Any risk with a score higher than 5 (i.e. with a risk level of ‘Medium’) will be formally reviewed at a Steering Group meeting and a proactive response...
Section 14: Risk Budget

14.1 A risk budget, if used, is a sum of money included within the project budget and set aside to fund specific management responses to the project’s threats and opportunities. Consideration to the requirement when the project budget requirement is scoped.

14.2 In order to arrive at a risk budget for the project, a financial approach to risk management is needed. Each risk must be fully analysed for the impact costs, response costs and likelihood. The aggregation of the costs (for responses and impact) weighted by each risk’s probability generates the monetary value for the set of risks. The total monetary value of all project risks is to be used to determine a risk budget for the project.

14.3 The risk budget for the project will be agreed by the Partnership during Risk Workshops and approved by the Partnership Board. Authority to spend funds from the risk budget is held by the Partnership Board, although the board may delegate this decision to the project’s SRO up to an agreed threshold.

Risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives. It consists of a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impact on objectives, where:

- **Threat** is used to describe an uncertain event that could have a negative impact on objectives.
- **Opportunity** is used to describe an uncertain event that could have a favourable impact on objectives.

A risk will typically have a related cause, event and effect:

- **Risk cause** describes the source of the risk.
- **Risk event** describes the area of uncertainty in terms of the threat or the opportunity.
- **Risk effect** describes the impact(s) that the risk would have on the project objectives should the risk materialise.
Appendix 6

Communications and Engagement Plan

1. Introduction

The Transforming Care Partnership (TCP) aims to drive forward redesign and system-wide change to improve services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. It aims to enable more people to live in the community, with the right support, and close to home, in line with Building the Right Support – a national plan to develop community services and close inpatient facilities.

The experts on the services that would be needed to make this happen and the support that would be required are the people living with a learning disability and/or autism along with their families and carers. Engagement is the most accurate way of identifying the issues that are most important to them and therefore needs to be embedded at the start and throughout this programme of work. Direct engagement is also in line with the National Autism Strategy’s recommendation to involve people with autism in the planning and commissioning of services.

People with a learning disability and/or autism and their families/carers should be supported to co-produce the Transformation Plan. Engagement should include those with direct experience of using inpatient services as well as those who have not.

If the Partnership is to achieve system-wide change however, the communications and engagement activity needs to reach beyond those people living with a learning disability and/or autism and their families and carers. Providers of all types across Staffordshire and Stoke on Trent should be involved in the development of the plan as well as other key stakeholders such as Education, Housing, the Criminal Justice System and Probation. The plan also needs to inform and involve the wider community.
2. Purpose

The purpose of this document is to outline how the Partnership intends to engage people and stakeholders in the development of a cohesive transformation plan. It will outline who has been involved to date and who needs to be involved in the future. It will explain how people with lived experience of services, including their families/carers, will be engaged in the co-production of the plan and how success will be measured.

This document will also set out the planned approach to communications and engagement to support the Transforming Care Partnership to deliver its objectives. The key messages will be shaped going forward by the visioning events being held at the start and throughout the programme with service users and stakeholders.

3. Communications and Engagement Objectives

The aim of this communications and engagement plan is to:

- Identify the different stakeholders
- Outline the planned communications and engagement activity to be employed
- Establish a range of mechanisms to enable patients, the public and stakeholders to feedback their views
  - Key audience – identify our target audience
  - Key messages - to communicate and share the messages
  - Tactics – methods of how to reach the audience
  - Timescales – in which to work, and to hit the trigger points
  - Resources – required to target audience
- Develop a final report detailing the outcome of the engagement/public consultation to collate views and themes for consideration by the CCGs Governing Body.
4. Considerations

When planning to engage with people with learning disabilities and/or autism, there are a number of factors that must be taken into consideration. These factors should be considered in the planning and delivery of any communications and engagement activity. It is also important to note that every individual will be different with a unique set of challenges and as such communications and engagement may have to be adapted accordingly.

Key factors to be taken into consideration include:

- Up to 90% of people with learning disabilities have communication difficulties
- Around 45% have significant difficulties with both expressing themselves and understanding what others say
- Only 5 -10% of people with learning disabilities have recognised literacy skills
- Most are not be able to access standard written information
- As communication difficulties increase, behaviours that are considered challenging typically increase in frequency, intensity or duration
- Up to 40% of people with learning disabilities also have a hearing loss that is often missed or undiagnosed
- People with autism have lifelong communication impairments around social communication, social interaction and social imagination

There are also a number of challenges to successful engagement with people with a learning disability and/or autism. These include:

- Organising engagement events that are accessible
- The need to gain a good cross section of opinions as some autistic people can only be focussed on their own current issues
- Getting views from across the whole autism spectrum
- Getting views from people with autism & co-morbidities
- Getting facilitators who understand autism
- Getting facilitators who know how to support people to communicate their views
Finding appropriate venues

The Transforming Care Partnership (TCP) recognises these challenges to effective engagement and has commissioned a local Advocacy Service, with extensive experience locally, to aid the support and involvement of people with a learning disability and/or autism.

5. Key Audiences

The following is a high-level stakeholder list of our target audience. The extent of involvement by the various stakeholders may vary during the course of the project and will be influenced by feedback from the visioning events.

Internal
- Staffordshire County Council
- Stoke-on-Trent City Council
- Stafford and Surrounds Clinical Commissioning Group (CCG)
- Cannock Chase CCG
- South East Staffordshire and Seisdon Peninsula CCG
- North Staffordshire CCG
- East Staffordshire CCG
- Stoke-on-Trent CCG
- NHS England Specialised Commissioning Teams / Hubs
- NHS England Local Area Team (Midlands and East)
- Lead GP Clinician for Learning Disabilities and Mental Health

External – General
- NHS Specialised Commissioning
- NHS England Transforming Care Local Area Team and national leads
- Mental Health NHS Providers in the local area and Independent and Third Sector
- Community Providers
- NHS Acute Trusts
- Police, Probation and other criminal justice systems
- Advocacy and Peer Support Organisations
- Health Scrutiny Committees
- Carer and service user representatives/Experts by Experience
- Learning Disability Partnership Boards (Staffordshire and Stoke on Trent)
- Housing Providers
- MPs
- Healthwatch
- Councillors
Government / Regulators / Assurance:
- Overview and Scrutiny Committees
- Care Quality Commission
- NHS England
- Local Government Association
- Associate Director of Adult Social Services

Patients / Carers / Public / Communities:
- Representatives from people with learning disabilities, families and carers
- Local advocacy groups i.e. Reach/ASIST/Powher
- Condition Support Groups, including youth services
- CCG patient council
- Patient participation groups
- Voluntary, community sector organisations

Partners:
- Staffordshire County Council Transformation Support Unit
- ASIST – Reach
- Local Medical Council, British Medical Association (and other relevant bodies)
- Local authorities: county and district councils
- Third sector
- Health and Wellbeing Boards
- Housing providers
- Midlands and Lancashire Commissioning Support Unit

Providers:
- GP practices
- Hospital Trusts
- Care/nursing homes
- Hospices
- Independent sector
- Housing

Media:
- Local – print and broadcast
- Website – CCG/links to LAs
- Pre-recorded media (screens in GP surgeries)
- Social media – Twitter/Facebook
5.1 Stakeholder mapping [populate using identified stakeholders above] (to be populated)
6. Roles and Responsibilities

Communications and Engagement Leads
- Develop the communications and engagement plan, core scripts and public-facing materials.
- Coordinate communications, e.g. provide event set up and management at the public facing events.
- Responsible for media relations – proactive and reactive. Includes ensuring spokespeople are trained/briefed.
- Responsible for coordinating any public-facing engagement activity, as outlined in the plan.
- Ensuring an ‘early warning system’ is in place to alert the project team of any issues.
- Responsible for engagement activities and customer facing engagement including engagement with protected groups as identified through data analysis.
- Responsible for public facing response materials in response to consultation.
- Develop the final report with engagement/consultation outcomes.
- Develop final communications ‘themes’ report for use in the wider urgent care strategy development to ensure patients views are fundamental to future strategy development.

Project Leads and Clinical Leads
- Sign off of scripts, responses and statements.
- Ensure an ‘early warning system’ is in place to alert the communications team of any issues.
- Responsible for supporting and facilitating engagement activity with clinical and front-line staff.
- Responsible for identifying spokespeople.

Others
- Staffordshire County Council Transformation Support Unit.
- Midlands and Lancashire Commissioning Support Unit to support delivery.
- GPs and other frontline staff to be briefed on messages.

7. Key Messages

Led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH), the Transforming Care programme focuses on the five key areas of:
- empowering individuals
- right care, right place
- workforce
- regulation
- data
The national plan, ‘Building the Right Support’ has been developed jointly by NHS England, the Local Government Association (LGA) and the Associate Directors of Adult Social Services (ADASS) is the current key milestone in the cross-system Transforming Care programme, and includes the Staffordshire and Stoke on Trent Transforming Care Partnership across England to re-shape local services, to meet individual’s needs. This is supported by a new national Service Model for commissioners across health and care that defines what good services should look like.

The plan builds on other transforming care work for people with learning disabilities and/or autism to strengthen individuals’ rights; roll out Care and Treatment reviews across England, to reduce unnecessary hospital admissions and lengthy hospital stays and to ensure we have the right skills in the right place.

The Transforming Care Programme is focusing on addressing key issues to ensure sustainable change that will see:

- more choice for people and their families, and more say in their care;
- providing more care in the community, with personalised support provided by multi-disciplinary health and care teams;
- more innovative services to give people a range of care options, with personal budgets, so that care meets individuals’ needs;
- providing early more intensive support for those who need it, so that people can stay in the community, close to home;
- but for those that do need in-patient care, ensuring it is only for as long as they need it.

8. Communication and Engagement Proposals including Pre Engagement

Stakeholder engagement proposals reflected in the current plan submission. A more detailed communication and engagement plan can be found at Appendix A.

- A mapping exercise to identify existing communications channels and networks that can be used to deliver the engagement.
- Establishment of an Engagement Task and Finish Group
- A Communications and Engagement plan to extend the current work programme to work with the wider public and Provider market (including accommodation and education providers)
- Local Authority Commissioners have developed robust Market Position Statements and are engaging with NHS Commissioners around the development of these and taking them forward into commissioning plans and the development of provider capability
- Plan to involve Housing and Education providers
- Individual patient engagement
• Parent/carer involvement - A framework is needed to identify that parents must be involved
• Parent/carer forums
• Co-produce the changes with parents
• Information, advice and guidance - single point of access” is important
• Potential to expand PPS to act as a “hub” for the Local Offer
• Stoke and Staffordshire - Learning Disability Partnership Boards (LDPBs)
• Engage with REACH self-advocacy groups
• Engage with People’s Parliaments
• Existing parent carer and young people’s forums

Previous engagements/evidence of co-production:

**Staffordshire**

• **Staffordshire County Council** - Staffordshire County Council’s All Age Disability Strategy 2013–18 was developed through a thorough consultation and engagement process

• **Cannock Chase and Stafford and Surrounds CCG - Call to Action** – The two CCGs held a series of engagement events as part of Call to Action across Cannock Chase and Stafford and Surrounds. These included events held with parents of children with autism and carers. The focus was what helps you to stay well, what are the challenges to staying well and self-management, what support would help you to stay well, what support do you need when things start to go wrong and how could services be more integrated. Although the focus was on health and accessing health services, the feedback covered wider issues such as schools and employers.

**Cannock Chase and Stafford and Surrounds CCG - Children and young people** – The two CCGs engaged with children and young people through youth clubs and youth forums about what were the health priorities for them and how they would like to receive information about local health services.

• **South Staffs Network for Mental Health** (charitable organisation) - has recently conducted a survey around the criminal justice system to look at the opportunities to identify:
  • gaps in knowledge or awareness of mental health or mental illness
  • the way in which communication happens between services operating within CJS environments
  • people with experience of mental illness.

This deadline for this survey was 9 March 2016 so the findings might be able to support the development of proposals around the CJS.
Stoke-on-Trent

- Stoke on Trent City Council’s Learning Disability Strategy 2010–15 was developed in partnership with people with a learning disability, closely involving self-advocates and experts by experience in setting the Strategy’s priorities and principles
- 2015, the City Council commissioned Staffordshire University’s Faculty of Arts and Creative Technologies to devise an innovative consultation exercise to gather views on the future design of day services within the City. Using craft activities, video logs, strong visual aids and as mixture of large scale events, small “pop up” and one to one sessions this consultation programme was able to gather a wealth of information and ideas from people who use services and their carers
- Commission the REACH self-advocacy service - regular Parliament meetings – two way feedback on how changes affect them and dissemination of information

County-wide

- Staffordshire and Stoke on Trent strategies for Emotional Wellbeing and Mental Health 0-18 includes recommendations in relation to vulnerable groups, including young people with learning disabilities. The strategy was subject to stakeholder engagement and consultation with children and young people
- REACH Experts by Experience and these Experts attend the Learning Disability Partnership Boards (one stakeholder co-chairs the Stoke Board)
- REACH involved in Care & Treatment Reviews as panel members
9. Targeted Engagement Approach

The CCG has due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, we aim to:

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;

(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

10. Evaluation and Reporting

It is important to monitor and benchmark performance of the communications and engagement activity to measure achievement against agreed objectives. Reporting on meeting the aims and objectives of the plan will be measured in a number of ways, including:

- Surveys completed – online and hard copy
- Letters and emails received
- Attendees at events
- Feedback from staff
- Level of complaints / campaign group activity/MP queries.
- Media coverage and tone of voice.
- Web/ intranet/ social media metrics.

All feedback received will be collated, analysed and organised into themes to enable understanding of public and patient opinion of the project.
### Appendix A

1. **DETAILED COMMUNICATION AND ENGAGEMENT PLAN BY STAKEHOLDER**

<table>
<thead>
<tr>
<th>STAKEHOLDERS</th>
<th>PROPOSED APPROACH</th>
<th>PURPOSE</th>
<th>SCHEDULING</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>NEW - Mapping exercise</td>
<td>• Confirm existing channels/networks to ensure these can be engaged/targeted effectively</td>
<td>w/c Mon 29/2/16</td>
</tr>
<tr>
<td>EXISTING – Review of previous engagements</td>
<td></td>
<td>• Review of evidence from previous engagements to see if there are findings that can be used to support the development of the Partnership’s vision and the design of proposals/solutions</td>
<td>29/2/16 – 11/3/16</td>
</tr>
<tr>
<td>NEW/EXISTING – Communication Action Plan</td>
<td></td>
<td>• Dissemination of information on the programme, its progress and key messages</td>
<td>Strategy to be developed March 2016</td>
</tr>
</tbody>
</table>

**The Partnership’s communication approach and proposals will be developed in more fully once the framework and action plan have been completed. This will be differentiated by audience and message. It is anticipated that this will include existing communication channels (press release, newsletters) and the development of new ones including a website, Facebook groups, existing groups (Umbrella, NAS, VAST, patient groups, Healthwatch), Special Schools Forums and surveys.**

The programme will explore innovative communication channels for service users including communication passports, toolkits and mobile apps as well as self and peer advocacy. All service user communications will be developed using the RCSLT communication standards with support from REACH, a local project for adults with LD and/or autism, part of the ASSIST advocacy services.

The Strategy will include measurements of success for
| **TRANSFORMING CARE PARTNERSHIP** | **NEW – Co-Production and Engagement Strategy to be led at Steering Group level with focussed activity.** | • Ensure effective engagement and communication with key stakeholders | 29/2/16 – 11/3/16 |
| **NEW - Development of a framework for engagement** | • To ensure engagement of strategic stakeholders (including housing and education) and providers (market development) | 29/2/16 – 11/3/16 |
| **HEALTH AND SOCIAL CARE PROFESSIONALS** | **NEW - Health and Care Visioning Event** | • Draw in wider health and social care commissioner and providers  
• Gain common understanding  
• Document ‘as is’ and ‘perceived as is’  
• Identify gaps  
• Shape vision  
• Commence the programme | 25/4/16 |
| **NEW - Workshop sessions – potentially including children/transitions, accommodation, Criminal Justice, employment** | • Focussed sessions where required on areas that require strengthening/improvement.  
• Also draw in service user, carers, families, providers as needed.  
The focus and scheduling of these will be agreed once we have reviewed the output of previous engagements. | Commencing May 16 |
| **NEW - Making it Happen Events/Gateways –** | • Building on the approach outlined in Birmingham’s TCP Plan, the proposal is to hold these sessions through the development and implementation of the new service model to ensure focus on shaping the design and delivery throughout the programme | Implementation |
| **SERVICE USERS** | **NEW - Stakeholder Visioning Event** | • Draw in service users, carers, family, providers and professionals  
• Gain common understanding  
• Focus on interventions that make a difference | w/c Tues 3/5/16 or Mon 9/5/16 |
- Support re-design of the system

This approaches adopted in this event will draw on previous approaches successfully used by Stoke-on-Trent City Council, ASSIST, Staffordshire University and Keele University to help shape the priorities, vision and new service model with service users, their families and carers. This successful consultation programme gathered views on the future design of day services using craft activities, video logs, strong visual aids and as mixture of large scale events, small “pop up” and one to one sessions to gather information and ideas from people who use services and their carers.

<table>
<thead>
<tr>
<th>NEW - REACH Focus Group Sessions</th>
<th>To ensure engagement of adults with LD and/or autism in an appropriate way</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To support the identification of specific issues</td>
</tr>
<tr>
<td></td>
<td>To consult and co-produce the design of new service model and the resettlement strategy proposals</td>
</tr>
<tr>
<td></td>
<td>To identify how proposals affect their lives</td>
</tr>
<tr>
<td></td>
<td>To disseminate information and support a two-way exchange</td>
</tr>
</tbody>
</table>

The focus and scheduling of these will be agreed once we have reviewed the output of previous engagements.

<table>
<thead>
<tr>
<th>EXISTING - REACH individual Client Support/Advocacy</th>
<th>REACH currently support individual service users with Care and Treatment Reviews and have been commissioned by SCC to deliver the County’s Self Advocacy Services.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One proposal is to explore the role of advocacy/peer advocacy to support 121 care planning potential</td>
</tr>
</tbody>
</table>

| NEW – Pilot of proposals including for LD and autism cohorts | Trial new approaches with specific groups to test the solution before wider roll-out |

<p>| Scheduling to be agreed | On-going | Design/Implementation |</p>
<table>
<thead>
<tr>
<th>EXISTING - Stoke on Trent and Staffordshire Learning Disability and Autism Partnership Boards</th>
<th>• Consultation and shaping of proposals</th>
<th>On-going</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXISTING - Stoke on Trent City Council Learning Disability Parliament</td>
<td>• Consultation and shaping of proposals</td>
<td>On-going</td>
</tr>
<tr>
<td>NEW – Website – Easy to ready - BIRMINGHAM</td>
<td>• Two-way dissemination of information</td>
<td>Design</td>
</tr>
</tbody>
</table>
| PARENTS/CARERS | EXISTING – CYP Parent Carer Forum | • To support the identification of specific issues  
• To consult with and shape the design of new service model  
• To resettlement strategy proposals  
• To identify how proposals affect their lives  
• To disseminate information and support a two-way exchange | Scheduling to be agreed |
| NEW - Parent Focus Groups | • To ensure engagement of adults with LD and/or autism in an appropriate way  
• To support the identification of specific issues  
• To consult with and shape the design of new service model  
• To resettlement strategy proposals  
• To identify how proposals affect their lives  
• To disseminate information and support a two-way exchange | Scheduling to be agreed |
| EXISTING/NEW - Surveys | • To identify issues and consult on new development  
• Regular Evaluation surveys to take a temperature check on progress throughout development | Scheduling to be agreed |
| PROVIDERS | NEW – Accommodation Providers Workshops and Follow-up Sessions | • Draw in wider housing providers (including local authority housing departments and other Registered Social Landlords)  
• Gain common understanding of current accommodation provision and needs  
• Identify gaps in provision | Commencing May 16 |
<table>
<thead>
<tr>
<th>Workshops and Follow-up Sessions</th>
<th>Description</th>
</tr>
</thead>
</table>
| **NEW – Criminal Justice System Workshops and Follow-up Sessions** | • Draw in Criminal Justice colleagues  
• Gain common understanding of current system, pathways and needs  
• Identify gaps in support  
• To design new support services  
This will need to draw in service users, their families and carers to ensure a full understanding of need. |
| **EXISTING/NEW – CYP, Education and Transitions Workshops and Follow-up Sessions** | • Ensure focus on CYP, Education and Transitions  
• Gain common understanding of current system, issues and needs  
• Identify gaps in support  
• To design new support services |
| **EXISTING/NEW - Market Development Workshops** | • These will build on a number of previously successful sessions with providers  
• To draw in wider providers including the community and voluntary sector.  
• To ensure they understand Commissioners and the Programme’s Vision  
• To identify gaps in current provision |

The Steering Group is currently reviewing the governance structure and membership to ensure housing providers are effectively drawn into the programme.

Commencing May 16

Scheduling to be agreed
To shape and develop the market
Following development of the vision, our combined commissioning intentions and confirmation of the service design, the Partnership will look at more formal way to engage providers including reviewing the governance structure and membership.

<table>
<thead>
<tr>
<th>SCC STAFF</th>
<th>EXISTING:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Team Talk</td>
</tr>
<tr>
<td></td>
<td>• Individual Functional Updates (People &amp; Place)</td>
</tr>
<tr>
<td></td>
<td>• Intranet</td>
</tr>
<tr>
<td></td>
<td>Use the existing communication mechanisms to engage all internal SCC staff via electronic newsletter to all managers down to OMT level</td>
</tr>
<tr>
<td></td>
<td>This will provide specific operational issues which managers are obliged to cascade to their teams</td>
</tr>
<tr>
<td></td>
<td>This approach will be complimented through targeted use of the Intranet – which provides immediate communication &amp; engagement with all colleagues across all levels (assuming access to the Intranet)</td>
</tr>
</tbody>
</table>

Scheduling to be agreed
High Level Co-Production & Stakeholder Model/Framework

2016

VISION

How?
- Service User Events
- Health & Care Events

Who?
- Engaging key stakeholders
- Gain in common understanding
- Shape vision
- Document 'AS IS'
- Agree 'TO BE'
- Identify gaps

What?
- Consult & co-produce new service model
- Identify how proposals affect their lives
- 2-way exchange of information

SOLUTION DESIGN

- Service User Focus Groups
- Families & Carers Focus Groups
- Bespoke Workshops

IMPLEMENTATION

- Service User Pilots
- Families & Carers Pilots
- Health Care 'Making It Happen' Events

PROVIDER ENGAGEMENT

How?
- Market Development Workshops

What?
- Engage market providers
- Support development of new services
- Market maturity

Key

- Service Users
- Parents, Families & Carers
- Internal Stakeholders
- External Suppliers

(approximate time scales)
<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Date Added</th>
<th>Description of Risk</th>
<th>Risk Category</th>
<th>Risk Area</th>
<th>Risk Owner</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score L x I</th>
<th>Proximity</th>
<th>Description</th>
<th>Owner</th>
<th>Completion Date</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Score L x I</th>
<th>Proximity</th>
<th>Description</th>
<th>Owner</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29/02/2016</td>
<td>Because the programme is large scale, complex and needs to be delivered within a limited timescale, there is a risk that partner organisations may not have the capacity or capability to deliver the required changes, with the result that outcomes are compromised and timescales are not achieved.</td>
<td>Resource</td>
<td>Programme Management</td>
<td>Programme Management</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Immediate</td>
<td>Initial Programme Plan identifies resource requirements and assesses risk. More detailed work stream plans are being developed and will include an assessment of required resource and whether this is currently available so that Partnership Board are able to identify additional resources or free up capacity or re-scope work stream plans if necessary to minimise the impact.</td>
<td>Workstream leads</td>
<td>Ongoing</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>29/02/2016</td>
<td>Because health and social care operate in a highly regulated environment, there is a risk that an Ofsted/CQC/other inspection may divert resources from the programme, with the result that outcomes are compromised and timescales are not achieved.</td>
<td>Resource</td>
<td>Programme Management</td>
<td>Programme Management</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Within-project</td>
<td>Programme plan will reflect any known reviews, budget is used to backfill resources.</td>
<td>Workstream leads</td>
<td>Ongoing</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>29/02/2016</td>
<td>Because of the number of related programmes, there is a risk that programme planning doesn’t take full account of dependencies, that activity is duplicated and that actions taken by other programmes impact negatively on the Transforming Care Partnership programme.</td>
<td>Interdependencies</td>
<td>Programme Management</td>
<td>Programme Management</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Immediate</td>
<td>Programme plan includes dependencies. Workstream PIDS include dependencies without and outside of the programme. PM3 system allows dependencies to be linked. Workstream leads will review throughout programme. The project is supported by SCC’s Transformation Support Unit as part of its Health and Care Programme Hub to ensure effective linkages and dependency planning. Inter-workstream meeting where necessary (i.e. HRI, Frail Elderly and LTC)</td>
<td>Project Management</td>
<td>Ongoing</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>03/02/2016</td>
<td>Because of the need for pace, there is a risk that the time needed to develop a common understanding, secure agreement and buy-in and agree outcomes is not taken, with the result that the programme fails to set a vision, define scope and prioritise and agree objectives and that as a result the programme fails to meet the needs of stakeholders (including service users), benefits are not realised and resource is wasted.</td>
<td>Benefits</td>
<td>Programme Management</td>
<td>Programme Management</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Immediate</td>
<td>The governance structure builds on current effective working relationships between the Councils and CCGs. All commissioning bodies are committed to the same vision to use the programme as a way to transform the model of care for service users with a LD and/or autism. A series of visioning workshops with health and social care commissioners and providers are scheduled to confirm our common understanding of current provision (including perceived ‘as is’) with further sessions planned with service users, their families and carers to identify improvements and co-design the solution.</td>
<td>Programme Management</td>
<td>Ongoing</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>29/02/2016</td>
<td>Because of the complexity and pace of the programme and the number of stakeholders needs that have to be met, there is a risk that too much time is spent agreeing outcomes and designing solutions, with the result that key milestones are missed.</td>
<td>Schedule</td>
<td>Programme Management</td>
<td>Programme Management</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>Immediate</td>
<td>Programme Plan developed and approach to developing the vision outlined in the Engagement Strategy. Initial sessions have been scheduled to progress development of the work stream plans.</td>
<td>Project Management</td>
<td>Ongoing</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td></td>
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<tr>
<td>6</td>
<td>29/02/2016</td>
<td>Because of the need for pace, there is a risk that external stakeholders condense timescales available and that this negatively affects the realisation of sustainable benefits for stakeholders.</td>
<td>Benefits</td>
<td>Programme Management</td>
<td>Programme Management</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Within-project</td>
<td>Regular engagement with stakeholders included in engagement plan</td>
<td>Partnership Board</td>
<td>Ongoing</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Risk ID</td>
<td>Date Added</td>
<td>Description of Risk</td>
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<td>Owner</td>
<td>Completion Date</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Score</td>
<td>Last updated</td>
<td>Status</td>
<td>Comments</td>
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<tr>
<td>7</td>
<td>29/02/2016</td>
<td>Because of the number of stakeholders that need to be involved in decision making, there is a risk that a streamlined and efficient governance process cannot be designed and implemented with the result that decision making is slow and does not enable the programme to move at the required pace.</td>
<td>Schedule</td>
<td>Programme Management</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Within project</td>
<td>Terms of reference for Transforming Care Partnership Board agreed. Approach to development of the TCP Plan submission has supported identification of the appraisal route and an agreement in principle how appraisals will be progressed in individual organisations agreed.</td>
<td>Project Management</td>
<td>Ongoing</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<td>8</td>
<td>29/02/2016</td>
<td>Because change of this scale and nature relies on behaviour change amongst the workforce and requires effective ongoing engagement, communication and organisational development, there is a risk that the workforce is not engaged sufficiently with the change process, that change is not embedded and that behaviours don't change.</td>
<td>Benefits</td>
<td>Outcomes</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Within project/Beyond Project</td>
<td>Organisational Development Plan to be developed to embed change IC workshop planned.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>3</td>
<td>4</td>
<td>12</td>
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<td>9</td>
<td>01/03/2016</td>
<td>Because change of this nature requires greater integration and culture change amongst organisations, there is a risk that the programme is not able to affect this nature of change within organisations, that organisations are not willing or able to change within the required time scales and that organisational development involvement is ineffective with the result that benefits are not realised.</td>
<td>Benefits</td>
<td>Outcomes</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Within project/Beyond Project</td>
<td>TCP Partnership Board to include representatives of seniority to be able to make recommendations to their own decision-making bodies and ensure placement of the programme within their respective organisations.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>3</td>
<td>4</td>
<td>12</td>
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<td>10</td>
<td>01/03/2016</td>
<td>Because of poor quality, and potentially inconsistent, information (including NHS England Specialised Commissioning data) on the numbers and needs of each cohort of service users including Out of Area Placements, there is a risk that service re-design is based on an under representation (likely) or over representation (unlikely) of need meaning that the support offered developed is insufficient or inappropriate</td>
<td>Resource</td>
<td>Implementation approach</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Immediate</td>
<td>The initial project plan includes an early activity to conduct a needs assessment and review of existing provision, services &amp; pathways so we have a better understanding of need and what is currently available. The validation process on numbers and needs of cohort, including patient numbers, will be iterative and on-going throughout the programme to deliver accurate sources of information on need of each cohort and individual service users.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td></td>
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<tr>
<td>11</td>
<td>01/03/2016</td>
<td>Because there is a need to shift resources to focus on prevention, early intervention and wellbeing to minimise inappropriate admissions, there is a risk that the provider market does not have the capacity or capability to support the new service model with the result that the outcomes of the programme are not delivered.</td>
<td>Quality</td>
<td>Outcomes</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Within project</td>
<td>The initial project plan includes an early activity to conduct a review of existing provision, services &amp; pathways so we have a better understanding of need and what is currently available. A number of market development sessions with existing and new providers are planned to ensure market development and maturity to deliver the required services.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<tr>
<td>12</td>
<td>29/02/2016</td>
<td>Because there is a need to shift resources to focus on prevention, early intervention and wellbeing to minimise inappropriate admissions, there is a risk that new provision cannot be sufficiently resourced to cope with demand with the result that there is a continued reliance on admission to inpatient settings in times of crisis.</td>
<td>Resource</td>
<td>Outcomes</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Within project</td>
<td>The assumption (and its potential impact on outcomes) will be evaluated in the workstream PIDs.</td>
<td>Workstream leads</td>
<td>Ongoing</td>
<td>3</td>
<td>4</td>
<td>12</td>
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<td>13</td>
<td>29/02/2016</td>
<td>Because there is a need to change staff behaviours to focus on prevention of admission, early intervention and wellbeing to minimise inappropriate admissions, there is a risk that the existing behaviours of staff will continue to interfere with the programme as it seeks to meet its objectives.</td>
<td>Benefits</td>
<td>Outcomes</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Within project/Beyond Project</td>
<td>The assumption (and its potential impact on outcomes) will be evaluated in the workstream PIDs.</td>
<td>Workstream leads</td>
<td>Ongoing</td>
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<td>Risk ID</td>
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<td>Description of Risk</td>
<td>Risk Category</td>
<td>Risk Area</td>
<td>Risk Owner</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Score L * I</td>
<td>Proximity</td>
<td>Description</td>
<td>Owner</td>
<td>Completion Date</td>
<td>Likelihood</td>
<td>Impact</td>
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<td>14</td>
<td>29/02/2016</td>
<td>Because of the scale of the programme, there is a risk that the costs required to deliver the programme can not be met by partner organisations within current budget constraints with the result that there is an insufficient budget for to fully transform the outcomes of all service users and objectives of the programme are not achieved.</td>
<td>Financial</td>
<td>Budget for change</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Within project</td>
<td>Management of Transformation Budget and monthly reporting of forecasted spend</td>
<td>Programme Management</td>
<td>Ongoing</td>
<td>4</td>
<td>5</td>
<td>20</td>
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<td>15</td>
<td>29/02/2016</td>
<td>Because all partner organisations are in financial difficulties and there is a history of financial deficit within the system, there is a risk that it is not possible to achieve the delivery of the full aspirations of the Staffordshire and Stoke TCP Plan.</td>
<td>Finance</td>
<td>Deficit</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td>Within project</td>
<td>Financial assessment of Staffordshire and Stoke on Trent organisations, and financial assessment of savings profiles in workstream PIDs.</td>
<td>Programme Management</td>
<td>Ongoing</td>
<td>4</td>
<td>5</td>
<td>20</td>
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<td>16</td>
<td>29/02/2016</td>
<td>If there is insufficient engagement and co-production with service users, their families and carer, that the designed solution does not meet desired objectives, represents a missed opportunity or the programme is subject to judicial review (which impacts reputation of the organisations and the programme)</td>
<td>Reputational</td>
<td>Stakeholders</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Immediate</td>
<td>The programme has developed a Co-production and Engagement Strategy to support the design and delivery of the vision and new service model. This includes innovative ways to engage and consult service users with LD and/or autism and their families and carers. This is supported by ASSIST, a voluntary organisation to ensure the engagement of service users. The framework provides the overarching structure for our co-producing and engagement proposals set out in the supporting Action Plan.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>4</td>
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<td>12</td>
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<td>17</td>
<td>29/02/2016</td>
<td>There is a risk that the required pace of the resettlement programme will mean that there will be insufficient, appropriate provision developed locally to ensure that service users are moved to accommodation that fully meets their needs or the vision and aspirations of the programme</td>
<td>Quality</td>
<td>Implementation approach</td>
<td>5</td>
<td>5</td>
<td>20</td>
<td>Immediate</td>
<td>Once the plan is finalised and the proposals for service redesign are developed during the initial stages of the project, the financial plan for delivery will be confirmed and prioritised by the TCP Partnership Board and relevant governing bodies of each commissioner. Development of the proposals will include consideration of the most efficient ways of delivering and, where necessary, include redistribution of funding to meet the aims and aspirations of the programme. Where there is a shortfall of appropriate accommodation, the Partnership Board will consider ways of developing this including seeking additional funding to support development</td>
<td>Operational Group</td>
<td>Ongoing</td>
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<td>18</td>
<td>29/02/2016</td>
<td>There is a risk that the timescales for the resettlement programme and data quality on patients provided by NHS England means there is a risk that individual patients may initially be moved to inappropriate accommodation resulting in additional stress, risks to patient safety and need for further moves.</td>
<td>Safety</td>
<td>Outcomes</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td>Immediate</td>
<td>The plan for the resettlement programme will be in line with national requirements/timelines and will include significant focus on individual patient planning with the service user, their families and carers</td>
<td>Operational Group</td>
<td>Ongoing</td>
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<td>19</td>
<td>29/02/2016</td>
<td>The opportunities to maximise benefits and economies of scale by working in partnership with Shropshire and Telford are missed as they don’t want to engage.</td>
<td>Strategic</td>
<td>Outcomes</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Immediate</td>
<td>The SRG for Staffordshire and Stoke’s Transforming Care Partnership has had discussions with Shropshire about the opportunities, however, Shropshire do not wish to progress this at the current time. The Partnership Board will continue to look at strategic opportunities and dependencies throughout the programme.</td>
<td>Partnership Board</td>
<td>26/05/2016</td>
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<td>Risk ID</td>
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<td>Risk Category</td>
<td>Risk Area</td>
<td>Risk Owner</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Score L * I</td>
<td>Proximity</td>
<td>Description</td>
<td>Owner</td>
<td>Completion Date</td>
<td>Likelihood</td>
<td>Impact</td>
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<td>20</td>
<td>29/02/2016</td>
<td>The timescales for submission mean Staffordshire and Stoke TCP fail to engage users in the re-design of the service model meaning that opportunities to maximise benefits are missed</td>
<td>Quality</td>
<td>Outcomes</td>
<td>Staffordshire and Stoke TCP</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Immediate</td>
<td>Unblocking receipt of feedback on the draft submission from NHS England, the TCP Board took the decision to focus on finalising the approach to development and delivery of the vision to reflect in the updated submission rather than progressing the visioning activity alongside. This is to ensure that we maximise the full potential by allowing the Operational Group engage service users and to plan and effectively resource what is needed to deliver the scale of transformation outlined in the submission rather than focussing on timescales. The initial engagement sessions to progress the vision outlined in the Engagement Plan have been scheduled with supporting activity from SCC Transformation Support Unit to research national best practice models.</td>
<td>Operational Group</td>
<td>Ongoing</td>
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<td>12</td>
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<td>21</td>
<td>29/02/2016</td>
<td>The national funding may be insufficient to support the development of the Staffordshire and Stoke Transforming Care Partnership Board's aspirations to redesign the service model and delivery</td>
<td>Financial</td>
<td>Budget for change</td>
<td>Staffordshire and Stoke TCP</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Immediate</td>
<td>Resource requirements to support delivery of the programme are being scoped during project initiation including budget requirements. Subject to review and confirmation of this, the SRO will request commissioning bodies contribute to support development and delivery of the programme.</td>
<td>Programme Management</td>
<td>Ongoing</td>
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<td>6</td>
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<td>22</td>
<td>10/03/2016</td>
<td>The transformation funding requires match funding</td>
<td>Financial</td>
<td>Stakeholders</td>
<td>Staffordshire and Stoke TCP</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Within project</td>
<td>Work being undertaken to fully understand how to test and revise existing services.</td>
<td>Operational Group</td>
<td>Ongoing</td>
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<td>23</td>
<td>29/02/2016</td>
<td>If there is insufficient engagement and co-production with providers the market is unable to deliver the designed solution which means the programme does not meet its objectives</td>
<td>Quality</td>
<td>Stakeholders</td>
<td>Staffordshire and Stoke TCP</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Within project</td>
<td>The Engagement Strategy sets out various sessions and approaches to ensure that providers are drawn into the scoping of current provision and pathways and development of the new service model. The Operational Group are currently considering the most appropriate way to ensure the formal engagement of providers in the development phases of the project through a Provider Group to ensure they input within the scope of procurement rules.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>3</td>
<td>3</td>
<td>9</td>
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<td>24</td>
<td>29/02/2016</td>
<td>Because of the existing pressures on residential and homecare market, there is a risk that the programme makes changes that destabilises the care home market further.</td>
<td>Strategic</td>
<td>Stakeholders</td>
<td>Staffordshire and Stoke TCP</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>Within project</td>
<td>The assumption (and its potential impact on outcomes) will be evaluated in the Workstream PIDs.</td>
<td>Workstream Leads</td>
<td>Ongoing</td>
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<td>25</td>
<td>29/02/2016</td>
<td>Because there is a need to redesign the accommodation services 'offfer' falling to draw housing departments in Stoke-on-Trent, District and Borough Councils and RSL buy-in prevents this being achieved.</td>
<td>Strategic</td>
<td>Stakeholders</td>
<td>Staffordshire and Stoke TCP</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Immediate</td>
<td>The assumption (and its potential impact on outcomes) will be evaluated in the Workstream PIDs. The engagement plan will include RSL and District/Borough council engagement. The Operational Group are currently considering the most appropriate way to engage third tier Councils.</td>
<td>Operational Group</td>
<td>Ongoing</td>
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<td>26</td>
<td>31/03/2016</td>
<td>There is a need to fully engage current providers in the development phase however this poses a risk regarding any future procurement that might be required at a later stage.</td>
<td>Legal / Procurement</td>
<td>Stakeholders</td>
<td>Staffordshire and Stoke TCP</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>Within project</td>
<td>Current providers are excluded from the TCP Board and a multi-disciplinary Clinical Reference Group in being developed to support the clinical input into the programme. Legal advice has been sought.</td>
<td>Partnership Board</td>
<td>Ongoing</td>
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<td>27</td>
<td>29/02/2016</td>
<td>There is a risk that local councillors are not engaged in the programme and do not therefore have political buy-in to the programme and that this affects achievement of benefits and timescales.</td>
<td>Strategic</td>
<td>Stakeholders</td>
<td>Staffordshire and Stoke TCP</td>
<td>4</td>
<td>4</td>
<td>12</td>
<td>Within project</td>
<td>Development of programme plans to understand the likelihood of this risk, and engagement with Councillors as per Engagement Plan</td>
<td>STC and SCC Lead Commissioners</td>
<td>Ongoing</td>
<td>3</td>
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<td>Risk Owner</td>
<td>Likelihood</td>
<td>Impact</td>
<td>Score (L*I)</td>
<td>Proximity</td>
<td>Description of Risk</td>
<td>Owner</td>
<td>Completion Date</td>
<td>Likelihood</td>
<td>Impact</td>
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<td>28</td>
<td>29/02/2016</td>
<td>Because the programme is a partnership of a number of different organisations and there is an assumption that all parties will act “in the best interests of Staffordshire”, there is a risk that individual parties may not be able to separate themselves from their organisation and make decisions for the good of the system as a whole, with the result that decision making is slow and this impacts on the achievement of benefits and outcomes and timescales.</td>
<td>Strategic</td>
<td>Stakeholders</td>
<td>A Gerald</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Within project</td>
<td>Independent Chair challenges individual parties if this occurs.</td>
<td>A Gerald</td>
<td>Ongoing</td>
<td>3</td>
<td>3</td>
<td>9</td>
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<td>29</td>
<td>29/02/2016</td>
<td>Because of the differences in the health system between the north and south of Staffordshire, there is a risk that different approaches prevent a Staffordshire-wide approach being developed and agreed with the result that solutions can not be designed within timescales and benefits are not realised.</td>
<td>Start</td>
<td>Context/ Environment</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Within project</td>
<td>Clarity in strategic work vs local delivery where required challenge.</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>4</td>
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<td>12</td>
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<td>30</td>
<td>29/02/2016</td>
<td>Because of the requirement for local government to make significant cuts (up to 40%) there is a risk that this diverts attention from the programme, that Councils can not devote resources to the programme and/or that the driving force for change is purely financial to the expense of patient outcomes.</td>
<td>Financial</td>
<td>Context/ Environment</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Within project</td>
<td>Ensure the service re-design maximises opportunities for efficiencies and a more effective service model</td>
<td>Operational Group</td>
<td>Ongoing</td>
<td>4</td>
<td>3</td>
<td>12</td>
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<td>31</td>
<td>29/02/2016</td>
<td>CCGs are under pressure to deliver performance, e.g. financial sustainability. (and that this may vary for each CCG.)</td>
<td>Financial</td>
<td>Implementation approach</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Within project</td>
<td>Identify the financial position of each CCG and how this may impact the programme</td>
<td>F Simpson</td>
<td>Ongoing</td>
<td>4</td>
<td>4</td>
<td>16</td>
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<td>32</td>
<td>01/03/2016</td>
<td>There is a risk that commissioning bodies fail to agree the approach and design of new services and arrangements eg integrated commissioning and local crisis service with the effect that the programme fails to deliver its vision</td>
<td>Quality</td>
<td>Implementation approach</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>Within project</td>
<td>The initial project plan includes a number of actions with commissioners and wider health and care professionals to develop the vision and agree what good looks like in terms of service design, which will be reflected in jointly agreed commissioning intentions and plans and market development plans.</td>
<td>Ongoing</td>
<td></td>
<td>2</td>
<td>4</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GUIDANCE: Activity Data

As part of the CCG planning round TCPs will be required to submit 3 year trajectories of inpatient numbers for patients with LD or autistic spectrum disorder. The information collected in this template about inpatient numbers uses the same definitions and timeframes and should match what is submitted through the planning round.

Who is included in the inpatient trajectories?
The definition for inclusion is that used by the Assuring Transformation data collection (http://www.hscic.gov.uk/assuringtransformation). Include any person in an in-patient bed for mental and/or behavioural healthcare needs who has learning disabilities or autistic spectrum disorder (including Asperger’s syndrome), of any age, ward security and status under the Mental Health Act.

Quarterly Trajectories over 3 Years (No. of Learning Disability Inpatients at the end of each quarter)
The trajectories are aiming to capture the total number of people with a learning disability and/or autism in inpatient care at the end of each quarter, in a specialist hospital bed (either MH or LD). The inpatient trajectories must be on a Transforming Care Partnership (TCP) basis. Trajectories are not based on who pays for care, but on the CCG/TCP of origin, i.e. where their home, or normal place of residence prior to hospital admission, is located, so patients whose care is commissioned by NHS England Specialised Commissioning Teams are reported against their TCP of origin. Figures presented in the TCP Joint Transformation plan through this annex should be consistent with the figures supplied through Unify as part of the CCG planning round.

<table>
<thead>
<tr>
<th>Submitting CCG:</th>
<th>NHS Stafford and Surrounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitting CCG Code</td>
<td>OSV</td>
</tr>
<tr>
<td>Name of Transforming Care Partnership (TCP):</td>
<td>Staffordshire</td>
</tr>
</tbody>
</table>

Select the CCGs within the Transforming Care Partnership (TCP)

- NHS East Staffordshire
- NHS South East Staffs and Seisdon and Peninsular
- NHS Cannock Chase
- NHS North Staffordshire
- NHS Stoke on Trent

If entry is red, you have selected a CCG twice, please re-select

GP Registered Population (18+) of Transforming Care Partnership: 903709

Transforming Care Partnership Learning Disability Inpatient Projections (including all patients originating from within the TCP, both NHS England- and CCG- commissioned)

<table>
<thead>
<tr>
<th>Year 0 (2015/16)</th>
<th>Year 1 (2016/17)</th>
<th>Year 2 (2017/18)</th>
<th>Year 3 (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

NHS England commissioned inpatients

<table>
<thead>
<tr>
<th>Year 0 (2015/16)</th>
<th>Year 1 (2016/17)</th>
<th>Year 2 (2017/18)</th>
<th>Year 3 (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CCG commissioned inpatients

<table>
<thead>
<tr>
<th>Year 0 (2015/16)</th>
<th>Year 1 (2016/17)</th>
<th>Year 2 (2017/18)</th>
<th>Year 3 (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Total No. of Inpatients with learning disabilities and/or autism* (TCP level; and by TCP of origin)**

<table>
<thead>
<tr>
<th>Year 0 (2015/16)</th>
<th>Year 1 (2016/17)</th>
<th>Year 2 (2017/18)</th>
<th>Year 3 (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Total Inpatient Rate per Million GP Registered Population ***

<table>
<thead>
<tr>
<th>Year 0 (2015/16)</th>
<th>Year 1 (2016/17)</th>
<th>Year 2 (2017/18)</th>
<th>Year 3 (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Important Notes

* People in an in-patient bed for mental and/or behavioural healthcare needs and has learning disabilities or autistic spectrum disorder (including Asperger’s syndrome) of any age or security type.

** Quarterly projected figures are not on the basis of who pays, but on the basis of the Transforming Care Partnership the patient originates from, i.e. where their home, or normal place of residence prior to hospital admission, is located.

*** The national plan "Building the Right Support" published on 30 October 2015 sets out a planning assumption that each TCP will reduce reliance on inpatient care, and where they are currently above this level, will plan to reach an inpatient rate within the range 20-25 inpatients per million population for NHS England commissioned services and 10-15 inpatients per million for CCG commissioned services by March 2019.
ENCLOSURE: 14

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>REPORTING OFFICER /DIRECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Amanda Capewell</td>
</tr>
<tr>
<td>Title</td>
<td>Commissioning Development &amp; Support Manager, Stoke CCG</td>
</tr>
<tr>
<td>Name</td>
<td>Dr Steve Fawcett</td>
</tr>
<tr>
<td>Title</td>
<td>Clinical Director, Acute Services, Stoke CCG</td>
</tr>
</tbody>
</table>

REPORT TO  Stoke-on-Trent CCG Governing Body

TITLE OF REPORT  Non-emergency Patient Transport Procurement

DATE OF THE MEETING  5th April 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

<table>
<thead>
<tr>
<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

ACTION REQUIRED FROM COMMITTEE/GROUP/ GOVERNING BOARD

<table>
<thead>
<tr>
<th>APPROVE</th>
<th>ASSURANCE</th>
<th>DISCUSSION</th>
<th>FOR NOTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

RECOMMENDATION

The Governing Body is asked to:

- **Note** the process established to undertake the reprocurement of Non-Emergency PTS Service.
- **Note** the timeline outlined above, including the contract award date of no later than the 27th April 2016
- **Note**, that as the Governing Body does not meet again until the 7th June 2016, **approval for delegated authority** is requested to the following Sub-Committees:
- **Approve** that the outcome of the procurement process will be received and reviewed at the Joint Planning Committee on the 12th April 2016, prior to ratification of the contract award at the Joint Finance and Performance Committee on the 27th April 2016, on behalf of the Governing Body.
- **Note** that the outcome of the above will be reported to the next available Governing Body meeting (scheduled for the 7th June 2016).

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.</td>
<td></td>
<td></td>
<td>Improve access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>Improve health outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td>Improve quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td>Reduce health inequalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Governance &amp; Statutory</td>
<td></td>
<td></td>
<td>Cross Cutting / Statutory Duties</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. We will achieve all of the above while remaining within financial balance and achieving best value

PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY
(supporting information to be included, if applicable)

To inform the Governing Body of the reprocurement of the Non-Emergency Patient Transport Service and the process established to undertake the reprocurement to contract award.

Due to the deadline for contract award of the 27th April 2016, to seek delegated authority to the Joint Planning Committee and Joint Finance and Performance Committee on behalf of the Governing Body.

SUMMARY OF RISKS RELATING TO THE PROPOSAL

Risk that the outcome of the Non Emergency Patient Transport Service (NEPTS) procurement will not deliver a fit for purpose, high quality service within the current financial envelope.

ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS

2013 “Who pays” guidance.

Patient Transport Services (PTS)
37. CCGs are responsible for commissioning non-emergency PTS. Non-emergency PTS is defined as non-urgent, planned transportation of patients with a medical need for transport to and from a premises providing NHS healthcare, and/or between NHS healthcare providers.

QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

Date completed, please highlight any direct or indirect implications

Equality Impact Assessments are being undertaken in line with the procurement timeline attached within main body of report.

ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT

Patient and public engagement on the evaluation process.
Patient feedback being sought from patients utilising current provider to help to inform the service delivery expected from the new provider.

ACRONYMS

Within the main body of the report
Non-emergency Patient Transport Service

Introduction/ Background
The Non-emergency Patient Transport Service (PTS) is currently delivered by NSL Care Services. The 3 year contract end date is the 31st July 2016, with an option to extend for a further 2 years. The extension option is no longer viable as NSL have formally advised of their strategic business decision to withdraw from the PTS market.

The 6 Staffordshire Clinical Commissioning Groups have therefore commenced a re-procurement of the service with Stoke-on-Trent CCG being the lead commissioner.

A market engagement event was held on the 25\textsuperscript{th} January 2016 to invite potential PTS providers to listen to a presentation from commissioners to give an understanding on the service delivery model(s). The aim of this was to open the market to a wider number of bidders for this procurement.

Following best procurement practice, the service was advertised in OJEU (Official Journal of the European Union) mid-February 2016 requesting expressions of interest to participate in an open procurement process with a 4 week return date.

The intention of this report is to advise the Governing Body of the re-procurement of this service, including timelines, and to provide assurances of the robust governance that will be in place throughout this procurement process.

Procurement options
The decision has been made to undertake a wider joint commissioning approach to Non-emergency Patient Transport due to the potential procurement efficiencies to achieve alignment with the developing Staffordshire Local Health Economy.

There are many benefits in this approach, such as:
Economies of scale in:
- Procurement
- Contract monitoring
- Cross border logistical efficiencies from a provider perspective
- Share learning to ensure consistencies in contracts
- Potentially increase number of resources to mobilise/ react to surges in activity
- Potential cost savings

The Invitation to Tender (ITT) was published as part of the OJEU advertisement in line with the Lotting strategy detailed below:

Model 1: Separating the contract into three LOTS giving bidders the opportunity to tender for only one of the LOTS:–
LOT 1: North Staffordshire CCG and Stoke on Trent CCG
LOT 2: Staffordshire and Stoke on Trent Partnership Trust (SSOTP)
LOT 3: Stafford & Surrounds CCG, Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG, East Staffordshire CCG

Model 2: There will be an option for bidders to submit a variant bid to deliver a PAN Staffordshire service. This will be classed as LOT 4 (incorporating Lot 1, 2 and 3).
The evaluation methodology for assessing the ITT (Invitation to Tender) submissions was published in the ITT. The table below sets out the scoring methodology for the questions:

<table>
<thead>
<tr>
<th>Quality and Service requirements</th>
<th>weighting 40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial assessment</td>
<td>weighting 40%</td>
</tr>
<tr>
<td>Workforce/ HR</td>
<td>weighting 7%</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>weighting 6%</td>
</tr>
<tr>
<td>Contract Mobilisation and Management</td>
<td>weighting 7%</td>
</tr>
</tbody>
</table>

The evaluation process of submitted bids will be undertaken towards the end of March 2016 with the Evaluation Panel comprising of representation from:

- Commissioners
- Quality
- IM&T
- Contracting
- Finance
- Procurement
- Patients and public involvement
- HR

The Panel will score their respective sections and the scoring will be moderated by the Midlands and Lancashire Commissioning Support Unit Procurement Team. The approved procedural decision making process has been agreed by all Associates (neighbouring CCGs and SSOTP).

Following this process, Bidder interviews will be held week commencing the 4th April 2016 to give the assessors a further understanding of the bids. The proposal is to offer the tender for a 3 year period with an option to extend for an additional year, extension costs being fixed at the annual contract value.

To ensure the contract mobilisation timeline is adhered to the CCGs will need to ensure that the contract award is no later than the 27th April 2016.

**Recommendation**

The Governing Body is asked to:

- **Note** the process established to undertake the reprocurement of Non-Emergency PTS Service.
- **Note** the timeline outlined above, including the contract award date of no later than the 27th April 2016.
- **Note**, that as the Governing Body does not meet again until the 7th June 2016, **approval for delegated authority** is requested to the following Sub-Committees:
- **Approve** that the outcome of the procurement process will be received and reviewed at the Joint Planning Committee on the 12th April 2016, prior to ratification of the contract award at the Joint Finance and Performance Committee on the 27th April 2016, on behalf of the Governing Body.
- **Note** that the outcome of the above will be reported to the next available Governing Body meeting (scheduled for the 7th June 2016).
REPORT TO
Stoke-on-Trent CCG Governing Body

TITLE OF REPORT
Information Governance Annual Report 2015-2016

DATE OF THE MEETING
5th April 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

COMMITTEE/GROUP
Scheduled to be submitted to the Audit Committee – 19th April 2016

INDIVIDUAL
Iain Stoddart – Chief Financial Officer/Senior Information Risk Owner

ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD

<table>
<thead>
<tr>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>√</th>
<th>For noting</th>
</tr>
</thead>
</table>

RECOMMENDATION

The Governing Body is asked to:

- Note the contents of the Information Governance Annual Report 2015-2016; and in particular
- Note that the SIRO approved the contents of the Information Governance Annual Report and submission of version 13 of the Information Governance Toolkit on behalf of the CCG by the national deadline of the 31st March 2016.
- Note that the CCG has achieved the 95% compliance of staff who have completed their Information Governance Training during 2015 / 2016
- Note the Information Risk work is progressing really well and this is an on-going process within the CCG.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER (identify appropriate goals)

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Improve health outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Improve quality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Reduce health inequalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
**PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY**

The Annual Report provides the CCG with a final overview of the Information Governance Improvement Plan for 2015/16.

The report was requested earlier in order for the SIRO to confirm receipt of the annual report. The SIRO approved the contents of this annual report and submission of the toolkit on the 21st March 2016 ahead of the deadline of the 31st March 2016.

The CCG submitted an overall score of 91% which is a slight increase on the score achieved for 2014 / 2015 of 86%.

<table>
<thead>
<tr>
<th>SUMMARY OF RISKS RELATING TO THE PROPOSAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks relating to information assets and how these are mitigated against are detailed within the report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance Toolkit Version 13</td>
</tr>
<tr>
<td>Freedom of Information Act 2000</td>
</tr>
<tr>
<td>Data Protection Act 1998</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACRONYMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the main body of the report.</td>
</tr>
</tbody>
</table>
Stoke On Trent CCG Information Governance Annual Report – Summary for Governing Body

1st April 2015 – 18th March 2016

1. Introduction

The Annual Report provides the CCG with a final overview of the Information Governance Improvement Plan for 2015/16. The report has been requested earlier in order for the SIRO to confirm receipt of the annual report and approve submission of the Information Governance Toolkit on the 31st March 2016. The report will be submitted to the next available Governing Body meeting on the 5th April 2016. The SIRO approved the annual report and submission of the toolkit on the 21st March 2016.

Information Governance Toolkit

The MLCSU IG Team will publish the Information Governance Toolkit return on behalf of the CCG by 31st March 2016. Before this can happen, the senior management within the CCG must sign off each sub requirement of the toolkit as well as the overall score. The 2015-16 submission for Stoke on Trent CCG by sub-requirement is as follows:

<table>
<thead>
<tr>
<th>Assessment Period</th>
<th>Level</th>
<th>Outcome</th>
<th>Score &amp; Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance Management</td>
<td>0 0 1 4 0 0</td>
<td>93%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Confidentiality and Data Protection Assurance</td>
<td>0 0 1 6 1 0</td>
<td>95%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Information Security Assurance</td>
<td>0 0 4 6 3 0</td>
<td>86%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Clinical Information Assurance</td>
<td>0 0 0 1 1 0</td>
<td>100%</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Assessment Period</td>
<td>Level</td>
<td>Outcome</td>
<td>Score &amp; Status</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td>Version 13 (2015-2016)</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

2. **Improvement Plan 2015 – 16**

The CCG’s Improvement Plan has been confirmed as complete for 2015/16 and all elements delivered, following the approval of this report.

3. **Mandatory Information Governance Training**

The CCG achieved their target of 95% for 2015/16 with 97% of CCG staff completing their mandatory annual IG training.


**Information Asset Register**

181 assets are recorded within the UASsure system with the following risk scores:

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Number of Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>129</td>
</tr>
<tr>
<td>Moderate</td>
<td>37</td>
</tr>
<tr>
<td>High</td>
<td>8</td>
</tr>
<tr>
<td>Extreme High</td>
<td>7</td>
</tr>
</tbody>
</table>
Action Plan Management

There were 15 assets recorded on UAssure for which an action plan would need to be considered due to their having a risk score of 12 or higher.

The IG Support Officer worked with all IAO’s to complete an action plan and identify potential risk treatment options; the SIRO approved the recommended risk treatment option for 14 of the 15 actions plans on the 14th March 2016. The SIRO chose an alternative risk treatment option to the one recommended for the remaining asset for which an action plan was required. The IG Support Officer will meet with the IAO to interpret and implement the risk treatment option chosen by the SIRO.

Business Critical Assets

Business critical assets are defined as those which, if unavailable for 3 days or less, would result in a noticeable impact on the business. The following chart below details the business impact of the information assets logged on UAssure.

![Pie chart showing business impact analysis]

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Number of Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>127</td>
</tr>
<tr>
<td>Medium</td>
<td>34</td>
</tr>
<tr>
<td>High</td>
<td>19</td>
</tr>
</tbody>
</table>

In total 53 assets have been identified as business critical to the CCG, 34 assets pose a medium risk and 19 assets pose a high risk.

The CCG’s Business Continuity Plan currently doesn’t reflect information assets specifically. The IG Support Officer is working with the CCG to ensure that the business critical assets are reflected within an updated plan.

Data Flow Mapping

612 data flows have been identified to date. The chart below shows how the data flows by the direction.
As with information assets, where a risk of 12 or more is identified, the CCGs IG Support Officer will work with the relevant IAO to develop risk treatment options with a view to reducing the risk score. There are 504 data flows that had been scored as having a risk score of 12 or more for this review. It has been acknowledged that a large majority of these data flows are sent internally within the CCG by email, therefore whilst by the national best practice on which the data flows questions are based, they are classed as high risk as not sent from nhs.net to nhs.net, the internal email system within the NS domain is encrypted to the same standards as NHSmail.

The Information Risk Management Plan is a constant review cycle and so will never meet a ‘stop’ point and therefore each year the CCG must show that rather than stating that ‘all’ assets have been logged, show that substantial improvement has been made against the previous year.

**Systems and Software Register**

The CCG has identified two systems which hold information assets:

- Datix Insight system
- E-Referral System

Work in ongoing to complete questionnaires to assess the systems for compliance with both IT and IG requirements.

**Contracts and Agreements**

There are currently no data flows that require a contract or agreement.

Contracts with third parties not currently assigned to data flows will also be uploaded to UAssure. The IG Support Officer is continuing to work with the CCG to identify any potential contracts which fall under this scope.

Additionally, the CCG requests all third party contractors, temporary staff etc read and sign the CCG’s Compliance Agreement to adhere to the CCG’s Information Governance Handbook.
In total the CCG currently has 3 temporary contractors working on behalf of the CCG having access to CCG property of either equipment and/or information they come into contact with. All of the temporary contractors have signed the CCG’s confidentiality and compliance agreement.

Confidentiality Audit

The Confidentiality Audit is split into 3 sections; shared drive access, registration authority audit and systems access audit. The audits found only minor areas of non-compliance – discrepancies in access control groups which were due to genuine oversights by the IAO in identifying who should have access to assets, staff who have left the organisation still being shown as having active smartcards.

The full findings of the audit have been provided to the CCG in the full Annual Report.

Information Security Audit

The Information Security audit tests the physical information assets recorded to ensure the security arrangements stated were in place when audited.

All physical assets that were audited were found to be stored as stated within the information asset register.

5. Information Governance Incidents

The CCG have not alerted the IG team to any actual or near-miss breaches of confidentiality between 1st April 2015 and 18th March 2016.

Staff are regularly reminded that if an incident is identified even if it is only suspected these must be reported to the IG Support Officer within 24 hours of identification.

6. Information Governance Spot Checks

The Information Governance Support Officer completes bi-monthly spot checks alternating between Out of Hours and Working Hours. These checks have found only minor issues around compliance with the requirements set out in the CCGs IG Handbook and have shown an improvement in the knowledge of staff around basic IG, including knowing who the IG Lead, Caldicott Guardian and SIRO were in the CCG.

The full findings of the spot checks have been provided to the CCG in the full Annual Report.

7. Privacy Impact Assessments

There have been no Privacy Impact Assessments completed since 1st April 2015. There are currently five Privacy Impact Assessments on going for new projects in the CCG which have been summarised in the full Annual report provided to the CCG.
It is essential the CCG involve the information governance team in the planning of any new services, processes or systems that the CCG commissions that require the use of personal data, to ensure a PIA is completed.

8. **Caldicott Issues (including Information Sharing)**

There have been six issues added to the Caldicott Issues log from 1st April 2015 to date.

In addition to being consulted where PCD is to be shared, any breaches of confidentiality must be brought to the attention of the Caldicott Guardian. From these breaches, a process of lessons learned can be implemented and documented to ensure PCD is protected.

9. **Data Protection Requests (Subject Access Requests)**

There have been no reported Data Protection requests since 1st April 2015 – 18th March 2016.
# APPENDIX A

## Stoke on Trent CCG Information Governance High Level Work Programme 2015-16

<table>
<thead>
<tr>
<th>Improvement/Requirement</th>
<th>Detail</th>
<th>Interdependency</th>
<th>Resource</th>
<th>Completion Dates</th>
<th>IG Toolkit Requirement</th>
<th>Status</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Information Governance Management Assurance</strong></td>
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<tr>
<td>Review of the Information Governance Management Framework to reflect any changes in key personnel and also the resource sections to reflect the CSU restructure which took effect from the 1st April 2015.</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td>Incorporation of the Improvement Plan for 2015-16.</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Standard Information Governance Management Reporting</strong></td>
<td>Bi monthly Reporting to the organisations IG lead, Senior Information Risk Owner &amp; Caldicott Guardian to monitor performance against the IG Improvement Plan. To include:</td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>29th May 2015 31st July 2015 30th September 2015 20th November 2015</td>
<td>13-130 13-131 13-134 13-230</td>
<td>Complete, included within the IG Policy.</td>
<td>All bi-monthly reports have been completed and provided to</td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
<td>Status</td>
<td>Comments</td>
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<tr>
<td>standard items to be reported on a regular basis to the meeting with responsibility for Information Governance. This should be pro-active reporting (even if NIL return) rather than reactive.</td>
<td>• IGT scores&lt;br&gt;• IG Training&lt;br&gt;• Information Risk Management Plan&lt;br&gt;• Incidents&lt;br&gt;• PIA’s completed&lt;br&gt;• SIRO update&lt;br&gt;• Caldicott update&lt;br&gt;• Data Protection requests</td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>29th January 2016</td>
<td>13-231&lt;br&gt;13-234&lt;br&gt;13-235&lt;br&gt;13-237&lt;br&gt;13-340&lt;br&gt;13-341&lt;br&gt;13-345&lt;br&gt;13-346&lt;br&gt;13-349&lt;br&gt;13-350&lt;br&gt;13-351&lt;br&gt;13-420</td>
<td>the CCG on time. It was agreed with the CCG that the January report would be provided by 4th February 2016 to ensure the most up to date information can be provided to the CCG Audit Committee.</td>
<td></td>
</tr>
<tr>
<td>Information Governance Annual Report (incorporating the final Bi-monthly Report) highlighting the annual performance against the improvement plan and also sign off of the Information Governance Toolkit submission.</td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>17th March 2016</td>
<td></td>
<td></td>
<td>This report.</td>
<td></td>
</tr>
<tr>
<td><strong>Information Governance Training</strong>&lt;br&gt;All staff are required to undertake information governance training on an annual basis ensuring that the minimum training specification set out by the Health &amp; Social Care Information Centre is met. Additional training should be provided to staff in key roles to ensure that they remain effective within their roles and fully understand their role.</td>
<td>All Staff Refresher Training to be delivered throughout the organisation via face to face training sessions ensuring staff are not only informed of the national responsibilities but also the organisations local implementation of legislation &amp; guidance. This will be achieved via a 2 hour session open to all staff and will include an interactive assessment of staff training needs.</td>
<td>N/A</td>
<td>Information Governance Support Officer&lt;br&gt;All CCG Staff</td>
<td>August to December 2015</td>
<td>13-133&lt;br&gt;13-134&lt;br&gt;13-230&lt;br&gt;13-231&lt;br&gt;13-234&lt;br&gt;13-237&lt;br&gt;13-340&lt;br&gt;13-345&lt;br&gt;13-349&lt;br&gt;13-420</td>
<td>All training sessions have now been delivered. The training compliance stands at 96% which is compliant with the submission of the IG Toolkit. Any members of staff that are not currently compliant have...</td>
<td></td>
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<tr>
<td>Improvement/Requirement</td>
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<td>Interdependency</td>
<td>Resource</td>
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<td>information governance responsibilities.</td>
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<td></td>
<td>been reported to the IG lead. Non-complaint staff will now need to complete their IG refresher training via the HSCIC Training Tool.</td>
</tr>
<tr>
<td>1:2:1 IG Induction sessions for new starters. All new staff to the organisation need to be fully aware of their responsibilities in relation to information governance. To support this process a member of the Information Governance Team will meet with each new starter to take them through an IG induction which is separate to the organisation induction.</td>
<td></td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>Ongoing</td>
<td></td>
<td>All new starters since the 1st April 2015 to date have received their induction, as required. All new starters require 1:2:1 IG inductions with the IG Support Officer. Also, all new staff have to read the staff handbook &amp; IG policy &amp; sign a declaration that they have read and understood the contents. The IG Support Officer will keep a record of all received declarations.</td>
<td></td>
</tr>
<tr>
<td>Information Governance Training for Governing</td>
<td>N/A</td>
<td></td>
<td>Information</td>
<td>Planned November</td>
<td></td>
<td>This is complete.</td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
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<tr>
<td>Body members. It is essential that all staff working on behalf of the organisation understand their responsibilities, even if they only have access to very limited information or minimal access to IT facilities. This session is optional for those organisations that require members to be provided with high level overview training.</td>
<td></td>
<td></td>
<td>Governance Manager</td>
<td>2015</td>
<td>Information Governance Training for Body Members was delivered on 10th November 2015.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information Risk training for those staff nominated as Information Asset Owners &amp; Administrators. Face to face sessions to be held with the Information Security Manager for the organisation which include background to information risk, roles &amp; responsibilities and system user training.</td>
<td></td>
<td>N/A</td>
<td>Information Security Managers</td>
<td>July - August 2015</td>
<td>Two training sessions have been completed on 19th and 24th August 2015. Any IAO/IAA who did not attend the training sessions has received training on a 1:1 basis at their desk by the IGSO.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject Access Training for those staff identified as being responsible for the handling of Subject Access Requests under the Data Protection Act.</td>
<td></td>
<td>N/A</td>
<td>Information Security Managers, Key CCG staff</td>
<td>August to December 2015</td>
<td>This is now complete. The SAR procedure was approved by Audit Committee on 20th October 2015 and ratified by Governing Body on 1st December 2015. IGSO and IG lead identified the members of staff that required this training. IGSO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
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<tr>
<td>Information Governance Handbook Annual Review</td>
<td>Review of the current handbook against the newest version of the IG Toolkit, national guidance and any legislation changes within the year. Inclusion of any lessons learnt as a result of incidents within the year or areas of improvement identified via staff training, staff compliance checks and spot check audits.</td>
<td>N/A</td>
<td>Information Governance Support Officer Key CCG staff</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; November 2015</td>
<td>13-132 13-133 13-134 13-230 13-231 13-232 13-234 13-235 13-237 13-340 13-341 13-343 13-348 13-349 13-350 13-351</td>
<td>Completed – the handbook was approved on 16&lt;sup&gt;th&lt;/sup&gt; February 2016 at Audit Committee. Completed – the handbook was approved on 16&lt;sup&gt;th&lt;/sup&gt; February 2016 at Audit Committee.</td>
<td></td>
</tr>
<tr>
<td>Freedom of Information training for those staff who are involved in the collation of FOI responses on behalf of the organisation.</td>
<td>N/A</td>
<td>Information Governance Support Officer Key CCG staff</td>
<td>On request if required</td>
<td></td>
<td></td>
<td>has delivered training to all members of staffs that required this training. Not currently requested</td>
<td></td>
</tr>
<tr>
<td>Privacy Impact Assessment Training for those staff who need to be able to recognise the need for and undertake a PIA on behalf of the organisation.</td>
<td>N/A</td>
<td>Information Security Managers Key CCG staff</td>
<td>On request if required</td>
<td></td>
<td></td>
<td>Not currently Requested</td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
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<tr>
<td><strong>Information Governance &amp; Data Protection Clauses within Staff Contracts</strong></td>
<td>All staff working for or on behalf of the organisation are required to sign up to relevant clauses in relation to information governance. Clauses must be reviewed against the requirements within the toolkit to ensure that they remain up to date and fit for purpose.</td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>30th September 2015</td>
<td>13-132 13-133</td>
<td>Complete</td>
<td>Statement from most senior Human Resources Officer to confirm that all staff are covered by Information Governance Clauses.</td>
</tr>
<tr>
<td></td>
<td>Evidence that temporary staff and 3rd parties working on behalf of the organisation are required to abide by the organisations information governance policies and procedures whilst undertaking work on behalf of the organisation.</td>
<td>The organisation is aware of the third party and temporary contractor agreement and is actively using the agreement.</td>
<td>Information Governance Support Officer</td>
<td>On going</td>
<td></td>
<td></td>
<td>All temporary staff and contractors since the 1st April 2015 to date have received signed a confidentiality agreement. This is an ongoing process. When temporary staff and 3rd parties join the CCG they must sign the confidentiality and compliance agreement.</td>
</tr>
<tr>
<td><strong>Contracts &amp; Agreements</strong></td>
<td>Through the completion of data flow mapping the organisation is able to identify where data is shared with third parties either via data exchange or via a hosted system. Agreements can then be reviewed to ensure that appropriate Information Governance clauses are in place.</td>
<td>Data Flow Mapping</td>
<td>Information Governance Support Officer</td>
<td>September to December 2015</td>
<td>13-132 13-344 13-350</td>
<td>There are currently no data flows that require a contract or agreement to be in place. However work has been completed to satisfy IG toolkit.</td>
<td></td>
</tr>
<tr>
<td><strong>Register identifying third parties with access to the organisations data</strong></td>
<td>It is important that where a data controller appoints a data processor on their behalf that there are appropriate clauses in place to ensure that the data is only used in line with the stipulations set out by the data.</td>
<td></td>
<td>Information Governance Support Officer</td>
<td></td>
<td></td>
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<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
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<td>Comments</td>
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<tr>
<td>Information Governance Compliance Checks</td>
<td>Working hours compliance checks which will also include an assessment of staff understanding of the organisations policies and procedures.</td>
<td>N/A</td>
<td>Information Governance Support Officer CCG staff who are questioned</td>
<td>July 2015 October 2015 February 2016</td>
<td><strong>Green</strong></td>
<td>In hours spot check carried out on 10th July 2015, 3rd November 2015 and 23rd February 2016.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Information Governance Support Officer CCG staff who are questioned</td>
<td>N/A</td>
<td>13-133 13-134 13-231 13-234 13-237 13-349</td>
<td><strong>Green</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out of hours compliance check to ensure that staff follow the organisations policies and procedures in relation to clear screen &amp; clear desk, the securing of confidential data and the overall security of the office areas.</td>
<td>N/A</td>
<td>Information Governance Support Officer CCG staff who are questioned</td>
<td>August 2015 December 2015 April 2016</td>
<td><strong>Green</strong></td>
<td>Out of hours spot check carried out on the 24th August 2015 and 21st December 2015. There is another check scheduled for April 2016.</td>
<td></td>
</tr>
<tr>
<td>Support the Internal Audit programme for Information Governance</td>
<td>To work with the CCG to agree the internal audit scope and ensure that the evidence required, at the point of audit is available or a supporting plan is in place to achieve compliance where evidence is unavailable.</td>
<td>N/A</td>
<td>Information Governance Manager Key CCG staff</td>
<td>Preliminary date of mid / end January 2016 agreed with Internal Audit</td>
<td>N/A</td>
<td>Complete – North Staffs CCG IG Toolkit Audit was carried out between 11th - 15th January 2016.</td>
<td></td>
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<td></td>
<td>To provide a response to the internal audit findings and where required implement the audit recommendations or put a plan in place to incorporate the findings into the wider work programme for the following year.</td>
<td>N/A</td>
<td>Information Governance Manager Key CCG staff</td>
<td>January / February 2016</td>
<td><strong>Green</strong></td>
<td>Complete – report of the findings sent to the CCG and IG Team.</td>
<td></td>
</tr>
<tr>
<td>Service Review Meetings</td>
<td>Initial Service Review meeting to look at how the CCG Availability Information May 2015 – June</td>
<td></td>
<td>Information</td>
<td>May 2015 – June</td>
<td>N/A</td>
<td>Complete -</td>
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<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
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</tbody>
</table>
| It is important for the CCG IG lead, Senior Information Risk Owner and the Caldicott Guardian to be kept informed on the progress of the IG improvement plan and have an opportunity to identify any issues with the IG management team. | team performed in the previous 12 months, lessons learnt, areas for improvement and the structural changes following the CSU management of change.                                                                 | Governance Support Officer  
Information Security Manager  
Information Governance Manager  
Key CCG staff | Governance Support Officer  
Information Security Manager  
Information Governance Manager  
Key CCG staff | 2015                                                                       |                                                        | Complete - meeting took place on 18th June 2015. |
| 6 month service review meeting to review progress against the improvement plan and ensure that service delivery remains on track. | CCG Availability                                                                                                                                                                                      | Information Governance Support Officer  
Information Security Manager  
Information Governance Manager  
Key CCG staff | information Governance Support Officer  
Information Security Manager  
Information Governance Manager  
Key CCG staff | October – November 2015                                                     |                                                        | Complete - meeting took place on 3rd December 2015. |

**Confidentiality & Data Protection Assurance**

<table>
<thead>
<tr>
<th>Data Transferred outside of the UK</th>
<th>Identifying personal data transferred outside of the UK and whether there are</th>
<th>Data Flow Mapping</th>
<th>Information Governance Support Officer</th>
<th>30th November 2015</th>
<th>13-236 13-350</th>
<th>Complete – following data flow mapping exercise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
<td>Status</td>
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<td>appropriate agreements in place.</td>
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<tr>
<td><strong>Fair Processing</strong></td>
<td><strong>Data Controllers are required to issue a fair processing notice to their service users identifying how they process data and who they share data with (data recipients).</strong></td>
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</tr>
<tr>
<td></td>
<td><strong>Review of the current fair processing notice in place to ensure suitability for the forthcoming year and whether there are any new data uses that need to be reflected.</strong></td>
<td>Data Flow Mapping</td>
<td>Information Security Manager Nominated IAOs and IAA</td>
<td>30th November 2015</td>
<td>13-250 13-350</td>
<td>Complete – The Fair Processing Notice was approved by Audit Committee on the 16th February 2016 and will be ratified by the Governing Body on 5th April 2016.</td>
</tr>
<tr>
<td></td>
<td><strong>Identification through data flow mapping of third party recipients that need to be included in the fair processing notice for the organisation.</strong></td>
<td>Data Flow Mapping</td>
<td>Information Governance Support Officer</td>
<td>30th November 2015</td>
<td></td>
<td>Complete – Through the data flows that have been logged, there are no 3rd parties that need to be included into the fair processing notice.</td>
</tr>
<tr>
<td></td>
<td><strong>Staff data also needs to be included as the staff of the organisation are a service user. The fair processing notice needs to identify what staff data is collected and the purposes of the processing.</strong></td>
<td></td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>30th November 2015</td>
<td></td>
</tr>
<tr>
<td><strong>Confidentiality Audits</strong></td>
<td><strong>Audits of access to the following will be monitored:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Information Asset</strong></td>
<td>Information</td>
<td></td>
<td>December 2015 to</td>
<td>13-235</td>
<td>Complete - The</td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
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</tbody>
</table>
| It is essential that the organisation routinely monitors access to confidential information. | • Smart Card Access  
• Systems Access  
• Shared Drive Access to Electronic Assets | Register | Governance Support Officer  
Information Security Manager  
Nominated IAOs and IAAs | January 2016 | 13-343  
13-344  
13-348 | Complete - System access audit is currently on-going due to the system/software module not being complete at the time of reporting. |
| **Caldicott**  
To support the Caldicott Guardian in the implementation of the Caldicott Framework and to focus on the implementation of the recommendations of Caldicott 2. | Process for the identification of Caldicott issues and the regular reporting of the information included. | N/A | Information Governance Support Officer  
Caldicott Guardian | July to September 2015 | 13-230  
13-231  
13-234 | Complete - Following a 1-1 session with the Caldicott Guardian, a process has been agreed to ensure issues are added to the log when they are received by the Caldicott Guardian and ensuring the IGSO supports the process. |
| Caldicott Guardian support in the form of 1:2:1 training to support them in their role and understanding their responsibilities. | N/A | Information Governance Support Officer  
<table>
<thead>
<tr>
<th>Improvement/Requirement</th>
<th>Detail</th>
<th>Interdependency</th>
<th>Resource</th>
<th>Completion Dates</th>
<th>IG Toolkit</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedure for the management of Subject Access Requests including legislative requirements and template correspondence.</strong></td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>July to September 2015</td>
<td>Complete – Procedure approved at Audit Committee meeting on 20th October 2015. This was then ratified at Governing Body on the 5th January 2016.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Privacy Impact Assessments</strong></td>
<td>Privacy Impact Assessments have been mandatory within the NHS since 2008; however the completion of them is still quite adhoc. There is a clear need to raise the awareness of Privacy Impact Assessments and embed the process.</td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td></td>
<td></td>
<td></td>
<td>This is an ongoing process throughout the year. There are currently five PIA’s in progress.</td>
</tr>
<tr>
<td><strong>Information Sharing/Data Processing Agreements</strong></td>
<td>It is important to ensure that where the organisation will be party to the sharing of personal data that appropriate agreements are in place.</td>
<td>N/A</td>
<td>Information Governance Support Officer</td>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information Security Assurance</strong></td>
<td>Review of the current information held within information asset registers and also the addition of further information to the asset register to build</td>
<td>N/A</td>
<td>Information Governance Support</td>
<td>July to November 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
<td>Status</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>information assets that it holds, in whatever format and record the access controls associated with them.</td>
<td>on the previous years’ work.</td>
<td></td>
<td>Officer</td>
<td>July to November 2015</td>
<td>13-346 13-351</td>
<td>Complete – assistance of the IG Support Officer.</td>
<td></td>
</tr>
<tr>
<td>Identification of business critical assets which need to be afforded additional protection and need to be transferred onto the organisations risk register.</td>
<td>N/A</td>
<td>Information Governance Support Officer Information Security Manager Nominated IAOs and IAAs</td>
<td>Information Governance Support Officer Information Security Manager Nominated IAOs and IAAs</td>
<td>July to November 2015</td>
<td></td>
<td>Complete – IAO/IAAs completed with assistance of the IG Support Officer.</td>
<td></td>
</tr>
<tr>
<td>Information assets with a risk score of 12 and above need to be considered by the IAO and consideration given as to whether these will be accepted risks or whether there are steps that can be taken to mitigate the risk.</td>
<td>Information Asset Register</td>
<td>Information Governance Support Officer Information Security Manager Nominated IAOs and IAAs</td>
<td>Information Governance Support Officer Information Security Manager Nominated IAOs and IAAs</td>
<td>October to December 2015</td>
<td></td>
<td>Complete – Action plans have been created by IAOs and approved by the SIRO.</td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
<td>Status</td>
<td>Comments</td>
</tr>
<tr>
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<td>----------</td>
</tr>
<tr>
<td>Identification of information held within systems or software and the access controls associated.</td>
<td></td>
<td>Information Asset Register</td>
<td>Information Governance Support Officer&lt;br&gt;Information Security Manager&lt;br&gt;Nominated IAOs and IAAs</td>
<td>August to November 2015</td>
<td></td>
<td></td>
<td>Two systems have been identified through the information asset register. This work stream is currently ongoing.</td>
</tr>
<tr>
<td>Data Flow Mapping</td>
<td>Review of the current recorded flows linked to the information assets and additional flows recorded once new assets have been added. These will include details of the controls in place when the assets are in transit.</td>
<td>Information Asset Register</td>
<td>Information Governance Support Officer&lt;br&gt;Information Security Manager&lt;br&gt;Nominated IAOs and IAAs</td>
<td>July to November 2015</td>
<td>13-350</td>
<td>Complete – IAO/IAAs completed with assistance of the IG Support Officer.</td>
<td></td>
</tr>
<tr>
<td>Information Security Audits</td>
<td>Information security audits will 'test' that the information recorded within the asset register and data flows is accurate and effective and that the organisation procedures are being appropriately followed.</td>
<td>Information Asset Register&lt;br&gt;Data Flow Mapping</td>
<td>Information Governance Support Officer&lt;br&gt;Information Security Manager</td>
<td>December 2015 to January 2016</td>
<td>13-341&lt;br&gt;13-350&lt;br&gt;13-351</td>
<td>Completed on 26/01/2016.</td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
<td>Status</td>
<td>Comments</td>
</tr>
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<td>----------------------------------------------------------------------------------------------------------</td>
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<td>------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Incident Management</strong></td>
<td>Working with the organisation to carry out a severity assessment based on the national requirements and where required working with the organisation to ensure that level 2 incidents are reported externally within 24 hours of becoming aware of the incident.</td>
<td>Nominated IAOs and IAAs</td>
<td>Information Governance Support Officer Information Security Manager Nominated IAOs and IAAs</td>
<td>Ongoing</td>
<td>13-133 13-235 13-349</td>
<td>Ongoing</td>
<td>This is an ongoing process throughout the year. The IG team have not been alerted to any incidents to date.</td>
</tr>
<tr>
<td><strong>Mobile Working Arrangements</strong></td>
<td>Identification of those staff that have the ability to work 'remotely' and a check to ensure that those staff understand the processes to be followed when working remotely and the restrictions that are in place.</td>
<td>IG Handbook</td>
<td>Information Governance Support Officer Information Security Manager</td>
<td>December 2015</td>
<td>13-348</td>
<td>Complete – Information received from the IT helpdesk.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of current remote working procedures to ensure that they remain relevant and fit for purpose.</td>
<td>IG Handbook</td>
<td>Information Governance Support Officer Information Security Manager</td>
<td>December 2015</td>
<td></td>
<td>Complete – included within the IG Handbook approved at Audit Committee 16th February 2016.</td>
<td></td>
</tr>
<tr>
<td><strong>Information Quality Assurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement/Requirement</td>
<td>Detail</td>
<td>Interdependency</td>
<td>Resource</td>
<td>Completion Dates</td>
<td>IG Toolkit Requirement</td>
<td>Status</td>
<td>Comments</td>
</tr>
<tr>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Records Management Strategy</td>
<td>It is essential that organisation manage all records appropriately and that they ensure standards around the creation, recording, review, retention and destruction of those records are implemented and up held.</td>
<td></td>
<td>IG Handbook</td>
<td>November 2015</td>
<td>13-420</td>
<td>Complete – included within the IG Handbook approved at Audit Committee 16th February 2016.</td>
<td></td>
</tr>
<tr>
<td>AUTHOR Name</td>
<td>Julia Allen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REPORTING OFFICER /DIRECTOR Name</td>
<td>Sandra Chadwick</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Equality &amp; Inclusion Business Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Chief Operating Officer</td>
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</tr>
</tbody>
</table>

**REPORT TO**
Stoke on Trent CCG Governing Body

**TITLE OF REPORT**
Equality and Inclusion Update Stoke-on-Trent CCG

**DATE OF THE MEETING**
5th April 2016

**WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?**

| COMMITTEE/GROUP | INDIVIDUAL |
| Joint ODC 29 March 2016 | None |

**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD**
(please identify all applicable and provide details below)

<table>
<thead>
<tr>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**RECOMMENDATION**
The Stoke-on-Trent Governing Body is requested to:

- Note the EDS Update and that Cheryl Hardisty, Interim Director of Commissioning is the EDS CCG Joint Lead in 2016 re *Goal 2: Improved patient access and experience*;
- Note that all information must be published in a way that makes it easy for people to understand it (PSED requirement);
- Note the Easy Read version of the November 2015 EDS grading report which will be available on the CCG website shortly;
- Note that all senior and middle managers from NSCCG and SOTCCG are due to attend Equality and Inclusion Awareness session during 2016;
- Note the postal engagement with local communities of interest including protected group representatives of the Equality and Inclusion Strategy 2015 to Oct 2017;
- Note that a joint Equality and Inclusion Action Plan (Nov 2015 to Oct 2017) has been produced; and
- Note the Accessible Information Standard (AIS) update.

**STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER**
(identify appropriate goals)

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>2. Improve health outcomes</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3. Improve quality</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>4. Reduce health inequalities</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY
(supporting information to be included, if applicable)

- EDS annual public grading of CCGs joint equality performance evidence takes place annually. In 2016 Goal 2: Improved patient access and experience will be jointly graded on 17 May 2016. Preparations are underway to gather commissioner (and larger provider) evidence re April 2015 to May 2016 performance showing how do local people from protected groups fare compared to people in general in healthcare?

- Joint CCG Equality Delivery System evidence gathering is to begin once agreement by CCGs on focus of evidence which shows how local people from protected groups fare compared to people overall in healthcare. Practice run through of the second joint CCG EDS public event and evidence presentation, is planned for 5 May 2016. Cheryl Hardisty, Interim Director of Commissioning is the EDS lead for North Staffs and Stoke CCGs in 2016 re Goal 2: Improved patient access and experience. 2016 public grading event will take place on the morning of 17 May 2016 at NSCCG Headquarter Offices.

- All information must be published in a way that makes it easy for people to understand it (PSED requirement). A summary Easy Read document of the October 2015 EDS annual public grading has been developed by People First Tameside (learning disability support organisation) and will be available on the CCG website shortly.

- All middle and senior managers are due to attend Equality and Inclusion Awareness training during 2016 to meet EDS required Outcome 4.3 ie middle managers and line managers support their staff to work in culturally competent ways within a work environment free from discrimination. CCG will also maintain a 2016 log of who attends which Equality training / development for inclusion onto ESR. EDS 4 Goals and 18 required Outcomes 1 page summary shown in Appendix 2.

- The refreshed Equality and Inclusion Strategy 2015 to Oct 2017 will be circulated for postal engagement with local communities of interest including representatives from protected groups. The strategy focuses on CCGs legal equality responsibilities under the Equality Act 2010; health inequalities of protected groups under the Health and Social Care Act 2012; and three new Equality Objectives. A corresponding Action Plan has been developed with a set of E&I strategy deliverables.


- NHS England have introduced a new Accessible Information Standard (AIS) which will apply to all providers across the NHS and adult social care system (implementation is required by 31 July 2016). All providers of NHS care or treatment, including independent contractors providing NHS services such as GP practices; all providers of publicly-funded adult social care; adult social care or services bodies (in their role as service providers); providers of care from the voluntary and community or private sectors; providers of public health services, including advice and information.

- Commissioners must support providers to comply with the Standard. There are milestones to achieve for both commissioners and providers, prior to 31 July 2016 implementation date.

SUMMARY OF RISKS RELATING TO THE PROPOSAL
Highlight any implications, including finance, quality, reputation, governance, strategic workforce, clinical, medicines optimisation, equality related or other

Reputational risk to CCG if annual EDS Action Plan is not accurate and if CCG fail to consider lessons learnt
and recommendations made by local protected group representatives at the last annual EDS public grading event (27 October 2015).

CCG need to robustly monitor the equality compliance status particularly of its larger provider partner organisations. The National Standard Contract is out shortly from NHS England and may include some equality requirements on providers such as publishing their EDS annual public grading findings and recommendations.

CCG need to put into place an effective mechanism for gathering frequent feedback on key healthcare changes specifically from a ‘captive’ group of protected group representatives by locality – including voluntary sector support group reps (providing secondary feedback on any impacts arising). Such a stakeholder group could help support CCGs in discharging their ‘due regard’ duty more effectively linked to commissioning of services and programme / strategy / policy changes.

---

### ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS

<table>
<thead>
<tr>
<th>Equality Act 2010</th>
<th>Public Sector Equality Duty (PSED) (general and specific duties arise)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health and Social Care Act 2012 (equality and health inequalities)</td>
</tr>
</tbody>
</table>

*Equality Delivery System (EDS)*  
*Workplace Race Equality Standard (WRES)*  
*Accessible Information Standard (new in 2015)*  
* mandated by NHS England

---

### QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

*Date completed, please highlight any direct or indirect implications*

Not required as frequent governance reporting for Equality & Inclusion as standing agenda update items for EDS and WRES.

---

### ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT

*Provide further information, including dates if applicable*

The requirement to produce an audit trail of inclusive engagement seeking feedback on impacts arising from local protected group representatives is a key part of the EDS annual public grading of CCGs’ equality performance. Also, understanding the demographic profiles of our local communities can provide essential information to each CCG for engagement, feedback and improved patient experience purposes.

---

### ACRONYMS

*If not listed in the report, please list*

| E&I | Equality & Inclusion |
| EDS | Equality Delivery System |
| ODC | Organisational Development Committee |
| PSED | Public Sector Equality Duty |
| NSCCG | North Staffordshire Clinical Commissioning Group |
| SOTCCG | Stoke on Trent Clinical Commissioning Group |
| ESR | Electronic Staff Record |
## The goals and outcomes of EDS2

<table>
<thead>
<tr>
<th>Goal</th>
<th>Number</th>
<th>Description of outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better health outcomes</strong></td>
<td>1.1</td>
<td>Services are commissioned, procured, designed and delivered to meet the health needs of local communities</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>Individual people’s health needs are assessed and met in appropriate and effective ways</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td>
</tr>
<tr>
<td></td>
<td>1.5</td>
<td>Screening, vaccination and other health promotion services reach and benefit all local communities</td>
</tr>
<tr>
<td><strong>Improved patient access and experience</strong></td>
<td>2.1</td>
<td>People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td>
</tr>
<tr>
<td></td>
<td>2.2</td>
<td>People are informed and supported to be as involved as they wish to be in decisions about their care</td>
</tr>
<tr>
<td></td>
<td>2.3</td>
<td>People report positive experiences of the NHS</td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td>People’s complaints about services are handled respectfully and efficiently</td>
</tr>
<tr>
<td><strong>A representative and supported workforce</strong></td>
<td>3.1</td>
<td>Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
</tr>
<tr>
<td></td>
<td>3.2</td>
<td>The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td>
</tr>
<tr>
<td></td>
<td>3.3</td>
<td>Training and development opportunities are taken up and positively evaluated by all staff</td>
</tr>
<tr>
<td></td>
<td>3.4</td>
<td>When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td>Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
</tr>
<tr>
<td></td>
<td>3.6</td>
<td>Staff report positive experiences of their membership of the workforce</td>
</tr>
<tr>
<td><strong>Inclusive leadership</strong></td>
<td>4.1</td>
<td>Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed</td>
</tr>
<tr>
<td></td>
<td>4.3</td>
<td>Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination</td>
</tr>
</tbody>
</table>
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Liza Pursey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Interim Primary Care Strategy Manager</td>
</tr>
</tbody>
</table>

REPORTING OFFICER /DIRECTOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Emma Sutton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Clinical Director Primary Care</td>
</tr>
</tbody>
</table>

REPORT TO

Stoke-on-Trent CCG Governing Body

TITLE OF REPORT

Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan

DATE OF THE MEETING

5th April 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

<table>
<thead>
<tr>
<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Planning Committee 9th January – Approved Northern Staffordshire Primary Care Steering Group 2 February 2016 – Approved Stoke-on-Trent Patient Congress 5th January 2016</td>
<td>All GP members, practice managers and other members of the wider primary care team have been actively engaged in the development and ‘sign off’ of this document through direct representation and through a number of engagement events. A programme of patient and public engagement events commenced in January and will be completed in March.</td>
</tr>
</tbody>
</table>

ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD

<table>
<thead>
<tr>
<th>Approve</th>
<th>X</th>
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</thead>
<tbody>
<tr>
<td>Assurance</td>
<td></td>
</tr>
<tr>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>For noting</td>
<td></td>
</tr>
</tbody>
</table>

RECOMMENDATION

The Governing Body is asked to approve the overall vision and key principles described within this strategy to enable a detailed implementation plan to be developed.

The Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan describes a vision for primary care over the next five years and recognises that primary care is a key enabler to support the delivery of models of care which will reduce unwarranted variation, ensure sustainability and improve health outcomes of the local population.

This strategy acts as a local vision to support the 5 Year Primary Care Strategy for the ‘Together We’re Better’ Staffordshire Transformation Programme.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER (identify appropriate goals)

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve access</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Improve health outcomes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improve quality</td>
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<tr>
<td>3.</td>
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</tbody>
</table>

**PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY**

The Northern Staffordshire Primary Care Strategy sets out Stoke on Trent and North Staffordshire CCG’s vision for Primary Care for 2015-2020. It is aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire, supports the Staffordshire Transformation Programme, ‘Together We’re Better’ and builds on the new opportunities provided through primary care co-commissioning.

The key aims of the strategy are to:
- Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’;
- Deliver better patient outcomes through effective federated and collaborated arrangements with key partners;
- Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle;
- Reduce health inequalities and unwarranted clinical variations; and
- Achieve all of the above while remaining within financial balance and achieving best value.

The strategy proposes that Northern Staffordshire and Stoke-on-Trent CCGs in partnership with the Shropshire and Staffordshire Area Team begin supporting GPs in working collaboratively, to develop a sustainable, holistic and high quality model of Primary Care and ensure that all patients have access to the full range of enhanced locally available primary care services. The CCGs will continue to work closely with the Northern Staffordshire GP Federation to achieve this ambition.

In addition, in order to achieve our vision, over the next five years, the strategy proposes to develop a Multispecialty Community Provider (MCP) model of care. This model will initially incorporate enhanced Primary Care and Community Services, and will subsequently support integration and joint working across other out of hospital services across the area.

An Implementation Plan is being developed which will oversee

1. An implementation plan for the Development of the Northern Staffordshire Primary Care Commissioning Strategy; and

2. The development of a Multispecialty MCP Model of Care

The strategy will be supported by a number of enabler work streams which will be developed through the Staffordshire Transformation Programme and aligned to our local implementation plan for primary care:

- An Organisational Development and Workforce Plan;
- A Commissioning Framework which will address the contracting, performance and payment approaches required to enable new approaches to integrated working; and
- Estates and IT development plans
In addition a localised financial model is being developed to enable better understanding of the impact on investment and the release of savings through the development of primary care and the creation of an MCP model of delivery.

It is recognised that the progression of a primary care strategy and implementation requires transformation across the wider primary care team and across the health and social care system and with this in mind the Primary Care Delivery Plan Steering Group with representatives of the wider primary care team and all stakeholders, which developed the strategy, will continue to be used to oversee plans for implementation.

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**

High level risks have been described within the Primary Care Strategy. Having a Primary Care Strategy is a key requirement of Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21.

Key risks will be identified within the implementation plan.

**ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS**

N/A

**QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT**

An EIA has been developed to support this work. In addition a series of public and patient engagement have been organised across Northern Staffordshire. Focus Groups are being used to ensure the views of people from protected groups are captured.

**ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT**

The Primary Care Steering Group is composed of stakeholders from the wider health and social care economy and includes representation from UHNM, SSOTP and the North Staffordshire Combined Healthcare Trust. In addition attendees include Public Health and Social Care. GP views are represented by two locality leads and the LMC attend. Other members of wider primary care team such as nursing and pharmacy are invited and the Shropshire and Staffordshire Area Team participate. Dr Emma Sutton chairs this group. In addition GP, Practice Managers and the wider primary care team have participated in a programme of direct engagement including an online survey. An event for GPs to actively engage with this strategy was held on the 11th February.

Healthwatch have organised a series of engagement events with members of the public and patients throughout January and February. This work has been led by Dr Emma Sutton and although planned to end in March, followed by an evaluation report, engagement will be ongoing.

**ACRONYMS**
DRAFT
Northern Staffordshire
5 Year
Primary Care
Strategic Delivery Plan
Final Version
Executive Summary

This document sets out Stoke on Trent and North Staffordshire CCG’s vision for Primary Care for 2015-2020. It is aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire, supports the Staffordshire Transformation Programme, ‘Together We’re Better’ and builds on the new opportunities provided through primary care co-commissioning.

The key aims of the strategy are to:

• Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’;
• Deliver better patient outcomes through effective federated and collaborated arrangements with key partners;
• Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle;
• Reduce health inequalities and unwarranted clinical variations; and
• Achieve all of the above while remaining within financial balance and achieving best value.

This is an ambitious programme of large scale change recognising the importance of primary care at the heart of our entire health system. Most health system contact begins and ends in primary care with nine out of ten NHS contacts taking place in primary care, of which eight are in general practice. The GP record is the only place where an individual’s complete health history is recorded, thus enabling the delivery of integrated and coordinated care. The CCGs have valued and developed engagement via localities since their inception and more recently have asked practices to consider the transformation agenda. This strategy builds on this approach and sets out a vision for Northern Staffordshire with primary care at the centre of system transformation.

Our future vision for care has the patient and their GP at the heart of a multi-disciplinary model of provision where General Practice remains an attractive career choice and practices can flourish and work together, integrating with other providers of care as a part of a truly effective community health and social care system.

Throughout this document, the reference to patient care and wellbeing refers to both the patients physical and mental health needs, and by delivering a holistic approach we aim to achieve improvements in population wellbeing and ensure primary care sustainability. This multi-speciality community provider (MCP) model will enable patient-centred coordinated care, which will be provided in a locality; achieving improvements in health, developing resilience and supporting the population to stay as well and as healthy as possible. The development of our current localities to work together across a footprint of delivery of around 30-50,000 patients, and to obtain economies of scale through collaboration, will bring opportunities at practice level that cannot be achieved by individual practices alone.

The development of the MCP model will take into account the needs of our diverse population; empower patients to self-manage their care; improve population health and wellbeing by focussing on early intervention and prevention; encompass the three characteristics of care that matter most to patients, (proactive, accessible and coordinated care) and work across the system to develop a hub and spoke model to meet the requirement to provide 7 Day Access and winter resilience.

Enablers within this strategy will support the development of MCPs and the benefits that can accrue from integrating services around registered list based populations. Enablers include new technologies, organisational development, and financial modelling that will support emergent organisational structures and opportunities, acknowledging that the new MCP based delivery structures have the potential to maximise new ways of working such as care coordination and integrated systems around the registered lists.
It is clear that local primary care as we know it is under threat from significant workforce and economic pressures, a substantial increase in the number of appointments required, the complexity of presenting problems, increased bureaucracy and a transfer of unfunded work from secondary care. Any new model of care will need to address these issues and rapidly develop enabling work streams around workforce, estates and infrastructure (including IT) and robust financial modelling.

To this end, the CCG’s are committed to developing a workforce plan that analyses need, identifies workforce requirements, identifies gaps and implements solutions; in addition the work force plan will enable clinical time to be focused on patient need; resolve the issue of indemnity fees for all primary care professionals; support practices to develop and implement workforce models; enable greater use of the voluntary sector; place an increased emphasis on learning and development and promote work opportunities and the message that Stoke-on-Trent and North Staffordshire are good places to live and work.

We will develop a financial model which will identify current spend on primary care services and will explain how Northern Staffordshire will invest in primary care, mental health and community services. This investment strategy will enable practices to achieve the organisational capability required to deliver scale. It will support a viable workforce plan, deliver a viable estates portfolio and achieve technological solutions which enable data to be shared across the system. In addition there will be a shift to an outcome based approach, developing contracts which enable primary care to achieve outcomes and remain financially stable. This will be achieved through an implementation plan which enables change and maximises the use of all sources of funding so that we are able to provide the best services for our patients, in the right place, at the right time for the lowest cost.

In summary, this strategy will allow us to address the diverse needs of our population, promote primary care now and in the future whilst continuing to recognise the importance of the doctor patient relationship. It grows and develops the concept of locality working, by integrating services with and around primary care in a MCP model. It reflects the national ambition of working to scale and makes local primary care ‘future proof’ by providing a viable primary care provider model that can be supported by the emerging GP federation.

In addition by giving voice to primary care through one vision we are ensuring that the contribution that primary care makes in delivering good health for our populations is universally recognised and places primary care at the heart of our healthcare system.
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1.0 Summary on Two Pages

Our vision for primary care is to build a clinically and financially sustainable model for primary care services, in partnership with the wider health and social care system. The patient and their GP will be at the heart of a multidisciplinary model of care enabling patient-centred coordinated care, which will be provided in a locality, achieving improvements in health, developing resilience and supporting the population to stay as well and as healthy as possible.

Our Proposed Model

The Key Aims of Our Strategy are aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire which describes the outcomes that health, social care and public health are committed to achieve. In addition we are working to support the Staffordshire Transformation Programme, ‘Together We’re Better’. Our aims are:

- Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’
- Deliver better patient outcomes through effective federated and collaborated arrangements with key partners
- Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle
- Reduce health inequalities and unwarranted clinical variations
- Achieve all of the above while remaining within financial balance and achieving best value

We will develop a commissioning framework which will enable us to agree a future model of primary care taking into account the needs of our diverse population:

- Placing increased emphasis on the integration of mental health services into a primary care model of care which is essential to support holistic wellbeing
- We will progress an MCP Model of Care which will act as a catalyst for the transformation of primary care
- Empowering patients to self-manage their care
- Encompassing the three characteristics of care that matter most to patients; proactive, accessible and coordinated care
- Creating a shift from treatment to a model of improving population health and wellbeing focusing on early intervention and prevention recognising the importance of good mental health and social prescribing in overall well being
- Work across the system to develop a hub and spoke model to meet the requirement to provide 7 Day Access

Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan Final Version 22 February 16
Author: Liza Pursey Interim Primary Care Strategy Manager
We will continue to engage with our patients, members, our primary care teams and our other key stakeholders to develop a Primary Care Implementation Plan that:

- Gives voice to primary care
- Reflects local diversity
- Delivers success as defined by the achievement of aims
- Is supported in principle
- Harnesses expertise to achieve a valued and sustainable vision for the future

Taking into account the needs of our diverse population but better managing demand

- Recognising that no one model of primary care will be advocated
- Empowering patients to self-manage their care
- Encompassing the three characteristics of care that matter most to patients; proactive, accessible and coordinated

Develop a workforce plan that:

- Analyses need, identifies workforce requirements, identifies gaps and delivers solutions
- Puts in place systems which enable clinical time to be focused on patient need and protects the patient doctor relationship
- Resolves the issue of indemnity fees for all primary care professionals
- Supports practices to develop and implement workforce models
- Enables greater use of the voluntary sector
- Places an increased emphasis on learning and development
- Promotes work opportunities and the message that Stoke-on-Trent and North Staffordshire are good places to live and work

Northern Staffordshire Primary Care Strategic Delivery Plan Outline Timescales

Alignment of System Views

Stakeholder Engagement
2.0 Introduction to Northern Staffordshire

This strategy reflects our vision for primary care for the next five years. We need a clinically and financially sustainable model for primary care services which places all that is good about general practice at its centre.

Most contact between local people and the NHS occurs within primary care yet planning too often centres around secondary care services. We need to design services that meet the individual needs of those that are unwell, providing care in the place that is the most appropriate, delivered by those that are best placed to provide it. We believe that this will be more often in community settings than formerly.

The focus of our Primary Care Strategic Delivery Plan is on the primary care services that are in place to meet the needs of the population of Northern Staffordshire; Northern Staffordshire being defined as the geographical areas served by North Staffordshire Clinical Commissioning Group (NSCCG) and Stoke-on-Trent CCG. We have ensured that the strategy is aligned to the priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire and which both CCGs are committed to achieve.

Our intention is to:

- develop specific solutions that meet the needs of the populations of both Stoke-on-Trent and Northern Staffordshire CCG
- identify key principles that will enable the development of a model of care that is scalable across Staffordshire,

We see general practice as sitting at the centre of our future plans, but to be truly effective GPs and their teams have to work very effectively with the many other Health and Social Care professionals, third sector organisations and community groups that exist within North Staffordshire. The challenge is to keep what is good, but to use the opportunities that are offered by considering different ways of shared working to improve the health of the communities we serve.

In addition this strategy aims to focus not just on the contribution made to population wellbeing by General Practitioners but also aims to recognise the value and importance of the extended primary care team composed of GPs, Dentists, Opticians, Pharmacists, nurses, administrative and managerial staff. This is vital if we are to develop models of care that are both sustainable and able to meet the clinical needs of patients both now and in the future. The extended primary care team is therefore what is meant by ‘primary care’ within this Strategic Delivery Plan.

The actually practicalities of implementation will be developed in our Primary Care Implementation Plan which will be developed in early 2016.
3.0 The Need to Change

There are many good things to say about primary care; 72% of people say that it is easy to get through to someone at their GP practice on the phone, nine out of 10 patients find the receptionists at their GP practice helpful and the majority of patients think the service provided by their GP and practice staff is good (Source: Access to GP Appointments: Healthwatch Telford and Wrekin, Healthwatch Stoke-on-Trent, Healthwatch Staffordshire and Healthwatch Shropshire).

General practice is, however, under significant strain. There are areas within Northern Staffordshire where remedial action is needed quickly to prevent breakdown of the current system. It is also clear that difference in both quality and access needs further investigations, to understand the reasons and implications of this variation.

Challenges include an increasing workload; an expanding population; people living longer and with increased care needs. These have occurred whilst investment in general practice has fallen significantly as a proportion of total health spend. General Practice has become a much less popular specialism for doctors at the end of their training and there are many fewer doctors permitted to work as GPs in the country from South Asia than formerly. As the challenge increases, significant numbers of experienced GP principals are opting to retire early or are reducing their commitment to their practices. This comes at a time when primary care nursing posts are also increasingly difficult to fill.

The net effect is that there are unlikely to be enough UK general practitioners willing to work in Staffordshire to sustain our existing delivery structure in the medium term.

The pressures on primary care are described in the diagram below:

Diagram 1 The Pressures on Primary Care
4.0 Challenges within the Northern Staffordshire Health and Social Care System.

A strategic needs assessment produced jointly by the public health departments of Staffordshire and Stoke highlighted the following key issues.

<table>
<thead>
<tr>
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<th>North Staffordshire CCG</th>
<th>Stoke --on-Trent CCG</th>
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<tbody>
<tr>
<td><strong>Population</strong></td>
<td>Older population compared with England; fewer children and people under 40 with exception of student population</td>
<td>Younger population; otherwise generally similar structure to England</td>
</tr>
<tr>
<td><strong>Deprivation</strong></td>
<td>Around 11% of people live in the most deprived areas across North Staffordshire CCG. However pockets of deprivation are also hidden in rural areas.</td>
<td>High deprivation with over half of its population living in the most deprived areas. Ranks as 24th (of 211) most deprived CCG in England (and 16th / 326 LAs)</td>
</tr>
<tr>
<td><strong>Life Expectancy</strong></td>
<td>Inequalities in life expectancy: – Stoke men and women and Newcastle men have shorter lives than average – inequalities by deprivation. There is gap in life expectancy of nearly 10 years between people living in our most affluent and disadvantaged localities</td>
<td>Both men and women across the two CCGs spend more time in poor health than average</td>
</tr>
<tr>
<td><strong>Preventable Mortality</strong></td>
<td>North Staffordshire have similar rates to England although some localities (e.g. Newcastle Central) have higher than average death rates. Rates for liver disease are stable</td>
<td>Higher than average early death rates of cancer, respiratory disease and liver disease in Stoke-on-Trent</td>
</tr>
<tr>
<td><strong>National Issues</strong></td>
<td>Mental ill health accounts for over a third of all illness in Britain and 40% of all disability</td>
<td>Cancer survival rates poor across both CCGs</td>
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<td></td>
<td>People with severe mental illness are less likely to have their physical health problems diagnosed and treated and as a result die on average 15 - 20 years sooner than the general population</td>
<td></td>
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<tr>
<td></td>
<td>Ageing population and increasing life expectancy – however healthy life expectancy is not keeping up adding burden to finite health and care resources</td>
<td></td>
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Source: Joint strategic workshop – Public Health analytics, Commissioning Intentions
5.0 Primary Care in Northern Staffordshire

The CCG is a clinical membership organisation with 32 GP practices in North Staffordshire and 52 GP practices in Stoke-on-Trent CCG. These member practices are geographically based in a total of eight localities; five localities across North Staffordshire which are Newcastle North, Central and South, Moorlands Rural and Leek and Biddulph and three localities in Stoke-on-Trent which are ANEW, Stoke South and NEB.

Each of our localities has responded to the unique needs of patients in their respective areas. This local knowledge and responsiveness is one of the benefits of a locality model for clinical commissioning. Each of these localities engages closely with its respective member practices and patient groups, and holds regular locality meetings. The locality meetings are supported by the CCG’s Primary Care team but remain autonomous of the CCG.

Clinical leadership in each locality is provided by an experienced GP and practice manager lead. Locality leads help to shape and influence CCG strategy, commissioning intentions, service redesign and implementation of the commissioning cycle. The locality meetings also provide the platform for peer review.

5.1 Northern Staffordshire GP Federation (NSGPF)

General Practice is largely based around independent contractors serving relatively small populations. It has proved to be a very effective and appreciated service since its inception as a list based service from the birth of the NHS in 1948. Everyone person living in the country has a right to a GP and that GP is expected to be able to offer a view on any social, psychological or physical problem that their patient presents with.

Northern Staffordshire GP Federation exists to transform the local delivery of primary care. Its published aims are:

- To protect the future of primary care by creating a united, resilient and sustainable general practice that will benefit the entire Northern Staffordshire Community.
- To provide enhanced, integrated, patient centred care.
- To provide a means for practices to work together
- To contribute to county wide solutions to the problems of recruitment and retention
- To ensure that General Practice is appropriately rewarded for the work that it does.
- To develop and extend the traditional values of General Practice in order to foster healthier local communities
- To enhance the capacity of practices to compete with external private sector companies
- To strengthen clinical governance and improve the quality and safety of services
- To develop training and education capacity

Practices have recently joined together to form this federation and are looking for shared ways that they can work more effectively. Practices see the federation as a credible provider for community services beyond those traditionally offered from individual practices. This is described in the diagram below.
Many elements of this strategy require movement towards the development of Multispecialty Community Providers (MCP). The GP federation provides necessary skills and organisational resource for these developments and will be supported. As commissioning organisations, North Staffordshire and Stoke-on-Trent CCGs cannot and should not determine the precise make up of a provider organisation. However, in line with their duty to support improvements in the quality of primary care, the CCGs are actively encouraging the development of federated working across Northern Staffordshire.

6.0 The Vision for Primary Care

This strategic delivery plan sets out an ambitious and attractive vision of general practice that provides primary care where it is needed, and in partnership with the wider health and care system. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This should occur in general practices which are recognised as centres in each neighbourhood, developing community resilience and supporting the population to stay as well and as healthy as possible.

The Strategic Delivery Plan focuses on ‘function’ not ‘form’ and sets out a new patient offer that can only be delivered by primary care teams working in new ways and by practices coming together when it makes sense for them to do so. How this looks will differ from area to area and will need to be designed and owned locally. It will require an environment which supports innovation; shares best practices and new technologies; and is recognised as an attractive place to work for a variety of healthcare professionals.

It is clear that for primary care to deliver a new patient offer and to make the changes required, additional financial investment is necessary.
There will be elements that only make sense for practices in localities to deliver between them, so joint working to get the economy of scale will be required.

There is no one-size-fits-all solution and given the diversity of our populations we know that we need to develop different solutions. However there are key principles that need to be addressed to reach a model that suits our local needs. These are set out below.

1. **The way we deliver care**: Inside and outside of the practice; how we best use skill-mix; how we work in and out of hours; how we work with others – not confined by our individual consulting rooms, practices and organisations; and how we work best with the primary, secondary, mental health, community, voluntary and charity sectors.

2. **The way we organise ourselves**: This applies to normal working hours and out of hours; how we deliver unscheduled care and how we organise our physical environment – the buildings we work from. Individual practices may want to form part of something bigger.

3. **How we work together to deliver personalised care** for certain groups of patients across a wider population for example:
   - finding creative ways of connecting with the vulnerable, isolated and socially marginalized who are at highest risk of becoming ill and least likely to seek out support to stay well.
   - developing services across groups of practices where the complexity of care and range of professionals involved is such that it requires a central focus for higher intensity care coordination and frequent specialist input (e.g. complex frail elderly, people living with learning disabilities, people in care homes and prisons).
   - creating alternative access points for high volume, low complexity care services for minor ailments in order to free-up additional capacity in each GP surgery for the patients who need us most.
   - Clinicians in primary and secondary care need to work better together so the latter become a resource for groups of practices, enhancing the level of care and support offered in specific areas and providing additional training and development activities for GPs locally. Conversely secondary care clinicians need to be encouraged to think more widely about those with multiple morbidity so that care becomes uniformly patient centred rather than disease centred. In addition we need to enhance and utilise the skills that other members of the extended primary care team are able to offer so that clinical expertise is directed to appropriately.

4. **How we meet the different access needs**: By allowing patients to choose from a range of service options (length of appointment, rapid access, booking ahead, GP of choice); accessing different professionals, enabling choice in the way patients access general practice (in person, online, by phone, email or video conference); and looking at how we meet any personal accessibility requirements (e.g. physical or sensory disability, language, chaperone/advocacy).

5. **How we use data**. Not simply to identify different patient needs but also to inform us; to provide intelligence that will improve the quality of clinical care; to provide early warning for system failure;
to enable us to see patients on different sites; and to help us deliver care in different ways, for example through remote care (e-health and telecare).

In addition we know that many patients want to manage their own care and therefore we need the develop the systems that enable patients to access their own data and source information that will empower patients and better enable them to manage their own care.

6. How we improve ourselves and become a learning environment through a well-developed infrastructure and the implementation of a wide range of factors to ensure that primary care develops as an effective learning medium for all healthcare practitioners

7. How we disseminate innovation.

8. How we develop a vibrant, attractive workplace with career prospects for clinical and non-clinical staff

9. How general practice can support patients, families and communities to stay well and cope with minor illness so that the system moves from one of perceived dependence on clinical consultation towards self-reliance and positive lifestyle choices. We want resilient healthier communities. To enable this to be achieved and empower patients to manage their own care we know that patients need access to better and targeted information.

It is clear that changes are needed to support primary care in delivering a new vision to develop solutions that will better meet the future needs of the populations of Northern Staffordshire and provide a sustainable model of primary care for the next 5 years. Our vision is for integrated working between Primary Care, Community Services, Social Care, the Voluntary Sector, Public Health and Mental Health providers to develop a model of care that will meet the needs of our population, address current and future challenges and develop a strong mandate for the overall direction of primary care development. Vital to the success of our model is to place the patient at the centre of our model so that care is delivered on the basis of patient need.

6.1 Patient Expectations

The aspects of care correlating most closely with good patient experience are relational. Patients want to be listened to, to be given explanations that are meaningful to them, to have their questions answered, to share in decisions, and to be treated with empathy and compassion.

People want many other things from healthcare, including continuity of care and smooth transitions. These require planning and co-ordination. They may not require organisational ‘integration’, but by efficiently deploying multi-professional resources, co-ordinated care systems are better able to deliver the other things patients require: fast access, effective treatment, respect for their preferences, support for self-care, and the involvement of family and carers. Hence ‘integration’ is the top demand from patient, service user and carer organisations. Patients have little interest in organisational/institutional priorities or mergers. They want organisations not to argue between themselves or send conflicting messages.
They expect professionals to work together as a ‘team around the patient’, and they want services to work together likewise: that is, to come together at the point they are needed, and to meet people’s needs in the round.

People understand that there are resource limitations, and indeed are often self-limiting in the use they make of services and professionals’ time. But they want to know clearly what their entitlements are (not just to care, but to support and finance), and what costs they might incur, at any key point on their journey. They want services easily to agree on these and not to argue between themselves. They want obvious efficiencies to be achieved – not least in use of their own time – for example by making it possible for multiple appointments to happen on one day; or by linking diagnostics and consultations seamlessly together. They want agreed packages of care to be delivered without delay.

‘Care is care is care’ for the person who needs it. Divisions into ‘primary’, ‘secondary’, ‘community’ and ‘social’ care are relatively meaningless. The people for whom integration is most relevant, especially those with long term conditions, consistently say that they are looking for the ‘system’ to combine two things in one place:

- knowledge of the patient/service user/carer as a person, including their home circumstances, lifestyle, views and preferences, confidence to care for themselves and manage their condition(s), as well as their health status and symptoms
- knowledge of the relevant condition(s) and all options to treat, manage and minimise them, including knowledge of all available support services

People know they may need a variety of professionals and support services, but within this they want a single trusted point of liaison, to which they can have recourse as necessary, where the above knowledge is held. They expect this person/service to advise them on how to take next steps and, ideally, to co-ordinate their care or to help the patient/carer to co-ordinate it. (Source: Integrated care: what do patients, service users and carers want? A paper commissioned by the Integration work stream of the NHS Future Forum)

**6.2 Delivering High Quality Equitable Care**

In terms of the current quality of care, the majority of care provided by general practice is good, but our aspiration is to bring all up to the standard of the best. Practices need support to encourage them to seek out and address variable performance, including: appropriate data and information; skills development; protected time; and appropriate rewards for excellence (as well as consequences for poor performance that does not improve despite the offer of support).

Nationally specific variations in quality exist as described below:

- There is considerable scope to improve the quality of care co-ordination for patients with long-term chronic and mental illnesses, for those at the end of life, and in maternity care. Links between general practice and other services need to be strengthened in areas where patients with complex problems receive care from multiple providers.
• There is considerable scope for improvement in ensuring that all patients receive appropriate care as defined in clinical best-practice guidance.

• There are wide variations in patient experiences in terms of access to care, continuity of care, and patient engagement. Patients remain poorly engaged in making decisions about their own health and more could be done to support patients to make choices, to be engaged in decision-making, and to care for themselves.

Delivering high-quality care requires effective team working within general practice. The skill-mix in general practice will need to evolve, to include a wider range of professionals working within and alongside it. The GP should no longer be expected to operate as the sole reactive care giver, but should be empowered to take on a more expert advisory role, working closely with other professionals.

Delivering high-quality care also requires new models of shared care to be developed with other care providers, including those working in the community, in hospitals, and in care and well-being services. Multi-specialty local clinical partnerships need to develop that integrate services across boundaries. Such models of care will need to articulate the roles and responsibilities of general practice clearly to ensure that care for patients is well co-ordinated.

7.0 Strategic Drivers

To meet the challenges described above requires a transformation in the way our health and social care system delivers services, both in the quality and the cost-effectiveness of care. To do this our vision for primary care must address some significant drivers which are described below. For the future the health service must be built on a foundation of integrated, community-shaped, generalist healthcare services. This will require a greater number and diversity of skilled, generalist-trained professionals, able to care for patients in their homes and communities, both in and out of hours. It will require investment, not just in people but also in premises, to provide high-quality services, education and training and to enable GPs to spend more time with those patients who have complex needs. The future health service will see more person-centred systems of care and less division between primary, secondary and social care organisations.

7.1 Meeting Local Need

To address the challenges identified by the Joint Strategic Needs assessment, our CCG aims are:

• Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’;
• Deliver better patient outcomes through effective collaboration between key partners;
• Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle;
• Reduce health inequalities and unwarranted clinical variations; and
• Achieve all of the above while remaining within financial balance and delivering cost effective care.

### 7.2 The Workforce

Primary care in England is under pressure as a result of multiple drivers of demand. There is evidence that demand for primary care has been rising significantly over time, with the number of general practice consultations having risen by 75 per cent between 1995 and 2009, resulting in an increased clinical workload of over 40 per cent when compared to 1998 (Securing the future of general practice: new models of primary care. The Kings Fund July 2013).

The general practice workforce including GPs and practice nurses and community based primary care nurses is under significant workload pressure with many staff considering early retirement. The number of mid-career doctors (under the age of 50 years) considering leaving the profession is also rapidly rising. Nationally the growth in GP numbers has not kept pace with that of hospital consultant numbers (per Whole Time Equivalent) and boosting numbers entering GP training is proving difficult.

In addition practice nurses are becoming increasingly difficult to recruit and whilst the existing nursing workforce is made up of very experienced staff, here too there is a need to create a succession plan to ensure the development of the nursing workforce in the future.

These demands, coupled with technological advances and the adoption of best practice across care settings have important implications for how to develop and train primary and community clinicians and the wider workforce of the future.

Implementation of a new model of care will require localities to offer an extended scope of services; more convenient opening times; personalised care; and further development of access options to match the desires of the population. Practices of all sizes will be faced with the challenge of how to:

• configure the workforce to ensure safe practice, ongoing training and development
• maintain continuity of care; and harness the potential of temporary and locum staffing
• expand flexible working arrangements
• prevent professional isolation
• ensure staff are up to date on evidence based practices, treatment developments,
• efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.
• effectively manage the risk of providing clinical services through multidisciplinary workforce teams

Effective clinical governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings.
Delivering integrated primary care using multidisciplinary models of working in community settings will require new approaches to support safe clinical practice whilst ensuring staff are supported to continually learn and develop.

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- efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.

Different roles and responsibilities are likely to evolve in each local area as experience grows. Broadly it is anticipated that the roles detailed below will be required:

- **within each practice**: GPs, practice nurses, advanced nurse practitioners, matrons, practice nurses, healthcare assistants, volunteers, receptionists, managers, physician associates, pharmacists, medical secretaries and other administrative staff.
- **aligned to each practice but working across a wider geography/at-scale primary care organisations**: prescribing advisors, care coordinators, wellbeing teams, community support teams (as an extension of the current matron services) and managerial staff with sufficient skill to lead the development and operational management of larger primary care organisations that wrap around or integrate existing practices.
- **as part of, for example, a wider Multispecialty Community Provider (MCP)**: secondary care specialists, social care, mental health and community services teams, and community pharmacy.

A number of extended roles are appearing in the general practice setting enabling the delivery of high quality care, improved patient experience and improved clinical outcomes. These are additional to what is now considered a core team of GPs, practice nurses and advanced nurse practitioners, managers and reception staff. A few examples are provided below to illustrate the functions these new roles are performing and how they are supporting new ways of working both within general practice and across a wider primary care team. These new roles include:

- **Clinical personal assistant.** The Primary Care Clinical PA (PCCPA) is an administrative worker trained to support GPs with their day to day clinical work as an extension of traditional secretarial or administrative roles. As an example they can help process clinical letters coming into the practice. By using a clear and agreed workflow, the PCCPAs can carry out delegated work where it safe to do so, leaving GPs to deal with those letters requiring medical input or oversight.
• **Practice pharmacists** Practice pharmacists can consult with and treat patients directly, relieving GPs of casework and enabling them to focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. As part of the multidisciplinary team, practice pharmacists can advise other professionals about medicines, resolve problems with prescriptions and reduce prescribing errors. They can work with GPs to resolve day-to-day medicine issues and with practice teams to provide advice on medicines to care homes, as well as visiting patients in their own homes when needed. There are many opportunities for practice pharmacists and these must be matched to the experience and qualifications of the pharmacist and linked to practice plans for the pharmacist’s professional development.

• **Healthcare assistants (HCA)/Assistant Practitioners:** provide clinical support to the primary care team to enable staff to allocate their time appropriately to patient need.

• **Health and wellbeing coordinators:** enable patients to maintain their health and wellbeing and improve self-management of their condition.

• **Physician associates:** work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.

• **Care coordinators/navigators:** provide a central coordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

We already have some examples of innovative workforce developments in Northern Staffordshire but it’s clear that we need to put in place a comprehensive workforce plan to deliver the requirements of our model.

### 7.3 Co-commissioning

On 1st May 2014, Simon Stevens announced new opportunities for CCGs to co-commission primary care services in partnership with the NHS England. The NHS Five Year Forward View describes primary care co-commissioning as a key enabler in developing seamless, integrated out of hospital care,

It will also drive the development of new models of care such as multi-specialty community providers and primary and acute care systems.

Co-commissioning is essential to the delivery of transformed primary care by:

• Facilitating the development of a clearer, more joined up vision for primary care, which is aligned to wider CCG plans for improving health services.

• Encouraging clinical leadership and public involvement in primary care commissioning, enabling more local decision making.

• Giving more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services.

• By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.
The CCG is a level 2 joint commissioning organisation and expects to achieve full delegation in 2017. Given this the CCG is committed to working closely with Member practices, NHS England and the LMC to ensure primary care services are developed over the coming months to ensure that primary care is in a state of readiness to take forward a delegated commissioning agenda.

In addition it is vital that these key stakeholders are actively engaged in how the primary care strategy is developed and how the local delivery plan is shaped and implemented. The CCG continues to engage with member practices to ensure productive relationships with GPs as both commissioners and providers of services.

7.4 Medicines Optimisation

The CCGs Medicines Optimisation team role is to focus on introducing systems which support medicines adherence as a proxy of treatment outcome, so that pharmacist knowledge, skills and experience in commissioning and their analytical expertise is re-focussed to support waste reduction and the safe prescribing of medicines which can transform patient outcomes.

The broad aim of medicines optimisation is to ensure that patients get the best possible outcomes from their medicines. The Medicines Optimisation Team therefore promotes good quality, evidence-based prescribing, which involves the use of medicines which are safe and clinically and cost-effective, working closely with local GP practices, community pharmacies, CCG colleagues and other NHS organisations to achieve this. This helps to ensure that patients and the NHS get better value from the investment in medicines.

The key strategic aims of the Medicines Optimisation Team are as follows:

- To deliver the medicines optimisation QIPP agenda and effectively manage the CCGs’ prescribing budget
- To commission safe, clinically appropriate and cost-effective medicines
- To contribute to the development and redesign of clinical services involving medicines
- To work in partnership with key stakeholders to ensure that patients receive seamless care regarding medicines across the primary /secondary care interface
- To promote evidence based medicine in order to ensure quality outcomes
- To obtain value for money when procuring medicines
- To improve communication around medicines with all key stakeholders
- To support care homes to improve medicines processes and patient outcomes
- To ensure that there are robust governance arrangements in place for the commissioning, prescribing and use of medicines
- To minimise the amount of medicines that are wasted

7.5 7 Day Working

Northern Staffordshire recognise that there is a need to understand and define exactly what patient access requirements are, and in response, undertake a review of current capacity and access to GPs as part of a system wide approach to care. This work aims to identify barriers to access together with potential solutions to ensure that patient are seen in the right place at the right time.
Consideration also needs to be given to the requirement to deliver 7-day care for all patients by 2020.

However, evidence suggests overall satisfaction with our practices is good, with Healthwatch finding that very few patients were waiting for excessive periods of time to be seen.

However it is difficult to determine a relationship between opening hours and patient satisfaction and this research may mask key issues such as:

- if access to appointments is equitable and length of appointment
- if surgery opening times are matched to population need
- whether the process for making an appointment is clear
- if patients are being seen in the right place at the right time by the appropriate health professional
- the demand for a same day appointment may be placing undue pressure on surgeries

To ensure that every patient has access to 7-day services by 2020, the model of care we develop needs to take stock of our existing primary care provision, the system wide provision for care specifically urgent care and use this information to determine how to best use the resources we have to meet patient need. This means that rather than asking every GP Practice to open extended hours we will need to develop a hub and spoke approach taking into account our locality models.

We need to recognise the importance of developing a whole systems approach using our other primary care resources such as our GP led health centres, our walk in centres and the Out Of Hours service. In addition we need to work with our key partners who provide other health care services such as A&E, to develop a whole system approach to better manage demand and access requirements.

Finally we need to recognise the expertise that existing within the workforce. Extended access does not necessarily have to be medically led and nurses, pharmacists and other community professionals have much to add in developing an extended service for patients.

In essence we need to look at what we do currently and do things better to ensure the service best serves the rural and geographically diverse population that live in Northern Staffordshire. However it is clear that providing 7 day access will require additional investment and this factor will be considered as part of the development of a primary care investment plan.

8. Meeting Patient Expectations

National policy focuses on improving the productivity and sustainability of all health services with a strategic shift of activity from hospitals to the community by providing care closer to people’s homes. This will mean that primary care will become all the more important, making it essential that the CCG works in a supportive and collaborative way with wider primary care, including its member practices, as well as social care, housing, education, leisure services and other determinants of health.
Alongside this, the health needs and expectations of our population are changing and inequalities exist. In order to address these, the whole health and social care sector will need to move towards a system of integrated care, where clinicians work flexibly around the needs of the patient, their families and the communities in which they live not only providing health care services but coordinating social care and advocating for social prescribing.

Public Health services have a key role to play in placing increased emphasis on health promotion, early intervention and wellbeing services.

We need to work closely with our patients and populations to achieve a primary care system that refocuses on wellbeing, prevention and restorative health, empowering patients to take greater responsibility for their health.

Conversely, when in need of health care, it must be accessible and equitable and within a system in which our patients are valued and involved in shared decision-making.

Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health care. Given that the provision of social care services is based on needs assessment and eligibility criteria, there are significant challenges in moving towards an integrated model of care. The principles of sustainability are aligned with the policy direction in the health and care sector: more integrated health and social care service provision, integrated connections between service providers, empowered patients, improved use of information and communications technology (ICT), supported self-care and management of long term conditions.

Primary care is a key player in delivering these principles, which are reflected in our local primary care priorities of: Improving the quality and performance and reducing inequalities and unwarranted variation in primary care.

Developing a model with closer integration of services provided out of hospital in the community Improving access to primary care and managing workload

These principles are supported by:

- Member practice engagement and citizen participation
- Development of the workforce and meeting the educational and premise needs of our practices in order to deliver a sustainable healthcare system.

8.1 The Patient at the Centre

There are six guiding principles that drive our strategy and put patients at the centre. These are the important things that we know our patients and the public want from primary care.

8.1.1 Improving quality and performance and reducing inequalities and unwarranted variation in primary care

Whilst the quality of most primary care services is good, there are wide variations in performance. The CCGs believes that all patients should have access to the same range of and quality of services to
meet their health needs. Patients should be able to get the care they need when they need it, as close to their home as possible. At the same time we need to put in place measures to reduce any unwarranted variation so that patients, the public, and our professional colleagues across health and social care system are assured that primary care services are consistently of the highest quality.

8.1.2 Achieving equitable access

Access encompasses a range of circumstances including availability, ability to source services and ease of finding services and subsequently using these services. Variations exist in all types of access especially for people from vulnerable groups. To ensure a sustainable primary care system it is critical that practices are supported to provide responsive primary care services for those that most need it, when they need it. This will involve improving access through increased capacity in the right place, provided by the right person at the right time.

8.1.3 Local people are supported to stay well, preventing ill health

There are huge advantages in focusing on keeping people well rather than waiting for them to become ill. By doing this, people will be healthier and we will reduce the overall costs of care. Good primary care is fundamental to managing the health of populations and reducing health inequalities. By developing high quality, strong primary care services it will be possible to build healthier and more resilient communities. Tackling the root causes of ill health will be achieved through developing an emphasis on providing universal, preventative services which have a focus on patient centred care and supporting people to be more in control of their health.

Empowering patients is key to enabling patients to stay well and manage their own wellbeing if patients do become ill and the voluntary sector have a valuable role in supporting patient and their carers with information, signposting, support and advocacy.

8.1.4 Patients and carers of all ages are empowered to take an active part in their own care

Evidence shows the benefit of engaging patients, their carers and families about their care and treatment – they are likely to experience greater satisfaction, have fewer unwanted treatments and achieve better outcomes. In addition 6.5 million people in the UK are carers and with this number continuing to rise the specific needs of this group need to be addressed.

8.1.5 Patients will receive their care and treatment in the right place – at home or as close to home as possible

People would often rather receive healthcare in their own home or in their local community, and older people lose their independence if they spend long periods in hospital. So it makes sense to help people to stay at home and stay as independent if possible.

8.1.6 Patients will experience services that are joined-up

Organising health and care services around the needs of patient’s means that they will be better signposted, coordinated and delivered. This will ensure that providers focus on quality and dignity for patients and on getting the results that really matter to them. A more joined-up way of doing things will help us to reduce gaps and duplication.
How we intend to put patient’s health and wellbeing at the centre of our model is described below.

**Diagram 3 Patient Centred Care**

9.0 The Future of General Practice in Five Years

The central function of the GP in the NHS, which will remain fundamental to its success in the future, is to provide comprehensive, compassionate medical care within the community setting, to an identified population of patients with whom the general practice team has a continuing relationship and responsibility. This involves managing a wide range of health problems; making accurate risk assessments; dealing with multimorbidity; leading a multidisciplinary team; coordinating long-term care; and addressing the physical, social and psychological aspects of local patients’ wellbeing, in the context of their individual needs, their families and their communities.

There is strong evidence that high-quality, well-led general practice results in better and more cost-effective patient care. However, to continue to carry out this key role effectively in the future, the role of the GP will need to be adapted to meet the challenges confronting the NHS. In the NHS of the future GPs will play a vital role in preventing disease, reducing health inequalities, developing community resilience and delivering high-quality, cost-effective care. They will do this by further developing their core professional skills and expertise as generalist clinicians but some will choose to become the leaders of the larger scale organisations that will develop.
9.1 Definition of Primary Care

The National Association of Primary Care (NAPC) identifies Primary Care as both a level in a health system (its form) and a strategy or philosophy for organising approaches to care (its function). The NAPC regards effective Primary Care as having five central features:

1. The first point of contact for all new health needs;
2. Provide care to an optimum, registered population of between 30,000 and 50,000; Practical configurations are subject to CCG commissioning requirements recognising that there is no one size fits all model and local issues could determine scale.
3. Person-centred (holistic), rather than disease-focused, continuous lifetime care;
4. Comprehensive care provided for all needs that are common in a population; and
5. Co-ordination and integration of care when a person’s need is sufficiently uncommon to require special services or provision from another sector (secondary or tertiary care).

9.2 Core Principles

No one organisational model of primary care provision should be advocated. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population. However to deliver the core principles of care, in a form that is sustainable and achieves improvement in health any model of primary care must:

1. Be the first point of contact to enable access to health and health related wellbeing services
2. Operate as single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals.
3. Encompass an integrated workforce, with a strong focus on partnerships spanning primary, community, secondary and social care
4. Maintain a combined focus on personalisation of care with improvements in population health outcomes
5. Achieve equitability in terms reaching all people equally including people who do not routinely access services and who may be at higher risk of ill health
6. Deliver universal access to primary care services which achieves defined constitutional standards of care
7. Enable access to primary care health professional across seven days of week in their local area, for pre-bookable and unscheduled care appointments

9.3 Key Characteristics of Care

At the heart of this strategy is a new service compact for general practice. This supports the need to define and commission a consistent service for the population including adults, children, young
people, carers and families; reducing variations in access, patient experience and clinical outcomes. The strategy provides a single definition of high quality care.

For primary care provision to thrive and deliver a specification for care that patients need and value, the model of care needs to encompass the three characteristics of care that matter most to patients:

**Proactive coordination of care** – Primary care works with key stakeholders within the community to co-design approaches to improve the health and wellbeing of the local population. This is planned together with people, particularly patients with long term conditions so that people use their own capacity for improving their own health and their health improvement goals and are empowered to remain healthy. Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing.

**Accessible care** – There is universal access to primary care services which delivers constitutional standards of care. Patients will be given a personalised, responsive, timely and accessible service which ensures fast responsive access to care and prevents avoidable emergency admissions and A&E attendances.

**Coordinated care** – Primary care is often the first point of contact for patients, coordinating care to ensure that patients experience services that are truly seamless and through partnership working with other providers organise high quality cost effective care in the right place at the right time. Continuity between patient and GP is paramount. Care is personalised by involving and supporting patients, their carers and supporters in managing their own healthcare.

### 9.4 What Will Patients Notice

- Patients and the public will be able to have the right length of consultation, provided by the most appropriate health professional, in better premises, using up-to-date technology. There will be more responsive care which will be delivered in a range of ways, for example online, email and telephone rather than just face-to-face consultations. People will only need to make one call or click to book their appointment and won’t be told to call back the next day. There will be no need to take a day off work to see a GP as there will be the choice of early or late appointments or telephone consultations. Those who need to, will be able to book appointments up to several weeks ahead at a time to suit them. Care will be centred around each person so they won’t need to have multiple appointments about different long term conditions; they will be arranged around them.

- Patients will experience better management and care of long-term diseases; when they are frail and elderly; and at the end of life. General practices will be encouraged to organise themselves so that all patients have a named GP accountable or care coordinator for their care. The need for continuity of care should be defined by the patient and has the potential to be regarded as important irrespective of age. This care might be delegated to other GPs or healthcare professionals in the practice team as appropriate.
10.0 Model of Primary Care

The model proposed is an integrated one. The Royal College of General Practitioners champions integration of care as crucial to patient-centred practice, seeking approaches that improve patient care and experience as well as being efficient and effective.

For general practice, the integration of care should be ‘Patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational boundaries to deliver the best possible health outcomes.’

Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong team working, both within and across organisational boundaries. Primary care practices will include a wider range of disciplines. As well as GPs, nurses and administrative support, primary care teams may include healthcare assistants, physician associates, paramedics, allied health professionals, social workers and others. Pharmacists will increasingly become a core part of the practice team.

How roles and teams fit together in delivering future care will need to be determined and different roles and responsibilities are likely to evolve in each local area as the model of care is implemented.

10.1 New Models of Care for General Practice

The health system needs to be primary care orientated so that it is focused on improving population health and wellbeing. In order to ensure that patients receive the maximum benefit from this, general practice needs to have a collaborative approach involving, for example, voluntary and community organisations; community health services; community pharmacies; mental health services; public health, social care and other partners. Some elements of the model can only be delivered by working with patients and other partners to deliver high quality care.

This will give groups of practices the opportunity to focus on population health and provide extended opening hours whilst protecting the offer of local, personal continuity of care. What begins as a conversation about greater collaboration will move towards formation of practice networks that
increase joint working and will then go further towards shared teams and infrastructure requiring a single primary care organisation.

While the ability to extend the scope and scale of primary care is important, no one organisational model of primary care provision is advocated. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population.

However given the challenges that primary care faces including the changing workforce, the desire to improve quality, and the need to respond to rising patient demand, staying the same is not an option.

10.1.1 Multispecialty Community Provider (MCP)

The NHS Five Year Forward View describes the development of a Multispecialty Community Provider (MCP) which could offer increased efficiencies through wider collaboration and integration. These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable provision of a wider range of services including diagnostics; shared infrastructure, expertise and specialists e.g. for mental health or children; create new career paths; training and learning together. Shared systems for peer review, developmental and supportive learning should improve patient safety, clinical quality and outcomes for all practices involved.

The organisations will contain teams that support care coordination and will have arrangements in place for closer partnerships with a wider range of practitioners and specialists beyond general practice.

How this all looks will vary across our diverse areas and the development of a model will need to take into account the issues that affect access such as public transport and car ownership for example. Given this the CCGs will involve our members, local communities, patients and other key stakeholders to develop and agree how models of care will be developed and implemented.

Patients will benefit through receiving care from a greater range of generalists, more specialist care and improved access to services in a better environment. We need to work together to achieve this ambitious specification to ensure we can deliver the future requirements of our population.

In addition, committing to the development of an MCP will form a catalyst for the CCGs to begin supporting GPs in working collaboratively, to develop a sustainable, holistic and high quality model of Primary Care and ensure that all patients have access to the full range of enhanced primary care services locally. In this way, development of the MCP will enable the CCGs to deliver a number of its ambitions around Primary Care Transformation; supporting General Practice to deliver on the specifications set out in the Northern Staffordshire Strategic Delivery Plan and address identified variations in the range and quality of the primary care services delivered.
The figure below illustrates the proposed model of care for a Multispecialty Community Provider (MCP) model.

Diagram 4 Proposed Model of Care Multispecialty Community Provider (MCP) model

10.2 Primary Care at Scale

However just working collaboratively will not be enough to enable both primary care and the health and social care system to meet the challenges that are faced and continue to deliver care consistently to the majority of patients in the NHS. Patients’ needs are different and keep changing and the systems that are in place to care for them have to evolve to keep pace with this change.

The CCG is committed to supporting general practice in all its forms, to ensure it remains the cornerstone of patient care in the UK and a specialty of choice for future healthcare professionals. However it is clear that to achieve significant economies of scale and in light of the current political and contractual landscape - particularly in the wake of the Five Year Forward View – there is a clear move towards ‘at scale’ delivery.

The table below describes the various advantages and disadvantages of different levels of sale working.

Table 2

Description of Different Sizes of ‘At Scale’ Working with Advantages and Disadvantages
<table>
<thead>
<tr>
<th>At Scale Levels</th>
<th>Description of Model of Care</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Enablers Required to Deliver Outcomes</th>
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</thead>
</table>
| **Practice Level** | Core GP workforce  
GP Practices operate as individual entities but work together in a geographically defined locality | GP has a direct relationship with the patient and coordinates care on behalf of the patient  
Access is personalised and responds to all patients needs at different times  
Access to 7 day services is through a hub and spoke approach | Sustainability  
Variation in service delivery / performance by practice  
Access to services and appointments is varied by practice  
Focus is on treatment with limited early intervention and prevention  
Outcomes relate to individual patient rather than to improving the health of the population  
Other services are commissioned centrally with GPs sharing access to a pot of services | Investment  
IT solution to enable sharing of records across primary care  
Workforce plan for medical staff |
| **Locality** | GP Practices work together to deliver one agreed specification but retain own identity within the locality.  
Practices share access to other services.  
Back office functions are rationalised. | Community services are aligned to identified local need  
Efficiencies achieved by contracting for back office services and sharing of other resources  
All patients within the locality have equitable access to appointments and services  
Access to 7 day services is through a hub and spoke approach which could be locality based | Variation between localities  
Acute services continue to be contracted centrally resulting in inefficiencies in pathways.  
Social care is commissioned separately so health and wellbeing not necessarily aligned | Investment  
IT solution to enable sharing of records across primary and community care  
Workforce plan for all members of primary care team |
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<tbody>
<tr>
<td>Commissioned Locality</td>
<td>GP Practices work together to deliver one agreed specification on the basis of local need. Community services are commissioned and aligned to the locality. Acute services continue to be contracted centrally. Social care aligned to locality but contracted separately Back office functions are commissioned by each locality.</td>
<td>Community services are commissioned on the basis of local need Efficiencies achieved by contracting for back office services and sharing of other resources All patients within the locality have equitable access to appointments and services Access to 7 day services is through a hub and spoke approach which could be locality based</td>
<td>Acute services continue to be contracted centrally resulting in inefficiencies in pathways Social care is commissioned separately so health and wellbeing not necessarily aligned</td>
<td>Investment IT solution to enable sharing of records across multidisciplinary team Workforce plan for all members of primary care team</td>
</tr>
<tr>
<td>MCP Model</td>
<td>GP Practices work together to deliver one agreed specification The MCP directly commissions all health and social care services on the basis of local need. GPs oversee and manage the work of fully integrated multidisciplinary health and social care teams Hospital consultants are based in the community and provide acute in-reach services. Care is fully integrated and commissioned as a single integrated pathways. Back office functions are directly commissioned at scale by the MCP</td>
<td>Community services are commissioned on the basis of population health Efficiencies achieved by rationalisation of pathway All patients within the locality have equitable access to appointments and services Patients can expect the same outcomes GP taking lead responsibility for care coordination, management of multi-morbidity, risk management and holistic approach Patient enabled to provide self-care with coordinated care across pathway supported by community consultant</td>
<td></td>
<td>Finance aligned to population needs Investment in primary care system Fully integrated health and social care system in place Contractual framework in place Workforce plan for all members of primary care team Rationalisation of estates</td>
</tr>
</tbody>
</table>
Whilst the principles described above describe a model of care, it is sufficiently flexible and adaptable for groups of practices to design how a model of care might be delivered consistently for all patients. Delivering the model of care described above will require local planning and customisation in order to ensure that these are provided in the best possible way for the whole population.

The key drivers for at scale working are based on a desire to improve patient care – to extend services for patients, to improve clinical outcomes and to improve access to primary care – as well as to create efficiencies in back office function and to maximise the development of clinical and non-clinical staff However further work will need to consider the key discussion points including the role of the federations, the importance of considering function before forming at scale organisations, the role of training and education in workforce evolution, motivators for working at scale and the impact GPs can have in a leadership role.

11.0 Quality

In his report ‘High Quality Care for All’, Lord Darzi defined Quality in the three domains of patient safety, effectiveness and patient experience (DoH 2008). The NHS Constitution describes the NHS Value of ‘Commitment to quality of care’ in which;

“We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes” (page 5)

The Health & Social Care Act (2012) gave NHS England a statutory duty to improve the quality of care in the NHS. In the modern, patient-centred NHS, improvements in quality will be driven by the new clinically-led, local commissioning system.

Northern Staffordshire hold overall responsibility for the quality of commissioned health services and provide assurance through the Quality Strategy. Specifically for primary care, under joint commissioning arrangements, the CCGs in Staffordshire have a joint responsibility with NHS England for monitoring quality and responding to concerns arising from general practice. NHS England has the responsibility to monitor the quality of the primary care services it directly commissions; dental, pharmacy and optometry.

In discharging our duties and responsibilities for quality, the CCGs in Staffordshire and NHS England – North Midlands have identified key priorities for quality improvement in this strategy:

- To support the ambitions in the NHS England Five Year Forward View (2014) to deliver primary care services that are safe, effective and give an excellent patient experience
- Ensure patients have equitable access to services throughout Staffordshire when they need it
- To reduce clinical variation in quality
- To encourage all providers to report and learn from untoward incidents
- To publish quality metrics so patients can easily compare their service to others

Northern Staffordshire Primary Care Strategy
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We will address these priorities by focusing on the following areas:

- Access
- Variation in outcomes
- Constitutional Standards

**Access**

Research cited in the local Healthwatch report ‘Access to GP appointments’ has identified that nine out of ten public interactions with the health and social care systems are through primary care services. Following local concerns regarding access to GP’s, Healthwatch Telford and Wrekin, Healthwatch Stoke-on-Trent, Healthwatch Staffordshire and Healthwatch Shropshire commissioned a piece of research to consider the experiences of patients in booking and accessing their GP practice.

Despite concerns about the delays in being able to access appointments the research found that very few patients were waiting for excessive periods of time to be seen. Those people who stated they had waited weeks to be seen were of a similar number to those who indicated this was what they needed at the time of booking the appointment. The report identified areas for consideration to improve access and these are being progress with stakeholders.

There are several quality metrics that collect data to monitor issues relating to access to GP’s; GP Patient Survey, Healthwatch feedback, NHS Choices feedback and CQC inspection reports.

**Variation in outcomes**

This will be monitored through various metrics including; Primary Care Web Tool and QoF. Our CCGs have already developed a suite of tools used to generate intelligence, evaluate for performance and drive peer review with the ultimate intention of reducing unwarranted variation. The professional forums and Quality Leads Group will provide a mechanism for sharing and promoting best practice to support improved clinical outcomes.

**Constitutional Standards**

A Primary Care Joint Commissioning Quality Leads Group has been established to support and drive quality improvements across primary care in Staffordshire. The group is developing a quality dashboard which will be used by the CCGs and NHS England to monitor quality in General Practice using the following quality metrics:

- Primary Care Webtool
  - General Practice Outcomes Standards
  - General Practice Higher Level Indicators
- Quality Outcomes Framework CQC visit status and outcome
- Incident reports/serious untoward incidents – STEIS/Controlled Drug incidents
  - Patient Experience feedback
  - GP Patient Survey
  - Friends & Family Test
  - Complaints
A risk matrix will support implementation of the quality dashboard. It will provide a structure for the interpretation of the findings from use of the quality metrics in the dashboard and guidance on what action should be taken to support improvement.

A key indicator in quality surveillance is the report and findings from a practice visit by the Care Quality Commission (CQC). This approach dovetails with the model agreed by the CCGs in Staffordshire focusing on; urgent care, Long Term Conditions and Complex & Frail Elderly.

Practices are rated as either; outstanding, good, requires improvement or inadequate in the areas of care; safe, effective, caring, responsive and well-led. This assessment is completed for all population groups:

- Older people
- People with long term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People with poor mental health (including people with dementia)

Practices identified as ‘inadequate’ or ‘requires improvement’ will receive support from the CCG and NHS England to develop an action plan for improvement. The action plan will be monitored by the CCG & NHS England until actions have been implemented.

The aim of the strategy will be in reducing the number of practices identified as ‘inadequate’ and increasing the number of practices graded as ‘outstanding’.

12.0 Consultation and Engagement

12.1 Members

During the summer of 2015, member practices were asked, through the use of a brief questionnaire, their views on the future of primary care. This was followed by a primary care workshop, to which all member practices were invited. The intention was to discuss the development of primary care services of the future. The outcomes of this workshop have been used to build on and provide direction for the development of the Primary Care Strategy.

Practices are at the heart of delivering a transformational strategy for primary care and, supported by the Primary Care Team, will, together with the Local Medical Committee (LMC), be actively engaged in the development of the strategy at a locality level.
All localities will be consulted on the development of the strategy during December and we have sought the views of every member through the use of an electronic questionnaire and the circulations of the Strategic Delivery Plan to each and every GP member.

We will use the feedback we receive to consolidate the vision and ensure that there is wide support from member practices to proceed to implementation stage.

12.2 Stakeholders

Although strongly focused on the role of general practice in primary care, the strategy recognises that successful implementation of a future model of care for primary care will require the support of the extended primary care team; optometrists, pharmacists, nurses and other allied health professionals. In addition transforming primary care will require everyone to look at the way care is provided so we can ensure that we provide care in the most cost effective way possible and in a way that best meets people’s needs.

To harness the expertise of our stakeholder organisations, ensure professionals work together from the beginning to deliver coordinated care, a Northern Staffordshire Primary Care Delivery Plan Steering Group, with membership from a wide range of stakeholders and professional bodies has been set up. This group meets monthly. This Task and Finish group has been established to provide expert comment on the development and implementation of a Primary Care Strategy for Northern Staffordshire making recommendation to ensure the effective delivery of a model of care. Our Local Medical Committee is actively engaged in this group with the intention of supporting good working relationships and a strong sense of partnership with practices. Terms of Reference for the group are included in Appendix 1.

An initial review of the challenges and threats to the future provision of primary care was carried out by members of the Steering Group with potential solutions proposed. The rich data that was obtained by this group will be used as a bases for the development of the onward development of models of care through the delivery plan. A summary of this review can be found in Appendix 2.

In addition we sought the views of all members of our Steering Group on a version of our draft Primary care Strategic Delivery Plan and again we have used the comments that we received to guide the development of this document.

12.3 Public and Patient Engagement

Work has already taken place using both the existing patient networks and a one off engagement event that took place in the summer. The intention is to build on the patient views expressed through these forums to carry out further public and patient engagement, in three main ways:

- Inform and listen events across the local areas followed by review, evaluation and acceptance of the draft Primary Care Strategy. These events are supported by Healthwatch Stoke and Engaging Communities, Staffordshire.
- Development of a comprehensive consultation and engagement strategy using the CSU communications team

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• Harnessing of patient expertise and knowledge through the existing patient engagement processes such as Patient Locality Groups, Patient Congress, Patient Membership Scheme again supported by the CSU

### 13.0 Key Measures of Success

Phrases such as ‘improving the quality of primary care’ are used frequently, but in order for this to be meaningful for practitioners and patients there is a need to define what is meant by ‘good’ or ‘high quality’ and identify how this would be measured or demonstrated.

**National Assurance Framework**

There are now some performance indicators from NHS England which apply to all practices and Area Teams nationally and allows for comparisons to be made across CCGs or practices. This data will be used to measure quality in primary care, with additional measures being included as they are developed.

- A reduction in the variation of clinical outcomes across primary care in Staffordshire
- A reduction in the number of practices being graded ‘inadequate’ or ‘requires improvement’ following an inspection from the Care Quality Commission
- Patients reporting they feel safe in the care they receive and they would recommend their service to a friend or relative
- Greater opportunities to learn from untoward incidents through an increased reporting of incidents, near misses and errors

### 14.0 Enablers

As Making Time in General Practice notes in a report commissioned by NHS England there are clearly things within primary care that we need to do better and a number of issues that simply need to change to strengthen primary care and release capacity to introduce new care models. In addition there are a number of other key factors which need to be considered in order to deliver successful change. These enablers are described below

#### 14.1 Clinical Leadership

The transformation of primary care is challenging, and the role of the general practitioner is at its heart in creating co-ordinated care close to the communities where patients live, with the patient experiencing seamless and frictionless care no matter where it is practiced. General practice will lead the redesign programme, designing integrated care pathways for patients that span primary, secondary and social care. GPs will co-ordinate care, and integrate information and knowledge derived from many sources for a single patient.
The principal interactions between the patient and health care will therefore be through general practice: the practice will be both the starting and the ongoing reference points for most patients.

Consequently, general practitioners will need to build working relationships with all aspects of health and social care, including local authorities and secondary care. Such relationships are new for general practice, and new leadership capabilities are needed to prepare GPs for them.

We are already benefitting from the contributions of our GPs and their practices – our members. Clinicians are now at the forefront of local decision-making and we will harness this clinical leadership to:

- **Spearhead the necessary changes to clinical and operational models and forge new ways of working across professional boundaries.** This recognises the role of local clinical involvement in service redesign and engaging with clinicians across our providers and partners in health and social care to develop the most appropriate services.
- **Implement and embed clinical innovation.** This might include being more rigorous and systematic about the way in which care is delivered (reducing unwarranted variation) or introducing new technologies and approaches to delivering care, such as telemedicine and telehealth.
- **Produce a comprehensive workforce strategy that matches the needs of this clinical strategy covering, for example, clinical leadership development, health and care skills development and the promotion of research to support the delivery of our guiding strategic principles.**

However we recognise that in order to develop the clinical leadership required to develop and implement new models of care there is a need to ensure that the future development of primary care remains a central focus off the CCG and receives an appropriate share of time and resources to develop models for the future.

### 14.2 Organisational Development

To deliver a transformed model of primary care there will be a need to establish place-based ‘systems of care’ which will support the need to work together to improve health and social care for the populations they serve. This means organisations collaborating to manage the common resources available to them. These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

However in developing new models of care, the focus should not just be on primary care but will also need to focus on the ability of organisations to work together to achieve better care. For example evidence indicates that unnecessary demand created by hospitals (failure in the booking of outpatient appointments for example) account for a total of 4.5% of appointments in GP practices. In addition other providers continue to enforce a medicalised model of care by only accepting appointments from a GP rather than other appropriately qualified professionals.

It is clear that organisations will need to develop internally but in addition to ensure systems work effectively there is a need for investment in time for clinical colleagues to talk and learn together.
14.3 Financial Plan

The overall share of the NHS budget for general practice has reduced by nearly 20% over the last decade (Source: Making Time in General Practice). Whilst 2015 has seen the introduction of additional monies into primary care through the Prime Ministers Challenge Fund, for example, it is important that any financial investment is targeted at the areas where more money will make a difference and where sustainability is assured.

In addition, funding can be released through working more effectively both in terms of the way things are done but also in ensuring that valuable professional clinical expertise and time is directed to where it is most needed.

Finally in delivering transformational change, it is likely that money will need to shift from other parts of the system into primary care. This is likely to require an investment in terms of transitional funding but also additional investment into primary care to enable primary care to develop the models, leadership and systems to enable new ways of working.

The CCGs will therefore be working closely with NHS England, the Staffordshire Transformation Programme and with key stakeholders within the system to develop a financial strategy to support the implementation of this Primary Care Strategic Delivery Plan.

Priorities for investment in primary care are seen by the Steering Group as,

**Workforce**

- Short term critical investment to support immediate staffing solutions
- Staffing costs e.g. indemnity costs
- Investing in learning and development

**Infrastructure Costs**

- Estates – specifically LIFT building
- Information Technology Solutions

**Organisational Development**

- Clinical leadership
- Supporting working together
- Reducing unwarranted variation

**Mechanisms to support new ways of working**

- Investing in the existing workforce and investing in developing the workforce of the future
- Facilitating 7 Day access

It is worth noting that in developing a community service specification based on outcomes and commissioned on a capitated budget basis, primary care is an essential component of this vision and will need to be resourced to meet both capability and capacity requirements.
14.4 Market Development

In light of the challenges that primary care services are facing and the complexity in developing solutions across a range of services and a wide stakeholder base there is clearly a need to ensure that Staffordshire and Stoke-on-Trent CCG work together to harness the expertise from within the system and develop one agreed vision. Therefore there is a need to work with NHS England, North Midlands who have a key role for setting the national context and the Staffordshire Commissioning Congress who are implementing a whole system transformation programme.

Secondly, there is a need for shared local commitment from commissioners (CCGs supported by their CSU and Local Authorities), local hospitals, community services and practices to own and work together to fix the obstacles that patients and members of the primary care team encounter every day.

Finally, there is a need for individual practices, or practices working together in groups, to work together to determine solutions that could improve the system.

Subsequently this learning needs to be harnessed into the development of practical solutions for new models of care and which will then need to be implemented. Therefore there needs to be a shared agreement about the best approach to be taken in commissioning and procuring services that will meet the needs of patients through the most cost effective means.

Significantly one area of market development could be to use the learning from programmes such as Better Together to activate the full potential of Community Health Champions to improve the health and wellbeing of their communities with positive results.

14.5 Workforce Plan

- The Strategy aims to maximise the skills that are available within primary care to ensure that primary care has the capability and capacity to meet the needs of local populations now and in the future. This will require the alignment of workforce planning (recruitment, retention and development) alongside education, learning and development programmes across the system and those that already exist in primary care. In an integrated model of care it is important to ensure that all agencies understand and are equipped to support and implement different ways of working. For example, currently, in some cases other agencies will not accept referrals from primary care non-medical staff even those these professionals are highly skilled and have been enabled to deliver constitutional care. Therefore the CCG will work with the Deanery, the Federation, stakeholder organisations and other workforce development and planning agencies to: Improve recruitment and retention of medical staff, nurses and administrative staff within primary care
- Continue to work with Health Education England and Health Education West Midlands to develop and implement training and education programmes which support primary care nursing.
- Utilise the existing training programmes and expertise available at Keele University School of Medicine to develop and retain primary care expertise
• Develop new workforce models using different skills and professions that is focused on prevention and wellbeing as well as treatment
• Maximise the use of the voluntary sector integrated with the primary care team
• Align social care provision alongside health provision to create a holistic model of care
• Map required skills (clinical and management) and develop workforce to deliver at scale. With time, develop major functions on locality (rather than practice) footprint e.g. HR function, pensions, nurse specialist role, investigations, GP SI or equivalent
• Instigate a system of patient education to understand skill mix/ use of personnel. Supported self-care.

In addition it clear from discussions with professionals working within the primary care system that the rising costs of indemnity fees are becoming a real barrier to both the recruitment and retention of staff but also to the expansion of individual professional roles. It is clear therefore that as part of our workforce plan there is a need to put in place mechanisms to control and manage the issue of indemnity fees and thus reduce personal liability and risk.

One way of doing this would be, for example for providers to employ and indemnify staff and absorb the risk and centralise risk, hence reducing the total cost to the health and social care economy. In addition groups of GP practices could be aligned with partner organisations buddy scheme enabling the sharing of risk. Such options will need to be explored further.

Finally a key indicator of success is that primary care in Northern Staffordshire is seen as an attractive career proposition. There is a need to utilise the very real growth in co-operation across the economies to support promotion of work opportunities accompanied by the message that Northern Staffordshire is a good place to live and work.

14.6 Information Technology and Data Sharing

The ability to implement common systems and provide integrated care has been complicated by the NHS’s poor record on developing integrated information systems. It is vital that the right information technology and data sharing infrastructure is in place to promote integrated care records and robust systems for data sharing between practices and other health and social care professionals. The CCGs are aiming to introduce a shared clinical record across the health and social care system that is entirely accessible to the patient by 2017. This will put patients at the centre of their care and create shared responsibility for their own health.

The CCGs will adopt innovative approach to the development of Information Management and Technology in primary care to ensure right electronic infrastructure is in place to enable more integrated working.

This will include systems and processes to enable the sharing of clinical information between health and social care professionals that will deliver better clinical outcomes for patients. Key outputs will include the introduction of:

• Consistent practice systems which enable the management and sharing of data
• Systems that enable patients to have a greater role in accessing their own notes and sharing this information with everyone involved in their care across organisational and professional boundaries.
• Software (EMIS Web)
• Summary Care Records and locally shared records.
• E-Referrals
• Electronic Prescribing2
• Single shared solution with providers for electronic discharge process.
• Electronic ordering of investigations and viewing of secondary care results.
• Improving Data Quality
• Increased patient access via online prescription ordering and appointment’s.
• Mobile working solutions

Responsibility for the operational management of primary care IT services is delegated to the CCG from NHS England. Funding to support this has also been delegated, currently at less than historic funding levels. It is unclear at the time of writing this strategy exactly how primary care IT will be commissioned and funded from 2015/16 onwards as national policy is awaited.

14.7 Estates

Across Northern Staffordshire, the quality of the general practice estate is highly variable and there is a real challenge to improve the primary care estate portfolio. A poor estate means poorer patient experiences, poor working conditions for GPs and the wider primary care team and lost opportunities to improve health and healthcare.

Strategic estate planning will assist the NHS to make better use of its estate and ensure that the management of these assets is aligned with the “Five Year Forward View” with its vision of more integrated community based services, offering a greater range of diagnostic and treatment services in local hubs.

The strategic estate plans are intended to support the health economy to create a fit for purpose estate portfolio at less cost, specifically addressing:

• changes in demography and population demand;
• changes in the way that health care services are provided - specifically reflecting plans for integrated health and social care, greater levels of care within communities and new commissioning models;
• challenges in funding and affordability.

14.7.1 The Primary Care Estates Portfolio

The current primary care estate is in a variable condition. It is not always in the right location to deliver local services to the population and it is often not fully utilised.

Significant issues include:

• insufficient space to meet demand
• void space in long-term core buildings.
• bookable space that is not fully utilised.
• inappropriate tenants – for example, core clinical space is often filled with administration and support services. These services could be relocated, in most cases more cheaply and the space could be used to accommodate integrated clinical services.

• space is often not fully utilised – for example, a treatment room may be used by one provider for one session a day, three days a week.

• lack of joint working across organisations - this can lead to parochial decisions, for example, where new buildings are commissioned close to existing estate, which could have been utilised, potentially negating the need for the new estate.

Specifically, the development of primary care premises through the Local Investment Finance Trust (LIFT) presents real challenges.

Whilst these buildings have delivered improved access into primary care facilities, particularly in areas of social deprivation, in some cases they have resulted in high costs, unaffordable rents and as a result underutilised buildings.

14.7.2 The Development of a Strategic Estates Plan

Recognising that the development of a robust estates infrastructure is vital to enable the transformation of primary care, NHS England (NHSE) is working with Northern Staffordshire CCGs, Community Health Partnerships (CHP) and NHS Property Services (NHSPS) to complete a strategic estates plan for primary care properties within the area. The aim of this review is to achieve the following:

• provide an overview of the existing health economy estate and related partners estate

• articulate the estates needs that fall-out from the commissioning plans

• create deliverable implementation plans to provide fit for purpose estate

And as a result will involve:

• committing to, and maximising use of the “Core Estate”

• rationalisation and disposal of surplus or “unfit” estate

• improving effective utilisation of the estate

• ensuring appropriate utilisation – for example, focus on core clinical space delivering integrated clinical services and not admin/support services

• using the estate to deliver new models of care, through more integration and a wider range of co-located services

• partnering across organisations to achieve maximum system benefits

14.7.3 Investment in Estates

Following the Primary Care Infrastructure Fund (PCIF) application process, it was identified by CCGs and NHS England that there was a need to develop a primary care strategy to help identify priorities for future PCIF funding. (Renamed: Primary Care Transformation Fund (PCTF).

An estates task to finish group was established in August to develop a primary care estates strategy by December 2015. This group includes representation from CCGs, LMC, NHS England, NHS Property Services and Community Health Partnerships and Local Authorities have been invited from December onwards.
The December version will provide a stock take of the current position on primary care estate and will identify the known gaps in the strategy and the actions required to address these gaps, together with timescales, linking into the need to submit PCTF bids by February 2016.

In terms of update on progress a GP premises questionnaire has been developed and practices are to respond by 27th November. The CCG will continue to work with NHS England and the national team to develop a process to approve and allocate funds to bids which meet the priorities of the CCG.

14.8 Contract Management and Procurement

Making Time in General Practice notes that the chief sources of bureaucracy in general practice is getting paid with this becoming a huge burden for all contractors of primary care services. Streamlining practice payment systems to minimise bureaucracy and maximise speed of data entry and payment would have immediate positive effect on releasing capacity.

If we acknowledge that the specification described here can only be delivered in full by general practice working together at scale and with other parts of the statutory system there is a need to align contractual incentives, removing the barriers for working together across a local area - including financial incentives that cut across effective collaboration.

Part of this approach must be to put all providers of care on an equal footing if an integrated care model is to be implemented successfully. For example if the voluntary sector is to be commissioned to provide specific services with agreed outcome then to enable this to be carried out efficiently and to be monitored a robust contract mechanism needs to be put in place equal to those awarded to the statutory sector.

The Framework proposes new funding, not at an individual practice level but delivered through wider population-based contracts. The exact nature of these arrangements will vary depending on the provider landscape, but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which investment will be made. However there is a need to review the way in which primary care is contracted for both within general practice and across the system with community nurses and other health and care professionals if contracts are to enable the provision of integrated seamless, person-centred care for patients.

Local approaches will be determined within each CCG area, supported by co-commissioning. It is likely that the contracting vehicle will need to ‘wrap around’ existing national contracts

The contracting vehicle may also need to be flexible to wider collaborations and partnerships with other types of providers, for example where the strategic intent locally is for accountable care organisations that can hold capitated budgets and shared risk for whole populations.

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15.0 Implementation of the Northern Staffordshire Primary Care Strategic Delivery Plan

Clearly there are many issues that must be addressed in order to develop our vision for primary care and implement future models of care. It is recognised that one model might not meet the needs of our diverse communities and we need to continue to work with patients and our other key stakeholders to develop a model that is fit for purpose

15.1 Project Plan

We are working with patients, our members and our stakeholders to agree the model of care and key principles of our proposed primary care strategy. However he mapping and more detailed work will take place in the New Year. The proposed timescales are described below.

Diagram 5 Northern Staffordshire Primary Care Strategic Delivery Plan Outline Timescales

15.2 Governance

The Primary Care team will support the delivery of the Primary Care Strategy, as well as ensuring the operational requirements of the CCG are delivered through each of the Primary Care Sub Committees and the overarching Northern Staffordshire Primary Care Delivery Plan Steering Group. The Sub Committees are made up of primary care representation from each practice locality (both practice manager and clinical lead) supported by representation from stakeholders from within each CCG; LMC and public health for example. The Northern Staffordshire Primary Care Delivery Plan Steering Group will hold responsibility for integrating comment from stakeholders and assuring the overarching Northern Staffordshire Primary Care Strategy for sign off by both CCG Governing bodies and ultimately by The Primary Care Joint Co-Commissioning Board.

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Led by the Clinical Director of Primary Care for North Staffordshire and Stoke-on-Trent CCG, the Northern Staffordshire Primary Care Delivery Plan Steering Group, through harnessing primary care expertise and stakeholder skills will ensure that the Northern Staffordshire Primary Care Strategy supports and underpins delivery of the CCGs vision and operational delivery plans. The approach will be through both direct engagement with key stakeholders, as and when required and via virtual engagement.

Integrated working with the Primary Care Team, NHS England, North Midlands will ensure a consistent approach to the development of key objectives across Staffordshire and upwards to the Staffordshire Transformation Programme.

Overall programme targets and milestones will be monitored on a monthly basis by the Primary Care Strategy Group and reported to the Primary Care Joint co-Commissioning Board.

This board provides the governance link for the Staffordshire and Stoke-on-Trent CCGs to the Transformation Programme. These governance arrangements are described below.

**Diagram 6 Governance Structure Northern Staffordshire Primary Care Strategic Delivery Plan**

15.3 Stakeholder Development

Although strongly focused on the role of general practice in primary care, the strategy recognises that the implementation of the strategy will require the support of all independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care. Community-based services such as district nursing, health visiting, community mental health services and therapy services are partners as members of the Extended Primary Care Team. In addition organisations which provide other care services such as local authorities and voluntary organisations will continue to be key partners in the commissioning of integrated models of care.

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It will be essential that the CCG works closely with the Local Medical Committee to ensure good working relationships and a strong sense of partnership with practices.

In addition, the CCG will work with partner organisations such as the Local Pharmaceutical Committee and Local Optometry Committee to develop new models of care.

The CCG will work closely with patients and service users to ensure primary care services are person-centred, taking into account the aspirations of individuals alongside the diversity of the community.

**15.4 Public and Patient Engagement**

Patients are at the heart of every decision we make as commissioners. Our aim is to ensure that we have regular and ongoing dialogue with North Staffordshire residents and patients and, as part of this, work with as many people as possible to make sure everyone in North Staffordshire receives the best possible NHS services.

This year we have engaged and involved people through our patient membership scheme, the Patient Congress and through our GP practice patient groups to shape our future commissioning plans.

**15.5 Monitoring and Evaluation**

This strategy will be approved by The Northern Staffordshire Primary Care Delivery Plan Steering Group who will then be responsible for its implementation and delivery reporting on a quarterly basis to the Joint Planning Committee. Twice yearly updates reports will be provided to the Member Council and Stakeholder Council. In addition ongoing reports will be made to both the Staffordshire and Stoke-on-Trent Health and Wellbeing Boards to ensure that the development of primary care services is aligned to the strategic partnership priorities.

**15.6 Risk and Mitigation**

A full Risk Register for this project will be developed as part of the corporate risk register. Risks will be monitored by the Primary Care Board. A summary of the key emerging risks are described in the table below.
### Table 3 Key Risks Primary Care Strategic Delivery Plan

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
<th>Rag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical workforce issues are identified and managed within an appropriate timescale</td>
<td>Working with the Area Team key workforce risks are identified and a range of solutions developed and implemented</td>
<td></td>
</tr>
<tr>
<td>Competing priorities and limited resources in terms of staff, time and resources mean that organisations are not able to work together.</td>
<td>Continuing engagement of all stakeholders through Steering Group plus alignment of strategy to individual organisational aims with intention of delivering whole system outcomes – e.g. emphasis on prevention as well as treatment.</td>
<td></td>
</tr>
<tr>
<td>GP and practices do not engage</td>
<td>Robust engagement strategy with use of Localities to enable good communication and engagement.</td>
<td></td>
</tr>
<tr>
<td>Failure to engage extended primary care team and other stakeholders</td>
<td>Expert Advisory Group in place with representation from all stakeholder organisations and professional networks.</td>
<td></td>
</tr>
<tr>
<td>Patients and public unaware of need to change</td>
<td>Full Public and Patient Involvement strategy being implemented, utilising existing patient forums such as Patient Participation Groups</td>
<td></td>
</tr>
<tr>
<td>Failure to develop agreed future primary care models of provision for example: 7 day working</td>
<td>Models developed with full engagement of members and LMC. Use of evidence based models and expertise developed through Prime Ministers Challenge Fund supported by Area Team</td>
<td></td>
</tr>
<tr>
<td>Unable to implement agreed model of co-commissioning</td>
<td>Area Team actively engaged in both development of strategic primary care framework and development of local strategy</td>
<td></td>
</tr>
<tr>
<td>Key Enablers to achieve success will not be aligned to delivery of outcomes</td>
<td>Programme management approach implemented alongside development of strategy to ensure success.</td>
<td></td>
</tr>
</tbody>
</table>
16.0 Appendices

Appendix 1 Terms of Reference

Northern Staffordshire Primary Care Delivery Plan Steering Group

Terms of Reference

1. Purpose

1.1 This Terms of Reference outline the purpose and accountability arrangements of the Northern Staffordshire Primary Care Delivery Plan Steering Group. The Steering Group is a time limited Task and Finish Group established to provide expert comment on the development and implementation of a Primary Care Delivery Plan for Northern Staffordshire making recommendation to ensure the effective delivery of a model of primary care that improves coordination of care, access to services and enables a proactive approach to health and wellbeing with the intention of making care better.

1.2 The Staffordshire Commissioning Congress has been formed with the six NHS Clinical Commissioning Groups (CCGs), Staffordshire County Council, Stoke-on-Trent City Council and NHS England to identify and drive delivery of a collective transformation programme to ensure citizens in Staffordshire and Stoke-on Trent have high quality, sustainable services going into the future. A key element of this transformation programme is the development of a Primary Care Strategic Commissioning framework, which will enable the transformation of primary care across the pan Staffordshire economy.

1.3 The Steering Group will ensure that the Primary Care Delivery Plan developed for the Northern Staffordshire health and social care locality acts as a local delivery plan, enabling the members to make collective decisions on the review, planning and development of a framework for primary care services describing what best meets the needs of the local community. This group will ensure that this plan delivers the strategy framework for primary care, setting out a new patient offer for the people of Northern Staffordshire.

2. Definition of A Primary Care Service

2.1 A primary care service operates as the patient’s first point of entry into the health care system for health (excluding emergency treatment) and wellbeing needs and as the continuing focal point for all necessary health care services providing continuity and integration of health care services to ensure improvement in individual health and wellbeing outcomes. A key principle is that the principal aim is to provide an easily accessible route to care, whatever the patient’s need. Primary health care is based on meeting an individual’s wellbeing needs rather than treating specific diseases.

3. Function and Duties

3.1 The key responsibilities of the Steering Group will be in the planning and coordinating of a consistent approach to the commissioning of primary care, acting as an expert advisory body to ensure the development of a Primary Care Delivery Plan that delivers quality, efficiency, productivity and value for money through:

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• Developing new models of care for primary care, to align with national strategic direction set by the Commissioning Congress;

• Identifying local models of primary care provision based on the views of patients, carers, and the local community, as well as evidence from the stakeholder community; and

• To co-ordinate a common approach to the commissioning of a primary care framework enabling the support of key stakeholders as represented by the Steering Group to improve care outcomes.

3.2 Specifically, to work together to direct a model of delegated commissioning which enables the development of a model of integrated care which supports the needs of local people and delivers the following benefits:

• Improved access to primary care and wider community centred provision with more services available closer to home
• High quality, consistent care
• Improved health outcomes, better access to services and reduced health inequalities.
• A better patient experience through more joined up services.

3.3 To work together to ensure the engagement of the stakeholder community across Northern Staffordshire, specifically identifying opportunities for effective public and patient contribution to discuss, debate and develop the key proposals of the Primary Care Delivery Plan commending appropriate mechanisms to support providers in optimum delivery, including:

• Supporting the development of GP networks and federations;
• Succession and resilience plans; and

• Strategies for providing additional financial investment in primary care

3.4 A key part of delivery is that members of the Steering Group will work together to ensure that the enablers required to deliver new models of care are aligned and managed through systematic review and evaluation, developing solutions to ensure models of care achieve outcomes and are sustainable. Specifically these enablers are recognised as:

• Clinical Leadership;
• Workforce;
• Information Management and Technology;
• Estates; and
• Contracts.

3.5 To achieve a local vision for Primary Care it is recognised that co-commissioning is a key enabler to deliver a primary care transformation Delivery Plan. Therefore the Steering Group will work to develop a model of co-commissioning which facilitates the development of primary care and maximises the benefits of a Primary Care Delivery Plan.

3.6 The Group will work in an advisory capacity to support the development of primary care commissioning proposals and ensure that milestones are achievable.

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The Group will also identify and log key risks which will be escalated and managed as part of the implementation stage in developing a primary care strategic framework.

3.7 The Group will ensure that the Primary Care Delivery Plan is locally designed and best meets the needs of the local community, but will work collaboratively as part of the Commissioning Congress to enable the transformation of Primary Care across Staffordshire.

4. Governance and Accountability

4.1 The Steering Group does not have any delegated authority in relation to primary care commissioning and as such does not have the ability to make formal decisions. However the Primary Care Steering Group will act as the group responsible for overseeing the primary care work programme across Northern Staffordshire. As such members have a duty to enable the group to direct, coordinate and manage the delivery of all work streams that enable the transformation of primary care by ensuring that primary care developments are governed through the Steering Group.

4.2 Members have a collective responsibility for the operation of the Steering Group. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

GOVERNANCE STRUCTURE TO BE REVISED

5. Membership

5.1 This is a complex programme of work and its delivery will require all of those involved, in the care of Northern Staffordshire patients to work together. The Steering Group membership has been designed to reflect the breadth of organisations and professions involved in care of patients across the local health economy, as well as reflecting the geography of the area.
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Representation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Staffordshire GP Federation Limited</td>
<td>Dr Paul Roberts</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Locality Reps</strong></td>
<td>Dr Jag Boyapati</td>
<td>Stoke Locality Lead</td>
</tr>
<tr>
<td></td>
<td>Dr Barry Edwards</td>
<td>Northern Staffordshire Locality Lead</td>
</tr>
<tr>
<td>Local Medical Committee</td>
<td>Dr Paul Scott</td>
<td>LMC Chair</td>
</tr>
<tr>
<td></td>
<td>Dr Harold Van Der Linden</td>
<td>LMC Secretary</td>
</tr>
<tr>
<td>Northern Staffs and Stoke Local Pharmaceutical Committee</td>
<td>Tania Cork</td>
<td>Chief Officer</td>
</tr>
<tr>
<td><strong>Local Optical Committee</strong></td>
<td>Stewart Townsend (Chair):</td>
<td>Chair, Staffordshire</td>
</tr>
<tr>
<td><strong>Local Dental Committee</strong></td>
<td>Ms Carole Hollins</td>
<td>Chair, Northern Staffordshire</td>
</tr>
<tr>
<td><strong>Primary Care Nursing</strong></td>
<td>Kellie Johnson</td>
<td>Primary Care Nurse Lead - CCG Quality and Improvement</td>
</tr>
<tr>
<td></td>
<td>Charlotte Harper</td>
<td>Primary Care Nurse Lead, Northern Staffordshire</td>
</tr>
<tr>
<td><strong>NHS England</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Rebecca Woods</td>
<td>Primary Care Lead</td>
</tr>
<tr>
<td><strong>Provider Organisations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffordshire and Stoke-on-Trent Partnership NHS Trust</td>
<td>James Shipman</td>
<td>Medical Director</td>
</tr>
<tr>
<td></td>
<td>Kieron Murphy</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Northern Staffordshire Combined Healthcare NHS Trust</td>
<td>Claire Holmes</td>
<td>Interim Head of Directorate – Adult Community</td>
</tr>
<tr>
<td>University Hospitals of Northern Midlands NHS Trust</td>
<td>Helen Lingham</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td>West Midlands Ambulance Service NHS Trust</td>
<td>Sean Coleman</td>
<td>Area Manager</td>
</tr>
<tr>
<td><strong>Social Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Care Stoke –on- Trent City Council</td>
<td>Melanie Dunn</td>
<td>Strategic Manager for Commissioning</td>
</tr>
<tr>
<td><strong>Social Care Staffordshire - Staffordshire and Stoke-on-Trent Partnership NHS Trust</strong></td>
<td>Leanne Eardley</td>
<td>Area Manager, Stoke-on-Trent</td>
</tr>
<tr>
<td><strong>Public Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health Stoke on Trent</td>
<td>Professor Zafar Iqbal</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>Public Health Staffordshire County Council</td>
<td>Dr Chris Weiner</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td><strong>Voluntary Organisations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>Garry Jones</td>
<td>Chief Executive Support Staffordshire</td>
</tr>
<tr>
<td></td>
<td>Lorien Barber</td>
<td>Strategic Liaison Manager VAST</td>
</tr>
<tr>
<td><strong>Patient Representation</strong></td>
<td></td>
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</tr>
<tr>
<td>Healthwatch Stoke</td>
<td>Dave Rushton</td>
<td>Engagement Officer</td>
</tr>
</tbody>
</table>

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5.2 When not able to attend, members may send a deputy to participate and advise on their behalf. Each member must nominate a deputy at the start of the appointment period. In case the nominated deputy is also unable to attend the meeting, the member will not be able to send any other person on his/her behalf. Deputies must have similar expertise and be of similar level of seniority as the member they substitute.

5.3 Chair - Dr Emma Sutton  Clinical Director of Primary Care North Staffordshire and Stoke-on-Trent CCG

6. Frequency of Meetings

6.1 The Steering Group is established as a focused task and finish group for a 6 month period. Meetings will be held monthly on a Tuesday from 12 pm until 2 pm

7. Operation of Meetings

7.1 The Steering Group will be supported by the Primary Care Team of the Northern Staffordshire CCGs. A secretary will produce minutes and be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than seven days before the meeting.

8. Declaration of interests

8.1 The Code of Conduct and Accountability in the NHS and the Code of Conduct for NHS managers requires all Directors and staff to declare interests which are relevant and material. The declaration should be made on the declaration of interests form. Members are asked to inform the Secretariat before each meeting of any change in their relevant interests. The minutes of each meeting will record declarations of interest, and whether members took part in discussion and decision making.

8.2 Where the Chair of any meeting of the group, including committees, sub Committees of the Governing Board, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting.

8.3 Where arrangements have been confirmed for the management of the conflicts of interests or potential conflicts of interest in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy Chair may require the chair to withdraw from the meeting or part of it.
### Appendix 2 Key Challenges, Threats and Potential Solutions to the Future Provision of a Model of Primary Care

<table>
<thead>
<tr>
<th>Key Challenges</th>
<th>Key Threat</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0 Funding</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Insufficient funding within primary care to meet increased demands and key objectives such as 7 day working</td>
<td>Reduction in Public Health funding results in increase risk to primary care to delivery outcomes Move of funding from secondary care to primary care is based on transfer of activity NOT additional investment Current system includes significant unfunded ‘non-core’ elements of primary care</td>
<td>Ensure key message of primary care strategy linked to overall strategic plan both locally and Staffordshire wide is increased investment in primary care system Ensure all delivery is commissioned, costed and paid for or remove from primary care</td>
</tr>
<tr>
<td>1.2 Back room / overheads increasing for GP practices</td>
<td>Multiple overheads for corporate function with limited resilience</td>
<td>Other organisations to provide Corporate functionality support and or delivery in terms of HR, Finance, estates, informatics, Comms, support to GP practices.</td>
</tr>
<tr>
<td>1.3 Efficiencies are implemented to generate savings but result in a reduction in quality / access</td>
<td></td>
<td>Funding strategy needs to recognise that improving quality / access may require investment</td>
</tr>
</tbody>
</table>
## 2.0 Outcomes

<table>
<thead>
<tr>
<th>2.1</th>
<th>Outcomes are defined by system rather than need</th>
<th>Comprehensive LOCAL needs assessment to be developed / built on shaped by all partners including voluntary sector and influenced by community</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>Patient voice not always ‘heard’ within the system</td>
<td>The way feedback is sourced from patients not always incorporated into needs assessment or is used to improve pathways or care</td>
</tr>
<tr>
<td></td>
<td>System is predicated towards treatment</td>
<td>Ensure that patients views are incorporated into needs assessment and utilised to create improvement</td>
</tr>
<tr>
<td>2.3</td>
<td>Lack of emphasis on health promotion, prevention, patient empowerment</td>
<td>Integration of the community &amp; voluntary sector into primary care to maximise potential around early intervention &amp; meeting the wider determinants of health.</td>
</tr>
</tbody>
</table>

Public Health needs to work collaboratively with primary care to identify and target hard to reach groups. Health promotion work to be carried out by pharmacists, dentists, opticians. Children to have access to healthy lifestyle messages. Increased uptake of immunisations amongst children and increased uptake of all the screening programmes E.g. - breast, cervical and bowel cancer. Patient education to self-manage long term conditions as much as possible-raising awareness of websites like British Heart foundation, diabetes UK, arthritis UK, asthma UK, access to expert...
## 3.0 Models of Care

<table>
<thead>
<tr>
<th></th>
<th>Models of Care</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Primary care not seen as a ‘real player’ in the system</td>
<td>Many experienced and skilled clinical leaders retiring</td>
<td>Financially support and develop the skills of local clinicians who want to take on managerial or leadership roles. Strategy to recognise that GPs will be central to the provision of any future models</td>
</tr>
<tr>
<td>3.2</td>
<td>Continuing with ‘corner shop’ model not sustainable</td>
<td>Amalgamate practices providing time and space to develop ‘Matchmaking’ between practices to support existing localities</td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>Social care provision vital to ensure delivery of effective health and wellbeing</td>
<td>Social care facing increasing pressures</td>
<td>Health providers to link with LAs to align social care provision in line with health needs as defined by GP practices</td>
</tr>
<tr>
<td>3.4</td>
<td>Social care provision vital to ensure delivery of effective health and wellbeing</td>
<td>Social care facing increasing pressures in terms of ability to meet demand and increase costs pressures.</td>
<td>Work with local authorities to fully understand pressures and agree approach in addressing issues and / or gaps in provision as appropriate’ and ‘consider funding issues facing LAs and ensure the local health economy work collectively to protect provision.</td>
</tr>
<tr>
<td>3.5</td>
<td>Mental health treatment and wellbeing takes up significant amount of primary care resources</td>
<td></td>
<td>NSCHT keen to align community teams around GP practices with continuity of workforce and in reach clinics into practices relevant to need of population</td>
</tr>
<tr>
<td>3.6</td>
<td>Voluntary Sector ‘invisible’ within primary care system</td>
<td></td>
<td>Integrating volunteering, fundraising, community activity into primary care to support practices, leverage in funds, develop community &amp; support workforce.</td>
</tr>
</tbody>
</table>
### 4.0 Commissioning

<table>
<thead>
<tr>
<th>4.1</th>
<th>Primary care system being asked to respond to increased demand, deliver more activity and deliver an increased number of health outcomes</th>
<th>Agree delivery plan and capacity targets. Increase investment in primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Commission primary care to provide fewer simpler outcome based activities to incentivise via local enhanced services</td>
</tr>
<tr>
<td>4.2</td>
<td>Voluntary Sector not always aware of commissioning strategy and voluntary sector needs support to adapt to changing environment</td>
<td>Commission services for longer than 1 year</td>
</tr>
<tr>
<td></td>
<td>Missed opportunity for Voluntary Sector to change and adapt to local need&lt;br&gt;Lack of clarity about area covered by model of care</td>
<td>Voluntary Sector should be seen as an equal partner in commissioning strategy and treated the same as other providers&lt;br&gt;Key commissioned geographical area to be defined&lt;br&gt;Proactive communication with voluntary sector</td>
</tr>
<tr>
<td>4.3</td>
<td>Avoid denominator commissioning. “We have x pounds for the service and want y levels of activity with z quality” so we will pay X/Y per unit</td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Current system doesn’t allow for identification and sharing of risk across the pathway</td>
<td>Disproportionate risk management within primary care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bench mark against national indicators. Incorporate into toolkit / commissioning system</td>
</tr>
</tbody>
</table>
## 5.0 Workforce

<p>| 5.1 | Reduction in GP numbers with difficulties in recruiting and retaining GPs | Rise in indemnity costs making GP posts unattractive | Develop roles for GPs who are retiring and fund their defence subscriptions. Create workforce solutions which enable GPs to gradually retire. Providers to employ and indemnify staff and absorb the risk and centralise and reduce total cost to health economy. Group of GP practices to align with partner organisations buddy scheme. Develop Health and Wellbeing Strategy for existing workforce. | Map demand for medical staff across system and make effective use of all medical roles. Develop overall workforce plan and accompany by marketing campaign to attract medical staff into Northern Staffordshire. Ensure succession plan in place for individual practices. |
| 5.2 | Develop extended primary care workforce | Potentially more costly, more difficult and is equally off putting for potential GP trainees | Health and social care commissioners and providers to collaborate on current contracting arrangements / services and agree shared approach to commissioning voluntary sector services at scale. |
| 5.3 | Voluntary sector commissioned on an ad hoc basis on short term contracts | | Local Representative Committee to Optometrists, Pharmacists and Dentists to be re-established |
| 5.4 | Lack of integration with other primary care contractors | | |</p>
<table>
<thead>
<tr>
<th>6.0</th>
<th>Information Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Information systems that support primary care are developed on an ad hoc basis without recognising specific needs of primary care</td>
</tr>
<tr>
<td>6.2</td>
<td>Integrated model requires ability to share patient information</td>
</tr>
<tr>
<td>6.3</td>
<td>Current IT systems mean it is difficult to evaluate performance or identify risk</td>
</tr>
<tr>
<td>6.4</td>
<td>Technology doesn’t currently enable innovative practice</td>
</tr>
</tbody>
</table>
### 7.0 Delivery

<table>
<thead>
<tr>
<th></th>
<th>Pace of change to great and cannot be implemented without alignment to enablers e.g. money</th>
<th>Develop a delivery plan with realistic timescales</th>
</tr>
</thead>
</table>

### 8.0 Access

<table>
<thead>
<tr>
<th>8.1</th>
<th>Access to appointments / services currently inequitable</th>
<th>Commissioning approach needs to recognise that improving access and quality may require additional investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2</td>
<td>Lack of clarity within community about which services are available and how to access them</td>
<td>LAs in line with care act requirements are currently working to develop a joint information and advice strategy. The LAs are proposing that this incorporate CCG’s as IAG (information, advice and guidance) has been identified as one of four big tickets under Workstream 2 of commissioning congress. The strategy won’t include children but will refer to IAG in transition from children’s to adult services.</td>
</tr>
<tr>
<td>8.3</td>
<td>Community transport is commissioned on an ad hoc basis</td>
<td>Inequitable access</td>
</tr>
</tbody>
</table>