PUBLIC MEETING OF STOKE-ON-TRENT CLINICAL COMMISSIONING GROUP
GOVERNING BODY
Tuesday, 7th June 2016 at 1.30pm – 4.00pm
The Minton Room, Stoke-on-Trent Clinical Commissioning Group,
Herbert Minton Building, 79 London Road, Stoke-on-Trent ST4 7PZ

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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<tr>
<td>1</td>
<td>Welcome and Apologies for Absence: Sandra Chadwick, Jayne Downey, Iain Stoddart, Noreen Dowd, Zara Jones, Simon Mellor</td>
<td>Verbal</td>
<td>To Note</td>
<td>RC 1.30pm</td>
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<td>2</td>
<td>Declarations of Interest</td>
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<td>Verbal</td>
<td>To Note</td>
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<td></td>
<td>In accordance with Standing Order 7.3.2 (i) members and non-members are asked to declare interests which are relevant and material to this meeting</td>
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<td>3</td>
<td>Confirmation of Quoracy (following consideration of interests declared pertaining to the agenda)</td>
<td>Enc 4.1</td>
<td>Enc 4.2</td>
<td>RC 1.30pm (5 mins)</td>
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<td>4</td>
<td>Minutes from previous meeting held on 5th April 2016 Action List and Matters Arising Dr Ruth Chambers, CCG Chair</td>
<td>To Note</td>
<td>RC 1.30pm</td>
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<td>5</td>
<td>Strategic</td>
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<td>1.30</td>
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<td>5.1</td>
<td>Chair’s Address Dr Ruth Chambers, CCG Chair</td>
<td>Enc 5.1</td>
<td>To Note</td>
<td>RC 1.35pm (10 mins)</td>
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<td>5.2</td>
<td>Clinical Accountable Officer’s Report • Planning Committee Chair’s Report • Organisational Development Committee Report Dr Andrew Bartlam, CCG Clinical Accountable Officer</td>
<td>Enc 5.2</td>
<td>To Note / Decision</td>
<td>AB 1.45pm (10 mins)</td>
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<td>5.3</td>
<td>Stoke-on-Trent and North Staffordshire CCGs’ Five Year Strategy Jane Tipping, Head of Strategy, Planning and Performance</td>
<td>Enc 5.3</td>
<td>Decision</td>
<td>JT 1.55pm (10 mins)</td>
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<td>5.4</td>
<td>Pan–Staffordshire Wheel Chair Procurement Cheryl Hardisty, Director of Commissioning</td>
<td>Enc 5.4</td>
<td>Decision</td>
<td>CH 2.05pm (10 mins)</td>
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<td>6</td>
<td>Quality</td>
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<td>6.1</td>
<td>Quality and Performance Report Lorraine Cook, CCG Head of Quality</td>
<td>Enc 6.1</td>
<td>To Note</td>
<td>LC 2.15pm (10 mins)</td>
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<td>7</td>
<td>Finance</td>
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<td>7.1</td>
<td>2015/16 Outturn and 2016/17 Planning&lt;br&gt;Alistair Mulvey, Interim Turnaround Director</td>
<td>Enc 7.1</td>
<td>To Note</td>
<td>AM 2.25pm (10 mins)</td>
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<td>8.1</td>
<td>Audit Committee Chair’s Report April 2016&lt;br&gt;Audit Committee Chair’s Report May 2016&lt;br&gt;Audit Committee Chair’s Report Annual Report 2015&lt;br&gt;John Howard, Chair of the Audit Committee and CCG Lay Member Governance</td>
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| 8.2 | Proposal To Revise The System Resilience Group<br>Dr Andrew Bartlam, Clinical Accountable Officer | Enc 8.2 | Decision | AB 2.45pm (10 mins) |

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<td>9.1</td>
<td>Governing Body Assurance Report&lt;br&gt;CCG Clinical Accountable Officer / Clinical Directors</td>
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| 9.2 | Primary Care Update<br>Dr Emma Sutton, Clinical Director Primary Care<br>Sarah Blenkinsop, Head of Primary Care | Enc 9.2 | To Note | ES / SP 3.15pm (10 mins) |

| 9.3 | Patient and Public Engagement / Patient Congress Update<br>Sally Parkin, Director Partnerships and Engagement<br>Margy Woodhead, CCG Lay Member - PPI | Enc 9.3 | To Note | SP / MW 3.25pm (10 mins) |

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<tr>
<th>10</th>
<th>Any Other Business</th>
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<td>Questions from the Public&lt;br&gt;Any other key issues&lt;br&gt;Committee Effectiveness</td>
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**DATE/TIME OF NEXT MEETING:**

<table>
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<th>Date</th>
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<th>Chair</th>
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<tr>
<td>Tuesday 2nd August 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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Agenda Item 4.1
Minutes of the Public Meeting of Stoke-on-Trent Clinical Commissioning Group Governing Body
Held on Tuesday 5th April 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:
Dr Ruth Chambers OBE (RC) CCG Chair (Meeting Chair)
Dr Andrew Bartlam (AB) CCG Clinical Accountable Officer
Margy Woodhead (MW) CCG Lay Member – Patient and Public Involvement
Sandra Chadwick (SC) CCG Chief Operating Officer
Iain Stoddart (IS) CCG Chief Financial Officer
Dr Steve Fawcett (SF) CCG Clinical Director, Acute Services
Dr Waheed Abbasi (WA) CCG Clinical Director, Mental Health & Specialist Groups
Jayne Downey (JD) CCG Director of Nursing and Quality
Noreen Dowd (ND) CCG Interim Director of Strategy, Planning and Performance

In attendance
Dr Rachel Barker (RB) CCG Executive Assistant
Lisa Taylor (LT) CCG Quality and Governance Manager
Prof. Zafar Iqbal (ZI) Public Health Director
Filippa St Aubin D’Ancey (FD) Communications and Press Manager
Kevin Day (Item 13) (KD) Joint Commissioning Manager
Emma Sutton (Item 17) (ES) Clinical Director Primary Care
Liza Pursey (Item 17) (LP) Interim Primary Care Strategy Manager
Sarah Blenkinsop (Item 17) (SB) Head of Commissioning Primary Care

Apologies:
John Howard (JH) CCG Lay Member – Governance
Dr Simon Mellor (SM) CCG Secondary Care Doctor
Cheryl Hardisty (CH) Director of Commissioning
Dr Harald Van Der Linden (HvdL) LMC Secretary
Val Lewis (VL) Manager, Health Watch Stoke-on-Trent
Louise Rees (LR) Interim Director of Adult Social Care and Protection, Stoke City Council

Members of the Public:
Ian Syme (IS) Member of the Public North staffs Healthwatch
Dave Blackhurst (DB) Member of the Press – The Sentinel
Louise Zandian (LZ) Member of the Public - CEO Lifeworks Staffordshire

7 Members of the Public in attendance

Action

1. Chairman’s Introduction, Welcome and Apologies

RC welcomed members to the Governing Body meeting.

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.

4. Minutes from previous meeting held on 2nd February 2016

The minutes of the meeting held on the 2nd February 2016 were noted and 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:

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

   RC advised that following a robust interview process Cheryl Hardisty had been appointed as Director of Commissioning, a shared appointment with North Staffordshire CCG and 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. The CCGs’ were exploring co-location options. 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.

**Staffordshire Transformation Programme**

RC confirmed that John MacDonald had been appointed to the role of Chair of the Staffordshire Transformation Programme and would undertake this role in addition to his role as Chair of University Hospitals of North Midlands (UHNM). Penny Harris would also be joining the Transformation Programme Team as Director of Transformation.

MW raised concerns around potential conflicts of interest in the appointment and advised that this issue had been raised with AB. There was a need to ensure that there was objectivity to allow the organisations to be brought together. The lack of lay representation on the Board was also a concern as there was a need for challenge. The clinical accountability and lay representation was the clear distinction of the CCGs from Primary Care Trust’s and should remain.

RC advised that John MacDonald was aware of these concerns and had confirmed to members that he was would remain objective. AB had raised the concerns regarding lay representation on behalf of the Governing Body with NHS England.

ND highlighted that the same strategy had been implemented across other localities with local leaders elected to lead each local Sustainability and Transformation Plan (STP).

**Healthwatch**

RC advised that Val Lewis had announced her resignation as Manager of Healthwatch Stoke-on-Trent and thanked Val for her continued support and commitment shown to the Governing Body and the local population.

The Governing Body duly received and noted the Chair’s Report.

6. **Clinical Accountable Officer’s Report**

   AB presented the report 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:

**DIRECTION**

**Health and WellBeing Board**

AB advised Sandra Chadwick, CCG Chief Operating Officer was now a voting member of the Health and WellBeing Board alongside himself.

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 and was also presented at the February meeting of the Stoke-on-Trent CCG Governing Body for review and discussion by members. Following approval the strategy will be published on the Stoke-on-Trent CCG City Council website.

My Care, My Way – Home First
AB confirmed that the formal consultation exercise on My Care, My Way – Home First ended on 17th January 2016. 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’
AB advised that the case for change would inform the Staffordshire and Stoke-on-Trent Sustainability and Transformation Plan (STP) and the significant support from outside of the NHS to help the CCG deliver a credible STP which was critical to secure national transformational monies.

**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.

Referral To Treatment (RTT)
AB confirmed that the 18 Weeks performance remained an area of concern. An improvement plan was submitted to NHS England on 19th February 2016, the CCGs will continue to work with UHNMs and other providers to ensure this is successfully implemented and delivers the required improvements. External support has been sought from the National Improvement Support Team (IST).

Financial Recovery
AB advised of the significant challenges throughout the course of the financial year, particularly financially transacting the implications of the step up and step down services. Significant mitigation has been undertaken however a financial gap remains. 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
AB highlighted that the CCG was in the final stages of the 2016/17 planning and had met all NHS England submission deadlines.

Development

Chairs Reports

Health Service Contribution To Reducing Health Inequalities in Stoke-on-Trent
It was noted that whilst the NHS had 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.

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

Walk In Centre Review
AB referred to the review that had been undertaken to understand the effectiveness of the services in both North Staffordshire and Stoke-on-Trent CCG

The Joint Planning Committee duly noted the progress on the Walk in Centre Review.
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**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. The 2016-2019 scheme aligns the QIF and QOFXL from the two Clinical Commissioning Groups to provide a consistent approach across northern Staffordshire.

**Voluntary Sector Strategy (VCS)**

AB advised that 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 Governing Body **ratified** the decision of the Planning Committee to approve the VCS.

The Governing Body duly **received** and **noted** the Clinical Accountable Officer’s Report, ratifying the decisions made at the sub committees of the Governing Body and **approved** the Voluntary Sector Strategy (VCS).

### 7. CCG Corporate Risk Register

LT presented the CCG Corporate Risk Register. Details as follows:

LT advised that since the last Governing Body meeting, all clinical risks had 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.

MW raised concerns around domiciliary care.

AB confirmed that this was discussed and monitored at the Systems Resilience Group. The Local Authority was aware and work was being undertaken to identify and to implement actions to close the gap. The quality of the service provider was also being monitored through the CQC.

IS reiterated that the constitutional waiting times were currently not acceptable. There was a need to review the individual elements on the register.

The Governing Body duly **noted** the contents of the Corporate Risk Register for risks scoring 15 and above.

### 8. 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:

**Patient Story**

At the March 2016 Quality Committee meeting, members received a patient story from the founder of an organisation called ‘Deafinitequality’. The Quality Committee heard the experiences of using local health services and agreed to seek assurance from each of its main providers on the support available for patients who are deaf or hard of hearing. 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.

**Patient Experience**

In Quarter 3 (October – December) 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).
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**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.

**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 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.

**Infection Prevention and Control**

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. Members noted that as at the end of December 2015, the CCG was 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.

**Quality Reports**

Members received Quality Reports in respect of its main providers (1) NSL Non Urgent Patient Transport Service; (2) North Staffordshire Combined Healthcare NHS Trust (NSCHT); (3) Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP); and (4) University Hospitals of North Midlands NHS Trust (UHNM), covering the three domains of quality: patient experience, safety and clinical effectiveness.

**Joint Quality Committee Terms of Reference (TOR) and Business Cycle**

The key changes to the TOR 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. 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 Governing Body duly **received** and **noted** the Quality Open Report and **ratified** the Terms of Reference for the Quality Committee for adoption from April 2016.

### 9. Audit Committee Chair’s Report

MW presented the report to highlight to the Governing Body the key issues discussed at each meeting, in line with its Terms of Reference and key responsibilities. Details as follows:

MW highlighted the items of business discussed at the last meeting held on the 16th February 2016 (1) External Audit Plan; (2) External Audit Appointments for NHS Stoke-on-Trent CCG; (3) Draft Head of Internal Audit opinion 2015 / 2016; (4) Counter Fraud; (5) Information Governance; (6) Declarations of Interest Quarterly Update; (7) Hospitality and Gifts Register; (8) Freedom of Information (FOI) Report – Quarter 3 2015 / 2016 (Including FOI Exception Report); (9) Audit Committee Terms of Reference; (10) Audit Committee Self-Assessment; (11) Assurance Framework and Risk Register (including exception reports; Better Care Fund & QIPP); (12) Internal Audit Recommendation Tracker 2014 / 2015 and 2015 / 2016; and (13) Waivers.

**Draft Head of Internal Audit opinion 2015 / 2016**

MW highlighted that the Audit Committee received the draft Head of Internal Audit Opinion for 2015 / 2016 advising that 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.

**Information Governance**

MW reiterated the strong progress made around Information Governance in the CCG and advised that members received the revised Information Governance Handbook (which is reviewed on an annual basis) following minor amendments being made and the Audit Committee approved this revised Handbook for submission to Governing Body for ratification. Following ratification by the Governing Body the revised handbook would be circulated to all staff to confirm that they are bound by a duty of confidentiality and agree to adhere to the Handbook at all times.

The Governing Body duly **ratified** the revised Information Governance Handbook.


MW advised that members received the Freedom of Information Report for the period 1st October 2015 – 31 January 2016 noting 83 requests were received and highlighting the formal complaint relating to a FOI which had not been responded to within timescales. MW assured the Governing Body that the complaint was now resolved with the complainant confirming that they were assured on the actions being taken to resolve this following an internal investigation.

**Audit Committee Terms of Reference (TOR)**

Following the annual review of the Audit Committee Terms of Reference, 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 to support 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 was asked to **ratify** the revised Audit Committee Terms of Reference for implementation with effect from April 2016.

The Governing Body duly **noted** the contents of the Audit Committee Chair’s report of the meeting held on the 16th February 2016, and in particular **ratified** the revised Information Governance Handbook for circulation to all staff and **ratified** the revised Audit Committee Terms of Reference for implementation with effect from April 2016.

**10. Month 11 Finance Report**

IS presented the month 11 finance report. Details as follows:

IS advised that the month 11 reported position is a £326k surplus which is out of line with the planned surplus of £3.706m up to the same period. It should be noted that planning assumptions for the current year saw funds reinvested at the outset for expected credits for marginal rate activity, fines and penalties. This was in line with a perceived view that contract levels had been set at excessively high levels and that underperformance would naturally arise as a by-product. As QIPP plans in the latter half of the year would ensure contractual underperformance with acute providers this would then allow redirection of savings to
non-recurrent activities. All contingencies have been applied in full (predominantly the 0.5% contingency of £1.9m and “headroom” of £3.5m, plus all sums in budget now assessed as contingent). At this stage the overall CCG forecast has moved to a £485k cumulative surplus at the year end. This broadly falls to non-delivery of activity reductions with the introduction of Step Up services, Non elective over-performance and other contractual overspending that is not covered by reserves.

A number of risks have become evident in the CCGs financial position; these will need to be mitigated in order to maintain the control totals. Significant pressures are evident within the system resilience planning budgets, which are over committed against the CCG baseline allocation that covers only “Tranche 1” costs of the system. The CCG has not accounted for the full risk of this wider system over commitment as it is considered that the bulk is covered through normal tariff payments, payment for over performance and issues that are the responsibility of other commissioners. These issues are currently being worked through the wider system, however for the next financial year Systems Resilience plans must be better aligned with system finances and established at the commencement of the year.

A discussion took place around (1) mitigations; (2) impact to the CCG and assurance from NHS England; (3) methodologies and the conflict between the local ask and the national ask; (4) coding; and (5) lessons learnt and the continual improvement process in place within the CCG.

The Governing Body duly noted: (1) The CCG’s cumulatively reported position for the year to Month 11 (February 2016) stands at £326k surplus, which is out of line with the £3.706m surplus planned at month 11. An adverse divergence from plan of £3.38m; (2) Due to the level of now unmitigated risk the CCG is unlikely to deliver to its control total and is currently forecasting a year end cumulative surplus of £485k; an overall move from original plan of £3.245m; (3) The current and forecast performance against the original £10.57m QIPP programme levels together with risk scenarios highlighting the potential risk levels being managed that will now impact on the out-turn performance; (4) the over performance in Acute, Mental Health and Prescribing areas; and (5) A significant level of risk mitigation actions have been taken through the Financial Recovery Group regime, but the forecast surplus has been under severe pressure, as not all mitigations sought have been successful. Full and final agreement of contract values with providers around transformation, performance and contract levers has not been achieved. Further actions have been taken through the internal turnaround regime to deliver as far as possible against the original plan.

11 Governing Body Assurance 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:

RC advised that the report was by exception and included only those indicators that were currently at risk or failing and narrative on key risks, actions and assurance was provided. It had been agreed that future reports would also include an overview of all commissioning areas and targets to provide assurance.

Referral To Treatment
SF advised that UHNM have now submitted a further trajectory outlining that performance will be back on track by the end of July 2016. February achieved 90% which was above the trajectory plan. It was expected that the cancelled operations as a result of the significant pressures in the system would have an impact. Work was ongoing with IST and discussions had taken place with UHNM around capacity and demand and the need to utilise the wider healthcare provision.

A&E
SF highlighted the significant increase in non-elective activity and the focus to bring admissions into the trajectory. A number of processes had been implemented to improve performance including assess to admit, todays work today, and discharge to assess.

MW questioned if there had been a significant change in the population demographics which could be
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ZI advised that there had been small changes in the population demographic but nothing that could be attributed to the increase.

SC advised of the Remedial Action Plan in place and that the contract was being used. Quality visits were being undertaken to ensure that the safety of patients was not being affected. A Board to Board meeting had been scheduled to discuss the concerns with the UHNMT Trust Board and to ensure that they were sighted on the issues.

Cancer
SF advised that (1) the target for Breast 2 week was achieved in February but not in March; (2) contract levers are in place for the 31 day target, which was achieved in February; (3) a detailed RAP is in place for the 62 day target, it was noted that cancelled operations may affect the performance.

It was noted that the impact of patient delays were being managed through the Care Quality Review Meeting (CQRM). Root Cause Analysis and harm statements were being completed. A meeting was arranged between the CCG Director of Nursing and Quality and the UHNMT Director of Nursing and Quality.

Mental Health
WA highlighted the two additional Mental Health targets that would be included within the reporting from April, Access to Waiting Times and Psychology Services, noting that 75% of patients should be referred within 6 weeks and 95% of patients within 15 weeks. The target for psychosis of 50% of patients’ diagnosed receiving treatment within two weeks had been met consistently since last year.

WA advised that Transforming Care remained high on the agenda for both the CCG and NHS England. There are now 14 patients remaining on the register in Stoke-on-Trent, the trajectory set by the CCG was to reduce this to 10 patients and actions were in place to work towards this target. Issues remain around the number of Providers available to provide for patients with complex needs. Work is ongoing with South Staffordshire to procure services for all patients. A new trajectory is expected to be issued from NHS England.

A discussion took place around CAMHS as access remained an issue, early identification was critical. A joint plan was in place and progress was being made. There was a need to interrogate the waiting lists to ensure that patients did not get lost within the system and that rapid access was available to patients using the services.

The Stoke-on-Trent CCG Governing Body duly received and noted the CCG Assurance Report.

12 Update on Patient and Public Involvement

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

MW highlighted the recruitment process being undertaken for outstanding members of the Patient Congress and advised that following a committee review, the PPI Steering Group would need to be invigorated and recalibrated. A workshop had been arranged which would also focus on how to operate the PPI Steering Group jointly with North Staffordshire CCG.

MW referred to the second large scale engagement event which took place on the 27th January entitled ‘Our Plans for Your NHS: a Community Conversation’, where engagement took place around urgent care access via walk in centres and A&E front of house and also on the SEND reforms and what this means locally.
MW advised that North Staffordshire CCG had recruited a Lay member for PPI, Peter Dartford, who commenced in post from April. A review would be undertaken to identify how the CCGs could work better together to work more efficiently.

MW raised concerns around the operational and managerial oversight of PPI, and advised that there was a need to refresh the strategy. MW thanked Laura Janda for her support to PPI over the previous year and the CSU for their continued support.

The Governing Body duly noted the contents of the report.

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<th>13. Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan</th>
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<td>WA and Kevin Day presented the report 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. Details as follows:</td>
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WA advised that 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. The two main elements of the programme are the delivery of a (1) new national service model to provide support to live in the community; and (2) 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 key focus of The Staffordshire and Stoke-on-Trent Transforming Care Partnership Board 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.

A discussion took place around (1) patient engagement; (2) the different ways of working; (3) the need for clarity within the plan around where specifically ‘Staffordshire’ refers to, whether this includes Stoke-on-Trent or whether this should be referenced separately; and (4) how to move the strategy through to implementation.

KD advised that following feedback from the national team, the plan had been further revised which was clearer around what areas were being referred to. The plans were now more consistent. 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.

KD highlighted that there was not an integrated Health and Social Care team managing the flow of patients across Staffordshire and the cohort were manged in separate ways across North and South Staffordshire. CCGs in North Staffordshire and Stoke-on-Trent jointly commissioned an 11 bedded in-patient service provided by the local NHS Provider Trust, 5 beds are designated as Assessment & Treatment beds and 6 as medium stay beds with a focus on rehabilitation. The North Staffordshire CCGs were working with the Provider in North Staffordshire to reduce the inpatient Assessment and Treatment bed base, however it was noted that the proposed reduction from 11 beds to 6 had not been approved, as further work was required to ensure that this was viable due to the lack of suitable services for patients with complex needs available within the local area following transfers of commissioning responsibility for a range of Learning Disability provision from the NHS to social care. The proposals to change the service were being developed and reviewed. **ACTION:** KD to update the language used within the report to reflect this.
A discussion took place around (1) the financials and the need to see the resource envelope and the details; (2) how to move away from bed based services; (3) the need to identify a senior Quality Manager; (4) the governance risks; (5) the widened spectrum and the need to design for the whole spectrum. **ACTION:** KD to share the County Autism Strategy and to present the Autism Strategy and timelines to the September meeting of the Governing Body.

The Governing Body duly **approved** 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 subject to the caveats discussed; and **noted** 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.

### 14. Non-Emergency Patient Transport Procurement

SF presented the report 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. Details as follows:

SF advised that due to the deadline for contract award of the 27th April 2016, the report was presented to seek delegated authority to the Joint Planning Committee and Joint Finance and Performance Committee on behalf of the Governing Body.

A discussion took place around the financial envelope (1) that the level of risk was unknown; (2) that the finances would not be available until the bids had been received; (3) that the finance team would review these once received and that this would then form part of the reprocurement discussions; (4) the financial viability would need to be reviewed; (5) that this was part of the standard process; (6) the need to ensure that the lessons learned following the previous procurement had been implemented; (7) the need to ensure that the review panel is comprised of the correct people and that the right questions are asked; and (8) the need to ensure value for money alongside quality of services, workforce, information management and technology, and contract mobilisation and management.

The Governing Body duly **noted** the process established to undertake the reprocurement of Non-Emergency PTS Service; **noted** the timeline outlined above, including the contract award date of no later than the 27th April 2016; **noted** 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: **approved** 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; and **noted** that the outcome of the above will be reported to the next available Governing Body meeting (scheduled for the 7th June 2016).

### 15. Information Governance Annual Report 2015-2016

IS presented the report which provides the CCG with a final overview of the Information Governance Improvement Plan for 2015/16. Details as follows:

IS advised that the contents of the annual report had been approved. Submission of the toolkit took place on the 21st March 2016, ahead of the deadline of the 31st March 2016.

IS thanked Lisa Taylor (Quality and Governance Manager) and Dan Pickford (Information Governance Support Officer, Midlands and Lancashire Commissioning Support Unit) for their hard work and continued support and advised that the CCG submitted an overall score of 91% which is a slight increase on the score achieved for 2014 / 2015 of 86%.

The Governing Body duly **noted** the contents of the Information Governance Annual Report 2015-2016; and in particular **noted** that the SIRO approved the contents of the Information Governance Annual Report
Agenda Item 4.1

and submission of version 13 of the Information Governance Toolkit on behalf of the CCG by the national deadline of the 31st March 2016; noted that the CCG has achieved the 95% compliance of staff who have completed their Information Governance Training during 2015 / 2016; and noted the Information Risk work is progressing really well and this is an on-going process within the CCG.

16. 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) preparations are underway to gather commissioner evidence showing ‘how do local people from protected groups fare compared to people in general in healthcare’; (2) the 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; (3) Cheryl Hardisty, Director of Commissioning is the CCG EDS lead for Goal 2: Improved patient access and experience; (4) the 2016 public grading event will take place on the 17th May 2016; (5) the refreshed Equality and Inclusion Strategy will be circulated for postal engagement; (6) NHS England have introduced a new Accessible Information Standard (AIS) which will apply to all providers across the NHS and adult social care system; and (7) commissioners must support providers to comply with the Standard.

SC advised that future Governing Body updates will be captured within the Organisational Development Committee report, currently included within the Clinical Accountable Officer’s Report.

The Stoke-on-Trent Governing Body duly noted 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; noted that all information must be published in a way that makes it easy for people to understand it (PSED requirement); noted the Easy Read version of the November 2015 EDS grading report which will be available on the CCG website shortly; noted that all senior and middle managers from NSCCG and SOTCCG are due to attend Equality and Inclusion Awareness session during 2016; noted the postal engagement with local communities of interest including protected group representatives of the Equality and Inclusion Strategy 2015 to Oct 2017; noted that a joint Equality and Inclusion Action Plan (Nov 2015 to Oct 2017) has been produced; and noted the Accessible Information Standard (AIS) update.

17. Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan

Sarah Blenkinsop and Liza Pursey presented the Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan. Details as follows:

SB advised that the Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan described a vision for primary care over the next five years and recognised that primary care was a key enabler to support the delivery of models of care which would reduce unwarranted variation, ensure sustainability and improve health outcomes of the local population it is aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire, supporting 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 (1) commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’; (2) deliver better patient outcomes through effective federated and collaborated arrangements with key partners; (3) improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle; (4) reduce health inequalities and unwarranted clinical variations; and (5) achieve all of the above while remaining within financial balance and achieving best value.
Agenda Item 4.1

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 order to achieve the 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.

It was noted that the Steering Group was working well and was progressing to implementation stage; there had been positive stakeholder engagement and buy in from localities, practices and the LMC. Support locally was key to drive the strategy.

AB applauded the strategy and the work undertaken by the teams but advised of the need for clarity around where the strategy would sit as part of the whole. There was a need to link with commissioning and ensure that the governance was right.

A discussion took place around (1) the need for Primary Care to have the same status as other Providers; (2) the links to the Operational Groups; (3) the need for a strengthened voice within the SRG; (4) the need for a clarification around the reporting mechanisms; (5) the differences between the funding available to practices; and (6) the need to be clear around how things are prioritised.

IS advised that there was no delegated budget for Primary Care and due diligence was required to ensure that this was appropriately funded to provide sustainability, this was being looked at nationally and a steer would be taken from NHS England, further work was required.

The Governing Body duly approved the overall vision and key principles described within this strategy to enable a detailed implementation plan to be developed subject to the caveats above around finances.

18. Questions From The Public

Ian Syme advised that he raised the FOI complaint at North Staffordshire CCG Governing Board and following his meeting with the Stoke-on-Trent CCG Chief Operating Officer and Governance Manager he was assured of the actions implemented.

Ian Syme raised concerns around (1) Patient Transport Service as no performance reports had been published by the CCG and requested that in future these be included; (2) staffing levels in UHNM as it was reported that during January 23 out of 44 wards were understaffed, with 3 falling below the 80% compliance; (3) Step Up and Step Down; and (4) Cancer and End of Life following the procurement report issued by NHS England.

SF advised that the PTS performance report were presented to the Joint Quality Committee.

JD advised that staffing levels are monitored through the Care Quality Review Meeting (CQRM) and a monthly report is received. Regular visits take place to the wards and staffing is a key focus. Further discussions will take place at CQRM. The CCG was not aware that any harm had come to patients. Further investigation would take place following the meeting.

AB advised that the Step Up Step Down detail was being worked through. As a result of the system pressures additional beds had been opened. ACTION: Update to be provided outside of the meeting.

AB advised the CCG and the Cancer and End of Life Programme Board were reviewing the Cambridge and Peterborough report and the recommendations and that the Programme would be reviewed as a result of the review. IS advised that the CCG had already implemented a number of the recommendations prior to
the report being published through the CCG’s due diligence. A joint meeting would be scheduled in May between the Programme Board and the CCGs.

Louise Zandian raised concerns around the treatment and care pathways for Autism due to the difficulty in accessing these as Autism falls between both Mental Health and Learning Disabilities, and the lack of funding.

RC highlighted the positive work being undertaken as part of the Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan, presented within the Governing Body meeting and the Autism Strategy that would be refreshed as part of this. It was agreed that a detailed discussion would take place outside of the meeting. ACTION: RB to pass details on to Mental Health Commissioning Team who would arrange a meeting.

Dave Blackhurst raised concerns around the targets that had not been met by NSL.

SF advised that monies had been held back as a result of the targets not being met in line with the KPI’s. Operational changes had been implemented and reviews took place monthly.

<table>
<thead>
<tr>
<th>18. Date, time and venue of next meeting</th>
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<tbody>
<tr>
<td>Tuesday 7th June 2016 at 1.30pm in The Minton Room, Stoke-on-Trent CCG, Herbert Minton Building, 79 London Road, Stoke-on-Trent.</td>
</tr>
</tbody>
</table>

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

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

Signed: ................................................................. Position: .................................. Date:............................
<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>Mental Health&lt;br&gt;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>
</tr>
<tr>
<td>5th April 2016</td>
<td>13.</td>
<td>Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan</td>
<td>KD to share the County Autism Strategy and to present the Autism Strategy and timelines to the September meeting of the Governing Body. &lt;br&gt;KD to update the language used within the report particularly around the proposed reduction in bed numbers.</td>
<td>Kevin Day</td>
<td>Will be presented to the September meeting of the Governing Body. Completed</td>
</tr>
<tr>
<td>5th April 2016</td>
<td>18.</td>
<td>Questions From The Public Step Up Step Down</td>
<td>Step Up / Step Down – Update to be provided following the meeting. &lt;br&gt;Staffordshire and Stoke-on-Trent Transforming Care Partnership Plan - update to be provided outside of the meeting. RB to pass details on to Mental Health Commissioning Team who would arrange a meeting.</td>
<td>Dr Andrew Bartlam</td>
<td>Update provided following the meeting. Details passed to Kevin Day following the meeting to arrange a further conversation regarding Autism.</td>
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<td>Name</td>
<td>Rachel Barker</td>
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<td>Executive Assistant</td>
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<tr>
<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**

7th June 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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**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD**

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<tr>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</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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<td>X</td>
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<td>2. Improve health outcomes</td>
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<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
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</table>
## 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.

## 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
None

## ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT
None

## ACRONYMS
N/A
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

Plans to co-locate the Stoke-on-Trent and North Staffordshire CCGs in shared premises have progressed, with the preferred option being Smithfield 1 in Hanley. Whilst agreed in principle, advanced negotiations are underway with the City Council, which if successfully concluded over the next few weeks will mean a move to the new premises in late summer.

To reiterate, whilst the executive, clinical and managerial workforce and committee structures will be shared by both CCGs and we will be co-located in shared premises, this is not a merger and both CCGs will remain sovereign bodies with their own Governing Bodies and Accountable Officers.

Executive Staffing

Following a robust interview process, I am pleased to announce that Zara Jones has been appointed as the Director of Strategy, Planning and Performance. Sara commenced in post from 6th June 2016. I am sure you will join me in welcoming Zara to the CCGs Executive Team.

Noreen Dowd has continued in the role of Interim Director of Strategy, Planning and Performance to hand over her portfolio and ensure a smooth transition for Zara. I would like to thank Noreen for her continued support to the CCGs.

Following the Management of Change process we have successfully recruited to the post of Clinical Director for Primary Care. We are pleased to announce that Dr John Gilby will commence in post from 1st August 2016 as a member of the single executive team for Stoke-on-Trent and North Staffordshire CCG and a voting member of the Stoke-on-Trent CCG Governing Body. Dr Gilby has supported the CCG as a Clinical Associate and a Locality Lead GP.

Patient Transport Services (PTS)

Over the last few months commissioners in Staffordshire from all six Clinical Commissioning Groups and Staffordshire and Stoke-on-Trent Partnership Trust have worked together to re-procure the Non-emergency Patient Transport service for the county as the existing PTS contract is due to terminate on the 31st July 2016. The evaluation of the tenders is now complete and the preferred bidder has been ratified by the relevant Bodies/ Committees. Bidders have now been notified of the outcome of the evaluation and E-зег Medical Transport Service have been chosen as the new provider of Non-Emergency Patient Transport Services across Staffordshire. The contract will be for a period of three (3) years with an optional one year extension. Commissioners in Staffordshire and E-зег have entered into the mobilisation stage of the contract and have a service commencement date of the 1st August 2016 with some south Staffordshire elements of the service going live on 1st October 2016.

Patients can be assured that they will not need to do anything when the change of provider happens, and they will continue to receive continuity of service.
**Individual Funding Requests**

During 2014/15 the CCG considered 44 potential Individual Funding Requests (IFR) requests; the majority of the requests were received from the GP (37) and Consultant (5).

Of these 44 requests:

- 38 were declined at initial review as the patients did not have clinically exceptionally circumstances as stated in the application
- 2 met the criteria (During this reporting period a Policy was agreed by the Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups Board to review requests for treatments that do not meet the criteria under the current Excluded and Restricted Procedures (ERP) or other treatments that are not commissioned by the CCG.)
- 4 were referred to the screening panel for review.

The screening panel includes Public Health Consultant, Medicines Optimisation Senior Manager and IFR Support Manager.

Outcome of screening:

- 3 were not considered to be an IFR as they had no evidence of clinical exceptionality or were considered to be a service development;
- 1 was referred to the IFR Panel

The IFR Panel includes a Lay Member (Governance) as Chair, Public Health Consultant, GP, Senior Medicines Optimisation Manager and a Senior Manager from the CCG.

The 1 case reviewed by the IFR panel was approved. The request was for dermatology / rheumatology drugs at an estimated cost of £12,730.
ENCLOSURE: 5.2

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<tr>
<th>AUTHOR</th>
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REPORT TO
Stoke-on-Trent CCG Governing Body

TITLE OF REPORT
Clinical Accountable Officer’s Report

DATE OF THE MEETING
7th June 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 and in particular ratify the changes to the policies detailed on pages 5-6 of the report and note the changes to the Excluded and Restricted Policy as detailed on pages 2-4 of 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 Dr 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
None

### ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT
None

### ACRONYMS
N/A
DIRECTION

Health and WellBeing Board (HWBB)

The last meeting was held on the 10th May 2016 at Civic Centre, Glebe Street, Stoke-on-Trent. The main items of business were (1) Tobacco Control & Reduce Smoking Strategy; (2) Reduce Under 18 Conceptions Strategy; (3) Board Member Updates; (4) Health & Care Transformation Board; (5) Communication & Engagement; (6) Clinical Commissioning Group Annual Report; (7) Better Care Fund Update; (8) GP Forward View; and (9) HWBB Governance & Performance Management Framework.

Pan Staffordshire Transformation Programme – ‘Together We’re Better’

The Staffordshire Sustainability and Transformation Plan (STP) short return was submitted to NHS England on 15th April 2016. The full plan will be submitted at the end of June 2016.

There are now five priority work streams Frail Elderly and Long Term Conditions (LTC); Urgent and Emergency Care; Enhanced Primary and Community Care; Planned Care (including Specialised Commissioning); and End of Life. Three other work streams Cancer; Mental Health; and Prevention and Well-Being. Seven enabler work streams, Communications and Engagement; Workforce; OD and System Leadership; IT and Technology; Cost Reduction; Contracting; and Travel (and Community Flows) each of which has a CEO/AO as Senior Responsible Officer (SRO) tasked with developing plans to drive delivery.

Planning guidance requires CCGs to deliver two separate but connected plans:

- A one year organisation based operational plan
- A five -year place-based Sustainability and Transformation Plan (STP)

The STP will be done on a Staffordshire and Stoke-on-Trent footprint and is being led by the ‘Together We’re Better’ transformation programme. This plan will include five year financial plans and needs assessments. The CCG strategy will form the basis of its contribution to the STP and therefore is limited in its financial and activity planning. It is focused on the overall clinical model of care, setting out our agreed strategies and the importance of patient/public engagement and the quality and safety of services the CCG will commission.

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 Standard. All formal contractual processes have been followed, with the issuing of a contract performance notice and the formation of a remedial action plan. As detailed in the agreed 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, February and March 2016.

You will note from the Integrated Performance Report as detailed below (Table 1), that performance has deteriorated since August 2015 and the March 2016 performance (76%) is the worst monthly position within 2015/16. In addition, the 12 Hour Trolley Breach Standard (zero tolerance) has been breached 88 times between April 2015 and March 2016.

Table 1

<table>
<thead>
<tr>
<th>A&amp;E waiting time - total time in the A&amp;E department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four hour wait Standard 99%</td>
</tr>
<tr>
<td>Current 75.6%</td>
</tr>
<tr>
<td>120% 83.4%</td>
</tr>
<tr>
<td>Percentage of patients who spent 4 hours or less in A&amp;E (E.B.S)</td>
</tr>
<tr>
<td>Month Mar-Jun</td>
</tr>
</tbody>
</table>

15 months annual trend to March 16.
The Systems Resilience Group (SRG) continues to manage the Local Health Economy Emergency Care Improvement Programme (ECIP) Plan, which will realise the high impact actions (Exemplar Front Door, Ambulatory Emergency Care, Frailty, Step Up, Therapies, Exemplar Ward, Home First and Step Down) and deliver performance in line with the recovery trajectory (Table 2 below). At April 2016, the actual performance is 5.2% below the recovery trajectory and in response, additional improvement workstreams have been commenced (e.g. Focus on emergency attendances from children and young people, further enhancing Discharge to Assess, amendments to the front door model, admissions audits, ambulance review, primary care (including clinical dialogue) and stranded patients.

ECIP continue to support the system with delivery of the high impact actions and the Capacity and Demand Model, which has been recognised as a national exemplar, is being utilised to further improve the system forecasting and response.

### Referral to Treatment (RTT)

Both 18 Weeks and Cancer RTT performance remain areas 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, year to date at Month 12 was 90.3%. An improvement plan is in place, with a number of key actions and an improvement trajectory to achieve the target. The CCGs will continue to work with University Hospitals North Midlands (UHNM) and our other providers to ensure that this is successfully implemented and delivers the required improvements.

The diagnosis of the problems faced at UHNM remain as previously reported, namely 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. In addition, the most challenged specialties are being directed through the Choice and Referral Centre. This will ensure effective utilisation of all providers capacity across the system and that commissioners are offering patients who have breached the 18 week standard the opportunity to transfer to an alternative provider.

### Better Care Fund (BCF)

The Stoke-on-Trent BCF Plan was submitted on 3rd May in accordance with national deadlines. However, as Governing Body will be aware from the report submitted to the meeting on 5th April 2016, the Plan is premised on the full funding requirements for delivery being met. At present the funding gap remains and as
such, although the Plan has been submitted, it has not yet been signed off by the City Council or the Health and Wellbeing Board.

Ongoing discussions between system leaders and the Regional Better Care Fund (BCF) Support Team are continuing to seek to resolve this situation. A further update will be provided to Governing Body in due course.

**Financial Update**
The CCG closed its accounts for 2015/16 and the year-end position saw the delivery of a £500k surplus against a planned target of £3.7m surplus. Unfortunately this meant that the CCG missed its control total by £3.2m. The accounts have gone through a process of external audit and approved with an unqualified opinion and the Auditors were satisfied that the CCG had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

In submitting our plans for 2016/17 the CCG has recognised that it needs to maintain a tight grip on its financial position and it will face significant challenges throughout the course of the financial year in delivering to a challenging QIPP target. The internal assurance regime will continue through the Financial Recovery Group meetings held jointly with North Staffordshire CCG. These will actively continue to review, challenge and manage the risks 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. The presentation later in the agenda from the CFO will outline the key messages and risks associated with the financial plans for 2016/17.

**DEVELOPMENT**
**Policies for ratification**
**Excluded and Restricted Procedures**
In order to make fair and reasonable decisions about how to get the most benefit for their populations from the investment in healthcare, the CCGs agreed that it would be right to create a ranked list of every service, and estimate the predicted costs for each service line. The purpose of the Commissioning Policy (which replaced the current policy on Exclusions and Restrictions) was to clarify the commissioning intentions of the CCGs in North Staffordshire and Stoke-on-Trent. The intention was to harmonise the policy with the revised policies of the CCGs in the south of Staffordshire, and wider afield. The revisions are the outcome of discussions with the CCGs in South Staffordshire, the clinical reference group for the Staffordshire Prioritised List, and meetings with clinical directors at UHNM. The purpose of the clinical discussions have been to:

- Provide an overview of the Prioritisation Process
- Discuss referral guidelines for General Practice and what more is needed to support referral management
- Discussion the current policy, restrictions and what can be improved
- Focus upon pathways of care and how these can be commissioned and improved to reduce demand.

The aim of the delivery of the Prioritisation Programme is to support the six Staffordshire CCGs through the Pan Staffordshire programme in the following areas:

- Identification of lines that can never be decommissioned but efficiencies can be made
- Identification of lines where eligibility criteria can be introduced or improved in Policy on restrictions
- Identification of services/interventions to be de-commissioned
- Identify areas of efficiency to deliver a 75% well managed system and in turn delivering a financially stable health economy.

In turn, this will deliver the following objectives:

- Support CCGs to deliver services in line with individual CCGs financial allocations
- Improved clinical outcomes through ensuring that finances are spent on the most clinically effective treatments/procedures/diagnostics
• Support effective referral management through the implementation of standardised pre-referral guidelines and Map of Medicine
• Reduce demand into elective services supporting the delivery of the RTT target
• Reduce zero length of stay admissions through identification of areas of high spend with limited clinical effectiveness supporting CCGs to redesign pathways of care.

The changes within the policy are listed on pages 2-4 of the attached policy (Appendix 1).

The Joint Planning Committee duly approved the proposed amendments to the Excluded and Restricted Procedures Policy. (Attached as Appendix 1).

**Commissioning Policy for Quality in Medicines Optimisation**

The policy had been reviewed and updated in line with changes to the high cost drugs commissioning process in liaison with the contracting team. In particular, the use of BlueTeq technology and an inclusion of a section referring to locally agreed commissioning arrangements for PbR tariff medication.

The contractual requirements in this policy are to satisfy the CCG that the medicines optimisation services provided are fit for purpose and demonstrate that the Provider has a clear understanding of how medicines are utilised within their Trust and that the associated administrative processes are efficient.

The Joint Planning Committee duly approved the Commissioning Policy for Quality in Medicines Optimisation.

**Commissioning Policy for the Funding of PbR Excluded Medicines**

The policy was designed to offer clarity to providers of health services on which PbR-excluded drugs were commissioned by North Staffordshire CCG and Stoke-on-Trent CCG for their patient populations. The policy had been reviewed and updated to reflect the minor amendments to organisational name changes.

The Joint Planning Committee duly approved the Commissioning Policy for the Funding of PbR Excluded Medicines.

**Non Medical Prescribing (NMP) Policy**

This policy has been reviewed to form a joint policy across Stoke-on-Trent and North Staffordshire CCGs. Minor amendments were made to include new sections as follows: (1) definition of non-medical prescriber; (2) section on dealing with changes to a NMP’s details such as name; and (3) prescribing data.

The policy includes a governance framework for exploring a new NMP’s prescribing intentions and giving relevant advice at the start of their prescribing career.

The Joint Planning Committee duly approved the Non-Medical Prescribing Policy.

**Primary Care Rebate Policy**

This policy has been reviewed to form a joint policy across Stoke-on-Trent and North Staffordshire CCGs. This policy provides the clarity and guidance for commissioners in Stoke-on-Trent CCG and North Staffordshire CCG when considering entry to a Primary Care Rebate Scheme.

Amendments include the incorporation of new sections within the policy as follows: (1) interface with the Pharmaceutical Industry; (2) contracts; (3) Information Governance; and (4) use of rebates - stating that monies received would be set against the prescribing budget.

The Joint Planning Committee duly approved the Primary Care Rebate Policy.
The above policies have been reviewed by Joint Medicines Optimisation Committee, prior to approval by Planning Committee. The Governing Body is therefore asked to ratify the revised policies for implementation.

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 8th March 2016
The Governing Body is asked to note the items of business discussed at the meeting on the 8th March 2016 including (1) Finance and Planning Update; (2) Draft Joint Strategy for North Staffordshire and Stoke-on-Trent; (3) Membership and Transformation Scheme; (4) Learning Disabilities In-patient Services; (5) Stoke-on-Trent Lifestyle Service – Future Commissioning Intentions; (6) Nursing Home LES Cessation; and (7) GP Out Of Hours / Front of House Service Redesign Update.

Membership and Transformation Scheme
The Membership and Transformation Scheme is refreshed on an annual basis and has been in place for North Staffordshire member practices since 2011 and this would be the second year of the scheme for Stoke-on-Trent Practices. The scheme is in two parts (1) to ensure that the membership is involved in the commissioning of services across Northern Staffordshire and to provide the opportunity for members to feed into the development of services by providing an evidence base at practice level; and (2) transformation and the practices being a member of the North Staffordshire GP Federation.

The Joint Planning Committee duly approved the Membership and Transformation Scheme for 2016/17.

Stoke-on-Trent Lifestyle Service – Future Commissioning Intentions
Stoke-on-Trent’s Primary Prevention Programme was launched in 2008 in order to identify patients at high risk of developing Cardio Vascular Disease (CVD) in the next 10 years and then offer these patients appropriate medical or lifestyle interventions. The programme remains in place today delivered via two linked services being (1) the provision of NHS Health Checks which was a mandated function of the local authority’s public health duties; and (2) the Lifestyle Service which was a locally developed service commissioned by Public Health with capacity to see up to 3000 adults per year.

The proposal was to refocus the Lifestyle Service on targeting patients with high risk of CVD and those with existing CVD, respiratory disease and diabetes and other local priorities such a patients with severe and enduring mental health conditions and chronic depression. This will be achieved through a change to the current referral criteria.

The Joint Planning Committee duly agreed the Stoke-on-Trent Lifestyle Service changes.

Nursing Home LES Cessation
The Joint Planning Committee duly agreed that the service would continue after 31 March 2016 and would be rolled back out within General Practice.

Joint Planning Committee Meeting on the 12th April 2016
The Governing Body is asked to note the items of business discussed at the meeting on the 12th April 2016 including (1) Finance and Planning Update; (2) Pan Staffordshire Update (Case for Change); (3) Five Year Strategy and Operational Plans; (4) GP Out of Hours / Front of House Service Redesign; (5) Pan Staffordshire
Wheelchair Procurement; (6) Procedures of Limited Clinical Value (POLCV); (7) Clinical Prioritisation Advisory Group (CPAG) Terms of Reference; (8) Staffordshire Integrated Care Record Business Case; (9) Non-Emergency Patient Transport Service; and (10) Fast Track Care Home Procurement.

Pan Staffordshire Update (Case for Change)
Following the submission of the Pan Staffordshire Case for Change, a Healthcare Transformation Board had been established, chaired by John MacDonald. Penny Harris has commenced in role as the Programme Director. The programme has been refocussed and the workstreams were confirmed as (1) fit and well; (2) high risk and independent; and (3) receiving care. The final version of the Staffordshire Transformation Plan was due for submission in June 2016.

The Joint Planning Committee duly noted the Pan Staffordshire Update (Case for Change).

Five Year Strategy and Operational Plans
A report was presented detailing the Stoke-on-Trent and North Staffordshire CCGs Five Year Strategy and Operational Plans. The Committee were asked to note the requirements for development of a Sustainability and Transformational Plan for the whole of Staffordshire; and to support the overall direction of the Strategic and Operational Plans to enable sign off by the CCG Governing Bodies.

The Joint Planning Committee duly approved the update on the Five Year Strategy and the Operational Plans.

GP Out of Hours (OOH) / Front of House (FoH) Service Redesign
The Joint Planning Committee duly noted the GP Out of Hours / Front of House Service Update and requested that a report be submitted to the following meeting detailing the vision for Out of Hospital care and how the GP OOH and FoH align with this.

Clinical Prioritisation Advisory Group (CPAG) Terms of Reference
The proposed changes to the Terms of Reference for the merged Clinical Prioritisation Advisory Group (CPAG) were presented to the Committee.

The Joint Planning Committee duly approved the amended Terms of Reference for the merged Clinical Prioritisation Advisory Group (CPAG).

Staffordshire Integrated Care Record Business Case
The Joint Planning Committee supported a proposal for a Staffordshire Integrated Care Record but requested further information at a future meeting.

Non-Emergency Patient Transport Service
The Joint Planning Committee were asked to endorse the procurement process established to undertake the re-procurement of Non-Emergency PTS Service and approve the award of a three year contract with a one year optional extension. SF confirmed the robust process undertaken and that the service was within the existing affordability envelope for all lots.

The Joint Planning Committee duly approved the Non-Emergency Patient Transport Service procurement process.
Fast Track Care Home Procurement - Outcome

The CCGs have recently concluded the procurement process for Home Care provision to support discharge from acute and community hospitals, for patients eligible for fast track Combined Health Care (CHC) funding and therefore End of Life. The pilot is to test contracting with the provider in a different and more cost efficient way to that currently. Three bids were received and following robust evaluation and moderation the single preferred provider is recommended.

The Committee duly received, noted and approved the outcomes of the Fast Track Home Procurement.

Organisational Development (OD) Committee held on the 3rd May 2016

The Governing Body is asked to note the items of business discussed at the meeting on the 3rd May 2016 (1) Management of Change – Update and Action Plan; (2) HR Policies; (3) Staff Survey Timing; (4) OD Engagement Group; (5) Workforce Statistics; (6) Herbert Minton Building – Capital Works; (7) Health & Safety and Security Reports 2015/16; and (8) Equality and Inclusion Update.

Workforce Statistics

A report was presented to members reporting on workforce statistics for Stoke-on-Trent and North Staffordshire CCGs.

The Organisational Development Committee duly received and noted the workforce statistics.

Equality Delivery System (EDS) and Workforce Race Equality Standard (WRES)

A progress report was presented on Equality and Inclusion within the CCGs. The Committee were advised that an Easy Read document had been produced following 27 October 2015 Equality Delivery System second joint CCG annual public grading event. The Specific Equality Duty requires key equality publications to be easily accessible by the public. The Easy Read version is available on both CCG websites and was produced by a learning disability led organisation and links closely with requirements of the Accessible Information Standard (AIS) mandated by NHS England.

The Committee were advised that by 31st July 2016, health and social care organisations must be fully compliant with all aspects of the AIS, which required CCGs and their provider partners to take a number of milestone actions. The aim of the AIS was to ensure that people who have a disability, impairment or sensory loss receive information that they can access and understand, and any communication support that they require.

The Organisational Development Committee duly received and noted the EDS / WRES Update.
Commissioning Policy

Excluded and Restricted Procedures

Version 4.7

April 2016

<table>
<thead>
<tr>
<th>Name of Responsible Board / Committee for Ratification:</th>
<th>Joint Planning Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued:</td>
<td>1st April 2016</td>
</tr>
<tr>
<td>Review Date:</td>
<td>1st Oct 2016</td>
</tr>
<tr>
<td>Version Number</td>
<td>Date</td>
</tr>
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</tr>
<tr>
<td>4.1</td>
<td>03/06/2011</td>
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<tr>
<td>4.2</td>
<td>17/06/2011</td>
</tr>
<tr>
<td>4.2</td>
<td>03/08/2011</td>
</tr>
<tr>
<td>4.2</td>
<td>03/08/2011</td>
</tr>
</tbody>
</table>
| 4.3            | 15/05/2012 | • Changes to the Blepharoplasty criteria  
• Additional policy as an appendix for gender reassignment  
• Removal of bobath therapy and pulmonary rehabilitation as both services routinely commissioned  
• Wisdom teeth criteria changed from excluded to restricted  
• Criteria added around spinal cord stimulation/dorsal column stimulation – changed from excluded to restricted  
• Removal of medicines management section of the policy  
• North Staffs CCG fertility criteria – additional policy as an appendix  
• Dermatology and Plastics merged  
• Carpal Tunnel criteria altered |
| 4.4            | 20/03/2013 | PCT removed and changed to CCG  
Addition of an excluded procedure based upon clinical evidence – Closure of PFO for prevention of Stroke  
Removal of the following due to move to specialised commissioning on the 1\textsuperscript{st} April 2013:  
• Bi ventricular pacing for heart failure  
• Cardiac electrophysical ablation  
• Implantable cardioverter defibrillators  
• ECLS  
• Cochlear implants (adult and paediatric)  
• Gender Reassignment  
• Bariatric surgery  
• Carotid endartectomy for carotid stenosis  
• Extra corporeal photopheresis  
• Spinal cord stimulation for chronic pain  
• BTA for children with cerebral palsy  
• Therapy for Facial Nerve Palsy  
• All oral surgery  
• All maxillofacial surgery  
• Autologous chondrocyte implantation  
Wording amended for the following: |
Skin procedures and lesions – clarity on criteria for commissioning
Abdominoplasty (Stoke CCG) – clarity on criteria for commissioning – no changes to the criteria
IUD’s and Mirena Coils – criteria for commissioning extended and criteria changed to restricted
Hip and Knee replacements – criteria remains the same but correction on the thresholds added as requested by Mr Lim
Codes amended and corrected as highlighted in the main text
Commissioning statement on non-specific low back pain added

Amalgamation of North Staffordshire CCG and Stoke on Trent CCGs Excluded and Restricted Procedures Policy April 2013(v 4.4) with the South Staffordshire Procedures of Low Priority Policy 2014(v.1.0).

Wording amended for the following:
Lesions – removal of wording Lesion is causing itching, bleeding, pain, active inflammation. It was felt that this would be captured under malignancy.
Lipomas – change from SIGN guidance to suspicion of malignancy
Sebaceous cysts moved under the criteria for lesions.
Criteria for Paediatric haemangiomas added
Split earlobe repair now excluded
Inclusion of removal of Supernumerary Nipples (Polymastia) – excluded procedure
Silicone Gel Sheeting for Preventing or Treating Hypertrophic Scarring included as an excluded procedure
Laser treatment for rosacea now excluded
Electrolysis treatment for any condition now excluded
Surgery for asymptomatic gallstones removed as cannot determine this through audit. Separate policy being developed around the treatment of gallstones.
Caesarean sections updated in line with NICE 2012 guidance.
Varicose Vein criteria reworded
Hip and knee and Carpal Tunnel criteria changed in line with CPAG scores and alignment with South Staffordshire policies.
Addition of first ring pessary to be fitted in secondary
4.7

1.0 Purpose

1.1 The purpose of this Commissioning Policy (which replaces the current Policies on Procedures of Limited Clinical Value and Low Priority Treatments, or Exclusions and Restrictions) is to clarify the commissioning intentions of the Clinical Commissioning Groups across Staffordshire, namely North Staffordshire CCG, Stoke on Trent CCG, Stafford and Surrounds CCG, Cannock Chase CCG, South East Staffordshire and Seisdon CCG and East Staffordshire CCG.

2.0 Introduction

2.1 This Policy supports the decision making process associated with the allocation of resources for commissioning. It will be used to support the development of effective, efficient and ethical Service Level Agreements with provider organisations, and the procurement of interventions on an exceptional basis.

2.2 The Policy establishes the framework within which the CCGs can demonstrate that their decision making processes are fair, equitable, ethical and legally sound.

3.0 Background

3.1 NHS Commissioners receive funding to commission health services for their resident population and make decisions within the context of statutes, statutory instruments, regulations and guidance. NHS Commissioners have a responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them.

3.2 NHS Commissioners are required to commission comprehensive, effective, accessible services which are free to users at the point of entry (except where there are defined charges) within a finite resource. It is, therefore, necessary to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the population.
3.3 This Policy is designed to help the CCGs to meet their obligation in providing equitable access to health care. It aims to achieve this by supporting a robust decision making process that is reasonable and open to scrutiny.

4.0 Definition of “Low Priority Treatments”

4.1 The term “treatment” describes clinical care and programmes of care that include:-

- Medicines
- Surgical procedures
- Therapeutic and other healthcare interventions

4.2 On systematic evaluation, some interventions have been identified as being either marginally effective or ineffective with limited clinical value in the vast majority of cases. Others have been shown to be an inefficient use of resource given their high cost per quality adjusted life year gained.

5.0 Operating Policy for the Development and Implementation of this Policy

5.1 Scope

5.1.1 A number of national organisations, such as NICE in England, SIGN in Scotland, and the Medical Colleges are committed to producing evidence-based commissioning policies. The emphasis is on high value care pathways. In addition Public Health clinicians from across Staffordshire and the West Midlands have developed evidence-based advice to inform both the prioritisation process and commissioning decisions on low priority treatments. Throughout this Policy these treatments or procedures are categorised as Excluded or Restricted. Excluded treatments or procedures will not be funded by the NHS Commissioners. Restricted treatments or procedures will only be funded for those patients where an appropriate threshold for the intervention as stated in this Policy has been met.

5.2 Determining the Evidence Base

5.2.1 Evidence for treatment effectiveness and efficacy is available from many sources, including NICE, the Cochrane Institute, Royal Colleges, other professional guidelines, and sources such as peer reviewed journals or technical notes. Evidence varies in its robustness, ranging from meta-analyses of randomised control trials with large populations of participants, to traditional consensus about best practice. The NHS Commissioners in arriving at this Policy have taken advice from Public Health locally on the source, extent and quality of the evidence in reaching their decisions, and assessed the relative clinical value of many specific procedures through the local prioritisation process.

5.3 Populations

Unless stated otherwise the restrictions within this policy apply to both paediatrics and adults. A paediatric case is defined as a child between the ages of 0 and 18.

Unless stated otherwise the restrictions within this policy apply to patients within North Staffordshire CCG, Stoke CCG (and South Staffordshire CCGs).
5.4 Ethical and Legal Policy for Decision Making

5.4.1 The NHS Commissioners have Prioritisation Frameworks which are reviewed on an ongoing basis. Utilisation of these prioritisation frameworks informs the review of this policy and the procedures and treatments that it covers.

5.5 Implementation

5.5.1 The schedule showing low priority treatments is set within this policy. This can be incorporated into contractual and service level agreements. NHS Commissioners will require primary and secondary care service providers and other organisations acting on behalf of NHS Commissioners to embrace and abide by the policy and to advise patients accordingly.

5.5.2 The Policy is implemented by GPs and Primary Care health professionals when advising and referring patients and by providers when considering the treatment options for patients. Those making referrals should not refer to any provider for a treatment or procedure covered by this Policy. Providers should not suggest, recommend or otherwise offer excluded treatments or procedures covered by this Policy to any patient. Providers should only suggest, recommend or otherwise offer restricted treatments or procedures covered by this Policy to patients who satisfy the appropriate threshold statement for that treatment or procedure.

5.5.3 Within the policy, and as stated against individual treatments or procedures listed in Appendix 1, treatments and procedures are classified as Excluded or Restricted. Unless specifically stated all treatments and procedures are classified as Excluded or Restricted by both NHS Commissioners.

5.5.4 Excluded procedures and treatments are not commissioned by the NHS Commissioners. Where individual patient circumstances require the escalation of their care and a procedure or treatment classified as excluded is being proposed then providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests.

5.5.5 Restricted procedures and treatments are not commissioned by the NHS Commissioners except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment. Clinicians considering offering a patient a restricted procedure or treatment should satisfy themselves that the threshold statement or criteria against the procedure or treatment are satisfied. Where a patient satisfies the threshold statement or criteria the procedure or treatment is prior approved and can be undertaken. Where the threshold statement or criteria are not met then the procedure or treatment is excluded for that patient and paragraph 5.5.4 above applies.

5.5. This Policy is distributed to all providers, primary care contractors and CCG Localities.

5.6 Monitoring the Policy

5.6.1 NHS Commissioners will monitor the adherence to this policy through the contractual process, using contractual levers where breaches of the Policy are identified.

5.6.2 Referrals to secondary care that are outside of this Policy will be routinely monitored by the Commissioning Management and the Contracts Management Teams of the NHS Commissioners.
5.6.3 NHS Commissioners will provide periodic reports to their Boards reporting the number and nature of breaches of the Policy, by provider and by procedure.

5.6.4 Where there are defined thresholds, the compliance with the criteria will be subject to regular clinical audits carried out or organised by NHS Commissioners. The audit process will require providers to produce patient specific evidence that confirms the threshold criteria for procedures were satisfied at the time the decision to offer the procedure to the patient was taken. Where audit shows that the evidence is not available or is deficient or fails to satisfy the auditor that the threshold criteria were met at the time the decision to perform the procedure was taken, then the default will be to consider the procedure was excluded and therefore it will not attract payment from the NHS Commissioners.

5.6.5 NHS Commissioners reserve the right to reduce the value of all payments for procedures with OPCS codes that match those for Excluded and Restricted procedures (as listed within this policy).

5.6.6 Any procedures marked as ‘Requires Prior Approval’ must be approved by CCGs before the surgery is undertaken using the agreed form. Commissioners will not pay for any procedures undertaken without the required approval from the responsible commissioner.

Audit

5.6.7 The Trust should consider, in advance, how it will provide sufficient patient specific evidence to show that criteria have been met, by providing documented evidence in line with the commissioners’ requirements for standards of evidence, and that this is provided at the first audit. There will be no further opportunities to provide information (such as by reaudit) unless with the written consent of the Commissioner.

5.6.8 All audits will be completed jointly between the Trust and clinical representatives from the CCGs.

5.6.9 Audits will be undertaken quarterly against at least 600 records across all specialties. There will then be an extrapolation for that quarters activity e.g if it is determined that 5% of the sample audit for Carpal Tunnels are non-complaint with the policy, this will be extrapolated for that particular quarters Carpal Tunnel activity but would not be carried forward into a full year effect.

5.6.10 The next quarters joint audit would then determine any extrapolation for that quarter and so on to give the Trust opportunity to tackle any areas of non-compliance.

5.6.11 Commissioner will provide the Trusts with an audit timetable at the beginning of the financial year.

5.7 Maintaining an Up-to-Date Policy

5.7.1 NHS Commissioners will abide by this policy when making decisions relating to the provision of low priority treatments. Specifically, the role of the NHS Commissioners is to:
• Monitor the implementation of the Policy and the impact it has on clinical decision making;
• Inform referrers of the Policy;
• Inform all service providers with whom the NHS Commissioners have formal contractual arrangements of the Policy;
• Review the policy and the accompanying schedule on an ongoing basis and/or where an urgent consideration of new evidence is justified.

6.0 Managing Expectations

6.1 In their dealings with patients and the public providers should, if necessary, make it clear that the decision by NHS Commissioners to consider treatments or procedures to be of low priority under this policy is a considered decision made against their responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them and that it is necessary for the NHS Commissioners to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the local population.

6.2 Where individual patient circumstances require the escalation of their care providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests.
### Behavioural Therapy

<table>
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<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
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<tbody>
<tr>
<td>Not applicable</td>
<td>Psychotherapy for Borderline Personality Disorder</td>
<td>Not routinely commissioned</td>
<td>Excluded – by prior approval only</td>
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<tr>
<td>Not applicable</td>
<td>Chronic fatigue syndrome – inpatient cognitive behavioural therapy</td>
<td>Not routinely commissioned</td>
<td>Excluded – by prior approval only</td>
</tr>
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### Cardiology

<table>
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<th>Thresholds</th>
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<td>K16.5</td>
<td>Closure of Patent Foramen Ovale (PFO) for Migraine Headache</td>
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<td>Excluded</td>
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<tr>
<td>K16.5</td>
<td>Closure of Patent Foramen Ovale (PFO) for the prevention of stroke</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
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### Complementary Medicine/Therapies

<table>
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<th>Thresholds</th>
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<tr>
<td>X61.1, X61.2, X61.3, X61.4, X61.8, X61.9</td>
<td>Acupuncture</td>
<td>Acupuncture will only be commissioned as an adjunct to pain management and only through specialist pain clinics</td>
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<tr>
<td>X61.2, X61.3, X61.4, X61.8, X61.9, Y33.1</td>
<td>Complementary Therapies/medicines</td>
<td>Alexander technique, Aromatherapy, Ayurveda, Environmental medicine, Healing, Hypnosis, Massage, Applied Kinesiology, Autogenic training, Chiropractic, Osteopathy, Herbal medicines, Homeopathy, Meditation</td>
<td>Excluded</td>
</tr>
<tr>
<td>Dermatology and Plastic Surgery</td>
<td>Naturopathy                                      Nutritional therapy</td>
<td></td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td></td>
<td>Reflexology                                     Reiki</td>
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<tr>
<td></td>
<td>Shiatsu                                         Gerson Therapy</td>
<td></td>
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<tr>
<td></td>
<td>Chelation Therapy                               Radiation Therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
</table>
| S05.1, S05.2, S05.3, S05.4, S05.5, S05.8, S05.9, S06.1, S06.2, S06.3, S06.4, S06.5, S06.8, S06.9, S08.1, S08.2, S08.3, S08.9, S09.1, S09.2, S09.3, S09.8, S09.9, S10.1, S10.2, S10.3, S10.4, S10.8, S10.9, S11.1, S11.2, S11.3, S11.4, S11.8, S11.9, D02.1, F02.1, S60.8 | Treatment of Minor Skin Lesions including benign pigmented moles, comedones, corns/callous, lipoma, milia, molluscum contagiosum, seborrhoeic keratosis, skin tags including anal tags, spider naevus, warts, xanthelasma and neurofibromata, epidermoid/Pilar (sebaceous) cysts | Only commissioned where there is:  
- Suspicion of malignancy  
- Obstruction of orifice or vision | Restricted |

| Lipomas                           | Will be routinely commissioned under the following circumstances:  
- Severely functionally disabling and/or subject to repeated trauma due to size and/or position  
- Suspicion of malignancy | Restricted |

| C 12.1                            | Excision of lesion of the eyelid                | Will be routinely commissioned under the following circumstances: | Restricted |

10
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Criteria</th>
<th>Commission Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>S09.1, S09.2, S09.3, S09.8, S09.9</td>
<td>Paediatric haemangiomas</td>
<td>Potential malignant, infected, symptoms of pain, irritation, discomfort, functional deficit, lid malposition, interference with vision</td>
<td>Restricted</td>
</tr>
<tr>
<td>S09.1, S09.2</td>
<td>Port Wine Stain</td>
<td>Treatment will be offered for those which threaten life or function, including compromising eyesight, respiratory, cardiac or hepatic functions, other internal lesions sited in an area liable to scar, large facial haemangiomas that have failed to regress by school age, show a tendency to bleed or become infected, Kasabach-Merritt syndrome (coagulopathy)</td>
<td>Excluded</td>
</tr>
<tr>
<td>S02.1, S02.2, S02.8, S02.9</td>
<td>Abdominoplasty/Apronectomy North Staffordshire CCG and South Staffordshire CCGs</td>
<td>Will be considered providing that all the following criteria are met: documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring repeated courses of treatment for a minimum period of one year or disability resulting in severe restrictions in activities of daily living, the patients BMI before weight loss must have been no less than 40kg/m2</td>
<td>Excluded</td>
</tr>
</tbody>
</table>
- The patient's current BMI must be between 18kg/m² and 25kg/m² and has been within this range for a minimum of 1 year as measured and recorded by the NHS. If this is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin.
- The patient's weight must have been stable and within this range for a minimum of 1 year as measured and recorded by the NHS.
- An abdominoplasty/apronectomy has not already been performed.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Procedures</th>
<th>Commissioning Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cosmetic operations on the external ear including Pinnaplasty, split earlobes, excision of lesion of external ear, others</td>
<td>Not routinely commissioned</td>
</tr>
</tbody>
</table>
| D03.1, D03.2, D03.3, D03.8, D03.9, D06.2 | **Cosmetic Operations on Breast (female)**  
**North Staffordshire CCG**  
Breast Augmentation  
Breast reduction  
Mastopexy  
Revision of breast augmentation | Restricted  
Excluded  
Excluded  
Restricted |
|     | Will be routinely funded following mastectomy, post burns or for breast asymmetry following prophylactic bilateral mastectomy for cancer prevention in high risk cases. |                             |
|     | The CCG will fund the following:  
- Removal of implants  
- Removal of implants complicated by recurrent infection |                             |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>B29.5, B30.1, B30.2, B30.3, B30.8, B30.9, B31.1, B31.2, B31.3, B31.4, B31.8, B31.9, B33.2, S48.2, B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9, B37.5</td>
<td>Cosmetic operations on breast (female)</td>
<td>The CCG will routinely fund under the following circumstances:</td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td><strong>Stoke on Trent CCG</strong></td>
<td>Developmental failure resulting in unilateral or bilateral absence of breast tissue/asymmetry (congenital amastia)</td>
<td></td>
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<tr>
<td></td>
<td>Breast enlargement (augmentation mammoplasty)</td>
<td>Significant degree of asymmetry of breast shape and/or volume at least a difference of 2 cup sizes as a result of:</td>
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<td></td>
<td></td>
<td>Previous mastectomy or excision breast surgery for cancer/lumpectomy or following prophylactic bilateral mastectomy for cancer prevention in high risk cases</td>
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<td></td>
<td></td>
<td>Trauma to the breast – post burns. Breast asymmetry, endocrine abnormalities, developmental asymmetry</td>
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<tr>
<td></td>
<td></td>
<td>The following criteria must be met for surgery to be routinely funded:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient must have a BMI within the range of 18kg/m² to 25kg/m²</td>
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</tr>
</tbody>
</table>
Revision of breast augmentation

- Minimum age for surgery is 18 of age and evidence that pubertal growth of breasts has ceased

Breast revision surgery will only be supported if the original augmentation procedure was commissioned by the NHS and one of the following applies:
- Breast disease
- Implants with capsule formation that interferes with mammography
- Implants complicated by recurrent infection
- Implants with Baker Class IV contracture associated with pain
- Intra or extra capsular rupture of silicone gel filled implants

Please note that the following will not be routinely funded as part of this service:
- Correction of any asymmetry as explained in the section above on breast enlargement
- Mastopexy and other similar surgical procedures

Stoke on Trent CCG will commission the insertion of breast implants, and their replacement if they need to be removed, if the procedure was performed during or after mastectomy for breast disease or a prophylactic mastectomy.

Will be routinely commissioned under the following circumstances:
- Women with large breasts who are experiencing function symptoms which are not relieved by wearing a fitted brassiere (fitted by a trained bra fitter)
<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Requirements</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastopexy, Surgery for inverted nipples</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
| • If there is back/shoulder pain, there should be documented evidence of visiting their GP for this, duration of the problem and evidence that other approaches such as physiotherapy or NSAIDS have been tried  
• There is an expected need to remove at least 500mg of tissue from each breast  
• The patient must have a BMI within the range 18kg/m² and 25kg/m². | Excluded |
<p>| B35.1, B35.2, B35.3, B35.4, B35.6, B35.8, B35.9 | Removal of Supernumerary Nipples (Polymastia) | Not routinely commissioned |
| | | By prior approval only |
| S06.3, S06.4, S06.9 | Refashioning of scars/keloids including stretch marks | Not routinely commissioned |
| | | Excluded |
| B311 | Gynaecomastia | Not routinely commissioned |
| | | Excluded |
| S06.3, S06.4, S06.9 | Silicone Gel Sheet for Preventing or Treating Hypertrophic Scarring | Not routinely commissioned |
| | | Excluded |
| S01.1, S01.2, S01.3, S01.4, S01.5, S01.6, S01.8, S01.9 | Cosmetic excision of skin of head or neck – e.g. face left, brow lifts | Only commissioned for severe facial nerve palsy |
| | | Excluded |
| S03.1, S03.2, S03.3, (S03.8 or 03.9 with Z49.5 or 50.1) | Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm. Buttock/Thigh/Arm lift or body | Not routinely commissioned |
| | | Excluded |</p>
<table>
<thead>
<tr>
<th>Proc. Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Staffordshire CCG</strong></td>
<td><strong>Excision of excessive skin from thigh, leg, hip, buttock, arm, forearm.</strong> <strong>Buttock/Thigh/Arm lift or body contouring</strong></td>
<td>Individual cases will be considered provided that all the criteria listed in the section on abdominoplasty/apronectomy are met. Prior approval to be sought. <strong>Excluded unless by prior approval</strong></td>
</tr>
<tr>
<td>S03.1, S03.2, S03.3, (S03.8 or S03.9 with Z49.5 or 50.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stoke on Trent CCG</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S62.1, S62.2</td>
<td>Liposuction of subcutaneous tissue</td>
<td>Not routinely commissioned <strong>Excluded</strong></td>
</tr>
</tbody>
</table>
| C13.1, C31.2, C31.3, C31.4, C31.5, C31.8, C13.9 | Blepharoplasty | Blepharoplasty will be routinely commissioned only for upper lids in the presence of:  
- **visual field impairment** (reducing visual field to 120° laterally and 40°vertically)  
- **Severe congenital ptosis**  
This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.  
Note: Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction.  
Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and not for cosmetic reasons.  
The following procedures will not be funded:  
- Surgery for cosmetic reasons  
- Surgery for cyst of moll  
- Surgery for cyst of zeis  
- Removal of eyelid papillomas or skin tags  
- Surgery for pingueculum | **Restricted** |
<table>
<thead>
<tr>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Excision of other lid lumps</td>
<td></td>
</tr>
<tr>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Facial Atrophy – new fill procedures</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Excluded by prior approval only</td>
<td></td>
</tr>
<tr>
<td>P05.5, P05.6, P05.7, P05.8, P05.9, N29.1, N29.2, N29.8, N29.9</td>
<td></td>
</tr>
<tr>
<td>Aesthetic/Cosmetic Genital Surgery inclusive of labiaplasty</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Excluded</td>
<td></td>
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<tr>
<td>S60.6, S60.7</td>
<td></td>
</tr>
<tr>
<td>Hair Depilation for excess body hair, facia hirsutism or hypertrichosis</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Excluded</td>
<td></td>
</tr>
<tr>
<td>S21.2, S21.8, S21.9, S33.1, S33.8, S33.9</td>
<td></td>
</tr>
<tr>
<td>Correction of hair loss</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Excluded</td>
<td></td>
</tr>
<tr>
<td>S21.1, S21.2, S21.8, S21.9, S33.1, S33.2, S33.3, S33.8, S33.9.</td>
<td></td>
</tr>
<tr>
<td>Correction of male pattern baldness</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Excluded</td>
<td></td>
</tr>
<tr>
<td>S21.1, S21.2, S21.8, S21.9, S33.1, S33.2, S33.3, S33.8, S33.9.</td>
<td></td>
</tr>
<tr>
<td>Hair Transplantation</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>Excluded</td>
<td></td>
</tr>
<tr>
<td>S09.1, S09.2, S10.3, S11.3, S60.1, S60.2.</td>
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</tr>
</tbody>
</table>
| Laser Treatment for birthmarks and scarring                              | Laser Treatment for birthmarks and scarring will only be routinely commissioned for large (in excess of 5cm x 5cm) and will be routinely commissioned under the following circumstances:  
  • The area to be treated is on the face AND  
  • The patient has been through all other recognised treatments or it has been considered that the treatment would not be effective due to the size or condition of the area affected. |
| Restricted                                                                 |                                                                      |
| S09.1, S09.2, S09.3, S09.8, S09.9                                         |                                                                      |
| Rosecea                                                                   | Laser Treatment for this condition is not routinely commissioned regardless of age |
| Excluded                                                                  |                                                                      |
| S09.1, S09.2, S09.3, S09.8, S09.9                                         |                                                                      |
| Skin Resurfacing techniques: Dermabrasion, Chemical Peels and Laser treatment | Not routinely commissioned                                            |
| Excluded                                                                  |                                                                      |
| S11.4, S11.8, S11.9                                                       |                                                                      |
| Electrolysis treatment for any condition                                 | Only commissioned to manage misdirected lashes causing ocular irritation and corneal injury which would prevent need for further intervention/surgery. |
| Restricted                                                                 |                                                                      |
### SS3.2 with X85.1 (to identify Botulinum Toxin) and Z49.2

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td>Botox for excessive sweating</td>
<td>Not routinely commissioned.</td>
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</table>

**Excluded**

### X85.1 with Z60.1 (with or without X37.5)

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botox for facial aging or excessive wrinkles</td>
<td>Not routinely commissioned</td>
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</tbody>
</table>

**Excluded**

### Not applicable

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital vascular abnormalities</td>
<td>Not routinely commissioned</td>
</tr>
</tbody>
</table>

**Excluded** – by prior approval only

### S06.1, S06.2, S09.1, S09.2, S10.8, S10.9

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tattoo removal</td>
<td>Not routinely commissioned</td>
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</tbody>
</table>

**Excluded**

### Ear, Nose and Throat

<table>
<thead>
<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>E20.1, E20.8, E20.9</td>
<td>Adenoidectomy</td>
<td>Adenoidectomy will only be funded if undertaken in conjunction with Tonsillectomy and/or Grommets. Please refer to policies for Tonsillectomy and/or Grommets.</td>
<td>Restricted</td>
</tr>
</tbody>
</table>

### F34.1, F34.2, F34.3, F34.4, F34.5, F34.6, F34.7, F34.8, F34.9, F36.1, F36.8, F36.9

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonsillectomy</td>
<td>Restricted</td>
</tr>
</tbody>
</table>

To be undertaken in line with the SIGN 2010 guidance:

- The following are recommended as indications for consideration of tonsillectomy for recurrent acute sore throat in both children and adults:
  - Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year, or
  - Five or more such episodes in each of the preceding two years or
  - Three or more such episodes in each of the preceding three years
  - Sore throats are due to acute tonsillitis
  - The episodes of sore throat are disabling and prevent normal functioning
<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>F34.8</td>
<td>Tonsillo-adenoidectomy for OSA</td>
<td>To be undertaken when diagnosis of SDB in children is confirmed based on history, physical examination, audio/video taping, pulse oximetry, and limited or full-night PSG. AHI&gt;5 indicative diagnosis OSA</td>
<td>restricted</td>
</tr>
<tr>
<td>D15.1, D15.8, D15.9, D20.2, D20.3</td>
<td>Myringotomy with/without grommets for Otitis Media</td>
<td>To be undertaken in line with NICE clinical guideline 60 – Surgical Treatment of Otitis Media with Effusion. Children with persistent bilateral OME documented over a period of 3 months AND • A hearing level in the better ear of 25-30 dBHL OR • The worse ear averaged at 0.5, 1, 2 and 4 kHz (or equivalent</td>
<td>Restricted</td>
</tr>
</tbody>
</table>
Alternative indications for Grommets.

Children should only be considered for grommet insertion if:-

- The child has experienced persistent hearing loss for more than a year with deficit estimated to be more than 25 decibels; OR
- More than 6 episodes of acute otitis media in previous 12 months or
- The child has developmental impairment (e.g. speech/language/cognitive/behavioural) likely to be due to, or exacerbated by, clinically suspected hearing loss.
- Poor progress at school directly attributable to this condition, the child has proven hearing loss, plus a second disability such as Down’s Syndrome or cleft palate.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Commissioning Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32.4, F32.5, F32.6</td>
<td>Surgery for snoring (Uvulopalatopharyngoplasty)</td>
<td>Not routinely commissioned</td>
</tr>
<tr>
<td>F32.8 plus Y02.1 (NICE guidance)</td>
<td>Surgical Treatment for Sleep Apnoea (Obstructive sleep apnoea)</td>
<td>Will be routinely commissioned under the following circumstances:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients have Epworth Sleepiness Score 15-18 or: Patient sleepy in dangerous situations such as driving AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient has significant sleep disordered breathing (as measured during sleep study, usually by the Apnoea/Hypopnoea Index: 15-30/hr. = moderate, &gt;30/hr. = severe AND</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient has already tried CPAP unsuccessfully for 6 months prior to being considered for surgery OR patient has major side effects to CPAP such as significant nose</td>
</tr>
</tbody>
</table>
A clinical decision is that the patient will significantly benefit AND

- The patient is fully informed as to the limited effectiveness of procedures, the lack of long term outcomes and likely adverse effects including pain following surgery.

<table>
<thead>
<tr>
<th>Operations on nose: septralplasty or septorhinoplasty</th>
<th>Septoplasty or septorhinoplasty will be commissioned for the following clinical indications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>E02.3, E02.4, E02.5, E02.6, E07.3 E02.1, E02.2, E02.6, E02.7, E02.8, E02.9</td>
<td>1. Documented continuous nasal airway obstruction that results in nasal breathing associated with a septal/bony deviation of the nose</td>
</tr>
<tr>
<td></td>
<td>or</td>
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<tr>
<td></td>
<td>2. Post-traumatic nasal deformity associated with documented sustained interference of the airway;</td>
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<td></td>
<td>or</td>
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<td></td>
<td>3. As part of the treatment for congenital abnormalities e.g. cleft lip and palate</td>
</tr>
</tbody>
</table>

Restricted
<table>
<thead>
<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inguinal Hernia</td>
<td>Surgical repair will be commissioned when patients meet one of the following criteria:</td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Incarcerated hernia or not amenable to simple reduction</td>
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<td></td>
<td></td>
<td>• Symptomatic inguinal hernia</td>
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<td>• Strangulated hernia (emergency surgery)</td>
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<td></td>
<td></td>
<td>Patients with occult/asymptomatic/minimally symptomatic primary or recurrent inguinal hernias <strong>AND</strong> who have significant co-morbidity (ASA 3 or 4) <strong>AND</strong> who do not want to have surgical repair (after appropriate information provided) <strong>can be managed conservatively at primary care level.</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• All children &lt;18 years with inguinal hernia should be referred to a paediatric surgical provider</td>
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<td></td>
<td>• All hernias in women should be referred urgently to a specialist</td>
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<td></td>
<td></td>
<td>• Patients who are undergoing or plan to undergo peritoneal dialysis should be referred.</td>
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<tr>
<td></td>
<td>Umbilical and Para Umbilical Hernia</td>
<td>Not routinely commissioned unless the following exceptions are met:</td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To avoid incarceration or strangulation of bowel in narrow necked hernia</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patients who are undergoing or plan to undergo peritoneal dialysis.</td>
<td></td>
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<tr>
<td></td>
<td>Incisional Hernia</td>
<td>Not routinely commissioned unless the following exceptions are met:</td>
<td>Restricted</td>
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<tr>
<td></td>
<td></td>
<td>• Patients who are undergoing or plan to undergo</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Commission Status</td>
<td>Notes</td>
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<td>------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>H48.2</td>
<td>Surgery for anal/rectal skin tags</td>
<td>Not routinely commissioned</td>
<td>-</td>
</tr>
<tr>
<td>H22.1, H22.8, H22.9, H25.1, H25.8, H25.9, H28.1, H28.8, H28.9</td>
<td>Rectal bleeding</td>
<td>Investigation should be undertaken in line with RCS guidance.</td>
<td>Restricted</td>
</tr>
<tr>
<td>H55.1</td>
<td>Haemorrhoidectomy</td>
<td>Will be routinely commissioned under the following circumstances:</td>
<td>- Patient has recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Irreducible and large external haemorrhoids</td>
</tr>
<tr>
<td></td>
<td>Endoscopic radiofrequency ablation for gastro Oesophageal Reflux Disease (GORD)</td>
<td>Not routinely commissioned</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Linx Reflux Management system for Gastro Oesophageal Reflux Disease (GORD)</td>
<td>Not routinely commissioned</td>
<td>-</td>
</tr>
<tr>
<td>Procedure</td>
<td>Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Cholecystectomy for Asymptomatic Gallstones is not routinely commissioned</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cholecystectomy for Symptomatic Gallstones is commissioned in line with RCS and NICE guidance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sympathectomy for Raynaud's disease</td>
<td>Not routinely commissioned Excluded</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gynaecology</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility and Assisted Reproduction</td>
<td>Restricted</td>
</tr>
<tr>
<td>Subfertility services</td>
<td>Restricted</td>
</tr>
<tr>
<td>Intra Uterine Contraceptive Devices (IUCDs) including mirena coils</td>
<td>Restricted</td>
</tr>
</tbody>
</table>

**OPCS Codes**
- Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q383
- Q12.1, Q12.2, Q12.3, Q12.4, Q12.8, Q12.9

**Procedures**
- Infertility and Assisted Reproduction
- Subfertility services
- Intra Uterine Contraceptive Devices (IUCDs) including mirena coils

**Thresholds**
- Insertion, removal and checks of IUCDs should only be undertaken within primary care. It is not commissioned as a stand-alone secondary care service.
- Patients requiring a fitting within secondary care for clinical reasons where a fitting in primary care is not possible.
- Removals of lost or displaced IUCDs will be commissioned within secondary care where circumstances dictate that this cannot be managed within primary care and the fitting is not for contraceptive reasons alone.
- IUCDs fitted as a secondary procedure/OPCS code will be commissioned within secondary care
<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Commission Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>P26.2, P26.3</td>
<td>Vaginal Ring Pessaries</td>
<td>Insertion and removal of vaginal ring pessaries will only be commissioned within primary care. First fitting will be commissioned as part of a first outpatient appointment where clinically necessary.</td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td>Vaginal Shelf Pessaries</td>
<td>Insertion and removal of shelf pessaries will be commissioned within secondary care but only within an outpatient setting. The original shelf pessary plus three replacements will be routinely commissioned.</td>
<td>Restricted</td>
</tr>
<tr>
<td>Q18.8, Q18.9</td>
<td>Hysteroscopy</td>
<td>This procedure will be routinely commissioned within an outpatient setting</td>
<td>Restricted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment carried out within an inpatient or daycase setting is not routinely commissioned</td>
<td></td>
</tr>
<tr>
<td>Q10.1, Q10.3, Q10.8, Q10.9</td>
<td>Dilatation and curettage (D&amp;C) in women under 40 for Menorrhagia</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
</tbody>
</table>
| Q07.2, Q07.4, Q07.8, Q07.9, Q08.2, Q08.8, Q08.9| Hysterectomy for menorrhagia                   | Will be routinely commissioned under the following circumstances:  
  - There has been an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) and it has failed to relieve symptoms unless it is medically inappropriate, or contra-indicated. AND  
  - At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Experience (NICE) guidelines:  
    - Non-steroidal anti-inflammatory agents  
    - Tranexamic acid  
    - Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue) AND  
    - Surgical treatments such as endometrial ablation or myomectomy | Restricted|
have failed to relieve symptoms, or are not appropriate, or are contra-indicated

 Pelvic organ prolapse

Surgical repair will only be commissioned when **one** of the following criteria is met:

1. Presence of both pelvic organ prolapse AND urinary or faecal incontinence.
2. Trial of a pessary has either failed to satisfactorily relieve symptoms, OR is unacceptable to patient with a symptomatic pelvic organ prolapse.

<table>
<thead>
<tr>
<th>Obstetrics</th>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R42.1, R42.2</td>
<td>Routine Doppler ultrasound of umbilical and uterine artery in low risk pregnancies</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
<tr>
<td></td>
<td>R17.1, R17.2, R17.8, R17.9</td>
<td>A planned Caesarean Section should NOT be routinely offered to women with:</td>
<td></td>
<td>Excluded</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• With an uncomplicated twin pregnancy at term where the presentation of the first twin is cephalic.</td>
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<td></td>
<td></td>
<td></td>
<td>• With a 'small for gestational age' baby.</td>
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<tr>
<td></td>
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<td></td>
<td>• On the grounds of HIV status to prevent mother-to-child transmission of HIV to:</td>
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<tr>
<td></td>
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<td></td>
<td>o women on highly active anti-retroviral therapy (HAART) with a viral load of less than 400 copies per ml or;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>o women on any anti-retroviral therapy with a viral load of less than 50 copies per ml.</td>
<td></td>
</tr>
</tbody>
</table>
A planned Caesarean Section should be offered to women with:

- With a singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful,
- In twin pregnancies where the first twin is breach
- A placenta that partly or completely covers the internal cervical os (minor or major placenta praevia)
- A previous caesarean section where it is clinically indicated
- With injury/tears to the vagina
- With orthopaedic anomalies impeding the patient’s ability of having a vaginal delivery
- In patients with HIV who:
  - are not receiving any anti-retroviral therapy or
  - are receiving any anti-retroviral therapy and have a viral load of 400 copies per ml or more.
- With both hepatitis C virus and HIV
- With primary genital herpes simplex virus (HSV) infection occurring in the third trimester of pregnancy

Pregnant women who may require a planned caesarean section should have consultant involvement in the decision-making process.

### Ophthalmology

<table>
<thead>
<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>C13.1, C31.2, C31.3, C31.4, C31.8, C13.9</td>
<td>Blepharoplasty</td>
<td></td>
<td>Restricted</td>
</tr>
</tbody>
</table>
Blepharoplasty shall be routinely commissioned only for upper lids in the presence of:

- **visual field impairment** (reducing visual field to 120° laterally and 40° vertically)
- **Severe congenital ptosis**

This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Note: Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction.

Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and not for cosmetic reasons.

The following procedures will not be funded:

- Surgery for cosmetic reasons
- Surgery for cyst of moll
- Surgery for cyst of zeis
- Removal of eyelid papillomas or skin tags
- Surgery for pingueculum
- Excision of other lid lumps

<table>
<thead>
<tr>
<th>C44.2, C44.4, C44.5, C46.1</th>
<th>Laser Treatment for myopia (short sightedness)</th>
<th>Not routinely commissioned</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Screening for diabetic retinopathy by consultant ophthalmologists</td>
<td>Not routinely commissioned</td>
<td>Excluded – by prior approval only</td>
</tr>
<tr>
<td>Not applicable</td>
<td>Screening for glaucoma by consultant ophthalmologists</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
</tbody>
</table>
| C71.1, C71.2, C71.3, C71.8, C71.9, C72.1, C72.2, C72.3, C72.8, C72.9, C74.1, C74.2, C74.3, C74.8, C74.0, C75.1, C75.2, C75.3, C75.8, C75.9 | Cataract Surgery | The CCG will fund this treatment if the patient meets the following eligibility criteria for each eye:

* The patient should have sufficient cataract to account for the visual symptoms (6/9 or worse)
  [US 20/30 or worse
  Decimal 0.66 or worse
  LogMar 0.18 or worse
  VAS 91 or worse]

AND The patient’s lifestyle is affected:
- Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc.
- Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground.
- Ability to work, give care or live independently is affected.

This information, together with a report from a recent sight test, should form the minimum data on the referral form.

AND/OR
Other indications for cataract surgery include facilitating treatment for one or more of the following:
- Monitoring posterior segment disease e.g. diabetic retinopathy
- Correcting anisometropia
- Patient with Glaucoma who require cataracts surgery to contract intraocular pressure.

Patients with single sight (monocular vision)
The indications for cataract surgery in patients with monocular vision and those with severe reduction in one eye e.g. dense amblyopia, are the same as for patients with binocular vision, but the ophthalmologist should explain the possibility of total blindness if severe complications occur. | Restricted |
### Implantable Intraocular Lens Systems for Age Related Macular Degeneration

Not routinely commissioned | Excluded

### Respiratory

<table>
<thead>
<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>Non-surgical treatment for sleep apnoea (Obstructive sleep apnoea)</td>
<td>Will be routinely commissioned in line with the commissioning policy for the sleep service</td>
<td>Restricted</td>
</tr>
<tr>
<td>U06.1</td>
<td>Sinus X ray</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
</tbody>
</table>

### Trauma and Orthopaedics

<table>
<thead>
<tr>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>W37.1, W37.2, W37.8, W37.9, W38.1, W38.2, W38.8, W38.9, W39.1, W39.2, W39.8, W39.9 W40.1, W40.2, W40.8, W40.9, W41.1, W41.2, W41.8, W41.9, W42.1, W42.2, W42.8, W42.9</td>
<td>Hip and Knee Replacement</td>
<td>Patients will be referred for surgery only through the interface musculoskeletal service. The CCG will fund this treatment if the patient meets one or more of the following criteria: The patient has a BMI less than or equal to 35 supported by a primary care referral. <strong>AND</strong> Conservative means (e.g. Analgesics, NSAIDS, physiotherapy, advice on walking aids, home adaptations, curtailment of inappropriate activities and general counselling as regards to the potential benefits of joint replacement) have failed to alleviate the patients pain and disability <strong>AND</strong> Pain and disability should be sufficiently significant to interfere with the patients’ daily life and or ability to sleep/patients whose pain is so severe <strong>AND</strong></td>
<td>Restricted</td>
</tr>
</tbody>
</table>
Patient must accept and want surgery as the rehabilitation process after surgery can be a demanding time and requires commitment.

**OR**

**The patient has a BMI less than or equal 35** and the destruction of their joint is of such severity that delaying surgical correction would increase technical difficulty of the procedure.

Patients with a BMI of 35 or more will be actively supported to engage with local weight management programmes to reduce their BMI.

<table>
<thead>
<tr>
<th>Not applicable</th>
<th>Bespoke Knee Prosthetic</th>
<th>Not routinely commissioned</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>No directly linked OPCS code for endoscopic decompression</td>
<td>Endoscopic Lumber decompression</td>
<td>Not routinely commissioned</td>
<td>By prior approval only</td>
</tr>
<tr>
<td>A65.1, A65.9</td>
<td>Carpal Tunnel Syndrome</td>
<td>All patients referred into secondary care must have been through the MSK service for to optimise access to conservative treatment.</td>
<td>Restricted</td>
</tr>
</tbody>
</table>

The NCL CCGs will fund carpal tunnel surgery where:

1. Patient has acute, severe symptoms that persist for more than three months after conservative therapy with either local corticosteroid injection and/or nocturnal splinting

**OR**

2. Mild to moderate symptoms persist for at least four months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least eight weeks)

**OR**

3. There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar
4. Severe symptoms significantly interfering with daily activities and sleep which have been assessed.

| T59.1, T59.2, T59.3, T59.4, T59.8, T59.9, T60.1, T60.2, T60.3, T60.4, T60.8, T60.9 | Surgical removal of ganglion on wrist/feet | Will be routinely commissioned where there is evidence of neurovascular compromise. | Restricted |
| Surgical removal of seed ganglia at base of digits | Will be routinely commissioned where patients can demonstrate significant pain supported by a clinical decision that removal is required | Restricted |
| Surgical Removal of mucoid cysts at DIP joint | Will be routinely commissioned where nail growth is disturbed and the cysts are prone to discharge. | Restricted |

<p>| TS2.1, TS2.2, TS2.5, TS2.6, T54.1 | Dupuytren’s Disease – palmar fasciectomy | Surgery will be routinely commissioned where Patients have been through the MSK service AND function is impaired, contracture is progressing, or severe deformity is disabling. if the MCP joint contracture reaches 30 degrees or if PIP joint contracture occurs at any degree. The Hueston tabletop test is a good indication for referral to the MSK service. | Restricted |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Criteria</th>
<th>Commission Status</th>
</tr>
</thead>
</table>
| T69.1, T69.2, T69.8, T69.9, T70.1, T70.2, T71.8, T71.9, T72.3, T72.8, T72.9 | Trigger Finger – surgical treatment | Surgery will be routinely commissioned where:  
• There has been failure to respond to conservative measures such as a hydrocortisone injection  
OR  
• The patient has a fixed deformity that is non-correctable | Restricted |
| V38.2, V38.3, V38.4, V38.8, V38.9, V39.3, V39.4, V39.5, V39.6, V39.7 | Spinal Fusion | Will be routinely commissioned under the following circumstances:  
• Where the patient has unequivocal root compression  
• Where the patient has spinal stenosis  
• Where there is spinal instability  
• Where there has been a failure of an adequate conservative trial of over 6 month duration. | Restricted |
| A52.1, A52.2, (A52.8, A52.9 with Z06.3), (X30.6, X30.8, or X30.9 with Z06.3) V54.4 | Back pain  
Spinal epidural injections/therapeutic lumbar epidural injection/radiofrequency denervation/facet joint injections | • Epidural injections, either sacral or interlaminar and nerve root injections are not of value for patients with non-specific low back pain - **Not routinely commissioned**  
Therapeutic facet joint intra-articular injections for non-specific back pain are only to be done in the context of either special arrangements for clinical governance and clinical audit or research – **Not routinely commissioned**  
**Chronic back pain**  
Interventional pain therapies should be part of comprehensive treatment by a multidisciplinary team (MDT) where there should be arrangements for on-going assessment following a trial of treatment to show evidence of response.  
Facet Joint Injections & Medial Branch Block or Spinal/Epidural injections should be part of comprehensive treatment by an MDT.  
• Diagnostic Facet Joint injections are only commissioned for the assessment of patients being considered for surgical management of chronic back pain performed by a clinician trained in back pain | Restricted |
assessment, diagnosis and management as part of an MDT process. -OR as a screening tool to improve specificity if radiofrequency denervation is being considered.

Therapeutic facet joint injections are only commissioned for one injection if a patient meets ALL of the following criteria;
• Pain lasting more than or equal to 12 months AND
• Failed conservative treatment including maximum oral and topical analgesia AND
• A Clinician trained in back pain assessment, diagnosis and management has assessed the patient and considers it would enable mobilisation and participation in rehabilitation as part of an MDT approach AND
• Documented use of a standardised Pain and Quality Of Life (QOL) tool before and after procedure.
Further injections will only be funded as part of a pain management pathway if significant improvement is seen on PAIN score & QOL score. In such case no more than TWO injection sessions will be funded per year.

Radiofrequency & Endothermal Ablation for Chronic Back Pain - Denervation of Lumbar Spine:

Radiofrequency denervation should be part of comprehensive treatment by a multidisciplinary team. There should be ongoing assessment following a trial of treatment to show evidence of response. Two diagnostic Medial Branch Block will be funded prior to denervation techniques. Radiofrequency denervation should only be undertaken after a successful - >80% improvement on validated scoring tools (pain VAS
and ODI) - set of diagnostic local anaesthetic blocks and as part of a MDT managed programme of care.
Repeat radiofrequency procedure may only be offered to those patients with a previous successful response (as above) if the benefits of the procedure lasted for at least 6 months.
Repeat radiofrequency denervation is only permitted at a minimum interval of 9 months.

Epidural injections:
The first epidural steroid injection will be funded if the patient meets ALL of the criteria in Box A OR Box B.

**Box A**
Leg pain is rated at a level of ≥6 on a scale of 0 to 10. The level of pain must be assessed using a validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score);

AND
Pain causes significant impact on daily functioning which has been assessed using a validated tool (e.g. a score of ≥6 using the Brief Pain Inventory, >40% using the Oswestry Disability Index);

AND
Pain has not responded to physiotherapy interventions or appropriate medication.

AND
For leg pain diagnosed as radicular in nature (i.e. related to compression or irritation of spinal nerve roots) based on clinical examination and best available imaging (ideally MRI if not
contraindicated);  

AND  
Leg pain is worse than any associated back pain;  

AND  
Pain has lasted for more than 6 months  

BOX B  
For leg pain diagnosed as radicular in nature (i.e. related to compression or irritation of spinal nerve roots) based on clinical examination and best available imaging (ideally MRI if not contraindicated);  

AND  
Leg pain is rated at a level of ≥9 on a scale of 0 to 10 sufficient to mandate emergency hospital admission OR leg pain is ≥7 on a scale of 0 to 10 and coexistent disability prevents the patient being managed in the home environment. The level of pain must be assessed using a validated tool (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score)  

Repeat Epidural Injections  
Repeat epidural steroid injections at a minimum interval of 6 months are permitted for the management of persistent radicular or nerve root pain in patients when ALL of the following criteria are met:  

Patient has met policy criteria for a first epidural steroid injection (see 5.52);
AND
Pain has returned following previous epidural steroid injection;

AND
Previous epidural steroid injection gave ≥50% reduction in pain and associated disability as assessed by validated tools (e.g. McGill Pain Questionnaire, Pain Visual Analogue Score, Brief Pain Inventory, Oswestry Disability Index) for at least 6 months;

AND
All other available conservative pain management options (e.g. physiotherapy interventions, medication) have been exhausted;

AND
Patient either is not a suitable candidate for surgical intervention to decompress the nerve roots or does not want surgery.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Commission Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>W87.1, W87.8, W87.9</td>
<td>Diagnostic arthroscopy of the knee</td>
<td>Restricted</td>
</tr>
<tr>
<td>W82.2, W82.3, W83.3, W83.6, W85.2, W85.8, W85.9</td>
<td>Therapeutic arthroscopy of the knee</td>
<td>Excluded</td>
</tr>
</tbody>
</table>
Plain x-rays are restricted in line with the criteria set out in NICE clinical guideline 88 and the Royal College of Radiologists guidelines.

No not offer x-ray of the lumbar spine for the management of non-specific low back pain

MRI scans should only be offered in the context of a referral for an opinion on spinal fusion or if one of the following diagnoses are suspected:

- spinal tumour
- infection
- fracture
- Cauda Equina Syndrome
- Ankylosing Spondylitis or other
- Spinal stenosis or Root nerve compression

All other spinal referrals are expected to be referred though the MSK service where full work up will be undertaken including MRI where appropriate.

Not commissioned when a patient could be a candidate for joint replacement in the next 6-12 months except as a diagnostic tool prior to joint replacement in order to confirm the joint as the major source of pain/symptoms and for patients who are currently unfit or unsuitable for surgery or who do not wish to proceed to surgery.

Not commissioned in a sterile theatre unless x-ray screening or general anaesthesia is required and where they are performed with other procedures i.e. nerve blocks or manipulation.
<table>
<thead>
<tr>
<th>Not applicable – Commissioning Statement</th>
<th>Persistent non-specific low back pain</th>
<th>NICE guidance recommends that the following treatments should not be offered for the early management of persistent low back pain:</th>
<th>Excluded – by prior approval only</th>
</tr>
</thead>
<tbody>
<tr>
<td>O29.1, (W08.5 or 08.9 or 57.2 with Z81.2)</td>
<td>Excision acromioclavicular joint; Surgical decompression subacromial space</td>
<td>Will be routinely commissioned where there is evidence of a conservative trial or treatment and temporary improvement has been demonstrated using injection surgery</td>
<td>Restricted</td>
</tr>
<tr>
<td>Not applicable</td>
<td>Therapeutic ultrasound in physiotherapy</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
</tr>
<tr>
<td>Not applicable – no OPCS available</td>
<td>Low Intensity Ultrasound (Exogen) for the Healing of Fractures</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
</tr>
<tr>
<td>W85.1 in combination with W31.1</td>
<td>Autologous Chondrocyte Implantation in the Ankle</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
</tr>
<tr>
<td>Not applicable – no OPCS available</td>
<td>Bone Stimulators for Non-Union (LIPUS)</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
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<tr>
<td>Not applicable – no OPCS available</td>
<td>Bone Stimulators for Non-Union (PEMF- Pulsed Electromagnetic Field)</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
</tr>
<tr>
<td>Not applicable – no OPCS available</td>
<td>Modular Rotating Hinge Knee System</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
</tr>
<tr>
<td>Not applicable – no OPCS available</td>
<td>Intramedullary Nail in Lower Limb Length Discrepancy</td>
<td>Not routinely commissioned</td>
<td>Excluded - by prior approval only</td>
</tr>
</tbody>
</table>
| Shoulder surgery | Surgical interventions will not be routinely commissioned except: 1. rotator cuff  
Tendinosis and partial thickness rotator cuff tears may benefit from subacromial steroid injection and supervised exercise. If there is no improvement after 6 months, operative management should be considered.  
• Full thickness tears need early repair, if occurring in those who are active and physiologically young,  
2. frozen shoulder 
surgical treatment is not indicated  
3. glenohumeral instabilities 
Surgical Management for first time anterior shoulder dislocation for |
<table>
<thead>
<tr>
<th>Younger persons may be considered</th>
<th>Recurrent dislocation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Surgical intervention should be considered after the second dislocation.</td>
</tr>
<tr>
<td>Instability</td>
<td></td>
</tr>
<tr>
<td>• Includes anterior, posterior and multidirectional instability, as well as labral injuries</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hallux valgus</th>
<th>The presence of a bunion does not indicate a need for surgery. The decision to refer a patient for surgery should be based on pain, disability, and functional impairment.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bunion surgery will be commissioned when: the patient experiences persistent significant pain and functional impairment that is interfering with the activities of daily living. AND</td>
</tr>
<tr>
<td></td>
<td>all appropriate conservative measures have been tried over a 6 month period and failed to relieve symptoms, including: up to 12 weeks of evidence based non-surgical treatments, i.e.</td>
</tr>
<tr>
<td></td>
<td>• analgesics/painkillers. • bunion pads • footwear modifications</td>
</tr>
<tr>
<td></td>
<td>restricted</td>
</tr>
</tbody>
</table>

41
the patient understands that they will be out of sedentary work for
2-6 weeks and physical work for 2-3 months and they will be unable
to drive for 6-8 weeks, (2 weeks if left side and driving automatic
car)

OR
there is a higher risk of ulceration or other complications, for
example, neuropathy, for patients with diabetes. Such patients
should be referred for an early assessment.
A patient should not be referred for surgery for prophylactic or
cosmetic reasons for asymptomatic bunions.

<table>
<thead>
<tr>
<th>Urology</th>
<th>OPCS Codes</th>
<th>Procedures</th>
<th>Thresholds</th>
<th>Status</th>
</tr>
</thead>
</table>
|          | N30.3      | 5.5.1 Male Circumcision  
Male Circumcision for cosmetic, social, cultural and religious reasons | Not routinely commissioned | Excluded |
|          | N30.3      | Circumcision | Will be routinely commissioned under the following circumstances:  
Patients under 16 years of age  
• Symptomatic phimosis or paraphimosis and recurrent (>3) |         |        |
### Patients over the age of 16

- Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepuceal ring) and paraphimosis (inability to pull forward a retracted foreskin).
- Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin).
- Balanoposthitis (recurrent bacterial infection of the prepuce)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Commission Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q29.1, Q29.2, Q29.8, Q29.9</td>
<td>Reversal of Sterilisation: reversal of vasectomy or reversal of tubal ligation (Male and Female)</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
<tr>
<td>Q30.3, Q30.8, Q30.9, Q37.1, Q37.8, Q37.9, N18.1, N18.2, N18.8, N18.9</td>
<td>Surgery for protatism</td>
<td>Will be routinely commissioned where there is evidence of one of the below:</td>
<td>Restricted</td>
</tr>
<tr>
<td>M67.1, M67.2, M67.3, M67.4, M67.8, M67.9</td>
<td>Drug Treatment for Erectile Dysfunction – injection of therapeutic substance into</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
<tr>
<td>Code</td>
<td>Procedure</td>
<td>Commission Status</td>
<td>Exclusions</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>N29.1, N29.2, N29.8, N29.9</td>
<td>Penile Implants</td>
<td>Not routinely commissioned</td>
<td>Excluded</td>
</tr>
<tr>
<td>N17.1, N17.2, N17.8, N17.9</td>
<td>Vasectomy</td>
<td>Not routinely commissioned within secondary care unless there is a clinical reason why the patient needs a general anaesthetic</td>
<td>Restricted</td>
</tr>
</tbody>
</table>

**Vascular Surgery**

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
<th>Commission Status</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
- Varicose veins which have bled and are at risk of bleeding again  
  OR  
  - A history of varicose ulceration  
  OR  
  - Signs of prolonged venous hypertension (haemadsiderin pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes)  
  OR  
  - Superficial thrombophlebitis in association with varicose veins  
  OR  
  - Significant symptoms attributable to chronic venous insufficiency which are resulting in significant functional impairment. | Restricted |
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Jane Tipping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Head of Strategy, Planning and Performance</td>
</tr>
</tbody>
</table>

REPORTING OFFICER /DIRECTOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Noreen Dowd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Interim Director of Strategy, Planning and Performance</td>
</tr>
</tbody>
</table>

REPORT TO

Stoke-on-Trent CCG Governing Body

TITLE OF REPORT

Stoke-on-Trent and North Staffordshire CCGs’ Five Year Strategy

DATE OF THE MEETING

Tuesday 7th June 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>Planning Committee in April</td>
<td>CCG staff have been involved in providing information for the strategy over the course of its development</td>
</tr>
<tr>
<td>North Staffordshire Governing Body in May</td>
<td></td>
</tr>
</tbody>
</table>

ACTION REQUIRED FROM GOVERNING BOARD

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

RECOMMENDATION

The Stoke-on-Trent Governing Body is asked to consider and approve the Joint Five Year Strategy.

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.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>X</td>
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<tr>
<td>3.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY

The Northern Staffordshire and Stoke-on-Trent Five Year Strategy has been developed to bring together and align the strategic intentions for North Staffs and Stoke-on-Trent CCGs. The document sets out the national strategic aims, as set out in the Five Year Forward View planning guidance published at the beginning of the year.

The strategy also reflects the local issues and priorities:

- Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’;
- Deliver better patient outcomes through effective federated and collaborative arrangements with key partners;
- Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle;
- Reduce health inequalities and inappropriate clinical variations; and
- Achieve all of the above while remaining within financial balance and achieving best value.

The overall approach set out in the document reflects the need to move away from bed based care to community care closely linked to GP Practices, promoting healthier lifestyles and early intervention rather than reacting to the ever rising demand for care and support and working as part of a collaborative system across Staffordshire, engaging with patients and the public to shape services that are needed and deliver improved outcomes.

The local health and care economy have developed a number of Strategies for specific programme areas including Primary Care, Urgent Care, Mental Health and Frail Elderly/Long Term Conditions. These are summarised in Section Six along with a diagram which sets out how they link together or are whole system drivers.

The planning guidance required CCGs to deliver two separate but connected plans:

- A one year organisation based Operational plan
- A Five Year place based Sustainability and Transformation Plan (STP)

The STP will be done on a Staffordshire and Stoke-on-Trent footprint and is being led by the Together We’re Better transformation programme. This plan will include five year financial plans and needs assessments. Our Strategy will form the basis of our contribution to the STP and therefore is limited in its financial and activity planning. It is focussed on the overall clinical model of care, setting out our agreed strategies and the importance of patient/public engagement and the quality and safety of the service we will commission.

SUMMARY OF RISKS RELATING TO THE PROPOSAL

Strategic Risk – the work with Staffordshire may require the re-shaping of existing strategies
Financial Risk - further work is needed to develop more detailed implementation plans to enable the costing of the service changes and the development of a different contracting approach in the form of capitated budgets
Delivery Risk – the delivery of Strategic plans requires consensus of partners and stakeholders. Considerable consultation has been undertaken locally on a number of the strategies but this may not be applicable to the rest of Staffordshire and there may be different responses thus preventing the implementation of the plan.

These issues will be part of the work in the TWB programme in developing the STP by the end of June 2016.

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

The development of implementation plans following on from the STP will identify any implications which will need to be addressed as part of the programme.
<table>
<thead>
<tr>
<th>QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>This work will be part of the TWB programme, building on assessments that have been undertaken within each programme area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation and engagement on the individual Strategies and programmes has been undertaken however it is expected that further work with stakeholders and patients/public will be needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACRONYMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not listed in the report, please list</td>
</tr>
</tbody>
</table>
Northern Staffordshire

Five Year

Strategic Plan
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1. **Foreword from Andrew Bartlam and Marcus Warnes**

This Five year plan is an outcome of the ever closer working across Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups.

Our intentions within this plan are to commission services that are not only innovative and beneficial to patients but fundamentally start with the aspiration of putting patients first.

The increasing demand on services and our providers will make the next five years extremely challenging but we will continue to work closely with colleagues, stakeholders and Local Authorities across the whole of Staffordshire, with the aim of the population receives high quality and cost effective services.

Dr Andrew Bartlam  
Clinical Accountable Officer  
Stoke-on-Trent Clinical Commissioning Group  

Marcus Warnes  
Accountable Officer  
North Staffordshire Clinical Commissioning Group
2. **Executive Summary**

Our Northern Staffordshire strategy reflects the national policy direction laid out in the Five Year Forward View, building a clinically and financially sustainable model which will allow North Staffordshire and Stoke-on-Trent CCGs to deliver the best care for the population we serve. We want to create a ‘whole systems shift’, moving from an economy that is disproportionately dependent on bed based care to a community model that cohesively wraps an integrated workforce around our population to support them to have care closer to their homes.

Our strategy will deliver change so that only those who need an acute intervention will be treated in hospital. We will reinvest funding into developing and resourcing a Multispecialty Community Provider (MCP) model as described in the Five Year Forward View that is adapted to meet local need. We will focus on creating a multidisciplinary, integrated workforce, strengthened by specialist consultant support, underpinned by a community service specification based on outcomes and commissioned on a capitated budget basis.

The opportunities derived from delegated commissioning of primary care and wider public sector commissioning of community and social care provide us with timely mechanisms for delivering the whole systems shift towards community-based care improving the patient experience and releasing capacity in secondary care to ensure that those who need treatment receive care at the right time, in the right place and constitutional standards are delivered.

We will continue to build on our achievements delivered through the Staffordshire Prioritisation Programme which aims to provide a validated financial view that will support commissioning of priority services and will allow categorisation of spend so that population-based, capitated budgets are developed. This will be further supported by the use of the “Right Care” national tool which enables CCGs to benchmark their expenditure and outcomes with other CCGs and gives a focus for pathway and service redesign.

**While ensuring that everything we do is clinically driven, we will:**
- Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’;
- Deliver better patient outcomes through effective, federated and collaborative arrangements with key partners;
- Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle;
- Reduce health inequalities and inappropriate clinical variations; and
- Achieve all of the above while remaining within financial balance and achieving best value.
This document sets out our vision, principles and strategic aims and describes how we will meet the key commissioning objectives of the Staffordshire Sustainability and Transformation Plan (STP), support the aims of the Together We’re Better transformation programme whilst continuing to provide high quality clinical care appropriate to local need.

3. Vision, Principles and Strategic Aims

3.1 Guiding principle

Across Northern Staffordshire, we are working to create a clinically and financially sustainable health and care system that provides the highest quality services and delivers the best value for money for our population.

3.2 Overarching Vision

We will work with health and social care partners across Northern Staffordshire to reduce preventable illness. We will support and empower people to look after themselves in their own homes for as long as possible. For those who require care, we will deliver integrated, seven-day services to treat the ‘whole person’ at the most appropriate time, in the most appropriate setting.

3.3 Strategic aims:

- Improve health outcomes
- Improve the quality and safety of care
- Reduce health inequalities
- Improve access to services with care closer to home.

3.4 Looking to the future, in five years we will shape services that deliver:

- A much greater focus on prevention, early intervention and improved wellbeing
- Far greater control for patients when they do need health services.
- New models of care that break down barriers and recognise our local needs. These models will include options around:
  - Multispecialty Community Providers (MCP)
  - Primary and acute care systems (PACS)
  - Integrated urgent and emergency care systems.
- Better use of our existing infrastructure, including provider development and market management.
- Integrated health and social care services where appropriate.
- Support for people to be cared for in or as near to their homes as possible.
- Mental health support and parity of esteem throughout our services.
- A well-managed system that is efficient and effective, with all services benchmarked to ensure best practice.

Our aspirations are to establish a well-functioning MCP model over the next five years, as set out in the Model of Care table.
<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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice Level</strong></td>
<td>Core GP workforce&lt;br&gt;GP Practices operate as individual entities but work together in a geographically defined locality</td>
<td>GP has a direct relationship with the patient and coordinates care on behalf of the patient.&lt;br&gt;Access is personalised and responds to all patients needs at different times.&lt;br&gt;Access to 7 day services is through a hub and spoke approach</td>
<td>Sustainability&lt;br&gt;Variation in service delivery / performance by practice.&lt;br&gt;Access to services and appointments is varied by practice.&lt;br&gt;Focus is on treatment with limited early intervention and prevention.&lt;br&gt;Outcomes relate to individual patient rather than to improving the health of the population.&lt;br&gt;Other services are commissioned centrally with GPs sharing access to a pot of services</td>
<td>Investment&lt;br&gt;IT solution to enable sharing of records across primary care.&lt;br&gt;Workforce plan for medical staff</td>
</tr>
<tr>
<td><strong>Locality</strong></td>
<td>GP Practices work together to deliver one agreed specification but retain own identity within the locality.&lt;br&gt;Practices share access to other services.&lt;br&gt;Back office functions are rationalised.</td>
<td>Community services are aligned to identified local need.&lt;br&gt;Efficiencies achieved by contracting for back office services and sharing of other resources.&lt;br&gt;All patients within the locality have equitable access to appointments and services.&lt;br&gt;Access to 7 day services is through a hub and spoke approach which could be locality based</td>
<td>Variation between localities.&lt;br&gt;Acute services continue to be contracted centrally resulting in inefficiencies in pathways.&lt;br&gt;Social care is commissioned separately so health and wellbeing not necessarily aligned</td>
<td>Investment&lt;br&gt;IT solution to enable sharing of records across primary and community care.&lt;br&gt;Workforce plan for all members of primary care team</td>
</tr>
<tr>
<td>At Scale Levels</td>
<td>Description of Model of Care</td>
<td>Advantages</td>
<td>Disadvantages</td>
<td>Enablers Required to Deliver Outcomes</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------</td>
<td>------------</td>
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<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Commissioned Locality</strong></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><strong>MCP Model</strong></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 pathway. 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>
4. National Strategic Context

In December 2015, the NHS published “Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21. It requires the NHS to produce two separate but connected plans:

- A five year Sustainability and Transformation Plan (STP) submitted June 2016, reflecting a system wide approach to defining and achieving key strategic outcomes, aligned to a place-based financial model and driving the Five Year forward view; (covering the period October 2016 – March 2021). The STP will deliver the transformation agenda and be the mechanism for accessing central transformation funding.
- A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP, submitted in April 2016.

The STP for Northern Staffordshire will cover the Staffordshire and Stoke-on-Trent area and is aligned to the Together We’re Better (TWB) Transformation programme. The TWB board will oversee delivery of the STP and our Strategic plan will support the work of the board whilst delivering localised care.

**The Staffordshire and Stoke-on-Trent footprint has been approved:**

- The Together We’re Better Transformation Board will lead this work
- Footprints are not statutory bodies – they are vehicles for collaboration
- Planning will need to take place at different levels – subsidiarity is a key principle so we need to develop our own thinking and plans to contribute to the final STP

**A good STP will focus on big questions and early action, it is expected that:**

- We will take some early actions and not wait for the plan to be completed
- The STP as an “umbrella “ plan can be a way of making sense of competing priorities and should focus on populations not institutions or organisational form
- There will be technical challenges such as cross-footprint flows and boundaries and non-technical challenges in terms of building relationships, focussing on the long term and moving quickly whilst ensuring buy-in

4.1 The Five Year Forward View set out a number of key strategic drivers:

The Five Year Forward View set out a number of key strategic drivers:
Radical upgrade in prevention and Public Health National Programmes of work to reduce obesity, smoking and other major health risks.
- Development and support of new workplace incentives to promote employee health and cut sickness-related unemployment.
- Support stronger public health-related powers for local government.

When people do need health services, patients will have greater control of their own care
- Shared budgets combining health and social care, better support for unpaid carers, improved partnerships with voluntary organisations and local communities.
4.2 Integrated models of care

– Improved communication and integrated working across the system between physical and mental health and between health and social care.

– Care delivered locally but with some services in specialist centres organised to support people with multiple health conditions, not just single diseases.

5. Local Strategic Context

Delivering the key strategic objectives is a vital part of our plan but in achieving these improvements in healthcare we need to shape models of care to address the needs of our local population.

5.1 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>
<th>North Staffordshire CCG</th>
<th>Stoke –on-Trent CCG</th>
</tr>
</thead>
<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>
</tr>
<tr>
<td></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>
</tr>
<tr>
<td></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.</td>
</tr>
<tr>
<td></td>
<td>There is gap in life expectancy of nearly 10 years between people living in our most affluent and disadvantaged localities</td>
</tr>
<tr>
<td></td>
<td>Both men and women across the two CCGs spend more time in poor health than average</td>
</tr>
</tbody>
</table>

The Health Outcomes Framework sets out our aspirations for improving health outcomes over the next five years.
### HEALTH OUTCOMES FRAMEWORK

#### OUTCOMES

- Increase life expectancy and reduce inequality
- Reduce premature deaths from cancer
- Reduce premature deaths from respiratory conditions
- Reduce inappropriate admissions for frail elderly
- Improve health-related quality of life for people with long-term conditions
- Support frail elderly residents and provide Frailty Assessment Services
- Improve access to mental health services
- Reduce childhood obesity
- Help smokers to quit

#### END STATE AMBITION

- People on average are living at least a year longer than at present
- The average gain in life expectancy of over 7 years has reduced by at least 5% per annum
- Reduction in excess 10 years in life expectancy between our most affluent and deprived population
- More preventable conditions are diagnosed and managed earlier, deaths from cancer reduce by 45% in 10 years and deaths from respiratory conditions from 31% to 20% by 2027
- More people with long-term conditions feel supported to manage their condition
- More people identified by GPs and specialists as frail are referred to Frailty Assessment Services
- More people receive their care through the use of assistive technology

#### All schemes contribute to the end state

- **High volume users scheme**
  - Health checks
  - Cancer awareness
  - Reducing childhood obesity
  - Smoking cessation schemes
  - Universal and targeted physical activity, community nutrition
- **Development of new models of community care – multi-disciplinary providers**
  - Intermediate care schemes
  - Intermediate care assessment (CGA) frailty tools
  - CGA Frailty Tool
  - Frailty passport
  - Life-long learning
  - Single specialist LTC team providing for holistic assessment of frailty

#### Key Performance Indicators

- **Improved access and outcomes in Mental Health and Dementia**
- Less than 17.5% children overweight at end of yr 6
- More people dying in their place of choice
- Where people require a length of stay, reduce increase in people being cared for at home – reduction in NEL and A&E admissions
- 50% people admitted with LTC are screened by specialist team within 6 weeks

#### Key Performance Indicators

- **Reduce inappropriate admissions for frail elderly**
- **Improve health-related quality of life for people with long-term conditions**
- **Support frail elderly residents with proactive coordinated care plans**
- **Reduce inappropriate admissions for frail elderly**
- **Reduce inappropriate lengths of stay**

#### Key Performance Indicators

- **Frail and complex elderly and other people with high dependency needs are risk stratified and proactively managed at home**
- **People’s access to and flow through care pathways is better coordinated and managed**
- Care across all sectors is integrated and seamless
- More people receive their care through the use of assistive technology

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#### Key Performance Indicators

- **95% patients have a diagnosis appointment within 12 weeks of referral onto a service**
- **78.5% dementia diagnosis by March 2017**
- **75% referrals into IAPT service treated within 6 weeks**
- **95% referrals into IAPT service treated within 18 weeks**
5.2 Our Local Health Economy Drivers

Given the level of deprivation, the ageing population and the mix of rural and inner city areas, Northern Staffordshire is recognised as having a complex local health system. In addition the demands placed on health and social care providers’ means that the system is recognised as a ‘challenged economy’. In addition we have some significant workforce issues relating to recruitment and retention, with more GPs and nurses who are nearing retirement than entering the professions. These issues will affect the clinical sustainability of our economy.

High levels of demand and a reliance on an acute model of care means that there are issues with achieving and maintaining performance across some NHS Constitution targets, leading to an associated detrimental impact on the quality of care, an above average number of older people dying in a hospital setting for example.

In addition to the challenges described above, we know that we have to face these challenges in light of a forecast financial deficit. Therefore a key aim of our agreed models of care must be to reduce the overall cost of care by delivering more, high quality services in the community and our key principles have been developed accordingly.

We have therefore embarked on a county-wide transformation programme called Together We’re Better. Led by local senior leadership, this will support a coherent plan for services across Staffordshire as a whole. The programme has developed and agreed a Case for Change, which sets out the way transformation will be taken forward and the agreed strategic principles of care.

5.3 Principles of care

People have the right to a high-quality health and care service when they really need it. With rights, however, come responsibilities. We need to work with our local communities to help people help themselves. This is what most people tell us they want. We need to work with people to redesign the system. To do this, we will adopt the following principles of care:

Make prevention everyone’s business

- A universally adopted wellbeing strategy will target the major wider determinants of health - financial status, employment and work environment, education and housing
- A universally adopted prevention strategy will influence the choices which people make, which lead to ‘risk factors’ for disease - tobacco, high blood pressure, alcohol, cholesterol and obesity
• Improve our information and support to families so we support good parenting and our children get the best start in life.

Maximise independent living and ‘self-care’

• Enable patients and users to access accurate and local advice, guidance and information
• Detect problems earlier, involve people in their own ‘care plans’ and use technology to monitor conditions
• Adopt an ‘asset-based’ approach and local community delivery to harness the skills, energy, compassion and resources that residents and neighbourhoods already have

Provide more care in people’s homes and communities and less in hospital beds

• Enable primary care, social care and community services, including mental health and ‘third sector’ services, to operate in joined-up teams to support defined communities of 30-50,000 people. Clusters of GP practices could become hubs for this enhanced community care.
• Provide more hospital services in community settings
• Reduce the proportion of the health and care budget spent on hospital-based care.
• Integrate NHS and local authority care budgets.

Target proactive care for people at most risk of hospital admission and needing ‘high intensity’ care

• Use ‘risk stratification’ tools to identify people who would benefit from more services and help in the community to keep them well
• Employ multi-disciplinary teams to provide holistic care
• Develop robust ‘pathways of care’ for people at most risk, who require more care and who are recovering – for example, the frail and elderly, people with dementia or at the end of their lives
• Use digital technology at scale to change how we monitor people’s progress so they are better able to get on with their lives

Respond faster to problems as they arise

• Improve access to advice, guidance and help through a digital platform Improve and rationalise access to diagnostic tests and ensure they are available in the right place and not unnecessarily duplicated or repeated
• Use remote monitoring to detect exacerbation early in people at high risk
• Ensure people who have care plans can access their ‘key worker’ when they are concerned
Reduce the time people stay in hospital for and discharge them safely

- Maximise the number of people who can be assessed, treated and discharged without staying overnight in hospital
- Begin discharge planning on the day of admission
- Provide early, supported discharge through partnership, collaboration or integration of hospital and community services
- Maintain existing community support and care packages throughout short admissions to hospital.

Make ‘patient journeys’ across different sorts of care more joined-up and seamless, without repetition or duplication

- Design integrated care which ‘follows the patient’ across organisational boundaries
- Provide a single electronic record for every person that uses services which can be shared in every care setting and used to co-ordinate care properly
- Redesign the model of delivery for planned care with less duplication and variation in clinical practice and closer working in networks across hospitals
- Enable citizens to manage their own budgets for health and care
- Rationalise the specialised care offered by regional units to ensure a good balance between the quality of care provided and inconvenience to patients and service users. Offer care closer to home if appropriate or feasible.

Make Staffordshire and Stoke-on-Trent a great place to work with vibrant and sustainable health and social care organisations

- Provide a single, integrated financial model that shows cost by citizen across all aspects of health and care, and which allows funding to follow the patient across all care settings
- Review the way acute hospital services are organised, to see where improvements can be made in productivity, efficiency and care quality. This may involve collaboration between providers, concentrating services on fewer hospital sites or dispersing services to a wider range of community locations
- Enhance and define the partnership role of the ‘third sector’
- Review the role of community hospitals, with enhanced community care and fewer people spending less time in hospital, there is an opportunity to redefine their form and function
- Recognise that the health and care system employs lots of people locally and we have a significant role in broader regeneration and prosperity.

Prioritise investment in areas which bring maximum benefit to patients

- Ensure we don’t spend money on services which do not deliver better outcomes.
5.4 Improving quality

Quality is our guiding principle and underpins everything we do. By quality care, we mean that the health services we commission for the people of North Staffordshire will be safe; the interventions will be clinically effective and deliver a positive outcome, and the patient experience will be a good one. Our focus on quality will realise a quality premium – by doing things right the first time, we will secure best value from the resources we invest and achieve better outcomes for our patients.

Our Quality Strategy provides the basis for our continued focus on the quality and safety of the services that we commission. We believe that it will serve to strengthen our assertion that quality is our organising principle and provides the basis for the way we do business and influences our organisational culture. To achieve these goals, North Staffordshire and Stoke-on-Trent CCGs are committed to working with, system wide stakeholders to improve people’s experience of health care and improve wellbeing.

We recognise that we can’t deliver our quality improvement ambitions on our own and that patient journeys often involve elements of primary, secondary and specialist care. We know that large sections of our population rely on health and social care services working together to ensure their safety and quality of life, achieving the outcomes described in the NHS Outcomes Framework.

The CCG has well established good working relationships with our local providers and partners and we will work proactively to further develop our Quality Improvement Framework to ensure our vision for high quality patient care is delivered across the system.

To achieve this aim we will:

- Develop a joint Quality Strategy which will be ratified in the spring 2016. The strategy will include a work plan and quality assurance framework which will be used to support quality improvement initiatives focusing on the reduction of harm, transformation of care systems and utilisation of evidence based improvement methodologies, all of which will be monitored by the Joint Quality Committee, a sub-committee of the Governing Board/Body.

- Work with the providers utilising Quality Incentives where available to support our providers to improve their patient’s experience of care and their overall inspection rating to achieve good/outstanding.

- Ensure we listen to our patients, public and other key stakeholders and clinicians to ensure learning is captured and used to improve the commissioning of patient services.
• We will continue to engage with our providers on their mortality assurance processes and we will support their participation in the annual publication of avoidable mortality rates.

• We will support the delivery of the Children and Adult Safeguarding Board’s strategic objectives and plans in order to ensure the safety of the most vulnerable members of our population across Northern Staffordshire.

**Right Care**

Right Care is a national programme that is key to delivering the national Five Year Forward View. It recognizes that change has to happen at a local level and health economies should be comparing their outcomes and spend against their peers with the aim of constantly improving the quality and cost-effectiveness of care. It highlights areas where the economy is different and thus presents an opportunity to explore potential for improvements. The process to the use Right Care to:

• Identify the variations
• Understand the potential for improvements
• Gain consensus
• Design the optimal pathway
• Implement the improvements and achieve better health outcomes

It is about quality care leading to better health outcomes, making the best use of resources. It will be a key work stream for the CCGs and will be led by the Director of Nursing and Quality. Initial work has already begun, starting with the common issues across the two CCGs, namely Neurology, Respiratory and Trauma and injuries.
Stoke-on-Trent CCG

Headline opportunity areas for your health economy

Spend & Outcomes | Outcomes | Spend
---|---|---
Neurological | Neurological | Respiratory
Gastro-intestinal | Gastro-intestinal | Neurological
Trauma and Injuries | Trauma and Injuries | Endocrine
Genito Urinary | Maternity | Circulation
Mental Health

A note on the methodology used to calculate your headline opportunities is available on our website: https://www.england.nhs.uk/comm-for-value/

North Staffs CCG

Headline opportunity areas for your health economy

Spend & Outcomes | Outcomes | Spend
---|---|---
Respiratory | Trauma and Injuries | Respiratory
Trauma and Injuries | Maternity | Circulation
Neurological | Neurological | Gastro-intestinal
Circulation | Respiratory | Endocrine
Endocrine

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5.5 What our patients say

In order to put the patient first we must listen to the voices of our patients. We continue to engage with patients, public and other stakeholders and key themes that have emerged from our recent engagement events in the past 12 months are

- There is often a lack of communication between services
- Patients report often having to tell their stories on multiple occasions
- Patients’ records are often not available when attending consultations outside primary care
- Care is disjointed and does not provide an holistic service
- Patients prefer to be cared for at home and in their community, with support for them and their families.

We know we have to address these issues and whilst we know from major consultation and engagement exercises, such as the one to support the development of our Primary Care Strategy that feedback on our services is good, we also know there is more to do. We will continue to use public feedback from engagement and consultation to shape the strategic direction of future provision of health care across Northern Staffordshire.

We know:

- Patients benefit from being at home
- Patients prefer to be at home
- Patients supported the proposed model in principle.

Respondents requested assurances that:

- There is capacity in community services to support this
- We reassure the public about the future of community hospitals
- There will be support for patients’ spouse/family/carer
- Patients will be followed up in the community
- This is carefully implemented
- Investment is made to support changes to the model of care.

Further detail on the emerging themes from the consultation in support of the new model of care termed as My Care, My Way – Home First are shown in Appendix One.

5.6 Patient and Public Involvement (PPI)

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 and community care will become all the more important, making it essential that the CCG works in a supportive and collaborative way with key stakeholders 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 deliver a health and social 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.

From the work we have carried out in seeking the views of patients, members of the public and particularly our most vulnerable service users, we know that 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. A key objective of our strategy is to improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle.

The intention is to build on the patient views that were collected from the consultation on the model of community care – My Care, My Way – Home First and engagement on the draft Primary Care Strategy to develop a comprehensive consultation and engagement strategy and the harnessing of patient expertise and knowledge through the existing patient
engagement processes such as Patient Locality Groups, Patient Congress and Patient Membership Scheme.

The Patient at the Centre

There are six guiding principles that drive our Patient and Public Engagement strategy and put patients at the Centre. These are the important things that we know our patients and the public want from the care they receive.

Improving quality and performance and reducing inequalities and unwarranted variation

Whilst the quality of most 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 services are consistently of the highest quality.

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 system, it is critical that services are provided 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.

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 care is fundamental to managing the health of populations and reducing health inequalities. By developing high quality, appropriate 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 centered 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.
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 addresses.

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.

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, co-ordinated 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.

Patient Centered Care
The Northern Staffordshire CCGs believe that meaningful engagement with their population is essential to ensure that local people can shape their services in a constructive way. Working collaboratively with a range of stakeholders including our local Commissioning Support Unit Healthwatch in Staffordshire and Stoke-on-Trent, PPI is built into every stage of our commissioning cycle.

The CCGs have developed a structure for patient and public involvement which provides a range of engagement mechanisms. Feedback from the various engagement mechanisms is used by commissioners to develop service specifications. It provides the quality team with contextualized, qualitative information at their provider contract management meetings.

**Patient membership scheme** - This is a database of patients who agree to receive information via a regular newsletter and to take part in consultations.

**Patient Participation Groups (PPGs)** - These are groups of patients who work together to shape their local GP services.

**PPG Localities** - These are groups representing the PPGs within each of the CCGs’ localities; they consider pertinent issues in the wider community and share knowledge and insight from the various practices within the locality.

**Patient Congress** - We have two Patient Congress groups, one for North Staffordshire and one for Stoke-on-Trent; these are strategic groups that provide a patient perspective on a range of priorities and strategies. They have undertaken significant service reviews and help to determine the future direction and priorities of the CCGs. The Congresses include members of the PPGs and locality groups as well as representatives from the community and voluntary sector, who provide insight into and speak on behalf of those patients who might otherwise not be heard.
Patient involvement in the work of the CCGs - We routinely involve patients or representative groups in the day to day work of the CCGs. For example, we have patient representation on the Clinical Priorities Advisory Group (CPAG) a sub-committee of each CCG’s Governing Body that assesses interventions and treatments and allocates a prioritisation score, which then forms the basis of the CCG’s decision whether to fund or not.

Friends and family test - A nationally used test that asks a key question of people who use our services and is a fundamental litmus test of people’s experiences when using local services. The results are monitored on a regular basis by Quality Leads and feed into contract management meetings. Patient stories are considered at the Joint Quality Committee, the CCGs Governing Board meetings and at provider Clinical Quality Review Meetings (CQRM). This ensures that patients are central to our understanding and decision making and allows cross-referencing of the intelligence we gain from our own insight database and soft intelligence. Additionally, CQRM consider Friends and Family Test feedback, complaints and Patient Advice and Liaison Services (PALS) information, all of which provide a rich picture of patient experience.

The Citizens Jury - is the most recent form of innovative patient engagement, and involves a panel of patients supported by the CCG to receive information and question patients, carers and clinicians on the delivery of specific services, considering all aspects. The initial Citizens Jury has reviewed diabetes care across the economy and provided the CCG with key recommendations for action.

5.7 Effective, sustainable and successful voluntary, community and social enterprise (VCSE) Sector

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.

The National Council for Voluntary Organisations has identified the 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

Strategic direction and policy drivers
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.

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.

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 VCSE plays a valuable role 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.
North Staffordshire and Stoke-on-Trent CCG Priorities for Healthy Communities

The two CCGs have established 5 shared themes from their visions for local communities:

- 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 and as safely as 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.

The new model of care aligns with the vision for integrated health, mental health and social care. The Better Care Fund (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
- Providing 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.

**Stoke on Trent Joint Health & Wellbeing Strategy 2013-15**

“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.”

**Staffordshire County Council Health & Wellbeing Strategy 2013 - 18**

“….. 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.”

**Key principles for future investment in the VCSE sector**

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.

To date the commissioning of the sector has largely been needs led and responsive. Given the commitment by the CCGs to harness the opportunities within the VSCE, commissioners will work with the sector over the next five years to look for the opportunities to co-design, co-commission and coordinate services to meet local health needs.

The VCSE sector will need 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 Northern Staffordshire.
6. **Our Future Model of Care**

6.1 **Our Future Vision**

Our Future Vision is underpinned by our overall objectives which are:

- Seeking to redress health inequalities and deliver incremental improvements on our health outcomes
- Maintaining business as usual to ensure delivery of quality services
- Commissioning services to manage planned and unplanned acute demand
- Developing an intermediate care layer so that when interventions are required, they are delivered closer to home
- Developing primary care to increase community provision and wrap care around our most vulnerable patients
- Weaving parity of esteem into all our services.

As a result the vision for our model of care will be as follows:

- An integrated system wide model of care supporting populations of between 30 to 50,000. In this model, health and social care providers work together to deliver patient centered care in their communities.
- Primary care itself will operate more ‘at scale’ with practices coming together to achieve economies of scale and improved resilience, reducing unwarranted clinical variation and
enabling the delivery of a wider range of services, extended access and shared ‘back office’ support. Nationally a number of models for doing this are being developed and evaluated as part of the Five Year Forward view and we will be learning from that in deciding what works best in Staffordshire and Stoke-on-Trent

- the NHS and Social Care budgets will in effect be ‘pooled’ and decisions about how to spend resource will be driven by analysis of health, recipient and economic benefit rather than historic boundaries
- different systems for remunerating providers will be introduced designed to better share risk, remove unhelpful incentives (those that drive up activity for example), increase positive incentives (to innovate in delivering more preventative services for example) and make best use of the ‘Staffordshire pound’
- there will be fewer hospital beds; fewer Centre’s providing some acute services (concentration to achieve better quality and better value); more ‘hospital activity’ taking place in community locations
- There will be a rationalisation and concentration of the estate - money spent on buildings is money not spent on care
- The market for domiciliary care and nursing home care will be reshaped
- Hospitals will partner up to provide support services more effectively
- More care will be provided ‘on line’
- The proportion of the health and care budget spent on hospital-based care will reduce whilst that spent on prevention, on primary care, on care in community settings will increase

6.2 Shaping the Future

The CCGs have developed a number of Strategies to deliver our vision. They relate to

- Acute Reconfiguration
- Primary Care Transformation
- Whole systems integrated care
- Parity of Esteem for Mental Health

These key changes and how they fit in the whole systems strategic change that is needed is set out in the Strategic Framework – highlighting the key strategies and those that are system drivers and are crucial to effective delivery. These are further summarised in this section.
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 and which both CCGs are committed to achieve. 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; and
- Achieve all of the above while remaining within financial balance and achieving best value.

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<th>Key Objectives</th>
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<td><strong>URGENT CARE</strong></td>
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<td>- Achievement of 95% A&amp;E targets</td>
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<td>- No variation in performance seven days a week</td>
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<td>- Acute bed occupancy running at an average of 92%</td>
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<td>- Reduce attendances at major emergency care A&amp;E by 40%</td>
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<td>- Reduce emergency admissions by 11,900 over five years</td>
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<tr>
<td>- Improve access to primary care, especially at weekends/evenings</td>
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<tr>
<td>- Length of Stay (LoS) within community (step up) will be no longer than 14 days</td>
</tr>
<tr>
<td>- Achievement of Emergency Care Intensive Support Team (ECIST)</td>
</tr>
<tr>
<td><strong>PLANNED CARE</strong></td>
</tr>
<tr>
<td>- Work towards planning and delivering a well-managed system at 75% benchmark in line with prioritisation work</td>
</tr>
<tr>
<td>- Commission treatments and services that are clinically effective</td>
</tr>
<tr>
<td>- Allocation of resources in line with the outputs from CPAG and prioritisation work</td>
</tr>
<tr>
<td>- Efficiencies across the acute services</td>
</tr>
<tr>
<td>- Reduction in the follow-up backlog</td>
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<tr>
<td>- Demand management processes in place</td>
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<tr>
<td><strong>DEMENTIA</strong></td>
</tr>
<tr>
<td>- Feel included in society</td>
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<tr>
<td>- Be empowered and able to make decisions about their future</td>
</tr>
<tr>
<td>- Be treated with dignity and respect and know that people around them have an understanding and awareness of dementia</td>
</tr>
<tr>
<td>- Access high-quality, personalised care and support services</td>
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<tr>
<td>- Know they will be (or were) diagnosed in a timely way</td>
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<tr>
<td>- Know where to go for the right, information advice and support</td>
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<tr>
<td><strong>LEARNING DISABILITIES</strong></td>
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<tr>
<td>- 10% reduction of inpatient population by 2016</td>
</tr>
<tr>
<td>- Effective and consistent outcomes measurement for people with LD supported by health services</td>
</tr>
<tr>
<td>- Reduced admissions, particularly in a crisis, and a shorter length of stay</td>
</tr>
<tr>
<td>- People receiving care locally rather than out of area, and at a lower cost</td>
</tr>
<tr>
<td>- Improved patient experience due to the delivery of integrated health and social care services</td>
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<tr>
<td>- Improve and measure outcomes through framework agreements</td>
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<table>
<thead>
<tr>
<th>System Drivers</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Strategy</td>
</tr>
<tr>
<td>Frail Elderly / Long Term Conditions Strategy</td>
</tr>
<tr>
<td>Mental Health Strategy and Parity of Esteem</td>
</tr>
</tbody>
</table>
Our current delivery plan is based on a number of strategies that have key themes and this table details the objectives and outcomes from those key strategies

<table>
<thead>
<tr>
<th>Strategy Area</th>
<th>Objectives</th>
<th>Key Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Achieve effective alternatives to A&amp;E</td>
<td>Achievement of 95% A&amp;E targets</td>
</tr>
<tr>
<td></td>
<td>Incorporate primary care in A&amp;E</td>
<td>No variation in performance seven days a week</td>
</tr>
<tr>
<td></td>
<td>Early clinical assessment in A&amp;E</td>
<td>Acute bed occupancy running at an average of 92%</td>
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<tr>
<td></td>
<td>Responsive acute mental health services</td>
<td>Reduce attendances at major emergency care A&amp;E by 40%</td>
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<tr>
<td></td>
<td>Develop primary care at scale, resulting in improved access</td>
<td>No 12 hour trolley breaches</td>
</tr>
<tr>
<td></td>
<td>Promote self-care to patients to manage their conditions</td>
<td>Reduce emergency admissions by 11,900 over five years</td>
</tr>
<tr>
<td></td>
<td>Enhance local pharmacy services</td>
<td>Improve access to primary care, especially at weekends and evenings</td>
</tr>
<tr>
<td></td>
<td>Improve ambulance performance and integration</td>
<td>Length of Stay (LoS) within community (step up) will be no longer than 14 days</td>
</tr>
<tr>
<td></td>
<td>Child Assessment Unit pathway re-design</td>
<td>Achievement of Emergency Care Intensive Support Team (ECIP)</td>
</tr>
<tr>
<td><strong>Planned Care</strong></td>
<td>Work towards planning and delivering a well-managed system at 75% benchmark in line with the prioritisation work</td>
<td>Commission treatments and services that are clinically effective</td>
</tr>
<tr>
<td></td>
<td>Ensure pathways of care are delivered in the most effective and cost efficient way in line with prioritisation work</td>
<td>Allocation of resources in line with the outputs from CPAG and prioritisation work</td>
</tr>
<tr>
<td></td>
<td>Develop a clear plan for further decommissioning of restricted treatments in line with the outcomes from Pan-Staffordshire CPAG and prioritisation work</td>
<td>Efficiencies across the acute services</td>
</tr>
<tr>
<td></td>
<td>Redesign of the delivery of follow-up</td>
<td>Reduction in the follow-up backlog</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demand management processes in place</td>
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</tbody>
</table>
outpatient activity in order to reduce the follow-up backlog

Ensure that demand management processes remain in place for elective care

Improve access to diagnostics for both planned and non-elective work

Implement the Five Year Forward View for Maternity Services

<table>
<thead>
<tr>
<th>Primary care</th>
<th>General practice federated across Northern Staffordshire with delivery on locality footprints</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development of integrated multispecialty community provider model</td>
</tr>
<tr>
<td></td>
<td>High-quality, safe, effective and consistent primary care services delivering improved outcomes</td>
</tr>
<tr>
<td></td>
<td>Patients empowered through education, information and supported self-care</td>
</tr>
<tr>
<td></td>
<td>Appropriate primary care access for patients to the right person at the right time</td>
</tr>
<tr>
<td></td>
<td>Workforce adequately staffed and fit for purpose</td>
</tr>
<tr>
<td></td>
<td>Integrated IT communication solution between all health and social care providers</td>
</tr>
<tr>
<td></td>
<td>Estates fit for purpose, delivering modern primary care in safe, appropriate premises</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Develop closer links with service users and carers to ensure their input to future service design</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People with mental health needs will:</td>
</tr>
<tr>
<td></td>
<td>• Be empowered to stay in control of their lives</td>
</tr>
<tr>
<td>Implement Mental Health Strategy</td>
<td>• Be able to access treatment and support in an easy and timely way</td>
</tr>
<tr>
<td>Provide recovery-focused services</td>
<td>• Be able to access high quality services that meet both their mental and physical needs</td>
</tr>
<tr>
<td>Reduce stigma and discrimination</td>
<td>• Receive coordinated care and support which is focused on their recovery and independence</td>
</tr>
<tr>
<td>Implement crisis care concordat action plan for all ages linked closely with urgent care strategy</td>
<td>• Not be detained in police cells unless under exceptional circumstances</td>
</tr>
<tr>
<td>Reduce demand for out of area and NHS mental health service for both crisis and urgent care placements</td>
<td>• Reduced time in specialist services</td>
</tr>
<tr>
<td>Commission a Children and Young People’s Eating Disorder Team</td>
<td>• Reduction in suicides</td>
</tr>
<tr>
<td>Implement the local transformation plans for children and young people’s mental health which improve prevention and early intervention activity</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>Transform LD specialist services in line with Transforming Care principles</td>
<td>10% reduction of inpatient population by 2016</td>
</tr>
<tr>
<td>Reduction of 60% on current level of inpatient population by March 2019 across Staffordshire &amp; Stoke-on-Trent</td>
<td>Effective and consistent outcomes measurement for people with LD supported by health services</td>
</tr>
<tr>
<td>Establish framework agreement with providers for the delivery of local services for people with complex needs</td>
<td>Reduced admissions, particularly in a crisis, and a shorter length of stay</td>
</tr>
<tr>
<td>Explore pooled budgets with local authority seeking to commission integrated health and care services, particularly in respect of young people and the need to have Education, Health and Care plans</td>
<td>People receiving care locally rather than out of area, and at a lower cost</td>
</tr>
<tr>
<td>Reduce cost of out-of-area placements</td>
<td>Improved patient experience due to the delivery of integrated health and social care services</td>
</tr>
<tr>
<td>Implement of health inequalities</td>
<td></td>
</tr>
<tr>
<td>Framework</td>
<td>Measure service user outcomes</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Community Care</strong></td>
<td>Reduce avoidable hospital attendances</td>
</tr>
<tr>
<td>Single care plan for all patients based on individual needs</td>
<td>Focused and planned anticipatory responses to the health and social care needs of older people and patients with long-term conditions</td>
</tr>
<tr>
<td>Carers are supported to maximise independence for as long as possible for those they care for</td>
<td>Reduce acute length of stay for older people and bring health economy in line with our peer comparator group</td>
</tr>
<tr>
<td>Patients are supported to maintain their independence for as long as possible</td>
<td>Reduce avoidable emergency admissions</td>
</tr>
<tr>
<td>Patients and carers are empowered in self-care management and their response to changes in their condition</td>
<td>Reduce service duplication</td>
</tr>
<tr>
<td>Establish excellence in the anticipatory care of older people, including improving responses to their sub-acute and acute health and social care needs</td>
<td>GPs recognise and value contribution from their peers</td>
</tr>
<tr>
<td>Improve and sustain the quality and continuity of care in residential settings</td>
<td>Health inequalities for long-term residential patients addressed</td>
</tr>
<tr>
<td>Ensure access to community support for those with long-term conditions, establishing health navigators as a mechanism for targeting support for those at risk of poorer health outcomes</td>
<td>Patients empowered through education, information, peer support and confident self-care.</td>
</tr>
<tr>
<td>Improve access to diagnostics allowing clinical decision making to be undertaken through general practice by extended primary care team</td>
<td>Reduction in prescribing</td>
</tr>
<tr>
<td>Reduce demand for long-term residential care (based on proportion of people over 65 placed in care)</td>
<td>Alignment and/or pooled budget arrangement between commissioners</td>
</tr>
<tr>
<td>Continue to develop and sustain</td>
<td></td>
</tr>
</tbody>
</table>
parity for mental health throughout all community services

Realise system-wide benefits from transition to step up, step down model of care

<table>
<thead>
<tr>
<th>Dementia</th>
<th>Develop closer links with service users and carers to ensure their input to future service design</th>
<th>People with dementia will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spread the message of “Living Well” with dementia and improve the awareness of dementia among the public and professionals</td>
<td>• Feel included in society</td>
</tr>
<tr>
<td></td>
<td>Ensure that there is timely diagnosis and appropriate support for individuals and their carers</td>
<td>• Be empowered and able to make decisions about their future</td>
</tr>
<tr>
<td></td>
<td>Enable people to live well with dementia by providing access to high-quality, personalised support for both the person and their carer(s)</td>
<td>• Be treated with dignity and respect and know that people around them have an understanding and awareness of dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access high-quality, personalised care and support services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Know they will be (or were) diagnosed in a timely way</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Know where to go for the right, information advice and support</td>
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</tbody>
</table>

6.3 Northern Staffordshire Urgent Care Strategy

This strategy sets out the vision and strategic direction for the Local Health Economy for urgent care over the next five years. To complement the strategy there will be implementation plans that outline the steps that will be taken to deliver the vision. This will ensure that the local population of North Staffordshire are seen in a timely manner, with dignity, respect and quality of care and treatment at the right place and by the right clinical professional. The strategy will be underpinned by seven critical approaches to provide consistent, high quality and safe care, seven days a week.

➢ To ensure that patients receive the right care in the right place first time
Patients will be supported to remain at their usual place of residence wherever possible or will be treated closer to their homes where possible.

To provide better support for the public to self-care for their ailments/condition.

Deliver a sustainable urgent care system

Discharge planning starts on the day of admission and resulting in shorter stays and less de-functioning of patients

Responsive acute mental health services

What is Urgent Care?
The Department of Health in England issued a definition for urgent care:

‘Urgent care is the range of responses that health and care services provide to people who require—or who perceive the need for—urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need’.

Vision for Urgent Care

“Delivering an Urgent Care system that delivers high quality care in the right setting by the right professional in a timely manner seven days a week”

The vision for North Staffordshire Health economy encapsulates all levels of care and to aid comprehension is subdivided into pre-hospital, in hospital and post-acute settings. One can assess an Urgent Care system in a number of ways but it makes sense to approach it from the patient pathway. It is important to remember that while ED attendance is often the focus of Urgent Care performance the entire journey is interdependent – if one element does not work then it cascades problems before and after. There are also two cross cutting themes, 7 Day working and Information sharing, which will be considered separately because of their importance.

The key elements are:

Admission avoidance and prevention.

- Developing Primary Care at scale resulting in improved access
- Comprehensive community pathways for frail /elderly aligned to cross economy transformation programme
- Enhancing local Pharmacy services improving ambulance performance and integration.
- Robust primary care based mental health services
- Seamless management of Long Term Conditions (LTC) including promotion of self-care
- Redesign of Child Assessment Unit pathway
Hospital

- Developing effective alternatives to A&E aligned with Keogh model
- Early senior clinical assessment at all admission portals
- Co-location of Primary Care services in A&E
- Accessible and timely mental health services
- Development of Ambulatory Emergency care assessments
- Effective discharge planning and operational delivery

Post admission/Community

- Patients return to their place of residence as soon as is clinically appropriate.
- Ensuring only patients requiring further rehabilitation are admitted into a community bed.
- Social Care/Intermediate care intervention is timely, appropriate and efficient.
- Therapy intervention is timely, appropriate and efficient.
- Patients requiring nursing home convalescence or residence are reassured that the quality of the home is high in care/nursing standards and that there is adequate capacity

Urgent Care within North Staffordshire has encountered many problems.

1. The national target of seeing 95% of patients within 4 hours has consistently failed to be achieved.
2. Large numbers of 12 hour trolley waits
3. Admission rates are higher than the national average.
4. High bed occupancy
5. Mortality rates increase and discharges decrease over weekends.
6. Capacity issues relating to social care packages from both local authorities
7. Limited Primary Care investment and perception of poor access to GP appointments
8. Disjointed services outside of A&E causes confusion amongst patients

Another feature of the local health economy is that it is predominantly bed based. The number of community beds is relatively high and not used to its best effect. Domiciliary care activity is reciprocally low and does impede patient flow especially from community hospitals.

Benefits – what does success look like?

The vision will deliver benefits to the patients in terms of delivering an Urgent Care System that is:
• Easy to understand
• Easy to access
• Provide the opportunity for patients to self-manage their condition where warranted
• Deliver a level of appropriate care closer to the patients home, seven days a week
• Consistent care irrespective of geographical location within the health economy.
• Provide care at the patients’ place of residence whenever possible.
• Avoid an unnecessary admission when possible.
• Generate a pathway of care for vulnerable patient cohorts that will avoid exacerbation to secondary care
• Minimise the time spent in hospital for all patients admitted.
• Return patients to their place of residence as a default on discharge whenever possible.
• For patients requiring further rehabilitation, to reduce their stay in a community hospital bed.
• Ensure patients are returned home with an appropriate package as soon as possible without any delays.
• Generate high levels of patient satisfaction

The key metrics are:

1. Achievement of the 95% A&E Target consistently.
2. No variation in performance 7 days a week
3. Acute bed occupancy running at an average of 85%
4. Reduced attendances at Major Emergency Care A&E by 40%
5. Over 5 years we will reduce emergency admissions by 11,900
6. Improved access to primary care especially at weekends and evenings
7. Length of Stay within the community for step up will be no longer than 14 days.
8. Achievement of the ECIS targets for <2 day, <7 day and <11 day Los (60%, 80& and 90% respectively)

6.4 Primary Care Strategy

The Northern Staffordshire Primary Care Strategy sets out Stoke-on-Trent and North Staffordshire CCGs’ 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 strategy sets out a new patient offer that can only be delivered by primary care teams working in new ways and by practices coming together. The model proposed is an integrated one.
The Royal College of General Practitioners champions integration of care as crucial to patient-centered 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.’

This model 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.

**The proposed model of Primary Care will:**

- Support the population to stay as well and as healthy as possible;
- Overcome difficulties in recruitment and retention of Primary Care staff;
- Better manage increased patient demand;
- Improve performance of Primary Care services across the area and ensure that access to appointments and services is equitable;
- Deliver key health and wellbeing outcomes and create healthier communities;
- Empower patients to better manage their own care;
- Enable early intervention and prevention with an increased focus on wellbeing;
- Ensure that primary care works in collaboration with other services such as community services to ensure that care is joined up in the community; and
- Deliver agreed outcomes for the lowest cost while staying within budget

**New Model of Care for General Practice**

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.

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. The figure below illustrates the proposed model of care for a Multispecialty Community Provider (MCP) model.
Proposed Model of Care Multispecialty Community Provider (MCP) Model

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. It is clear that to achieve significant economies of scale there is a clear move towards 'at scale' delivery. To support this vision, the CCGS will work with the Localities, members and other key stakeholders to develop appropriate models of scale which will aligned to the agreed commissioning framework.

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.

The North Staffordshire GP Federation (NSGPF)

Highly organised primary care, delivered to consistent levels of quality, is a pre-requisite for the service transformation expected in our local health care system. The Federation is well placed to work alongside localities to provide assurance to the CCGs that its member practices are engaged, consulted with and that they are developing in their ability to deliver key objectives. In enabling a consistent and systematic approach to engaging primary care representatives, the Federation will continue to listen to member practices, support them and advocate for the need for long-term financial commitment to practices to enable them to invest in primary care services.
6.5 Frail Elderly and Long Term Conditions

The importance of commissioning a model of care that allows for the management of people before their needs escalate, responds to their needs in an anticipated and planned way, and reduces the need for crisis intervention and unscheduled care is a nationally recognised objective.

Analysis of emergency non-elective admissions activity confirms that there is significant overlap between the older cohort of frail patients (aged 75+) and those patients in the system as a consequence of their long-term condition(s). Therefore, this cohort of comorbid patients, characterised by frailty and often multiple long-term conditions is the focus of the Frail Elderly and Long Term Strategy.

Across Northern Staffordshire the over 65’s population will increase by 58% between 2008 - 2037. Within this cohort of patients the number of over 75 is expected to grow. Not only is the registered incidence of long term conditions for the Health Economy much higher when compared with the wider regions, comorbidity is a particular challenge with 27% of the population having one or more conditions.

Older people are not only the main users of NHS services but they are also a potentially vulnerable group with more complex health and social care needs. Despite the majority of urgent care being delivered in the primary care setting, an increasing number of older people are attending emergency departments and accessing urgent health and social care services. For this health economy, non-elective admission costs for this cohort of over 65’s equated to £51 million during 2012/13 and this is projected to increase to £53 million in 2017/18.

In addition older people who are frail (defined as those 75 and over) often require a different level and type of support to those who are younger and fitter as the majority of all patients identified as Frail Elderly have at least one long term condition.

Our vision is “to deliver care effectively in the setting appropriate to the need of the person, at the right time and at the lowest level of dependency and that patients are empowered to participate in their care”.

The proposed model of care for Frail Elderly and Long Term Conditions will deliver the following key elements:
- A step-up model which pulls specialist support into Primary Care to avoid patients presenting in crisis and presenting as non-elective admissions;
- A focus on case management of patients including case finding building on the work undertaken in the Integrated Local Care Teams (ILCT);
- Formulation of a single care plan which pulls together all clinical and social care contributions and recognises the role the patient/carer has in managing their own care throughout their lifetime;
- Timely responsive and anticipatory interventions by specialists which will prevent patients reaching crisis point in their condition;
- Recognition of multi-morbidity factors within the care management plan to ensure the “whole” patient’s needs are met;
- A new vibrant role for specialists;
- Promoting self-care and patient education which will equip and empower patients and their carers with the tools to understand and manage their own long term condition;
- Recognising the role the community and voluntary sector has to play in long term condition management including Community Pharmacy provision;
- Providing support and education to primary care personnel in managing long term conditions.

Instigating this model of care will deliver significant financial benefits in terms of a reduction in urgent care attendances and admission avoidance. These savings are described in the table below

**In addition the following direct outcomes will be achieved:**

- Improvements in patient satisfaction indicators (aligned to national outcome frameworks NHS and social care)
- Increase in number of GP Fellow sessions delivered in support of general practice
- Increase in number of Comprehensive Geriatric Care Assessments made linked with number of frailty passports issued
- Increase in the number of people dying in a place of their choosing

At the same time it is anticipated that there will be a number of indirect benefits such as a reduction in delayed transfers of care and improved utilisation of social care.

### 6.6 Mental Health Strategy

Achieving parity of esteem for people with mental health needs is one of our core priorities. For too long, mental health has lagged behind physical health in terms of priority and investment, and people have not achieved the high-quality support they need. Currently, one in four people will experience a mental health problem in their lifetime and the cost of mental ill health to the economy, NHS and society is estimated to be £105 billion a year. Both the human cost and the cost to the public purse have been rightly seen to be unacceptable.
The Five Year Forward View set out national ambitions for transformation in a number of clinical priority areas including mental health, dementia, and learning disabilities.

NHS England has committed to creating a separate clear rating for each of these clinical areas, on a four point ‘Ofsted-style’ scale. Assessments in the clinical priority areas will be overseen by independent groups with the first assessment for each to be published on My NHS by June 2016 derived from current baseline performance. In addition to this, mental health, learning disabilities and dementia feature in the new Improvement and Assessment Framework which will be used to assure individual CCGs and newly formed Sustainability and Transformation footprints on delivery and impact.

There has already been considerable progress. Since 2008 across Northern Staffordshire increasing numbers of adults with depression and anxiety have benefited from evidence based psychological therapies. In the past year, Stoke-on-Trent and North Staffordshire CCGs have achieved its 15% target for adults to access to psychological therapies, the 50% recovery rate, as well as the 6 and 18 week waiting time standards. In other areas too there have been important steps forward. Working with our local partners, we’ve developed a Children and Young People’s Mental Health Local Transformation Plan to focus on improving services, supported by new funding.

We have also ensured that the needs of people living with dementia are more clearly known by substantially increasing the rate of diagnosis, exceeding our ambition that a minimum of two thirds of the estimated prevalence are diagnosed. Of a target of 67%, Stoke-on-Trent CCG is achieving 87.2% whilst North Staffordshire CCG is achieving 71.5%.

We recognise, however, that there is more to be done. The Independent Task Force report, published in February 2016, sets out a blueprint for next steps to improve high quality, effective care and we have accepted their recommendations for the NHS locally. The National strategic deliverables and outcomes as outlined in the Independent Task Force report include:

- Improving access to high quality evidence based mental care for people of all ages
- Reduce the number of people with mental health problems dying prematurely from preventable causes
- Improving outcomes for people with mental health problems and their carers
- Supporting a continued improvement attitudes toward mental health
- Addressing fragmented pathways and identifying new co-commissioning, funding and service models

These are mirrored in our Pan-Staffordshire Multi-partner Strategy ‘Mental Health is Everybody’s Business’ which focuses on:
• Prevention – Starting Well, Developing Well, Living Well, Working Well and Ageing Well
• Improved access to and the delivery of mental health services with better outcomes for individuals with mental illness
• People will be able to access the right level of assessment, advice, support and intervention at the earliest opportunity
• Early intervention and care as close to home as possible
• People will have good healthcare and enjoy healthy lifestyles
• People can and will recover
• People will feel safer, happier and more supported in and by their communities
• Stigma and discrimination is essentially driven by ignorance and fear
• People with mental illness will gain and retain paid work

Our deliverables for 2016/17 across Northern Staffordshire match the National recommendations:

• Ensure the prioritisation of mental health and dementia within Sustainability and Transformation Plans to meet national challenges and ambition
• Ensure that we continue to increase investment in mental health services each year at a level which at least matches overall expenditure increase
• Conduct local workforce planning (coordinated with HEE) in order to deliver on mental health transformation, dementia priorities and access and waiting time standards
• Ensure that 50% of people experiencing a first episode of psychosis to commence a package of NICE-recommended care within two weeks of referral
• Ensure that 75% of people with common mental health conditions access psychological therapies within six weeks of referral; and 95% within 18 weeks
• Implement plans to improve crisis care for all ages, including investing in places of safety and improving crisis and acute mental health care so that people will be able to access a 24/7 response equivalent to that for physical needs
• Oversee the implementation of local transformation plans for children and young people’s mental health which improve prevention and early intervention activity; and be on track to deliver national coverage of the Children and Young People’s Improving Access to Psychological Therapies programme by 2018
• Commission a Children and Young People’s Eating Disorder Team to provide a service in line with the model recommend in the access and waiting time standard
• Maintain a minimum of two-thirds diagnosis rates for people with dementia, whilst agreeing an affordable implementation plan to deliver more consistent access to effective post diagnosis treatment and support
• Support trial of new models whereby secondary mental health providers manage care budgets for tertiary services
• Implement agreed actions from the Mental Health Taskforce:
  – Improved 7-day crisis resolution and intensive home treatment services to offer an alternative to acute hospital admission
  – Access to timely, evidence-based specialist perinatal care for women across England, closer to home, when they need it
  – Expanding the EIP standard to reach 60% of need
  – Evidence-based screening and interventions to meet the physical health needs of people with severe mental illness
  – A further expansion of access to psychological therapies for those out of work and those with long-term physical health conditions
  – Commission more evidence-based ‘step-down’ services from secure care

Thinking longer term, our 2021 deliverables for Mental Health across Northern Staffordshire include:

• Maintain current levels of access to IAPT services at a minimum of 15% of prevalence, whilst securing consistent delivery of a minimum of 50% recovery rate from treatment, and preparing to increase access to 25% over the next five years
• Develop implementation plans to ensure timely access to evidence-based specialist perinatal mental health services, including actions to strengthen workforce skills and capacity
• Expanding mental health liaison services to ensure teams are in place in all acute hospitals, and are working towards “Core 24” standards as a minimum
• Delivering a significant reduction in the use of out of area placements for acute inpatient mental health care
• Ensuring effective transition from children’s to adult services and on to older peoples services consistently for all
• Support providers to improve data quality and completeness, to drive an understanding of access, quality, outcomes and funding
• Support providers implementing one of the payment approaches set out for adult mental health (capitation or year of care plus outcomes/quality) in shadow or actual form, and ensuring no commissioning using a block payment contract
7. How Will We Make The Changes?

Our 2016/17 commissioning intentions set out the shape of the programme and its potential impact on the local economy. In particular, the likely transformation projects are:

- Redesign of surgical configuration
- Review of community beds
- County wide pathways/provider alliances
- Opportunities around specialist provision
- Provider efficiency
- A focus on mental wellbeing in all services.

The likely impact of these is:

- A more efficient use of elective capacity
- Teams working in the community and possibly multi-provider sites to coordinate care around individuals, irrespective of organisational boundaries
- Pathways to develop more streamlined access to tertiary services, reducing duplication and ensuring good communication with patients
- A significant scaling up of the use of technology-enabled care, with 30-40% of outpatients moving from face-to-face to phone, Skype or social media.

Given the importance of the community infrastructure, it is useful to consider broadly which core roles will make up the primary and community model. They could include the following:

- **Within each practice**: GPs, advanced nurse practitioners, matrons, practice nurses, healthcare assistants, volunteers, receptionists, managers and may also include physician assistants/associates and pharmacists
- **Aligned to each practice but working across a wider geography/at-scale primary care organisations**: prescribing advisors, care coordinators, wellbeing teams, and ‘super practice managers/directors’ with sufficient skill to lead the development and operational management of at-scale primary care organisations
- **As part of, for example, a wider Multispecialty Community Provider (MCP)**: secondary care specialists, social care, mental health and community services teams, and community pharmacies.

Building on the actuarial work from our prioritisation programme, we will identify a financial envelope for community health and social care. We will jointly develop a community specification with our local authority partners, and this service will then be commissioned with defined population outcomes. Funding will be through a capitated budget.

Significant input is required to define the capitated budget envelope. There is also a need to recognise that the elements described in the finance section, will have a bearing on the
scale and pace of our ability to transform the system. In order to fund the level of transformation and transitional costs required to invest in the development of primary and community provision we will have to stretch delivery of our QIPP savings before we realise the financial reduction from reduced non-elective activity. Given the pressure to reduce the base budget, this is a challenge. The alternative would be to work with providers using the most capable provider methodology to identify, and then incrementally deliver, the future provider configuration. This is a significant piece of work, which will need to be sufficiently resourced both in terms of capacity and capability. However, there are examples of this methodology nationally, and so there is learning that we could use.

There are a number of key enablers that exist alongside the Together We’re Better programme. Indeed, the first enabler is the programme and its anticipated timeline. This chapter will discuss these enablers in more detail:

- Financial Planning
- Collaborative Commissioning
- Leadership, Workforce and Organisation Development
- Information Technology and Data Sharing
- Estates
- Market Development, Procurement and Contract Management

### 7.1 Financial Planning

The financial five year plan is currently in development and will be shaped by the outcome of contract negotiations and the agreement to the CCGs’ implementation plans when developed to deliver their strategic intentions.

The CCGs have each published their one year operational plans which set out the financial plan for 2016/17. The Sustainability and Transformation Plan being developed on a pan Staffordshire basis will include financial and activity monitoring for the next five years.

### 7.2 Collaborative Commissioning

**Local Authority and Better Care Fund**

We currently have Joint Commissioning arrangements for mental health, learning disabilities and older people with our respective local authorities. We have also worked together to develop the Better Care Fund (BCF) agreement, which requires local authorities and CCGs to develop a plan to integrate health and social care, using a pooled budget. The aim is to ensure seamless commissioning of health and social care services, and deliver integrated health and care services.

Our aim is to empower people to live independently, and wherever possible self-manage their conditions. This will be achieved by strengthening and maintaining community based prevention and support, health and care networks so that people experience wellbeing, stay
well and recover quickly from episodes of ill health or other problems, whilst continuing to live at home.

We will deliver efficient and effective, localised and personalised, co-ordinated care and support. With an increased focus on proactive case management and targeted prevention and early intervention, our model of ‘enhanced community care’ will operate 7 day services. For people identified as being ‘at risk’, a joint assessment process will be in operation and a named accountable lead will ensure effective care co-ordination so that wherever possible people will avoid hospital or care home admission and when this is necessary, will ensure a timely return to a person’s usual place of residence.

Our approach to prevention and early intervention includes people with lower levels of need. We will ensure that people have access to clear, consistent information, advice and guidance whatever their point of contact. Working collaboratively with the voluntary sector and community at large we will ensure that people have the information and support to help themselves to live their life well.

This includes access to:

- A range of bespoke services developed by their community within their community
- A range of housing options to ensure that their home environment is suitable for their needs
- Digital solutions to promote independence and control

### Integrated Care and Support: Our Shared Commitment

Our vision for integrated health and care through the development of localised enhanced community care teams is premised on our aim to give people greater choice and control, and to deliver tailored and personalised support.

Building on positive developments to date in delivering our community wellbeing and co-
operative working models, our collaborative approach to working with a wide range of partners and stakeholders across the City means that we are challenging and radically rethinking the way in which care is provided so that care is better coordinated and joined up.

It is envisaged that this ‘framework’ will allow flexibility to meet local need and at the same time deliver the expectations of commissioners to fully implement the vision of the Five Year Forward View and requirements relating to our Better Care plan. The roll out of the enhanced community care specifically across Stoke and North Staffordshire is currently forecast to adopt two additional populations every 4-6 months and should see full adoption by mid to the end of 2017 thereby effectively moving to integrated health and social care services by 2020. The approach should enable natural learning and evolvement of enhanced community care developed by the communities.

**Lead Commissioner**

We have lead commissioner arrangements across all CCGs within Staffordshire, enabling ‘one voice’ when working with our main providers. In Northern Staffordshire we lead on University Hospitals of North Midlands, Staffordshire and Stoke-on-Trent Partnership Trust and Combined Healthcare NHS Trust,

Commissioners, providers and other key stakeholders have come together under the pan Staffordshire transformation programme ‘Together we’re Better’ to set out a model for ‘Enhanced Community Care’.

Responding to the ‘no one size fits all’ approach and a commitment to co-produce a localised response to understanding and meeting need, commissioners are working with a wide range of stakeholders to develop and implement a tailored community offer whilst adopting delivery of four common essential components:

- Identification of patient population and their associated health & wellbeing risks
- Ensuring proactive and preventative MDT care and well-being plans are in place for those with a risk identified e.g. case finding
- Creation of efficient pathways of care to reduce acute dependency and keep care close to home e.g. case management
- Delivery of interventions at the right time in the right place by the right skill set, maintaining people at their highest level of independence.

**7.3 Leadership, Workforce and Organisational Development**

**CCG workforce and organisational development**

We know that balancing these priorities and investing in service transformation at a time of acute financial focus on quality and efficiency will require strong, effective local leadership across Northern Staffordshire.
Across Northern Staffordshire, we have recently undergone a comprehensive management of change process which has created a much more integrated senior leadership team with extra capacity at Executive level. This management of change has been underpinned by a robust six month organisational development plan to support our two organisations working together, where appropriate, as one. Plans to move both CCGs into one location have commenced. This will enable much greater integration and efficiency of the collective CCG’s management capacity.

Continued investment in developing our staff is recognised as crucial in improving staff satisfaction, career prospects and talent management. A key factor in delivering this will be improved performance management, regular, meaningful appraisals and appropriate training and support. Promoting a meaningful focus on staff wellbeing is also important.

**Provider workforce and organisational development**

We know that the wider ‘care’ workforce is currently at a tipping point, facing the following key problems:

- Workforce shortages
- Reliance on temporary staff
- Conventional roles not matching patient need
- Duplication of roles across health economy
- Workforce in organisational silos
- Lack of integration across health and social care workforce
- A workforce focused on treatment, not prevention

We will work with providers on plans that demonstrate how they will manage organisational development to support the implementation of new provider models and ensure staff are fully engaged in all proposed service changes.

We will work closely with the Staffordshire transformation *Together We’re Better* Programme Organisational Development work stream which acts to:

- Deliver organisational development interventions acting to engage staff in the transformation strategy and process
- Support local leaders through coaching and learning, equipping them to deliver the *Together We’re Better* Programme
- Oversee the key workforce changes required to deliver the new models of cares, ensuring a smooth transition through robust education and innovative modelling
- Equip our staff across Staffordshire with the skills, support, motivation and confidence to enact the transformation required

This will support our role as commissioners in ensuring that provider workforce plans are
aligned to our commissioning intentions and that the projected staff groups changes are commensurate with required service delivery models and do not adversely affect the quality and safety of services. We will review their plans to ensure that they are realistic and affordable. As an output of this work, the CCG provides a level of assurance for each Trust submission, which is fed back to the Trusts and to Health Education England.

We will help the Together We’re Better programme focus on activities that support, equip and engage our current workforce, while modelling and commissioning for the workforce of the future.

The diagram below provides an indication of the success factors and outcomes we wish to derive:
7.4 Information Technology and data sharing

Collaborative working continues between primary, community and acute care to develop a road map for interoperable clinical systems. The key areas include:

- Developing an electronic shared care record available across primary, community and acute services
- Helping primary care to deliver access to GP records for individual patients online
- Promoting the use of electronic referral routes into acute services
- Integrating referral improvement technology into primary care
- Developing accessible, high quality information sources for patients
- Continuing the development of electronic prescribing, in particular EPS2.

The enabling IT work stream in the Together We’re Better programme will collate a pan-Staffordshire digital road map and seek to identify where county-wide, cost-effective solutions could be developed.

To underpin this we will further develop robust Information Governance (IG) protocols to protect patient data whilst facilitating wider sharing of patient records when appropriate. This will allow patients to flow more easily through the system.

Patients have already said that they would like to have access to a copy of their care records, where possible, and this potential solution is currently being tested in national innovation and vanguard models. We will look to build on this learning and develop appropriate models for Northern Staffordshire.

We have fully embraced telehealth opportunities to support the management of people with long term conditions to help manage their illness in their own home. We also anticipate adaptation locally of new technology, readily accessible to people through handheld devices, to manage those with low levels of need and aid in healthy lifestyles and self-care. These range from free and low cost ‘apps’ that encourage health and wellbeing, through diet and exercise monitoring, to intelligent technology that can be used in homes and care settings to monitor diagnostics and activity for individuals. We will support the national roll out of this digital agenda as it happens.

7.5 Estates

The development of new models of care will in part be determined by the availability and suitability of estates and will include all public community assets where appropriate. As part of co-commissioning of primary care, NHS England has undertaken a county-wide review of primary care estates, which will feed into the Staffordshire transformation Together We’re Better Programme.
Additionally, an estates strategy is being developed as an enabler from the Pan-Staffordshire Transformation Programme; this will need to be considered as we develop the strategy into an implementation plan. Services will need to be redesigned to accommodate more services in the community and provide opportunities for greater integration. This will mean:

- Creating flexible bases to support increasingly mobile workforce distributed across acute and community teams;
- Supporting integrated teams and services that are reflective of patient flow and pathways of care;
- Sharing facilities;
- Improving assets;
- Convergence of estate and facilities to support clinical and administrative workflows; and
- Collaboration between agencies and providers with multi-use and multi-site venues.

The additional benefits of this model of working are creating a more sustainable integrated estate by:

- Using the existing estate more effectively;
- Reducing running and holding costs;
- Sharing property (particularly with social care and the wider public sector); and
- Disposing of surplus estate to generate capital receipts for reinvestment.

### 7.6 Market Development, Procurement and Contract Management

We recognise that our economy is dominated by monopoly providers, with prime providers for acute, community and mental health services. We also know that capacity issues affect the performance against some of our constitutional standards and development of our intermediate care provision. We have a developing General Practice Federation and we need to support the development of such new entrants into the market, where appropriate. We need to further develop voluntary and community services as MCPs move forward, and work closely with our third sector providers.

We have a strong, county-wide procurement service that is provided through the Commissioning Support Unit. This will continue to provide us with good technical knowledge and effective procurement processes once we have defined the services we want to buy. The overall approach to testing and developing our market for healthcare services is set within the context of, and informed by, our Healthcare Services Procurement Strategy and is built around the key activities of:

- Benchmarking – identify and assess the current service provision compared to comparator CCGs
- Identify – highlight areas that require change and may benefit from market testing
 EVALUATE – confirm and test data used to review services and opportunities
CONSULT – identify and link activity to strategic direction
ASSESS MARKET – identify market structure and assess policy and legislation
COURSE OF ACTION – determine the options for service improvement, including its practicalities
METHOD – choose the method for service improvement
EVALUATE – ensure the service development has had the desired effect.

Market analysis in Northern Staffordshire has been supported by Health Market Analysis (HMA) as a staged approach to strategic market management. This has historically been used to segment the healthcare market, and a modified version of the classification was used to assess community provision. Provider scorecards are used to evaluate provider economics in all market segments and this provides a basis for challenge as to the capability of providers.

The management and ongoing monitoring of any NHS contract is provided at differing levels dependent upon the complexity and value of the contract.

All main Provider contracts for the CCG consist of a number of meetings to ensure quality, finance and performance is monitored on a monthly basis and the Provider of these services is adhering to contractual requirements to deliver safe and effective care to patients.

This formal process adheres to the contractual requirements and requires meetings to review contract performance and quality. This is done via the two forums: Contract Review Board (CRB) and Clinical Quality Review Meeting (CQRM).
These review meetings are mandated in line with the contract particulars and General Condition 8 (Review). The Clinical Quality Review Meeting (CQRM) and Finance & Activity (F&A) groups escalate any items to the CRB meeting to enact any contractual notices where applicable. Escalation of any items from the Contract Review Board are then resolved using Dispute Resolution (General Condition 15).

There are a significant number of other smaller contracts that are currently managed by the Contract Management Team. These Providers shall have the same NHS Standard contract however we need to ensure these have a satisfactory level of monitoring/support to provide assurance to meet contractual requirements.
8.0 From Strategy to Implementation

8.1 How will we know we are successful?

There are a number of key steps generally that need to be undertaken in order to measure success.

Baseline
- What is the current position in relation to the area of improvement. This could be activity, cost, or ideally both? These details form the anchor point from which improvement is measured.

Benchmarking
- Using CCG comparator data, what are the best performing CCGs delivering? This is the basis to determine the target improvement or change.

The Plan
- This provides detail of the incremental milestones that will need to be achieved in order to deliver the change.

The milestones should be based on a realistic timeline.
- Benefits Identification - outcomes
  The end goals need to be described and a time set out when they will be expected to be achieved. Benefits could be released over a period of time, or delivered as a lump sum once all of the delivery milestones are achieved.

Benefits Monitoring
- The level of monitoring required to assure that benefits have been developed will depend on all of the above points.

Examples of the improvements expected will be:

**Year-on-year, incremental improvement of health outcomes:**
- An improvement in life expectancy
- An improvement in the screening for, and diagnosis of, cancers
- A reduction in the number of people suffering from cardio-vascular and respiratory disease
- A reduction in the incidence of diabetes.

**In relation to the whole systems shift, we would expect to see:**

**In the acute setting**
- A reduction in non-elective admissions to the level of only those with acute conditions
• An appropriate relative increased conversion rate
• Reduction in inappropriate accident and emergency attendances.
• Improved ‘flow’ through the whole system
• We will be spending less on the acute contract.

Examples in relation to community and primary care

• Models of primary and community care that resemble MCPs will be in place with established processes
• More people cared for at home
• Fewer people will die in a hospital bed
• Reduction in the number of inappropriate residential and care home admissions
• Increased capacity within the ambulance service from a reduction of inappropriate emergency transportation that results in improved response times
• Improved patient and carer satisfaction demonstrated through all of the patient and public feedback mechanisms
• Improved staff satisfaction demonstrated from staff surveys and sickness and attendance levels.

All of the above and more performance indicators are available within our current contract and performance monitoring systems.

The work required to build up capitated budgets will be based on that which is currently in train from the Prioritisation Programme, the line-by-line identification of community service funding and financial planning for the next five years.

8.2 Creating a Road Map

In accordance with the NHS planning guidance, both CCGs have produced an Operational Plan for 2016/17. There are a number of key factors described in this strategy that will define the road map for delivering our strategic aims.

The problems we face are threefold:

Too many people are admitted to acute urgent care services, many for assessment, when a significant proportion could be cared for in the community. This is because:

- Work that could have been done in the community hasn’t been, e.g. rehydrating dehydrated patients;
- Community step up alternatives for assessment or treatment are not available or are full;
- Busy A&E departments admit more patients.
- General practice is struggling to cope with issues with recruitment and retention.
Occupancy of acute beds is too high, which is driven by:

- *Length of stay as people spend too long in acute beds waiting for something to happen, decompensate and become more dependent as a result;*
- *Discharges being delayed when people are medically fit for discharge, due to out of hospital services not being available to facilitate a timely discharge.*

Too many people are discharged from the acute into another service, often a bed, rather than going home first, due to:

- *A bed dependency culture, with too many community beds;*
- *A lack of understanding of the community services available to discharge and the level of care that can be provided;*
- *Risk adverse decisions that prevent people going straight home.*

**Our Strategic Direction is:**

- We will manage people in the community whenever possible (integrated teams, using specialist help when necessary).
- This will require a shift of investment delivered over the next five years and workforce support
- We will only admit people when necessary.
- When admitted, UHN will be responsible for these beds as preferred provider.
- SSOTP will work with Combined Healthcare, general practice, voluntary sector and adult social care to provide enhanced community care.
- Intermediate care bed numbers will reduce from 250 to 150, based on current modelling.
- These beds along with those at UHN will support people’s differing requirements from intensive care through to rehabilitative, supportive care and flexed according to demand.
- This reduction in the bed numbers will provide the required investment for non-bed based community services.
- UHN will work on the principles of assessing before admission with early senior clinical decision making only admitting to the right level of care following this assessment.
- Commissioners will commission services to deliver ambulatory care wherever possible through Front of House, Ambulatory Emergency Care Centre and related services, supporting best patient practice.
- When people are admitted they will receive early, senior decision making, speedy diagnostics and therapies so at to minimise their stay in hospital.
- UHN will work on the principle of discharging to assess and discharging people to their usual place of residence wherever possible.
- This improved care and the reduction in the length of stay for people will support our bed modelling and investment in the teams providing enhanced community care.
Plan for the Future

The CCGs will review step up services and resources across our Acute and Community providers, looking at the potential for:

- UHN M becoming the prime provider for both step up and step down and all long term conditions services (bed and home based assessment, specialist community and intermediate care services).
- This is on the basis that Trust clinicians admit patients, therefore are best placed to avoid admissions using alternatives that the Trust will control.

UHN M to take on the utilisation risk for non-elective admission avoidance.

- To agree the appropriate contractual mechanism for this.
- The CCGs’ preferred option is a block contract with UHN M managing all non-elective activity within the block. This will move away from PbR and payment for activity and disincentives the unnecessary admission of patients.
- Community services such as district nursing will remain with SSOTP.

Step up and step down beds to reduce and management control of these beds will move to UHN M.

- UHN M currently manages step down beds at Bradwell and Cheadle Hospitals. These step up and step down beds will be in the Haywood, Leek Moorlands and Bradwell hospitals.

SSOTP and Combined Healthcare will continue to work with the GP Federation and localities to develop the multi-specialty community provider (MSCP) model.

- The pilots underway will inform the configuration of services wrapped around practices and localities and the interface with step up and step down services required to keep people at home and to discharge more people home first.
- MSCP s are likely to be based on 30 -50,000 populations and expanded integrated locality care teams.

The CCGs will work with Staffordshire County Council and Stoke on Trent City Council to align commissioning intentions for 2016/17, commissioning jointly in areas such as intermediate care, with a view to integrating commissioning for 2017/18 supported by pooled budgets and single contracts.

Consultation on some or all of these service changes will be required and will follow on from those in the My Care, My Way – Home First consultation that concluded in January 2016.
Commissioners and providers want to work towards a new way of contracting for urgent care services. Commissioners and providers will work together to develop proposals to enable a shift to a capitated budget in 2017/18. Consultation with stakeholders will take place during 2016/17 once more detailed proposals have been developed.

8.3 Conclusion and Summary

Our overall strategic intentions are to have services, wrapped around the patient, working in a collaborative and seamless way. In order to achieve this, we will drive towards a clinically and financially sustainable health and care economy by delivering a ‘whole systems shift’. We will reduce high-cost, avoidable admissions to hospital, which will allow us to reduce our commissioned bed base. This approach is consistent with national policy.

This will mean that only those people who need an acute intervention will be cared for in an acute setting. The resources we save by this reduction will be reinvested to develop primary and community services.

We will develop a multispecialty community provider (MCP) model based on that described within the Five Year Forward View. This is because there is growing acknowledgement that there is no ‘one size fits all’ approach to creating an MCP – the structure and configuration of the model will depend on local capability and need. There needs to be a focus on putting people at the centre, rather than debate over various organisational structures. The ability to create a local model has to be balanced by the need to maximise benefits from economies of scale, which is particularly important when wrapping county or regional services such as ambulatory care around the patient. It is well known that the primary and community model of care needs to be based on populations of between 30,000-50,000 as a
minimum to be sustainable and this has been accepted within our new primary care strategy. We will incorporate key learning about from the vanguard sites which have developed new models of care.

We will work to develop a workforce with more generalist skills to increase versatility and flexibility. This will be strengthened by specialist consultant support when required. It is our intention to develop a community service specification based on outcomes and commissioned on a capitated budget basis.

The robustness of community provision will be key to delivering the integrated health and social care provision that will provide wraparound care closer to home. This is being developed from the My Care, My Way – Home First programme, which will deliver step up and step down intermediate care. The Primary Care Local Implementation Plan will play a key role in designing the MCP model of care, which in turn will align to the Together We’re Better Programme.

We will need to effectively manage the transition from existing services to the new models of care and we will work collaboratively with providers and stakeholders as we move services and funding from one part of the system to the other.
EMERGING THEMES FROM THE PUBLIC CONSULTATION ABOUT “MY CARE, MY WAY”

AUTUMN 2015

Whole person approach

- Problems don’t happen in isolation. Treat the person first, not the illness, assess the social circumstances, issues, problems, family circumstances.
- Patients are the experts in their own care – involve and empower them to make joint decisions with their healthcare professionals and their families.
- Understand and treat the whole person - e.g. do they need practical advice to support them that would help alleviate issues (finance advice, housing support etc.)
- Services should follow the patient, not the other way around.
- Improve in-patient discharge planning.
- Some people don’t have a home or a community or a safe house to go – what happens to these people? They also need the personal touch.
- Respect the “normal home circumstances” of people.
- Meaningful choice for people with specific needs (e.g. sensory impairment) for example, working with a BSL interpreter is not necessarily the most appropriate way for some deaf people.
- 24 hour services that wrap around patients and support discharge.

Support for carers and families

- Carer and family support, both in a one to one and group settings are key to the recovery of patients (links to the whole person approach).
- Support carers to prevent admission to hospital.
- Transport is important for families, carers and the patient for ongoing treatment.
- If you rely on public transport, visiting or appointments can take several hours and be expensive.
Access to treatment

- The role of GP as most people’s first port of call is important – The initial response a patient gets shapes their experience through the system.
- Easy accessible medical assessment in a crisis.
- Need to have one place; one contact number for people to have for when things happen
- There should be good care for all but cultural difference need to be rigorously observed.
- Make information available to everyone on where services are for patients already in the system, clear information about who to contact if they are in crisis.
- Clear, easily understandable information should be widely available to everyone which will support prevention.
- Use of community and voluntary organisations and teams to provide services and support people and made part of the care plan
- Difficulties in accessing GP appointment’s

Co-ordinated services

- Joined up compassionate services between agencies – it shouldn’t be the patients responsibility to make sure everyone knows their situation.
- Fill the gap between primary and secondary care
- Outpatient services need to be more joined up with in hospital care and what is available in the community
- Use expertise in the community and voluntary sector to support patients before crisis, and after discharge.
- Clear signposting for patients so they know who to contact when.
- More innovative approach on working together by different agencies – not competing.
- Build a stronger resilient communities, promoting cooperative working, involvement of community services and resources, involvement of community members

Quality

- Service equality of everyone- a lot of work is required to provide high quality services to BME, disability and sensory communities.
- Respectful and focused on recovery and outcomes, delivered by well trained staff.
- Open and honest monitoring of services
- Education and training for the deaf community is poor. Staff in all areas of the NHS including CCG’s should have deaf awareness training – the basic training is needed
- Maintain and aim to improve standards but be aware that change can be unsettling for patients.
Be Bold

- Consider new approaches to care which include widening who and what patients can have access to as a matter of course.
- Look at the language used—this can affect how people perceive patients. Also consider language that patients hear—“complex”, “Intervention” are negative words and need redefining change to “here to help” or “supporting you”
- Reduce the stigma of mental health by having clear messages to make people question their own behaviour. This will help people identify when they have a mental health issue but not scared to seek help.
- One compliment/complaint service to ensure independent reporting
- Invest in education programme in general.
- Prevention agenda is hugely important

Investment

- Sufficient resources to respond to individual need particularly in the community
- Training/ more GP’s in community services
- Innovative ways for the increased use of pharmacy services i.e. based within GP surgeries

Communication/Education

- Communication with staff and patients
- Joined up conversations between agencies
- Sharing information effectively and universal service involvement e.g. fire service, more community involvement
- Telephone contact with people that patients need
AUTHOR | REPORTING OFFICER /DIRECTOR
---|---
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Title | Commissioning Manager
Name | Cheryl Hardisty
Title | Director of Commissioning

REPORT TO | Stoke-on-Trent Governing Body

TITLE OF REPORT | Pan Staffordshire Wheelchair Procurement

DATE OF THE MEETING | 7th June 2016

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

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<td>Record which committee/group have already seen this report, note date and comments (if applicable)</td>
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ACTION REQUIRED FROM

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RECOMMENDATION
The Governing Body is asked to:

- **Note** the process to date of the procurement process of the Wheelchair Service;
- **Note** the timeline detailed within the report, including the contract award date of no later than the 23rd September;
- **Note** that the Stoke-on-Trent CCG Governing Body meeting of 2nd August 2016 does not correspond with the procurement timescale and therefore approval for delegated authority is requested to the following subcommittees:
  - **Note** that a progress report on the procurement process, including engagement and specification will be received and reviewed at the Joint Planning Committee on the 12th July 2016, prior to the approval of the contract award decision at the Joint Finance and Performance Committee on the 23rd August 2016, on behalf of the Governing Body.
  - **Note** that the outcome of the above will be reported to the next available Stoke-on-Trent Governing Body meeting on the 4th October 2016.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER
(identify appropriate goals)

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>1. Improve access</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2. Improve health outcomes</td>
<td>✓</td>
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<tr>
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<td>✓</td>
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<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
<td>✓</td>
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</table>
The purpose of the report is to provide information to date and assurance regarding the procurement process currently being undertaken for the ‘Staffordshire Wheelchair Service’ including timelines, engagement and governance process.

The report also seeks Governing Body to grant delegated authority to the Finance and Performance Committee to ensure that the contract award can be undertaken at the appropriate time of no later than 23rd September 2016.

### SUMMARY OF RISKS RELATING TO THE PROPOSAL

Any delay to the procurement timescales may result in delay in the award of the contract by the 23rd September 2106 which would then impact on the mobilisation period.

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

N/A

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

An Equality Impact and Risk Assessment (EI &RA) stage 1 Checklist has been completed (1/3/16) and a peer review undertaken (7/4/16).

Equality Impact and Risk Assessment (EI &RA) stage 2 is in the process of being completed and will be finalised following the completion of the engagement period on the 24th May 2016.

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

A bespoke patient and carer survey has been developed and circulated to local communities of interest to raise awareness of the request for feedback.

Commissioners have visited a range of patient and parent/carer groups and wheelchair clinics in North and South Staffs to speak with users of the service, request their completion of the survey and gain their feedback.

- North Staffs Wheelchair Users Group – 2nd March 2016
- Meeting with Chair of Saxon Hill Special School Parents Committee
- Multiple Sclerosis patient/carer group – 16th & 20th May 2016
- Stoke on Trent Parent Carer Forum – 18th May 2016
- North Staffs wheelchair clinics – 13th & 19th May 2016
- Staffordshire wheelchair clinic – 19th May 2016

### ACRONYMS

- EI &RA - Equality Impact and Risk Assessment
- ITT - Invitation to Tender
- OJEU - Official Journal of the European Union
- KPIs - Key Performance Indicators
- SSOTP - Staffordshire and Stoke on Trent Partnership Trust
Pan Staffordshire Wheelchair Procurement

1. Introduction

The purpose of the report is to provide information regarding the procurement process for the ‘Staffordshire Wheelchair Service’ including timelines, engagement and governance process.

2. Background

2.1 Current wheelchair services (all ages) for both North and South Staffordshire are provided by Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP) under separate contracts.

2.2 South Staffordshire CCGs under procurement law are required to go out to tender for their service and it has been agreed that this would be an opportunity for a pan Staffordshire approach to procurement of wheelchair services.

2.3 Notice of termination of service has been formally issued to SSOTP on the 18th February 2016 with the expectation that the service will terminate on the 8th January 2017.

2.4 An advert for expressions of interest has been issued on OJEU (Official Journal of the European Union) contracts finder in March 2016 including the intention to publish the Invitation to Tender (ITT) on 8th April via the Midlands and Lancashire Commissioning Support Unit (CSU) Bravo e-tendering solution.

2.5 The publication of the ITT has been postponed until the 31st May to allow for a period of engagement with service users and carers.

2.7 Patient and carers voices will also be listened to throughout the process from input into the service specification etc. through to patient representation at the evaluation panel.

2.8 To ensure the mobilisation timeline is adhered to the CCGs will need to ensure that the contract award is no later than 23rd September.

3. Procurement timelines

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Start Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>• Draft &quot;notice&quot; finalised</td>
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<td></td>
</tr>
<tr>
<td>• Advert OJEU/ Contracts Finder</td>
<td>Complete</td>
<td></td>
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<tr>
<td>• Expressions of Interest return</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>• Drafted Documents with specification, Invitation to Tender (ITT)</td>
<td>Feb 16</td>
<td>May 16</td>
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<tr>
<td>• questions and pricing schedule</td>
<td></td>
<td></td>
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<tr>
<td>• Agreed Scoring Matrix and Weighting</td>
<td>Feb 16</td>
<td>May 16</td>
</tr>
<tr>
<td>• ITT questions and scoring matrix finalised</td>
<td>Feb 16</td>
<td>May 16</td>
</tr>
<tr>
<td>• Evaluation scoring panel selected</td>
<td>Feb 16</td>
<td>May 16</td>
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</table>
4. Engagement

4.1 At the time of writing, a period of engagement is being undertaken and is due to close on the 24th May to obtain service user and carer feedback on their experiences of the current service.

4.2 A bespoke patient and carer survey has been developed and circulated to local communities of interest to raise awareness of the request for feedback.

4.3 Commissioners have visited a range of patient and parent/carer groups and wheelchair clinics in North and South Staffs to speak with users of the service, request their completion of the survey and gain their feedback.

4.4 Feedback will be incorporated as appropriate in the development of the specification, ITT questions and in Key Performance Indicators (KPIs).
4.5 Users and carers will be represented on the Tender Evaluation Panel.

6. **Recommendations**

The Governing Body is asked to:

- Note the process to date of the procurement process of the Wheelchair Service;
- Note the timeline above, including the contract award date of no later than the 23rd September;
- Note that the Stoke-on-Trent CCG Governing Body meeting of 2 August 2016 does not correspond with the procurement timescale and therefore approval for delegated authority is requested to the following subcommittees:
- To note that a progress report on the procurement process, including engagement and specification will be received and reviewed at the Joint Planning Committee on the 12th July 2016, prior to the approval of the contract award decision at the Joint Finance and Performance Committee on the 23rd August 2016, on behalf of the Governing Body.
- Note that the outcome of the above will be reported to the next available Stoke-on-Trent Governing Body meeting on the 4th October 2016.
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Lorraine Cook</th>
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<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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<tbody>
<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
7th June 2016

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

<table>
<thead>
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<th>COMMITTEE/GROUP</th>
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<tbody>
<tr>
<td>Joint Quality Committee – April and May 2016</td>
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ACTION REQUIRED FROM COMMITTEE / GROUP/ GOVERNING BODY

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<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
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<tr>
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RECOMMENDATION
The Governing Body is asked to note the contents of the report and request further information as required.

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 focusses on items of business discussed at the Quality Committee meetings held in April and May 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 April and May 2016 Committee meetings)

1. 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 at each of its meetings.

Members noted that the Clostridium difficile objectives for 2016 / 2017 have now been published and the objectives for both acute provider trusts and CCGs remain unchanged for 2016 / 2017. This has been prompted by the fact that there has been a slight increase in the median CDI rate from the year to November 2014 to the year November 2015. In addition, sanction implementation guidance has been issued which outlines that only the total of cases associated with lapses in care should be used as a basis upon which to apply contractual sanctions.

Stoke-on-Trent CCG reported 112 CDI cases during 2015 / 2016 against a trajectory of 87.

Members received assurance on the forums established on a Staffordshire wide basis responsible for reviewing and refreshing the Health Economy Clostridium difficile Recovery Plan.

2. Safeguarding Update - Children
Members received a Safeguarding Children’s Report, key points to note:

PREVENT
Members received an update on the PREVENT Statutory Duty which came into effect on the 1st July 2015 and is aligned to the NHS Contract. The CCG’s PREVENT Lead, Paula Carr – Safeguarding Nurse for Children advised that an e-learning package will soon be available for all staff to complete which is a mandatory requirement linked to a statutory competency framework. The CCG is required to report to the Regional Prevent Coordinator on a quarterly basis and will need to demonstrate 100% compliance by the end of quarter 1.

Child Sexual Exploitation
The CCG’s Safeguarding Nurse – Children advised of a campaign designed to raise awareness and understanding of child sexual exploitation, recognition of the warning signs and the increase reporting. By working in a co-ordinated way across the partnership, and by encouraging local organisations supporting young people and parents to use the campaign materials and take part, we aim to make an emotional connection and overcome people’s barriers to reporting.

3. Safeguarding Update - Adults
Members received a Safeguarding Adult’s Report, key points to note:

Domestic Homicide Reviews
Members received a progress report on areas discussed at the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board along with an update in respect of the two reports relating to domestic homicide reviews (DHR) recently published. Members received assurance that action plans from these DHRs are in place and monitored via the safer community partnerships and other relevant groups / Boards and lessons learned are shared widely.

Statutory Guidance to support local authorities in the implementation of the Care Act 2014 (Updated March 2016)
Members received an update on the key changes to the above statutory guidance relating to safeguarding at chapter 14 and noted that the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Policies and Procedures have been revised in light of these ready for final approval and relaunch.
4. Outcomes of the Citizens Jury Report into Diabetes
The Quality Committee received an update on the progress being made in implementing the action plan agreed following the recommendations of the Citizens Jury Report into Diabetes Care. Members noted that many actions had progressed and contractualised where appropriate. A buddying scheme is also in operation involving 9 consultants buddying with GP Practices, providing face to face and in year support, and this is monitored through the Clinical Network and Patient Congress.

The Quality Committee congratulated the team on this excellent piece of work and progress being made.

5. Primary Care Quality Assurance and Improvement
Members received a Primary Care Quality Assurance and Improvement Report, key points to note:

Primary Care Strategy
Members noted that the Primary Care Strategy had now been approved by the Governing Body of both North Staffordshire and Stoke-on-Trent CCGs and work continues on the development of a local implementation plan to support delivery of the strategy. Discussions are continuing in GP localities about practices working at scale and new models of working, including hubs and multi-speciality community provider models.

CQC Inspections
The CCG’s Primary Care Team have recently met with the CQC Inspector on the process and performance of the practices. Dr Rees and Lefroy’s practice in Stoke-on-Trent have been given a rating of outstanding for their recent inspection.

General Practice Nurse Evidence Based Practice Group
Members received an update on the work undertaken by the group which brings together interested practice nurses / nurse practitioners who work in collaboration with academics and researchers from Keele University. This work focussed on ‘Critically Appraised Topics (CATs): A method of integrating best evidence into general practice nursing.’

The group identified a number of areas where variation in treatment and practice was evident. Specifically, the group identified variations in clinical practice between practices and community nursing teams relating to the use of sterile saline for wound cleansing. This example of the group’s very first CAT question identifies the potential of a small team of clinical champions to influence and improve not only variation but quality and cost-effectiveness of practice.

The group are currently addressing their next CAT question relating to the management of croup and are rapidly developing a bank of questions in relation to other clinical areas.

Group numbers have increased at every meeting and have had their work published in the journal ‘Practice Nurse’ (March 2016) and have presented at the Annual General Practice Nurse Conference with the RCN and HEE in March 2016. The group hope to submit a second publication following the implementation of their first CAT question findings.

6. Quality Reports

6.1 North Staffordshire Combined Healthcare NHS Trust (NSCHT) CQC Quality Report
Following the comprehensive inspection, which included an announced inspection visit during week commencing the 7th September 2015, the Care Quality Commission (CQC) published their findings on the 22nd March 2016. The full report can be accessed here: http://www.cqc.org.uk/provider/RLY

Quality Committee members received this full report at its meeting on the 13th April 2016 noting that the CQC found that NSCHT were performing at a level which led to a judgement of ‘Requires Improvement’.
Members noted that at the Quality Summit held on the 16th March 2016 – an event held as part of the CQC process to report on their findings and provide the Trust with an opportunity to feedback on actions taken and those underway – the Trust outlined the progress made in the six months since the inspection.

The Trust’s overarching action plan submitted to the CQC was discussed at the Clinical Quality Review meeting on the 29th April 2016 where the CCG agreed to work with the Trust to support them in implementing and evidencing implementation of the action plan. Progress will be reported to future meetings of the Quality Committee.

6.2 Staffordshire and Stoke-on-Trent Partnership Trust (SSOTP) CQC Inspection
Following the comprehensive inspection, which included an announced inspection visit during week commencing the 2nd November 2015, the Care Quality Commission (CQC) published their findings on the 11th May 2016. The Quality Summit took place on 10th May and was attended by Jayne Downey (Director of Nursing and Quality). The CQC found that SSOTP were performing at a level which led to a judgement of ‘Requires Improvement’.

The full report can be accessed here:

The Quality Committee will consider the full report at its next meeting along with discussions and review of the action plan at a Clinical Quality Review meeting.

Pan Staffordshire CCGs continue to monitor staffing levels and skill mix at SSOTP. The Trust continues to report to their Board that safe staffing has been maintained across the community hospital in patient wards and that there has been no patient safety incidents as a result of staffing. However, turnover has increased and recruitment to vacancies at the community hospitals remains low. The Community Nursing Assurance Group, chaired by the Director of Nursing and Quality, receives a monthly breakdown of staffing and capacity in District Nursing Teams across the county. The Trust is continuing to proactively administer a programme of interviews for a variety of nursing vacancies and has commenced the international recruitment process and established strong links with Keele.
6.3 University Hospitals of North Midlands (UHNM)
Members noted that following the publication of the CQC Report in July 2015 the Trust developed an action plan to address all the recommendations of the report which has been monitored and discussed at the Clinical Quality Review meeting. Members noted that the Trust has met with the CQC one year after their initial inspection to review the progress UHNM have made with the actions within the improvement plan. The CQC were satisfied with the progress and raised no concerns.

In addition, in May the CCG invited to join UHNM on an unannounced visit to the A&E Department at Royal Stoke site when they were on escalation level 4 and the department was extremely busy. The CCG continues to receive root cause analysis reports for 12 hour breaches and attends the Trust’s internal review meetings for 12 hour breaches, pressure ulcers and falls to ensure patients are suffering avoidable harm and that learning themes are identified and appropriate action is taken. The Clinical Quality Review meeting continues to focus on seeking assurance that patients have not come to harm as a result of breaches of NHS Constitution targets e.g. long waits.

Quality Committee discussed the assurances received when the 80% fill rate as suggested by NICE is not achieved. Following on from the April Clinical Quality Review Meeting, UHNM submitted a report detailing their short, medium and long term actions in reviewing safe staffing levels on a monthly basis, which should have an impact at differing times over the next 3 years. CCGs will be working closely with UHNM to seek further assurance around safer staffing levels.

6.4 Staffordshire Doctors Urgent Care (SDUC)
Members noted that Staffordshire Doctors Urgent Care Clinical Quality Review Meeting became Pan Staffordshire during October 2015 and meets on a bi-monthly basis with an interim meeting / conference call taking place during the interim month. Members noted that there are approximately 30 key performance indicators in place with challenges being seen on meeting KPIs relating to workforce. SDUC have introduced a comfort calling protocol in addition to the contract to ensure that all patients are kept informed regarding timescales and delays along with identifying any changing or deteriorating symptoms which might indicate re-prioritisation of their case.

7. Quality Accounts
The CCG has been invited to make a Commissioner statement in respect of the Quality Account by our main NHS provider Trusts; NSCHT, SSOPT and UHNM. Commissioners have until the 27th May to provide a commissioner statement for inclusion verbatim within the Provider’s Quality Account 2015 / 2016. Providers then have to make their Quality Accounts publically available on the NHS Choices website by the 30th June 2016. Members received assurance on the process in place to undertake this in line with the above timescales.

Members received the report which detailed the key quality matters relating to quarter 3 2015 / 2016 noting that the CCGs meet with Douglas Macmillan Hospice twice annually via the Staffordshire Hospices Clinical Quality Review Meeting to monitor and seek assurance on the quality of services provided. Whilst the CCGs do not hold an NHS Standard Contract with DMH and therefore there are no KPIs or explicit reporting requirements, the DMH submit their internal quality report to CCGs and offer the opportunity for quality visits to take place. The last CQC Inspection undertaken on the 5th and 6th August 2014 was published on the 3rd February 2015 with an overall rating of ‘good’.

9. Patient Experience
The Quality Committee received a presentation and Insight (Patient Experience & Membership Feedback) Report 2015/16 Quarter 4 (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 294 feedback contacts recorded in the quarter by the following methods: Soft Intelligence – patient based (118), PALS (83), Media (50), MP Letters (11) and Complaints (31).
Stoke-on-Trent CCG directly received 17 complaints; this in line when compared with the previous quarter (14). The services the complaints were about include: NSL Patient Transport (3), Royal Stoke (4) and a further 10 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 is within the patient experience domain of ‘access and waiting’ which is consistent with previous quarters. Whilst the complaints received relating to Royal Stoke were for different services, when triangulating patient feedback received via complaints and PALS across both Stoke-on-Trent and North Staffordshire CCGs a small theme relating to patient experience within A&E was apparent, reflective of the current pressures. These examples of patient feedback are to be shared at the next Clinical Quality Review meeting for discussion and utilised at future quality visits.

Members also received the Annual Datix Review (GP Reported Events) for 2015 / 2016. Members noted the increase in GP Practice engagement over the last 12 months resulting in increased reporting which is pleasing to see. In 2015/16 there were 1154 events reported on Datix at practice level. This is a 21% increase from 2014/15. Out of 85 GP Practices, 80 have reported at least 1 event on the Datix system. This equates to 94% of the practices across North Staffordshire and Stoke on Trent.

2015 / 2016 has seen a number of changes within services as a direct result of reporting. These are disseminated to GP Practices and the CCG via the quarterly Datix newsletter 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.

11. Patient and Public Involvement

Members received a progress report on actions that have been put into place to develop the CCGs’ capacity and capability for this work in 2016 and beyond. Recent engagement activities involve a listening event held on the 27th January focussing on out of hours and front of house care, and walk-in centres and special educational needs and disability (SEND). The CCG has shared the feedback with commissioners to shape those services moving forward.

In addition, both Patient Congresses met in April, and received feedback from the My Care My Way – Home First Engagement and Consultation.

12. Healthwatch Stoke-on-Trent and Staffordshire Report

Members received the first joint Healthwatch Stoke-on-Trent and Healthwatch Staffordshire quarterly report which contained a summary of ongoing and recently finished focussed pieces of work completed to assist the Quality Committee in triangulating its intelligence to assist the work of the committee.

The report covered the following areas:
- Outpatient Survey – the results show that for the great majority, patients are happy with the service they receive at Royal Stoke. There was a suggestion in the feedback that more work can be done to better understand communication between the hospital and patients.
- Dementia Carers Project (ongoing)
- My Care My Way (ongoing)
- Homeless Access to Primary Care (ongoing)
- While we were waiting (CAMHS) (ongoing)
- Neurology (ongoing)
- Independent Living Fund (ongoing)
- Access to Community Services (ongoing)
- Supporting People Initiative Project (ongoing)
- Support for Carers Phase 3 (ongoing)
- GP Access Follow Up (ongoing)
**AUTHOR**

<table>
<thead>
<tr>
<th>Name</th>
<th>Alistair Mulvey</th>
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<tr>
<td>Title</td>
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**REPORTING OFFICER /DIRECTOR**

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**REPORT TO**

Stoke-on-Trent Governing Body

**TITLE OF REPORT**

2016/17 Planning Update

**DATE OF THE MEETING**

7th June 2016

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

<table>
<thead>
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<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
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<tr>
<td>Joint Finance and Performance Committee</td>
<td>Iain Stoddart, CFO</td>
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**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD**

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

For the Governing Body to note the timeframes and actions undertaken in developing the 2016/17 financial plan. The submitted plan highlighting an in year deficit of £1.7m.

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

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

The presentation is presented to provide members with an outline of the key areas of the 2015/2016 finance accounts and the 2016/2017 planning.

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**

N/A

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

N/A

**QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT**
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2015/16 Outturn and 2016/17 Planning

To update the Stoke on Trent Governing Body on the audited 2015/16 outturn position and the planning position for 2016/17 as at 7th June 2016
Overview

• 2015/16 accounts submitted on time to deadline
• Detailed review at Audit Committee 24th May 2016
• “Clean Audit Opinion”
• Outturn surplus £0.5m v’s £3.7m plan surplus
• Control total missed by £3.2m
• Shortfall against plan control total to be addressed in coming financial periods
• Tighter financial regime required for 16/17
• Higher level scrutiny of monthly reporting
2016/17 Planning Timeline

• The plan has been developed and shared through various iterations
• Initial work with NHSE area team summer 2015
• Allocations / Pbr published December 2015
• First cut plan submission Jan (summary level)
• First cut detail plan Feb
• Second cut March
• Final submission April
• Detailed budgets presented to Finance and Performance Committee on 26th April 2016
• Further submission re outturn May
• Final submission post contracts expected June
Construct of Plan

- Plan developed in line with strategic intent, with broad based engagement and based upon detailed analysis of volumes of activity required, over layered with national volume and pricing assumptions and requirements. Specifically
  - Activity
    - 3 year growth trend analysis – understand demand
    - Reflection of unplanned, planned and cancer trajectories and access targets – understand access targets
    - Compliance with 1% QIPP limit as “identified”
    - Volume abatement through “unidentified” QIPP
  - Financials
    - In year deficit
    - Application of national business on headroom and contingency
    - Application of national pricing and relevant “rules”
    - Financials driven by volumes and price of care
    - Non contracted QIPP still in discussion, reflected as negative budget
    - Risk management central to plan discussions
2016/17 Plan – submitted April

- CCG’s in year **deficit** – £1.7m
- QIPP requirement £13.2m (3.43%)
- As per NHSE guidance budget upload reflects this plan
- SSoTP Arbitration outcome has generated a further c£2m of risk

<table>
<thead>
<tr>
<th>Spend Area</th>
<th>Stoke 16/17 Planned Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>187,325</td>
</tr>
<tr>
<td>Mental Health</td>
<td>43,447</td>
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<tr>
<td>Community</td>
<td>58,488</td>
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<tr>
<td>CHC</td>
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<tr>
<td>Primary Care</td>
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<tr>
<td>Other</td>
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</tr>
<tr>
<td>Reserves</td>
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<tr>
<td><strong>Total Programme Costs</strong></td>
<td><strong>380,840</strong></td>
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<tr>
<td>Running Costs</td>
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<tr>
<td><strong>Total Costs</strong></td>
<td><strong>386,808</strong></td>
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<tr>
<td><strong>In Year Deficit</strong></td>
<td><strong>1,710</strong></td>
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2016/17 Plan – Risks / Mitigations

<table>
<thead>
<tr>
<th>Financial Plan Risks 2016/17</th>
<th>Stoke on Trent CCG</th>
<th>Control Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHNM QIPP yet to be fully contracted, discussions continue with agreements to CV in year</td>
<td>5,613,459</td>
<td>Detailed schemes are fully developed and being implemented, 33% of schemes currently contracted</td>
</tr>
<tr>
<td>SSoTP QIPP not contracted</td>
<td>1,071,000</td>
<td>Detailed schemes are fully developed and contract variations/procurement processes being undertaken, notice being given May 2016</td>
</tr>
<tr>
<td>Acute Contracts</td>
<td>50,000</td>
<td>Forensic analysis of performance and rigorous application of contract approach as undertaken in 2015/16</td>
</tr>
<tr>
<td>In Year pressures/variations</td>
<td>750,000</td>
<td>Budgets resourced through planning process, strengthening of operational budget management and disciplines</td>
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<tr>
<td>SRG in excess of fines/penalties</td>
<td>1,200,000</td>
<td>Revised SRG governance process, development of approval systems and objective criteria for proposals assessment</td>
</tr>
<tr>
<td>Running costs/Programme re structure</td>
<td>250,000</td>
<td>Detailed review of running costs being led at Director level, including establishment panel with NED membership</td>
</tr>
<tr>
<td>Total Potential Risks being Managed within Base Plan</td>
<td>8,934,459</td>
<td></td>
</tr>
</tbody>
</table>


Summary

- Detailed plans developed through analysis and engagement
- Volume of care bought meets access targets
- 15/16 outturn may impact 16/17
- Arbitration impact will impact 16/17
- Increased level of QIPP, relative to 15/16, reflected in baselines
- Reflection of QIPP in baselines does not ensure delivery
- Key risks identified at outset as noted previously
- Planning for 17/18 and beyond to begin
- Service decisions must align to appreciation of financial impacts and be underpinned by tighter financial governance
- Increased higher level scrutiny of financial position each month.
<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>Governance Manager</td>
</tr>
<tr>
<td>Name</td>
<td>John Howard</td>
</tr>
<tr>
<td>Title</td>
<td>Lay Member for Governance / Chair of Audit Committee</td>
</tr>
</tbody>
</table>

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

**TITLE OF REPORT**
Audit Committee Chair’s Report – April 2016 Meeting

**DATE OF THE MEETING**
7th June 2016

**WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?**
- COMMITTEE/GROUP: Audit Committee – 19th April 2016
- INDIVIDUAL: John Howard, Chair of the Audit Committee

**ACTION REQUIRED FROM COMMITTEE / GROUP / GOVERNING BODY**
- Approve: X
- Assurance: X
- Discussion: X
- For noting: 

**RECOMMENDATION**
The Governing Body is asked to:
- Note the contents of the report and be assured that the Audit Committee have discharged its duties;
- Note the contents of the Audit committee chair’s report of the meeting held on the 19th April 2016
- Support and approve that the Audit Committee has the Governing Body’s delegated authority to act in the capacity of the CCG’s Audit Panel for the procurement of external auditors.
- Note the committee approved the submission of the draft Annual Report and Accounts for 2015 / 2016
- Note the extraordinary Audit Committee scheduled for the 24th May 2016, in which Governing Body Members are invited to attend, to approve the final Accounts and Annual Report for 2015 / 2016

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

<table>
<thead>
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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 briefing summarises the key issues discussed at the Audit Committee on the 19th April 2016 and aims to provide to the Governing Body formal assurance on the CCGs system and processes reviewed by the Audit Committee, highlight any areas of concern and support the preparation of the CCG’s Annual Governance Statement for inclusion in the Annual Report 2015 / 2016.

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**
Detailed within the report.

**ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS**
Annual Report and Accounts Statutory obligations

**QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT**
N/A

**ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT**
N/A
1. **Introduction**

1.1 This briefing summarises the key issues discussed at the Audit Committee on the 19th April 2016 and aims to provide to the Governing Body formal assurance on the CCGs system and processes reviewed by the Audit Committee, highlight any areas of concern and support the preparation of the CCG’s Annual Governance Statement for inclusion in the Annual Report 2015 / 2016.

1.2 Jayne Downey, Director of Nursing and Quality was welcomed to her first meeting of the Audit Committee meeting.

2. **Key Headlines**

The key headlines from the April 2016 meeting to which the Committee wish to draw the Governing Body’s attention to are as follows:-

2.1 **Internal Audit Annual Report and Compendium of Final Reports**

Internal Audit presented their annual report which included the Head of Internal audit Opinion (HOIA). The Head of Internal Audit concluded that:

*“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”.*

The Governing Body was appraised of the draft opinion via the Audit Committee Chair’s Report at the last meeting and can be assured that this opinion remains unchanged. Factors and findings which have informed their final opinion are as previously advised and detailed below:

- Delivery of the CCG Financial Recovery Plan (FRP) – Phase One
- Stoke-on-Trent Clinical Commissioning Group Better Care Fund - Governance

The following final report has been issued which has also informed the opinion, this relates to:

**Primary Care Co-Commissioning – Governance and Conflicts of Interest**

The CCGs (Stoke-on-Trent CCG and North Staffordshire CCG) have attained approval to undertake commissioning of primary care services jointly with NHS England (level 2). Both CCGs aspire for approval to commission such services autonomously (fully delegated, level 3). The proposed arrangements for co-commissioning present additional risks to the CCGs in respect of potential conflicts of interests of its members, executives and officers, particularly where interests are held in GP practices within the CCGs’ boundaries. The arrangements for managing such potential risks and for maintaining transparency should be sufficiently robust to bear scrutiny and challenge and to ensure that the CCG and its officers remain above criticism. The collective CCGs are putting in place arrangements that will ensure that the associated risks are managed appropriately.

The Internal Audit review confirmed that many of the arrangements needed are already in place. However, identified a number of areas where the arrangements could be strengthened before full delegation is granted. Several issues were highlighted with the governance arrangements at the Joint Commissioning Meeting which is administered by NHS England. However, the collective CCGs need to protect themselves against any possible deficiencies which may occur, particularly in the management of conflicts of interest at the meeting. Internal Audit has therefore raised a number of management actions based around the CCGs as a whole highlighting issues to the administrators of the meeting.

In the remainder of work, all received either substantial or reasonable assurance. Where weaknesses have arisen, these have been incorporated within the CCG’s 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.
2.2 Local Counter Fraud Services
The Committee received the Anti-fraud Service Annual Report which outlined the work undertaken during 2015 / 2016 against the agreed anti-fraud work plan. The plan of work was set against the NHS Protect Fraud Standards for Commissioners, which were introduced during 2015/2016.

A summary of actual work against planned showed that the main area for under delivery to date related to the Hold to Account/contingency category which reflected the fact that there has only been two referrals for the year.

2.3 Internal Audit/LCFS Procurement Summary
During the latter part of 2015 / 2016 the CCG along with the other five CCG’s in Staffordshire undertook a formal procurement exercise for the provision of internal audit and local counter fraud services. Following a competitive procurement exercise PriceWaterhouseCoopers (PWC) was appointed to provide both internal audit and counter fraud services with effect from 1 April 2016 for a three year period, with an option to extend this for a further two years. The Committee were asked to approve the awarding of the contract.

One of the first pieces of work PWC are undertaking on behalf of the Chief Finance Officer is a ‘finance effectiveness exercise’ which will be reported back to members of the Audit Committee.

Members requested assurance of handover arrangements and progress towards developing the Internal Audit Plan for 2016 / 2017 involving the Chair of the Audit Committee at North Staffordshire and Stoke-on-Trent CCGs.

2.4 Planning for Commencement of Local External Audit Arrangements 2017/18 onwards
As from the financial year 2017, CCG’s will be responsible for selecting, appointing and managing contracts of external auditors. Legislation within the Local Audit and Accountability Act 2014 requires that the auditors are appointed by the 31st December 2016.

Each CCG is required to set up an Audit Panel. The Audit Panel functions are to advise the Governing Body on the selection and appointment of the external auditor, ensuring that this contract is finalised by the 31st December 2016.

This role includes:
- Agreeing and overseeing a robust process for selecting the external auditors in line with the organisation’s normal procurement rules.
- Making a recommendation to the Governing Body as to who should be appointed.
- Advising the Governing Body on the maintenance of an independent relationship with the appointed external auditor.
- Advising the organisation’s Governing Body on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
- Advising on and approving the contents of the organisation’s policy on the purchase of non-audit services from the appointed external auditor.
- Advising the organisation’s Governing Body on any decision about the removal or resignation of the external auditor.

The proposal is that the Procurement will be undertaken in conjunction with the other 5 CCGs in Staffordshire.

The Governing Body are asked to support and approve that the Audit Committee has the Governing Body’s delegated authority to act in the capacity of the CCG’s Audit Panel for the procurement of external auditors.
2.5 External Audit

2.5.1 The Audit Committee received a briefing in respect of the risk assessment undertaken on the CCG and a progress report. The auditors are required to obtain an understanding of management processes on the following areas:

- Fraud
- Laws and Regulations
- Going concern
- Related parties
- Accounting estimates

The Audit Committee were asked to consider whether the responses received from managers within the CCG was consistent with its understanding and whether members had any further comments we wanted to make. The committee concurred with the comments recorded by management.

2.5.2 The progress report provided a summary of the findings from the interim work completed to date. The auditors had no specific issues to raise, but flagged the accounting treatment of the Better Care Fund as an area the CCG need to consider.

2.5.3 The Audit Committee were asked to approve the External Audit planned fee for 2016 / 2017 of £56,250 as set out in the fees letter, noting that it is set by the terms of the external contract let by the Audit Commission (formerly PSAA).

2.6 Assurance Framework / Risk Register

The Committee received the above report, for the year ending the 31st March 2016. Members noted that:

- all eight principle risks detailed within the Assurance Framework are being carried forward into 2016 / 2017 as they remain active principle risks that may threaten the delivery of the CCG’s strategic objectives;
- the Audit Committee supported the suggestion that the following two risks are reviewed by the Joint Finance and Performance Committee with regard to the proposal to increase the risk score (noting that due to the timing of meetings, this would take place after the meeting of the Audit Committee)
  - 67 – there is a risk that the organisations will not deliver its agreed financial plans leading to the failure to achieve its statutory duties
  - 74- there is a risk that the CCGs fail to demonstrate or provide assurance to NHSE on their successful delivery against the requirements of the planning framework leading to interventions be reviewed

The Committee supported the joint Assurance Framework Risk Register be discussed and reviewed at a future Joint Board Seminar to enable alignment of strategic objectives across both CCGs and identify any new emerging risks.


The Committee received the above report noting the following:

- The closure of the backlog of breached FOI’s reported to the last meeting by the 31st March 2016.
- The new style of reporting by the FOI team which identifies any breaches and where these delays have occurred.
- The change in the operational system within the CCG from the 1st April 2016 and the implementation of an escalation process both within the CCG and the CSU.
2.8 Information Governance Annual Report 2015 / 2016
The annual report provides the CCG with a final overview of the information governance improvements plan for 2015-16. The contents of the annual report were approved by Iain Stoddart as Senior Information Risk Owner (SIRO) on the 21st March ahead of the deadline of the 31st March 2016. This report was submitted to the last meeting of the Governing Body in April 2016 and was reviewed by the Audit Committee retrospectively at this meeting.

The CCG submitted an overall score of 91% which is a slight increase on the score achieved for 2014/15 of 86%.

2.9 Draft Annual Report and Accounts 2015 / 2016
The Committee received the above and were asked to approve its submission prior to the deadline of Friday 22nd April 2016.

The Committee recognised that this was still a draft and that some data is not available until the middle of May and therefore this report will be updated prior to final submission by the 27th May 2016.

The Committee was assured that areas highlighted by Internal Auditors for inclusion in the Annual Governance Statement have been actioned and key issues arising from the accounts are shown below:-

- The financial performance for the year against the Revenue resource limit is shown as a surplus of £503,000 against an initial target of £3,731,000 which was later reduced to £486,000. This reflects the achievement of financial duty in this area;
- The CCG did not exceed its running cost allowance, with actual spend reported as £5,822,000;
- The CCG are required to achieve a cash balance of no more than 1.25% of the March monthly draw-down. The CCG achieved this with a closing cash balance of £90,957 (0.375%).

In addition, members reviewed the contents of the Remuneration Report and received assurance that this had been reviewed by the Chief Finance Officer prior to submission to Audit Committee.

2.10 Other areas reviewed by members of the Committee included:

2.10.1 Financial Position Statement 2016 / 2017 – an update of the development of the financial plans for 2016 / 2017 and thereafter and the review of the processes that support the financial management of the CCG.

2.10.2 Review of Scheme of Reservation and Delegation – the committee received the new proposed layout and that the new proposal will be received at the Audit Committee in June 2016.

2.10.3 Recommendation Audit Tracker Report - The Committee received a progress report detailing the implementation by the CCG of agreed management actions in response to recommendations made by Internal Audit as part of their review of system and processes operating within the CCG. The Audit Committee were assured of the progress made.

2.10.4 Single Tender Actions – The Committee noted the authorisation of one waiver since the last meeting. A detailed log will be included with future single waiver submissions to enable the Committee to monitor the frequency and detail of all waivers throughout the year.
2.10.5 Quality Committee Annual Report 2015 / 2016
The Committee received a comprehensive report on the Quality Committee’s activities during the year which provided assurance to members that the Quality Committee has fulfilled its delegated responsibly in accordance with its terms of reference for 2015/16.

The Quality Committee:–
• Is accountable for taking a holistic view of the quality of commissioned services across all healthcare providers enhancing the board oversight of quality performance and risk.
• Has continued to mature and strengthen its supporting structures which are becoming increasingly effective in providing robust monitoring and assurance.
• Can confirm from evidence provided throughout the year, confirmed by Internal Audit opinion, and in this report that the Governing Body can be assured that there are appropriate systems and processes in place to monitor the quality and safety of commissioned services, to promote quality improvements and to instigate actions to address any shortfalls.

2.10.6 CSU Auditor Reports 2015/16 (Phase 1 and Progress on Phase 2)
The Committee received the Phase 1 CSU auditor reports and noted the assurance provided by the Statutory Accounting Lead for Midlands and Lancashire Commissioning Support Unit that Phase 2 of the CSU auditor reports are due to be released no later than the 29th April 2016 and at this point in time through the audit process, no significant concerns have been raised.

2.10.7 Declarations of Interest and Hospitality and Gifts Register
The Committee received the quarterly update of the Governing Body Declarations of Interest Register to provide assurance to the Governing Body of the internal processes in place to monitor declarations within the CCG. There are no concerns to highlight to the Governing Body. In addition, the Committee received the Hospitality and Gifts Register for the period 2015 / 2016 noting that no items had been declared since the last meeting.

John Howard
Lay Member for Governance / Chair of Audit Committee
April 2016
**AUTHOR**
Name: Lisa Taylor  
Title: Governance Manager

**REPORTING OFFICER /DIRECTOR**
Name: John Howard  
Title: Lay Member for Governance / Chair of the Audit Committee

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

**TITLE OF REPORT**
Audit Committee Chair’s Report – Meeting Held on the 24th May 2016

**DATE OF THE MEETING**
7th June 2016

**WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?**
COMMITTEE/GROUP  
Audit Committee – 24th May 2016

INDIVIDUAL  
John Howard, Chair of the Audit Committee

**ACTION REQUIRED FROM COMMITTEE / GROUP/ GOVERNING BODY**
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<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

**RECOMMENDATION**
The Governing Body is asked to:

- **Note** the contents of the report, and in particular that the Audit Committee approved the final Accounts and Annual Report 2015 / 2016, on behalf of the Governing Body, prior to being submitted by the national deadline of the 27th May 2016

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

<table>
<thead>
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<th>STOKE ON TRENT CCG</th>
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**PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY**
This briefing summarises the key issues discussed at the extraordinary Audit Committee on the 24th May 2016 and aims to provide to the Governing Body formal assurance on the CCGs system and processes reviewed by the Audit Committee, and in particular confirm the scrutiny undertaken, on behalf of the Governing Body, to review the audited Annual Report and Accounts 2015/2016.

Governing Body members were invited to join the Audit Committee to review the final Annual Report and Accounts, and in addition to Committee members, were joined by the Chief Operating Officer and the Clinical Director Acute Services.

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**

**ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS**
Annual Report and Accounts Statutory obligations

**QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT**
N/A
Audit Committee Report to Governing Body
Presented by the Chair of the Audit Committee

Governing Body meeting 7th June 2016

1. **Introduction**
   1.1 This briefing summarises the key issues discussed at the extraordinary Audit Committee on the 24th May 2016 and aims to provide the Governing Body with formal assurance on the scrutiny undertaken in respect of the audited Annual Report and Accounts 2015 / 2016 following formal feedback from external audit and management, prior to national submission by the 27th May 2016.
   1.2 In addition, this briefing provides Governing Body members with a summary of the Internal Audit Strategy 2016 / 2017 and the Counter Fraud Work Plan 2016 / 2017.
   1.3 Members also received the Audit Committee Annual Report 2015 / 2016 which is submitted to this Governing Body as a separate agenda item following contribution, review and support from Audit Committee members.

**Key Headlines**
The key headlines from the May 2016 meeting to which the Committee wish to draw the Governing Body’s attention to are as follows:-

2 **External Audit Review**
   2.1 External Audit presented the Audit Findings report which highlights the significant findings arising from the audit for the benefit of those charged with governance.
   2.2 Members noted that at the time of the extraordinary Audit Committee meeting, the audit was substantially complete with procedures being finalised in a few remaining areas.
   2.3 Members noted that availability of some key staff due to annual leave and sickness had impacted on the speed of the audit this year, although CCG staff members had worked hard to respond to all queries raised.
   2.4 The Audit Committee is pleased to advise the Governing Body that External Audit has issued an unqualified opinion on the CCG’s financial statements with no adjustments identified affecting the CCG’s comprehensive net expenditure position which remained unchanged at £376.909m. In addition, based on External Audit review of the CCG’s Annual Report, which includes the Governance Statement and Remuneration Report, it meets the requirements of the DH Group Manual for Accounts and is consistent with the audited financial statements.
   2.5 Finally, based on the review undertaken by External Audit, confirmation was received that they were satisfied that in all significant respects, the CCG had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources.
   2.6 Moving into 2016 / 2017, the Governing Body should be aware that as Financial Plan is being negotiated with NHS England and therefore future recovery plans are still under review, the outcome of this process will determine whether External Audit are required to issue a referral letter in 2016 / 2017. External Audit has a duty to issue a referral letter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014, where the CCG has or plans to breach its duty under the NHS Act 2006 to breakeven. External Audit will there keep this area under review during 2016 / 2017.

3 **Annual Report and Accounts 2015 / 2016**
   3.1 The CCG’s Quality and Governance Manager presented the annual report to members and confirmed that all comments highlighted by External Audit during the formal audit had been incorporated.
   3.2 Members were assured that amendments incorporated since the draft considered by the Audit Committee in April 2016 largely related to the formatting and design of the document to ensure it reflected the Manual for Accounts National Guidance along with the inclusion of end of year data not available at the time of the draft submission. The end of year position in relation to the NHS Constitutional targets was now included along with actions being taken to improve this position.
3.3 In addition, members were advised that the CSU Service Auditor reports had now been issued and the CSU had shared these with the CCG, confirming that there were no issues to bring to our attention.

3.4 The CCG’s Deputy Director of Finance presented the annual accounts to members and advised that minor amendments had been requested by External Audit prior to the meeting and a list of amendments were tabled for members review. It was noted that these were minor adjustments or formatting requests and therefore members approved the final Annual Report and Accounts 2015 / 2016, on behalf of the Governing Body.

3.5 Members also reviewed the contents of the ‘Letter of Representation’ which confirmed that the financial statements give a true and fair view in accordance with International Financial Reporting Standards and that the CCG has fulfilled its responsibilities under the National Health Services Act 2006. This has since been signed by the Lay Member for Governance and Chief Finance Officer and formally submitted to External Audit.

3.6 Members noted that delegated authority for the signing of the Annual Report and Accounts had been granted by the Governing Body to either the Chief Operating Officer or Clinical Director Acute Services, in the absence of the Clinical Accountable Officer. Both were present and confirmed that this would be undertaken by either post holder, dependent on availability at the time signatures were required.

4  Internal Audit Strategy 2016 / 2017

4.1 Members received the first three year strategic Internal Audit Plan and Annual Plan for 2016 / 2017 Fraud Work Plan for both Stoke-on-Trent and North Staffordshire CCGs from the newly appointed Internal Auditors of PricewaterhouseCoopers LLP, compiled following meetings with the executive team, discussions with External Audit and a review of the CCGs Assurance Framework.

4.2 Committee members were assured that the internal audit service will be delivered in accordance with the Internal Audit Charter and noted that the 2016 / 2017 annual plan will cover the following elements 1) corporate governance 2) risk management 3) finance 4) IT risk diagnostic 5) audit follow up 6) use of resources 7) partnership engagement and 8) audit management.

4.3 Members requested clarity regarding Staffordshire Transformation Programme and Partnerships, including Better Care Fund being scheduled for the second year of a three year internal audit plan, given that these transformation programmes are in progress currently. It was noted that whilst these were scheduled for 2017 / 2018, elements of this year’s plan relating to corporate governance and use of resources will also cover these.

4.4 Members noted that the plan across the two CCGs equates to 80 days and noted the indicative start dates for each piece of work. It was agreed that certain areas such as ‘audit follow up and ‘corporate governance’ should commence earlier if possible.

4.5 Members approved the Internal Audit Strategy and Annual Plan and requested that further keep performance indicators be included to monitor management response times throughout each audit phase, along with the consideration by the lead manager of which Committee, if appropriate, should consider the final report.

5  Counter Fraud Work Plan 2016 / 2017

5.1 Members received the first Annual Counter Fraud Work Plan for both Stoke-on-Trent and North Staffordshire CCGs covering the period 1st April 2016 – 31st March 2017 from the newly appointed Counter Fraud Specialists of PricewaterhouseCoopers LLP.

5.2 Committee members were assured that the work plan has been developed with regard to the requirements of the Health and Social Care Act 2012 on counter fraud, with status reports tracking the progress against the plan to be presented to each quarterly meeting of the Audit Committee, along with an annual report at the end of the year.

5.3 The total number of days allocated to the plan equates to 39 days. The Audit Committee approved the contents of the Counter Fraud Work Plan 2016 / 2017.

John Howard
Lay Member for Governance / Chair of Audit Committee
May 2016
**Enclosure: 8.1.3**

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<th>Reporting Officer / Director</th>
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<tbody>
<tr>
<td>Name</td>
<td>Lisa Taylor</td>
</tr>
<tr>
<td>Title</td>
<td>Quality and Governance Manager</td>
</tr>
<tr>
<td>Name</td>
<td>John Howard</td>
</tr>
<tr>
<td>Title</td>
<td>Lay Member for Governance / Chair of the Audit Committee</td>
</tr>
</tbody>
</table>

**Report to:**
Stoke-on-Trent CCG Governing Body

**Title of Report:**
ANNUAL REPORT OF THE AUDIT COMMITTEE 2015 / 2016

**Date of the Meeting:**
7th June 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>N/A</td>
<td>External Audit</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Recommendation**

The Governing Body is requested to **note** the contents of the Audit Committee Annual Report for 2015 / 2016 as an accurate record of the Committee’s activities throughout the year.

**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 purpose of this report is to provide the Governing Body with assurance of the activity undertaken by the Audit Committee during 2015 / 2016, and to highlight key areas of achievement. In addition, the annual report identifies areas of further development and focus moving into 2016 / 2017.

This is consistent with the Terms of Reference of the Audit Committee.

The Audit Committee Annual Report provides written assurance of the activity undertaken by the Committee during 2015 / 2016 and covers the following areas:

- Terms of Reference and Membership
- Attendance at Meetings during 2015 / 2016
- Training
- Administration and Support
- Internal Audit
- External Audit
- CCG Risk Management and Assurance Framework
- Financial Performance
- Information Governance
- CCG Annual Report and Annual Accounts 2015 / 2016
- Other matters considered by the Committee
- Committee Self-Assessment (review of 2014 / 2015 areas for development and identified areas for 2015 / 2016)

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**

**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 main body of the report.
Introduction
The purpose of this report is to provide the Governing Body with assurance of the activity undertaken by the Audit Committee during 2015 / 2016, and to highlight key areas of achievement. In addition, the annual report identifies areas of further development and focus moving into 2016 / 2017.

This is consistent with the Terms of Reference of the Audit Committee.

Terms of Reference and Membership
The Audit Committee is chaired by John Howard, the Lay Member for Governance and consists of the following further members of the Governing Body, namely:
• Lay Member – Patient and Public Involvement (PPI)
• Secondary Care Consultant

Additional attendees are present at the Committee meetings as detailed below:
• External Audit
• Internal Audit
• Local Counter Fraud Specialist (LCFS)
• Chief Financial Officer (CFO) and/or Deputy CFO
• Director of Quality and Nursing (or Deputy)
• Quality and Governance Manager

The amendment to include the attendance of the Director of Quality and Nursing was undertaken at the February 2016 meeting with effect from April 2016, to strengthen the executive presence, noting that the Head of Quality would still be invited to attend to deputise for this post moving forward.

In addition, the Audit Committee has the flexibility to invite any CCG Manager or Executive / Clinical Director to be held to account if it is felt appropriate by the Committee.

The Terms of Reference for the Audit Committee were reviewed in February 2016, as required on annual basis, and changes made to include the Director of Quality and Nursing as detailed above, the option to hold meetings in common with North Staffordshire CCG Audit Committee, along with further detail relating to information governance to confirm the committee’s duties in this area. These were ratified by the Governing Body at its meeting in April 2016.

During 2015 / 2016, the Committee met on five occasions and has reviewed the Clinical Commissioning Group’s financial reporting and internal control systems and ensured an appropriate relationship with both internal and external auditors is maintained. The focus of the Committee has been driven by the priorities identified by the Clinical Commissioning Group, and the associated risks. The Committee has operated to a programme of business that has allowed it to be flexible to any new and emerging priorities and risks.

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 the CCG for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources;
- Reasonable steps are taken to prevent the potential for conflicts of interest and detect fraud and other irregularities.

**Attendance at Meetings during 2015 / 2016**
The following table shows the attendance of members at each Committee meeting during 2015 / 2016 or where apologies have been recorded, confirming quoracy was met at each meeting with good representation from External Audit, Internal Audit and Counter Fraud throughout the year.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>John Howard (Chair), Lay Member for Governance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Margy Woodhead, Lay Member for Patient and Public Involvement</td>
<td>✓</td>
<td>Apols</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Simon Mellor, Secondary Care Specialist</td>
<td>Apols</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Apols</td>
</tr>
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</thead>
<tbody>
<tr>
<td>CCG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iain Stoddart, Chief Finance Officer (from June 2015)</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>Apols</td>
<td>✓</td>
</tr>
<tr>
<td>John Leslie, Interim Chief Finance Officer (Until May 2015 only)</td>
<td>✓</td>
<td>Apols</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Adrian Tomkins, Deputy Chief Finance Officer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Apols</td>
<td>N/A</td>
</tr>
<tr>
<td>Gill Gardiner, Assistant Chief Finance Officer</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>Lorraine Cook, Head of Quality and Governance</td>
<td>Apols</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Lisa Taylor, Quality &amp; Governance Manager</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Internal Audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alex Hire, Internal Auditor, RSM Tenon</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chris Williams, RSM Tenon</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>External Audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Cook, External Auditor, Grant Thornton</td>
<td>✓</td>
<td>✓</td>
<td>Apols</td>
<td>Apols</td>
<td>✓</td>
</tr>
<tr>
<td>Ashley Wilson, External Auditor, Grant Thornton</td>
<td>Apols</td>
<td>✓</td>
<td>✓</td>
<td>Apols</td>
<td>N/A (sec)</td>
</tr>
<tr>
<td>Grant Patterson, External Auditor, Grant Thornton</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>N/A</td>
</tr>
<tr>
<td>Allison Rhodes, External Auditor, Grant Thornton</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
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</table>
Audit Committee Attendees Continued

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Westwood, Head - Counter Fraud, CW Audit Services (from Nov 2013)</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Caine Black, Deputy Head - Counter Fraud</td>
<td>Apols</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committee Administration</th>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rachel Barker, Executive Assistant (Minutes)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

In addition, the Committee has requested attendance from officers in the following positions of the CCG and CSU for ad hoc items:
- Interim Turnaround Director
- Head of Commissioning – Medicines Optimisation
- CSU Financial Accountant
- CSU CFO

Training
Members of the Committee receive updates from both internal and external auditors as part of progress reports made to the Committee. Members have also been actively engaged in CCG Governing Body Development Seminars during 2015 / 2016 with Ken Tooze, from TTI Development Ltd and Wendy Garcarz, from The Wendy Effect.

Copies of the Audit Committee Handbook published by the Healthcare Financial Management Association are available to members as indeed is the programme of professional development seminars.

Administration and Support
The Committee has been administratively supported during 2015 / 2016 by Rachel Barker, Executive Assistant. Wider support is provided from those individuals in attendance at the Committee, including CCG officers, Internal and External Auditors and the Local Counter Fraud Specialist.

The Chair of the Audit Committee has continued to appraise the Governing Body on the key highlights discussed at each Committee meeting via a written report following each meeting. This written report, prepared by the Quality and Governance Manager for approval by the Audit Committee Chair, provides quarterly assurance to the Governing Body on the Committee’s activities and work programme, including highlighting key issues to Governing Body Members.

Internal Audit
Internal Audit Services are provided by RSM Tenon. The Committee approved the Internal Audit Strategy for 2015/16 – 17/18 and Internal Audit Plan for 2015/16 in April 2015 and received regular progress reports and completed review reports following receipt of management responses to the issues raised.
The areas for review within the agreed Internal Audit Plan for 2015 / 2016 were as follows:

<table>
<thead>
<tr>
<th>Area Audited</th>
<th>Opinion Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Financial Systems 2015/16: General Ledger, Cash Management, Debtors,</td>
<td>Amber Green</td>
</tr>
<tr>
<td>Creditors and Payroll (7.15/16)</td>
<td></td>
</tr>
<tr>
<td>Delivery of the CCG Financial Recovery Plan – Phase 2 <em>(Joint report with North Staffordshire CCG)</em></td>
<td>Green</td>
</tr>
<tr>
<td>Board Assurance Framework and Risk Management <em>(Joint report with North Staffordshire CCG)</em></td>
<td>Advisory</td>
</tr>
<tr>
<td>Follow Up of High, Medium and Low Priority Management Actions - Phase 2 (9.15/16)</td>
<td>Good Progress</td>
</tr>
<tr>
<td>Information Governance Toolkit (Version 13) (10.15/16)</td>
<td>Advisory</td>
</tr>
<tr>
<td>Co Commissioning - Governance and Conflicts of Interest</td>
<td>Advisory</td>
</tr>
<tr>
<td>Off Payroll Payments</td>
<td>Carried forward into 2016 / 2017</td>
</tr>
<tr>
<td>Follow Up of High, Medium and Low Priority Recommendations – Phase 1 (1.15/16)</td>
<td>Good progress</td>
</tr>
<tr>
<td>Quality Assurance Systems incorporating Providing Quality Contract Management <em>(Joint with North Staff CCG)</em> (2.15/16)</td>
<td>Advisory</td>
</tr>
<tr>
<td>Operational Budgetary Control (3.15/16)</td>
<td>Green</td>
</tr>
<tr>
<td>Delivery of the CCG Financial (Recovery Plan) (Phase One) (4.15/16)</td>
<td>Advisory</td>
</tr>
<tr>
<td>Better Care Fund – Governance (5.15/16)</td>
<td>Amber Red</td>
</tr>
</tbody>
</table>

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group’s system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

*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.*

Internal Audit Reviews which contributed to this opinion related to:

**Delivery of the CCG Financial Recovery Plan (FRP) – Phase One 4.15/16 (Advisory)**
The workbooks utilised by the CCG to establish the schemes which formulate the FRP were much improved on previous years and formed a robust template to be used by scheme leads in order for planning purposes. Additionally, the governance structure put into place by the CCG to enable ongoing monitoring of the FRP had been well designed and was operating in line with its requirements.

However, there were elements of disconnect between the two, with information being planned as part of scheme workbooks not being consistently monitored through each of the various reporting forums.
Better Care Fund - Governance 5.15/16 (Partial Assurance)

We concluded that the CCG and Stoke-on-Trent City Council have not progressed well in terms of having key documentation i.e. the Section 75 and Section 256 Agreements, agreed by both parties, signed off and in place to enable them to manage, monitor and report on the progress being made towards the Better Care Fund Plan. This also included the Performance Management Framework and the Terms of References for the Section 75 Better Care Partnership Board and the Finance and Performance Sub-Group not being finalised and approved.

A Governance Structure with adequate reporting lines had been introduced and meetings were taking place in relation to the Better Care Fund Plan but the CCG was still in a ‘Planning Stage’ of getting all Groups up and running and Performance / Progress Reporting structures in place.

The review identified a number of issues, including that six of the seven previous recommendations had not been fully implemented, and these have been recorded and reported on within this report. The CCG would need to work and discuss with Stoke-on-Trent City Council to implement the management actions raised, as these would further strengthen the Governance arrangements and current management of the Better Care Fund Plan and Schemes.

Primary Care Co-Commissioning - Governance and Conflicts of Interest 11.15/16 (Advisory - joint review)

The CCGs (Stoke-on-Trent CCG and North Staffordshire CCG) have attained approval to undertake commissioning of primary care services jointly with NHS England (level 2). Both CCGs aspire for approval to commission such services autonomously (fully delegated, level 3).

The proposed arrangements for co-commissioning present additional risks to the CCGs in respect of potential conflicts of interests of their members, executives and officers, particularly where interests are held in GP practices within the CCGs’ boundaries. The arrangements for managing such potential risks and for maintaining transparency should be sufficiently robust to bear scrutiny and challenge and to ensure that the CCGs and their officers remain above criticism.

The collective CCGs are putting in place arrangements that will ensure that the associated risks are managed appropriately. Our review confirmed that many of the arrangements needed are already in place. However, we have identified a number of areas where the arrangements could be strengthened, before full delegation is granted. Several issues were highlighted with the governance arrangements at the Joint Commissioning Meeting which is administered by NHS England. However, the collective CCGs need to protect themselves against any possible deficiencies which may occur, particularly in the management of conflicts of interest at the meeting. We have therefore raised a number of management actions based around the CCGs as a whole, highlighting issues to the administrators of the meeting.

During the year, management have reviewed and actioned recommendations contained within the reports, and made a commitment to undertake a range of actions to close these recommendations down. Progress is tracked through the CCG’s Recommendation Tracking process and is monitored by the Audit Committee. As part of the normal Internal Audit Programme, follow up of agreed recommendations is undertaken by our Internal Auditors to confirm implementation of management actions.

This opinion contributed to the Committees’ assessment of the effectiveness of the CCG’s system of internal control, and to the completion of its Annual Governance Statement.

Progress into 2016 / 2017

At the time audit reports are received from Internal Audit, these are reviewed by officers of the CCG and management responses are made on actions proposed along with timescales which are received by the Audit Committee. During 2015 / 2016, the Audit Committee has received a recommendation tracker report at each meeting clearly evidencing progress against actions and identifying any areas of slippage / concern.
The Committee has been able to scrutinise these reports in more detail following the implementation of a summary cover report highlighting those areas in particular where it is deemed that timescales for implementation have not been adhered to, and to challenge and understand these areas further.

In addition, the Audit Committee has paid particular attention to the performance indicators following the issuing of draft internal audit reports for 2015 / 2016. Whilst Internal Audit advised that a 57% return rate for management responses received within 15 days during 2014 / 2015 was considered consistent with other organisations, members requested that management focus on showing improvement for this indicator during 2015 / 2016. A target was set for management responses to be received on average within 10 working days, and the CCG’s actual management response times equated on average to 14.7 days. This area will continue to be monitored moving into 2016 / 2017 and will be supported by a single recommendation tracker system across the two CCGs as we move to one Internal Audit Plan for both CCGs.

Both Stoke-on-Trent and North Staffordshire CCGs have appointed PricewaterhouseCoopers LLP as their Internal Auditors moving into 2016 / 2017 for a three year period and progress on the development of the Internal Audit Plan for 2016 / 2017 will be presented at the Audit Committee meeting in May 2016. The Internal Audit Plan for 2016 / 2017 should take into account any risks highlighted through internal audit reviews undertaken during the previous year.

Local Counter Fraud Specialist
The Local Counter Fraud Specialist (LCFS) Service has been provided by CW Audit Services during 2015 / 2016. The Audit Committee approved an action plan / work programme at the start of the year which focussed on the areas of fraud awareness and managing organisational fraud and risk, and has received regular progress reports during the year. The Chief Financial Officer continues to meet with the LCFS on a regular basis. The Committee noted that the LCFS had used 82% of the allocated work plan days, with the majority of work completed this year focussing on strategic governance, informing and involving and preventing and deterring fraud. A proportion of work related to a review of the self assessments completed by the CCGs main providers on their anti-fraud arrangements. This review confirmed that there were no recommendations made by the Anti Fraud Service for any of the CCG’s identified providers. An annual report for 2015 / 2016 from the LCFS was received at the Audit Committee meeting held in April 2016.

Moving into 2016 / 2017, Counter Fraud Services will be provided by PWC following the award of the internal audit contract, including counter fraud from May 2016. A work plan is currently being compiled.

External Audit
External Audit Services are provided by Grant Thornton. In 2015 / 2016, the audit programme was based on the statutory audit of the final accounts including an assessment of arrangements to achieve value for money in the use of resources. The annual work programme included nationally prescribed and locally determined work, and was undertaken in accordance with the Audit Plan issued in February 2016 and conducted in accordance with the Audit Commission’s Code of Audit Practice ('the Code'), International Standards on Auditing (UK and Ireland) and other guidance issued by the Audit Commission. The Code requires External Audit to issue a conclusion on whether the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money (VfM) conclusion.

At the time of writing (13th May 2015), External Audit are on track in respect of their progress against plan as at April 2016, with delivery of their Opinion and Value for Money conclusion all planned to be met.

CCG Risk Management and Assurance Framework
Risk management is embedded in the activity of the organisation and led through the implementation of the CCG’s Risk Management Strategy and Risk Management Policy, which highlights organisational and individual responsibilities for the management of risk. The Strategy and Policy supports the delivery of the CCG’s objectives. During 2015 / 2016, the CCG made the decision to integrate its risk management system together
with North Staffordshire CCG to further support the collaboration between the two CCGs. Throughout this process, the Audit Committee received regular updates on progress and received the single Risk Register and Assurance Framework once this integration was completed. Assurance was provided on the continued review of risks whilst this process was undertaken and the training and support to staff once the revised electronic system and risk register was launched.

Taking into account this integration, and the review of the meeting structure and management of change process, the Audit Committee approved for the review of its Integrated Risk Management Framework and Policy to be postponed until the summary of 2016, to enable the document to be accurately updated following the completion of the aforementioned changes. During 2015 / 2016 the Risk Register and Assurance Framework and process to align these across the two CCGs was subject to review by the CCG’s internal auditors with good assurance received.

During this alignment process, the CCG continues to set a risk management appetite at a risk score of 12 (high) utilising the impact and likelihood matrix contained within its Risk Management Strategy and Policy to identify those risks which threaten its opportunities. Using this tool ensures risk assessments are undertaken in a consistent manner using agreed definitions and evaluation criteria. This will allow for comparison to be made between different risk types and for judgements and decisions about resource allocation to be made on that basis.

The revised Assurance Framework for both Stoke-on-Trent and North Staffordshire CCGs was reviewed and adopted by the Governing Body at its public meeting in August 2015 and continues to be scrutinised by the Audit Committee on a quarterly basis. The Assurance Framework and Risk Register are also scrutinised at the Finance and Performance Committee and clinical elements, at the Quality Committee. The Committee continues to be extremely pleased with the progress and commitment from the CCG in this area.

The Audit Committee continues to seek further assurance on the actions being taken to mitigate these risks through attendance from officers and exception reports, as it has deemed appropriate. During 2015 / 2016, this saw the attendance of the Interim Turnaround Director to receive assurance on the QIPP processes across the two CCGs and an exception report relating to the Better Care Fund. This continues to be an effective tool in holding officers to account and allowing the Audit Committee to challenge progress and understand barriers to controls in a more detailed way.

Financial Performance
The Audit Committee is aware of the planning framework that governs the creation of the financial plan and the reporting to Governing Body on the challenges in this, and the likelihood of a deficit position for 2016 / 2017. However, the Audit Committee is aware that the final Financial Plan 2016 / 2017 is yet to be presented to Governing Body.

Information Governance (IG)
The Committee is responsible for ensuring that the CCG meets its statutory obligations in relation to information governance and considers this area as a standing agenda item at each meeting. The Committee has received assurance on the CCG’s compliance with Information Governance legislation and its progress towards the Information Governance Toolkit Version 13 Submission 2015 / 2016 noting a self-assessment of 91%, which is a slight increase to the 86% achieved the previous year.

The Committee has reviewed a range of Information Governance Policies and Procedures to the Governing Body for approval, noting that the CCG continues to promote these through the IG Handbook, where possible. In addition, the Committee has received information relating to information governance legislation changes, the number and type of freedom of information act requests received by the CCG, along with receipt of the Caldicott Guardian Log. During 2015 / 2016, the Committee noted the transfer of responsibilities of the Caldicott Guardian from Dr Steve Fawcett to Jayne Downey, Director of Quality and
Nursing, a role which she undertakes across both Stoke-on-Trent and North Staffordshire CCGs and of the completion of the associated training requirements to support her in this role.

CCG Annual Report and Annual Accounts 2015 / 2016
The Audit Committee is responsible for the timetable and review of the Annual Report and Annual Accounts, and for 2015 / 2016, the Audit Committee received delegated approval, on behalf of the Governing Body, to review and approve these, prior to submission, as undertaken during 2014 / 2015.

In-year, the Committee received assurance in relation to the timely delivery of the 2015 / 2016 annual report and accounts timetable and considered these documents, which also comprised of the remuneration report and annual governance statement in draft prior to submission in April 2016. These disclosure statements were also reviewed by Governing Body members throughout drafting stages, and scrutinised, together with the Head of Internal Audit Opinion prior to approving the draft submission. The Committee is scheduled to receive, review and approve with delegated authority, the final draft of the Annual Report and Accounts at its meeting scheduled for the 24th May 2016 and all Governing Body members have been invited to attend. Delegated authority has also been given by the Governing Body for the signing of the Annual Report and Accounts to be undertaken by either the Chief Operating Officer or Clinical Director – Acute Services, in the absence of the Clinical Accountable Officer due to annual leave.

Other matters considered by the Committee

Scheme of Delegation and Prime Financial Policies
The Committee received assurance of the local review of the Scheme of Delegation and Prime Financial Policies and a proposal to change the format template of this document moving forward.

CSU Service Auditor Reports
In addition, the Committee has received assurance on progress in respect of the operations of the Midlands and Lancashire Commissioning Support Unit via a two phase audit process along with progress of recommendations from the previous year’s audit.

Internal and External Audit Reprocurement
The Committee received assurance of the process undertaken to reprocure an Internal Audit service from 2016 / 2017 onwards for a three year period, along with the process for external audit reprocurement, with the CCG’s Audit Committee adopting the role of the required Audit Panel on behalf of the Governing Body.

Freedom of Information Requests
The Committee received quarterly reports on progress against its statutory duties in this regard including the actions undertaken to strengthen the internal controls within this service following the receipt of a formal complaint and the identification of poor response times in formally responding to FOI requests. The Committee has received assurance on actions taken and will continue to monitor this service as part of its business cycle moving forward.

Declarations of Interest and Hospitality and Gifts
The Committee has received assurance on the systems and processes in place in this regard and has monitored the successful implementation of further steps implemented to review and scrutinise identified conflicts of interest through Companies House. The Committee will review a revised Conflicts of Interest Policy during 2016 / 2017 following the consultation and proposed release of new NHS England guidance during June / July 2016.

Committee Self-Assessment
Review of Areas for Development identified during the 2014 / 2015 Self Assessment
Following the self-assessment completed at the end of 2014 / 2015, the Committee identified the following areas for improvement and development moving into 2015 / 2016 and progress against each is noted below:
• The Audit Committee may wish to consider more regular reports from the Quality Committee. 
The Audit Committee has received an annual report from the Quality Committee providing assurance on the activities and duties it has performed on behalf of the Governing Body.

• Whilst an annual private session is held with auditors in line with the terms of reference, the Audit Committee may wish to consider the frequency of these, in line with other organisations. An additional private meeting has been held with the auditors during 2015 / 2016 increasing the private meetings to two per year.

• The use of the Recommendation Tracker report – how it is presented, highlighting the areas of slippage allowing greater challenge and scrutiny from members. A summary report has been included at the front of the tracker showing progress of completion of recommendations in between meetings.

• Whilst the committee has a cycle of business, it could be enhanced by setting a small number of objectives it wishes to achieve. Areas suggested on one returned self-assessment form are to ‘promote the use of the Assurance Framework’ and to ‘champion standards of conduct in the areas of managing interests’. This was not progressed during 2015 / 2016 and will be discussed with North Staffordshire CCG moving into 2016 / 2017.

Self –Assessment Areas for Development 2015 / 2016
All Committee Members and those in attendance undertook an assessment of its performance at the end of 2015 / 2016 utilising the Self-Assessment Checklist detailed within the NHS Audit Committee Handbook (3rd edition).

The self-assessment covered the following areas:
• Committee Processes
• Committee Effectiveness

Feedback from members and those in attendance at the Committee was overall extremely positive, confirming that the Committee consider items within its remit and to a level that members feel they receive the appropriate assurance to be able to advise the Governing Body accordingly. Members commented positively in respect of the administrative support provided to the Committee and the standard of written reports received, with few late or tabled papers.

In addition, members felt that there was an appropriate length of time given to items and members were given the chance to review, scrutinise and challenge where they deemed necessary, with support from the Chair.

In addition, the Committee continues to review its performance at the end of each meeting to assure itself that it has considered appropriate items of business, it has escalated items of business / concern to the Governing Body as appropriate, and to ensure it has not considered items that would have featured more appropriately within other forums / committees.

Areas for development moving into 2016 / 2017 have been identified as follows:

• The formation of an Audit Committee ‘meeting in common’ with North Staffordshire CCG with effect from June / July 2016 aligning terms of reference and business cycle.
• In line with the review of the business cycle to enable meetings in common, be mindful of the increasing size of the agenda and plan the business cycle ensuring sufficient time can be allocated to items and discussion.
• Review the structure of the agenda of the Audit Committee to ensure quality, data quality, performance targets and financial control are fully covered.
• Strengthen the reporting from other committees eradicating the potential for ‘surprises – this could potentially be actioned via a half yearly report by exception.
• The integration of the recommendation tracker system with North Staffordshire CCG
• Further strengthen the reporting arrangements for single tender actions / waivers

Conclusion
In conclusion, this report provides an overview of the work undertaken by the Audit Committee during the financial year 2015 / 2016, which is consistent with its Terms of Reference. This annual report supplements the quarterly Audit Committee Chair’s reports submitted to the Governing Body following each meeting.

The Audit Committee has undertaken its role within the CCG in a thorough, detailed and effective manner. It has flexed and made improvements throughout the year to ensure it receives the assurance it deems appropriate to confirm to the Governing Body that governance, risk management and internal controls are sound and robust.

Moving into 2016 / 2017, the Committee will continue to ensure that through its activities and monitoring, that it can assure the Governing Body of the internal controls and governance arrangements within the CCG.

Recommendation
The Audit Committee is requested to review the contents of the Committee Annual Report for 2015 / 2016 prior to submission to the Governing Body as an accurate record of the Committee’s activities throughout the year.

John Howard
Lay Member for Governance / Chair of the Audit Committee
May 2016
**AUTHOR**

<table>
<thead>
<tr>
<th>Name</th>
<th>Kara Lawrence</th>
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<tbody>
<tr>
<td>Title</td>
<td>Head of PMO</td>
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**REPORTING OFFICER /DIRECTOR**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Andrew Bartlam</th>
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<tr>
<td>Title</td>
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**REPORT TO**

Stoke-on-Trent CCG Governing Body

**TITLE OF REPORT**

Proposal To Revise The System Resilience Group

**DATE OF THE MEETING**

7th June 2016

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

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<th>INDIVIDUAL</th>
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<tr>
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<td>Please indicate name of individual and date agreed/approved (as necessary), for example HR, Finance, Quality, Medicines Optimisation or other</td>
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**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD**

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**RECOMMENDATION**

The Governing Body is asked to note the report and to approve the Terms of Reference for the Systems Resilience Group.

**STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER**

(identify appropriate goals)

<table>
<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
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<tr>
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The System Resilience Group (SRG) provides the strategic and operational leadership across the health and social care system for North Staffordshire, Stoke on Trent and South Staffordshire for both unplanned (non-elective) and planned (elective) care for the populations it serves.

The purpose of the Staffordshire SRG is to ensure the right capacity is in the system to meet current demand and ensure system resilience and capacity is in place 12 months ahead. This includes:

- Ensuring delivery of the NHS constitution commitments for elective and non-elective care
- Implementation of recommendations following independent review of systems
- Determining the use of non-recurring resources to support system resilience
- Working with Urgent Emergency Care Networks (UECNs) ensuring determination of need and ensuring appropriate provision of urgent and emergency care services across the geographical footprint
- Initiating local change
- Eliminating barriers to whole system improvement
- Ensuring all relevant perspectives as to both unplanned and planned care within the local health and social care system are adequately considered
- Actively working to find innovative solutions to key risks within the economy i.e. Primary Care, Social Care and workforce solutions.
- Improving patient experience
- Assurance that appropriate systems and structures are in place and managed on a day to day basis.

This paper proposes a revision to the current SRG to enhance the decision making and deliver the necessary actions to improve and sustain system performance and resilience for the future.

The Terms of Reference are attached for Governing Body approval.
PROPOSAL TO REVISE THE SYSTEM RESILIENCE GROUP

1. INTRODUCTION AND BACKGROUND

North Staffordshire Combined Mental Healthcare NHS Trust, Staffordshire and Stoke on Trent Partnership NHS Trust, University Hospitals North Midlands, Staffordshire County Council, Stoke-on-Trent City Council, West Midlands Ambulance Service, Stoke on Trent, North Staffordshire and Stafford and Surrounds Clinical Commissioning Groups are working in partnership to deliver a System Transformation Programme across the Staffordshire Health and Care Economy. For the purpose of this paper, the collective organisations will be referred to as the Staffordshire Local Health Economy (LHE) Partnership.

The Staffordshire LHE Partnership is a delivery hub of the Pan Staffordshire Transformation, the relationship to Pan Staffordshire and the Urgent and Emergency Care Network is outlined in Figure 1.

The local health and social care economy aims to “deliver an urgent care system that ensures high quality care in the right setting by the right professional in a timely manner 7 days a week”. The delivery of whole system urgent care across Northern Staffordshire presents a significant challenge to all stakeholder organisations. The urgent care system has consistently failed to achieve the national target of seeing 95% of patients within 4 hours. Due to this consistent poor performance the economy is part of cluster one of the Emergency Care Improvement Programme (ECIP). Following a diagnostic visit by ECIP the programme for Urgent and Emergency care has been reframed to focus on priority areas that will achieve an improvement in performance. This has initiated a review of the SRG purpose and function.

This paper outlines the proposed changes to the System Resilience Group to enhance the decision making to deliver the programmes and projects to recover the economy performance against the constitutional targets.
Figure 1: The Northern Staffordshire System Architectural Framework & Relationship to Pan Staffordshire
2. PRINCIPLES OF THE SRG GOVERNANCE STRUCTURE

The following principles underpin the governance structure outlined in this paper:

- To support execution & delivery
- Supports effective & timely decision making
- Every activity drives and adds value to the next activity
- All activities culminate in delivery
- Joint design, planning & implementation with system partners (including users)
- Fit with Pan Staffs- local delivery arm
- Holds individuals/ organisations to account for delivery
- Clinically led and managerially supported

3. PROGRAMME DELIVERY FRAMEWORK

The programme management architecture is outlined in Figure 2. The architecture demonstrates the partnership approach to delivering the transformation.

Each Delivery Group will have a Senior Officer and Clinical Lead. Their role is to lead and direct the programme and ensure that the programme satisfies the systems agreed strategic objectives and that the outcomes of the programme promote high quality patient focused services. While at the moment the delivery groups have a predominantly operational focus (i.e. the here and now), it is essential that these groups move to having a strategic focus too. SRG can then direct these groups to help resolve urgent issues facing them.

Each Delivery Group will have a programme manager, working as part of the PMO, who will provide progress and assurance reports. Programme managers will formally report on progress of the operational hear and now of their respective programmes to the Integrated Operational Group with strategic matters being reported directly to the SRG.
Figure 2: The Architectural Framework for the Northern Staffordshire LHE Partnership

Northern Staffordshire System Architectural Framework

- System Programme & Change Management Resource
  - Supports Programme/Project Managers to monitor progress, risks, issues, benefits, system transformation
4. SYSTEM RESILIENCE GROUP

The System Resilience Group (SRG) provides the strategic and operational leadership across the health and social care system for North Staffordshire, Stoke on Trent and South Staffordshire for both unplanned (non-elective) and planned (elective) care for the populations it serves.

The purpose of the Staffordshire SRG is to ensure the right capacity is in the system to meet current demand and ensure system resilience and capacity is in place 12 months ahead. This includes:

- Ensuring delivery of the NHS constitution commitments for elective and non-elective care
- Implementation of recommendations following independent review of systems
- Determining the use of non-recurring resources to support system resilience
- Working with UECNs ensuring determination of need and ensuring appropriate provision of urgent and emergency care services across the geographical footprint
- Initiating local change
- Eliminating barriers to whole system improvement
- Ensuring all relevant perspectives as to both unplanned and planned care within the local health and social care system are adequately considered
- Actively working to find innovative solutions to key risks within the economy i.e. Primary Care, Social Care and workforce solutions.
- Improving patient experience
- Assurance that appropriate systems and structures are in place and managed on a day to day basis

a) It is essential that SRG owns any plan/improvement plan and that chief officers lead collectively and are individually accountable for the delivery of their organisation’s contribution to the plan.

Proposal: That Chief Officers are identified against key components of the plans.

b) Over recent months the membership of the SRG has steadily grown. This has made chairing of the meeting more difficult due to increasing numbers, continuity of membership, increasing number of views expressed, accountability of actions and confusion re accountability/regulatory role and results in a lost focus on decision making.

Proposal: The membership is slimmed down to just the Chief Officers of the Staffordshire LH&CE partnership and Healthwatch. Arm’s Length Bodies (ALBs) will continue to attend until such time as performance improves and then will attend when required.

c) Meeting twice monthly, often there hasn’t been the time to implement actions and more time is spent in meetings than in the doing (or ensuring the doing). More work will be executed through the structures described below to inform and enhance SRG decision making.

Proposal: That the SRG meets monthly rather than twice monthly.

d) Over the past year the financial consequences of SRG decisions have not been resolved causing organisational problems and negative impact on relationships in the health and care economy.

Proposal: That the following is added to the TORs:

- To approve and prioritise those schemes identified in the SRG plan against the available financial resource identified at the outset of the financial year. If planned schemes fall in excess of the available resource to determine which lesser priorities (in planned or unplanned
care) will be curtailed as a substitution to generate the difference in funding. To agree in advance of the financial year, through the planning round, the likely availability of funds from commissioners and the basis by which any substitute schemes are equitably distributed across SRG member organisations

- In the event that schemes are commissioned outside the SRG approval process and where costs are incurred where no financial provision exists, then those costs will be borne by the organisation that commissioned those services. For the avoidance of doubt, any agreement to fund schemes from systems resilience monies will be subject to a business case process and approval of the scheme and associated funding will carry a scheme reference number and agreed contract variation which sets out the basis of the non-recurrent award. If insufficient funds exist to cover a scheme at approval stage then the SRG (or its sub groups) will be tasked with identifying those substituted services that will be decommissioned in advance of entering into any commitments stemming from new scheme approval. The approval of schemes in any one financial year does not carry forward to the subsequent financial year. It is the responsibility of the SRG to ensure that it has properly costed and funded plans in advance of the financial year and to maintain that position throughout the financial year.

e) Working with the ‘Together We’re Better Programme’ and County and Northern Delivery group the SRG also has a role to ensure the system remains resilient into the future

Proposal: The County and Northern Delivery group is reinstated

The SRG will be accountable to the tripartite Monitor, NHS England (NHSE), and NHS Trust Development Authority (TDA). Members of the SRG will report to their own member organisations through their agreed governance and committee structures.

The proposed terms of reference are attached in appendix 1.

5. INTEGRATED OPERATIONAL GROUP

Reporting directly to the SRG the Integrated Operational Group (IOG) provides operational and clinical leadership and support to the Delivery Groups. The IOG operationalises implementation plans (“making it happen”) and will further assess the impact of proposed changes to services or systems on patient care policies, practices and staff resources, before such changes are implemented. The IOG is a decision making group within the scope of their own organisation boards and the mandate given by SRG. Members of the IOG will be responsible for ensuring that planned changes are communicated widely across all participating organisations, agencies and stakeholder groups. Clinicians will be responsible for leading and gaining wider clinical engagement in the changes, ensuring patient/user focus remains at the centre of planning and decision making.

There are a number of interdependencies between projects and a great deal of matrix working within and across Staffordshire LHE Partnership. The IOG will provide a forum to identify and explore interdependencies and monitor any unintentional or negative impact on service or business delivery.

6. DELIVERY GROUPS

The Delivery Groups will be led by Chief Officers. Programme Leads will produce Programme Reports to the IOG outlining progress against programme delivery, risk status and changes to the endorsed programme.

The Delivery Groups will be responsible for developing the vision and strategic direction for each project through whole system engagement and active participation in the Delivery Group. The Delivery Group will be further responsible for developing the project plans and accountable for
implementing the changes required to improve performance. There will be strong clinical leadership from primary, community and secondary care engaged in the Delivery Groups, providing clinical expertise and knowledge to the programme areas.

In addition the delivery groups will adopt a strategic focus and horizon scan for problems. At times they will be tasked to provide options for urgent issues that have the potential to compromise local health and care economy sustainability and resilience. On these matters they will report directly to SRG.

Proposal: to add a social care delivery group

7. CONCLUSION

This paper proposes a revision to the current SRG to enhance the decision making and deliver the necessary actions to improve and sustain system performance and resilience for the future.

8. RECOMMENDATIONS

SRG approved this revision, the TOR and the following proposals:

1. Chief officers identified against components of plans
2. The membership is slimmed down to the Chief officers of the Staffordshire LHE partnership and Healthwatch. ALBs will continue to attend until performance improves.
3. That the SRG meets monthly rather than twice monthly
4. That the following is added to the TORs:
   a. To approve and prioritise those schemes identified in the SRG plan against the available financial resource identified at the outset of the financial year. If planned schemes fall in excess of the available resource to determine which lesser priorities (in planned or unplanned care) will be curtailed as a substitution to generate the difference in funding. To agree in advance of the financial year, through the planning round, the likely availability of funds from commissioners and the basis by which any substitute schemes are equitably distributed across SRG member organisations
   b. In the event that schemes are commissioned outside the SRG approval process and where costs are incurred where no financial provision exists, then those costs will be borne by the organisation that commissioned those services. For the avoidance of doubt, any agreement to fund schemes from systems resilience monies will be subject to a business case process and approval of the scheme and associated funding will carry a scheme reference number and agreed contract variation which sets out the basis of the non-recurrent award. If insufficient funds exist to cover a scheme at approval stage then the SRG (or its sub groups) will be tasked with identifying those substituted services that will be decommissioned in advance of entering into any commitments stemming from new scheme approval. The approval of schemes in any one financial year does not carry forward to the subsequent financial year. It is the responsibility of the SRG to ensure that it has properly costed and funded plans in advance of the financial year and to maintain that position throughout the financial year.

5. The County and Northern Delivery group is reinstated
6. To add a social care delivery group.
STAFFORDSHIRE SYSTEM RESILIENCE GROUP (SRG)
TERMS OF REFERENCE

1. PURPOSE
The System Resilience Group (SRG) provides the strategic and operational leadership across the health and social care system for North Staffordshire, Stoke on Trent and South Staffordshire for both unplanned (non-elective) and planned (elective) care for the populations it serves. SRG need to ensure the appropriate capacity is in place to meet the predictive demand requirements on the health and care economy.

The purpose of the Staffordshire SRG is to manage, monitor and deliver the requirements of the SRG Plan which includes:

- Delivery of the NHS constitution commitments for elective and non-elective care
- Delivery of operational performance on the cancer waiting time standards in particular the 62 day cancer standard
- To deliver the recommendations of the national Cancer Waiting Times Taskforce and the Cancer Waits Action Plan.
- Implementation of recommendations following independent review of systems
- Determining the use of non-recurring resources to support system resilience
- Ensuring determination of need across the geographical footprint
- Initiating local change
- Eliminating barriers to whole system improvement
- Ensuring all relevant perspectives as to both unplanned and planned care within the local health and social care system are adequately considered
- Enabling the management of 4 hour performance and referral to treatment times, including all of the contributing factors to achieving these targets
- Improving patient experience
- Assurance that appropriate systems and structures are in place and managed on a day to day basis
- Actively working to find innovative solutions to key risks within the economy i.e. Primary Care, Social Care and workforce solutions.

The SRG will be supported by the Integrated Operational group that will be tasked with jointly shaping and co-ordinate the planning, integration and delivery of care in order to support the delivery of safe, responsive, effective, high quality accessible services for the system.

2.0 KEY ROLES AND FUNCTIONS
- Provide an opportunity for all parts of the local health and care system to co-develop strategy
- Collaboratively plan safe and efficient services for patients
- Provide the forum for system wide planning of service delivery
- Undertake joint whole system planning which includes capacity and demand modelling across both elective and non-elective care
- Maintain an overview of system pressures and take action on a collaborative basis to ensure solutions are identified and delivered
• Sharing intelligence and information to inform and support joint planning
• Monitor key performance indicators and agree actions to improve performance, this includes ongoing measurement of system performance against best practice
• Maintain oversight of links to other resilience matters for example Emergency Planning requirements
• To ensure that capacity planning is undertaken and agreed jointly across the whole system simultaneously and on an on-going basis, based on local needs and a robust understanding of the pressures and drivers in the local system
• To co-ordinate and pro-actively drive operational delivery across the whole system, reviewing and revising regularly as required, providing oversight and holding leads for work programmes to account (NB. programmes of work which contribute towards system resilience will be developed, mobilised, delivered and programme managed through a multitude of different groups.)
• To drive opportunities to extend work across health and social care further in order to achieve truly integrated service delivery
• To approve and prioritise those schemes identified in the SRG plan against the available financial resource identified at the outset of the financial year. If planned schemes fall in excess of the available resource to determine which lesser priorities (in planned or unplanned care) will be curtailed as a substitution to generate the difference in funding. To agree in advance of the financial year, through the planning round, the likely availability of funds from commissioners and the basis by which any substitute schemes are equitably distributed across SRG member organisations
• In the event that schemes are commissioned outside the SRG approval process and where costs are incurred where no financial provision exists, then those costs will be borne by the organisation that commissioned those services. For the avoidance of doubt, any agreement to fund schemes from systems resilience monies will be subject to a business case process and approval of the scheme and associated funding will carry a scheme reference number and agreed contract variation which sets out the basis of the non-recurrent award. If insufficient funds exist to cover a scheme at approval stage then the SRG (or its sub groups) will be tasked with identifying those substituted services that will be decommissioned in advance of entering into any commitments stemming from new scheme approval. The approval of schemes in any one financial year does not carry forward to the subsequent financial year, therefore need clear exit strategies. It is the responsibility of the SRG to ensure that it has properly costed and funded plans in advance of the financial year and to maintain that position throughout the financial year.
• To monitor delivery against plans, outcomes, KPIs and funding allocations
• To access, share and undertake detailed analysis of the full range of appropriate data to support evidenced based decision making
• To use local, national and international best practice to shape and model services that are fit for the local population.
• To benchmark against local and national peers
• To link with and implement the changes arising from the Urgent and Emergency Care Networks.

3.0 GOVERNANCE

The SRG is not a statutory body and does not have delegated authority. SRG representatives will have delegated authority from their member organisations by virtue of the roles that they hold in those member organisations, and as such are accountable to their individual organisational Boards. SRG representatives will make decisions as required in
relation to the delivery of agreed plans and to support further development of unplanned and planned care as developed and approved by their supporting working groups.

SRG decisions are not formally binding but should seek to represent all the links with delegated authority arrangements from relevant statutory bodies and their member organisations in order to drive consensus, alignment of plans and delivery at pace.

The SRG will be accountable to the tripartite Monitor, NHSE, and NHSTDA.

Members of the SRG will report to their own member organisation through their agreed governance and committee structures.

3.1 Quoracy
It is essential that members (or their deputies) attend every meeting as it is expected that decisions will be required to be made at each meeting. The Chair of the SRG plus one representative from each of the organisations will constitute a quorum. Meetings of the SRG will not be quorate if less than 50% of members are able to attend.

3.2 Reporting arrangements
The SRG will be chaired by the CCG Accountable Officer or their Deputy. The minutes of each meeting will be shared with Organisational Boards, usually accompanied by verbal or written feedback from attending member.

The agenda and supporting papers will be circulated four days before the SRG sits. All agenda items / reports should be submitted 7 days prior to the meeting.

4.0 FREQUENCY AND FORMAT OF MEETINGS
The SRG will meet monthly.

SRG may meet at more or less frequent intervals, as required by the status of the capacity plans and contributing programmes of work, or in response to acute pressures in the health and social urgent care system.

5.0 MEMBERSHIP
SRG will comprise of Chief Executive Officers/ Accountable Officers or their deputy in their absence representing the local health and social care partnership. Additional representatives will be invited to attend, as and when need is identified.

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<tr>
<th>Member</th>
<th>Organisation</th>
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<tr>
<td>AO- Chair</td>
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<tr>
<td>COO</td>
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<tr>
<td>Head of PMO</td>
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Date Agreed: 24th March 2016

Date for Review 24th March 2017

Signed: 

Designation: Clinical Accountable Officer, Stoke-on-Trent Clinical Commissioning Group
(Chair of the Staffordshire System Resilience Group)

Dated: 18/5/16
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Laura Janda</th>
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<tbody>
<tr>
<td>Title</td>
<td>Senior Planning and Development Manager</td>
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REPORTING OFFICER /DIRECTOR

<table>
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<tr>
<th>Name</th>
<th>Noreen Dowd</th>
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<tbody>
<tr>
<td>Title</td>
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REPORT TO

Stoke-on-Trent CCG Governing Body

TITLE OF REPORT

Governing Body Assurance Report

DATE OF THE MEETING

7th June 2016

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

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ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD

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<th>Discussion</th>
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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)

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<td></td>
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</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>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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>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>N/A</td>
</tr>
</tbody>
</table>
Performance Assurance Report
2015/16
Month 12 – Year End
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1. Performance overview 3
   1.1 Monthly Indicators 3
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Appendix Stoke-on-Trent dashboard 8
1. PERFORMANCE OVERVIEW

1.1 Monthly indicators

Please note that indicators Achieving or Not Achieving target are based on the reporting month and year end.

1.2 Indicators achieving at year end for Stoke-on-Trent Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Diagnostic test waiting times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients waiting for a diagnostic test waiting no more than 6 weeks from referral</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer waits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ambulance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes – Red 1</td>
</tr>
<tr>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes – Red 2</td>
</tr>
</tbody>
</table>

1.3 Indicators not achieving at year end for Stoke-on-Trent Clinical Commissioning Group

<table>
<thead>
<tr>
<th>Referral to treatment waiting times for non-urgent consultant-led treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral</td>
</tr>
<tr>
<td>Zero tolerance of over 52 week waiters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer waits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
</tr>
<tr>
<td>Maximum one month (31-day) wait for subsequent treatment where that treatment is surgery</td>
</tr>
<tr>
<td>Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A&amp;E waits (UHNMT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
</tr>
<tr>
<td>No waits from decision to admit to admission (trolley waits) over 12 hours (UHNMT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthcare Acquired Infections (HCAI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAI measure (MRSA)</td>
</tr>
<tr>
<td>HCAI measure (Clostridium difficile infections)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed-sex accommodation breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed-sex accommodation breaches</td>
</tr>
</tbody>
</table>

2. EXECUTIVE SUMMARY

2.1 Introduction

This report is designed to give the Governing Body assurance on the major performance issues in our health economy. The majority of the measures are commissioner based because these are the performance indicators that CCGs will be held to account for.

We have provided additional provider specific information where we have identified performance targets as not being met or at risk.
The list of indicators included in the report is not exhaustive. For this report we have concentrated on NHS Constitution and other Local and National Priority indicators.

2.2 Overall CCG Performance

The year-end shows that there has been consistent poor performance on meeting targets for acute care and this will be on-going into 2016/17.

The health economy are working with the national Emergency Care Improvement Programme (ECIP) Team and have developed an Improvement Plan which focusses on three areas:

- Assess before admission
- Today’s work today
- Discharge to Assess

The PMO is overseeing and monitoring the achievement of the improvement trajectories and this is reported monthly to the health economy System Resilience Group (SRG) where organisations are held to account for delivery.

The targets for 2016/17 for the failing indicators are:

- A & E four hour wait 90% achieved by July 16 and 95% by November 16, and 89% from December 16 to March 17
- RTT achieved by July 16
- Cancer achieved by March 16

NHS England have issued a new framework for monitoring in 2016/17. The Improvement and Assessment Framework (IAF) will shape our future reporting and we are currently working on embedding new requirements into the performance reports.

2.3 Scope

This report covers the following areas of non-performance for M12 for 2015/16:

- 18 weeks referral to treatment target
- 52 week waiters
- Diagnostic wait times
- Cancer two week wait – breast
- Cancer 31 day – definitive treatment, subsequent surgery
- Cancer 62 day – urgent GP, screening referral
- Ambulance standards
- A&E four wait
- 12 hour trolley wait

For information and assurance regarding parity of esteem, this report also includes the following:

- Mental Health access targets
- Dementia diagnosis
- Transforming Care (Learning Disabilities)
3. INDICATORS NOT ACHIEVING TARGET

3.1 18 week referral to treatment (RTT) & 52 week waits

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>M12</th>
<th>YTD</th>
<th>Variance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke-on-Trent RTT</td>
<td>92%</td>
<td>M12 91.1%</td>
<td>YTD 90.6%</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Stoke-on-Trent 52 weeks</td>
<td>0</td>
<td>M12 10</td>
<td>YTD 41</td>
<td>-41</td>
</tr>
</tbody>
</table>

Actions to improve performance
1. UHNM have confirmed that to achieve their internal trajectory of achieving in July, 100 breach patients need to be transferred (per month, for months 1-6). Commissioner/Provider Task and Finish Group set up to oversee transfer with different criteria being devised.
2. The majority of 52 week waiters are requiring Laparoscopic Cholecystectomy. Commissioners are actively targeting capacity from alternate providers for this procedure and have sourced capacity.
3. Practices are making their referrals through the Choice and Referral Team in order to manage capacity at UHNM and encourage referrals to other provider and this will continue into 16/17.
4. UHNM are also taking a number of steps to manage capacity internally including moving day cases to County Hospital wherever clinically appropriate, redesigning high volume pathways such as colorectal and upper GI pathways, and implementing nurse-led initiatives.

3.2 Diagnostic wait times

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>M12</th>
<th>YTD</th>
<th>Variance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke-on-Trent diagnostic waits</td>
<td>99%</td>
<td>M12 96.6%</td>
<td>YTD 99.1%</td>
<td>+0.1%</td>
</tr>
</tbody>
</table>

Actions to improve performance
1. MRI mobile scanner in place to complete MRI back log by end of May 2016.

3.3 Cancer wait times

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>M12</th>
<th>YTD</th>
<th>Variance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke-on-Trent 2wk breast</td>
<td>93%</td>
<td>M12 96.7%</td>
<td>YTD 69.4%</td>
<td>-23.6%</td>
</tr>
<tr>
<td>Stoke-on-Trent 31 day 1st treatment</td>
<td>96%</td>
<td>M12 98.2%</td>
<td>YTD 95.4%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Stoke-on-Trent 31 day surgery</td>
<td>94%</td>
<td>M12 100%</td>
<td>YTD 92.2%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Stoke-on-Trent 62 day GP referral</td>
<td>85%</td>
<td>M12 79.2%</td>
<td>YTD 76.9%</td>
<td>-8.1%</td>
</tr>
<tr>
<td>Stoke-on-Trent 62 day screening service</td>
<td>90%</td>
<td>M12 86.7%</td>
<td>YTD 88.3%</td>
<td>-1.7%</td>
</tr>
</tbody>
</table>

Actions to improve performance
1. Although there was improved performance for urology and colorectal these targets were not achieved leading to the application of penalties as defined in the remedial action plan (RAP).
2. UHNM provisional data indicates that in April 2016 the 62 day from GP referral target will not be achieved due to capacity issues in critical care, however the Trust predict achievement of all standards by June 2016.
3. In addition to the 8 HIA (High Impact Actions) a further 5 have been developed including the development of a ‘backstop policy’ which requires the Trust to review all patients on the PTL over 104 days with and without a confirmed cancer diagnosis, to assess if the patients have come to harm and collective review 62 day plus weight to inform mitigating actions.
4. Continued growth - Clinical/directorate management teams are continuing to carve out additional outpatient and surgical capacity for cancer to ensure further improvement in performance. Additional capacity is being sourced at the County site. A number of business cases for additional clinical staff have been approved in challenged specialties.

5. Delivering HIAs - Daily cancer PTL meetings are taking place, chaired by the AD for Surgery, in attendance are members of the cancer services team and directorate management teams. Each individual patient’s pathway is discussed; updates and actions to mitigate delays are agreed. CQUIN in place to support delivery of the ‘backstop policy’.

6. The cancer services team are supporting Lung to reduce delays in the tertiary referral process with SaTH, a second follow up meeting is planned for 10th June 2016.

3.4 Ambulance

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>M12</th>
<th>YTD</th>
<th>Variance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke-on-Trent red 2</td>
<td>75%</td>
<td>M12 74.5%</td>
<td>YTD 79.3%</td>
<td>+4.3%</td>
</tr>
</tbody>
</table>

Actions to improve performance
1. Activity demand fluctuation has been problematic, with increased activity against plan
2. Analysis undertaken by West Midlands Ambulance Service (WMAS) has identified significant increase in activity from the Tunstall and Burslem postcodes
3. 111 activity still continues to rise, particularly midweek between 18:00 – 00:00 hours which is believed to be the result of call advisor workforce issues. This has been passed to the Staffordshire Urgent Care Team as lead commissioners for NHS 111 to investigate.
4. As reported previously, the WMAS contract is commissioned on a regional footprint, there are 22 CCGs with Sandwell & West Birmingham leading as the host CCG. Local commissioners have queried the option to raise a contract performance notice due to non-performance of the Red 2 target, unfortunately the contract does not allow individual CCGs to raise such notices if the contract on a regional footprint is performing, which it is in this case.
5. The 16/17 WMAS contract has now been signed and performance will continue to be monitored and challenged at the WMAS Staffordshire Divisional Meeting chaired by the Staffordshire Lead with any issues/ concerns escalated to the System Resilience Group (SRG) for support and action.

3.5 Accident and Emergency

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>M12</th>
<th>YTD</th>
<th>Variance YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke-on-Trent 4hour</td>
<td>95%</td>
<td>M12 75.6%</td>
<td>YTD 83.4%</td>
<td>-11.6%</td>
</tr>
<tr>
<td>UHN as a whole 12 hour breaches</td>
<td>0</td>
<td>M12 8</td>
<td>YTD 88</td>
<td>-88</td>
</tr>
</tbody>
</table>

Actions to improve performance
1. Stoke-on-Trent have formed an Urgent Care Project Management Office to lead and drive the required improvements to the urgent care system.
2. Due to the non-attainment of the 95% 4 hour standard, commissioners raised a Contract Performance Notice on the 05 June 2015. At this point, commissioners proposed that the LHE ED Improvement Trajectory (agreed by the SRG) should form the basis of the RAP, which UHN rejected.
3. In line with the formal contract mechanism (General Condition 9), a Joint Investigation was commenced, reported in October 2015 and recommended the construction of a Remedial Action Plan (RAP). The RAP was agreed in October 2015. In adherence to the RAP, commissioners 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, February and March 2016.
4. The plan sets a trajectory which achieves 90% by June and deliver recovery against the 4 hour standard, by November 2016.
5. The unvalidated data indicates that performance year to date is 77.4%. Should performance for April 2016 be formally confirmed as <95%, commissioners will submit a Contract Performance Notice.
4. ASSURANCE ON ACHIEVING PARITY OF ESTEEM

4.1 Increased Access to Psychological Therapies (IAPT)
- Access Target – 15% achieved
- Recovery target – 50% achieved
- Waiting List targets – 75% within 6 weeks/95% within 18 weeks achieved

4.2 Early intervention in psychosis (EIP)
From April 2016 EIP services need to ensure that more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.

Data has been submitted to UNIFY since December 15 and the target has been consistently achieved

4.3 Dementia Target 67% of patients 65+ with a dementia diagnosis
- Stoke-on-Trent 87.9% for March 16
- In 2016/17 as part of the CCG Improvement and Assessment Framework (IAF) the number of dementia care plans and support following diagnosis will be measured via the QIF programme

4.4 Transforming Care (Learning Disability Services)
- Stoke-on-Trent CCG currently have 15 CCG funded individuals in the CCG funded cohort

The Regional and Director of Commissioning and Operations Teams have confirmed that the Staffordshire and Stoke-on-Trent Transforming Care Partnership (TCP) has now ‘met’ the requirements of the finance and activity planning template. Under Transforming Care, each TCP area is tasked with reducing the number of in-patient beds used to support people with LD to between 10 – 15 per million head of population.

The combined GP registered population of the Staffordshire and Stoke on Trent TCP is currently a little over 900,000 and so the target figure for bed numbers by March 2019 has been set for Staffordshire and Stoke on Trent at 13 by NHS England.

The figure of 13 includes any highly specialist services spot purchased by a CCG to support an individual patient and also people with LD who may be in beds provided by mainstream mental health services.

To give some idea of the change required, the TCP area currently purchase a total of 33 beds for adults with LD.

Commissioners have met with NHS England Specialised Commissioners to understand the cohort from secure services who will potentially step down to local services over the next 12 months to three years. A high level trajectory is in place which outlines the current status of the individuals of which there are 12 from Stoke on Trent.
<table>
<thead>
<tr>
<th>Service</th>
<th>Month</th>
<th>YTD</th>
<th>Current</th>
<th>Trend to Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Non-admitted</td>
<td>Standard</td>
<td>95%</td>
<td>93.1%</td>
<td>94.4%</td>
</tr>
<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>91.1%</td>
<td>90.6%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>RTT Incomplete</td>
<td>Standard</td>
<td>92%</td>
<td>91.1%</td>
<td>90.6%</td>
</tr>
<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>96.7%</td>
<td>95.8%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Wait</td>
<td>Standard</td>
<td>99%</td>
<td>96.6%</td>
<td>99.1%</td>
</tr>
<tr>
<td>The percentage of patients waiting 6 weeks or more for a diagnostic test. (E.B.4)</td>
<td>93%</td>
<td>90%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Four hour wait</td>
<td>Standard</td>
<td>95%</td>
<td>75.6%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Percentage of patients who spent 4 hours or less in A&amp;E. (E.B.5)</td>
<td>93%</td>
<td>91%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Urgent GP Referrals</td>
<td>Standard</td>
<td>93%</td>
<td>98.5%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer. (E.B.6)</td>
<td>96.7%</td>
<td>69.4%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Breast Symptoms Referrals</td>
<td>Standard</td>
<td>93%</td>
<td>96.7%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected. (E.B.7)</td>
<td>98.2%</td>
<td>95.4%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>First Definitive Treatment</td>
<td>Standard</td>
<td>96%</td>
<td>98.2%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis. (E.B.8)</td>
<td>100%</td>
<td>92.2%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Subsequent surgery</td>
<td>Standard</td>
<td>94%</td>
<td>100%</td>
<td>92.2%</td>
</tr>
<tr>
<td>Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is Surgery. (E.B.9)</td>
<td>100%</td>
<td>99.2%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Drug Treatments</td>
<td>Standard</td>
<td>98%</td>
<td>100%</td>
<td>99.2%</td>
</tr>
<tr>
<td>Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen. (E.B.10)</td>
<td>95.8%</td>
<td>97.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Radiotherapy Treatments</td>
<td>Standard</td>
<td>94%</td>
<td>95.8%</td>
<td>97.3%</td>
</tr>
<tr>
<td>Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Radiotherapy Treatment Course. (E.B.11)</td>
<td>89.2%</td>
<td>88.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Urgent GP referral</td>
<td>Standard</td>
<td>85%</td>
<td>79.2%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. (E.B.12)</td>
<td>92.6%</td>
<td>91%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Screening service referral</td>
<td>Standard</td>
<td>90%</td>
<td>86.7%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within 62- days of referral from an NHS Cancer Screening Service. (E.B.13)</td>
<td>95%</td>
<td>99.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Consultant upgrade</td>
<td>Standard</td>
<td>N.O.S</td>
<td>92.6%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within 62- days of a consultant decision to upgrade their priority status. (E.B.14)</td>
<td>97.3%</td>
<td>99.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Ambulance Red 1</td>
<td>Standard</td>
<td>75%</td>
<td>79.2%</td>
<td>81.6%</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 1 incidents: life threatening and the most critical. (E.B.15.i)</td>
<td>74.5%</td>
<td>79.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Ambulance Red 2</td>
<td>Standard</td>
<td>75%</td>
<td>79.2%</td>
<td>81.6%</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 2 incidents: life threatening but less time critical than Red 1. (E.B.15.ii)</td>
<td>74.5%</td>
<td>79.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
<tr>
<td>Ambulance Red 19</td>
<td>Standard</td>
<td>95%</td>
<td>99.3%</td>
<td>98.9%</td>
</tr>
<tr>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes. (E.B.16)</td>
<td>95%</td>
<td>99.3%</td>
<td>Trend to Mar-16</td>
<td></td>
</tr>
</tbody>
</table>
## Author
<table>
<thead>
<tr>
<th>Name</th>
<th>Sarah Blenkinsop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Head of Primary Care Commissioning</td>
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</table>

## Reporting Officer / Director
<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Emma Sutton</th>
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<tbody>
<tr>
<td>Title</td>
<td>Clinical Director for Primary Care</td>
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## Report to
Stoke-on-Trent Governing Body

## Title of Report
Primary Care Update Report

## Date of the Meeting
Tuesday 7th June 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>Integrated Operational Group</td>
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### Action Required From Committee/Group/Governing Board
| Approve | Assurance | Discussion | For noting | X |

### Recommendation
The Governing Body is asked to note the update on Primary Care.

### Strategic Objectives Supported by This Paper

<table>
<thead>
<tr>
<th>Objective</th>
<th>Stoke on Trent CCG</th>
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<tbody>
<tr>
<td>1. Improve access</td>
<td>YES</td>
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<td>YES</td>
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<tr>
<td>5. Cross Cutting / Statutory Duties (more than one of the above)</td>
<td>X</td>
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ENCLOSURE: 9.2
**PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY**

This paper is intended to provide an overview of the key Primary Care programmes across Northern Staffordshire which support the wider healthcare system. It is also intended to pick up on the key recommendations made as part of the ECIP review of Primary Care.

**SUMMARY OF RISKS RELATING TO THE PROPOSAL**

N/A

**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**

Included within Report
1.0 Primary Care Review
The interim review letter from ECIP, dated 26th March summarised the following about Primary Care:

In our initial whole system diagnostic, we raised the challenge of primary care recruitment, particularly in North Staffordshire. As such, our initial impression, that primary care was not well integrated into the whole system management of urgent care was strengthened during this visit. Federations are now in place but are new and are learning how to operate. We heard that managerial input and support to primary care lacked capacity. A primary care strategy was discussed; however, many were unaware of it or of a vision for primary care within the system. As previously highlighted, primary care is struggling with national issues such as demand, recruitment and low morale.’

2.0 Primary Care Strategic Delivery Plan
The Northern Staffordshire Primary Care Strategic Delivery Plan has now received approval by both CCG Boards, and implementation of the key programmes of work has now started.

The strategy sets out the vision for how Primary Care will look over the next 5 years. The emphasis being on large scale change, which recognises the importance of Primary Care at the heart of the entire health system.

The plan, which links closely to the pan Staffordshire Primary Care Strategy, has been developed alongside key stakeholders to identify how best Primary Care services can be transformed to sustain them for the future.

The new model of care has the patient and the GP at the heart of a multi-disciplinary model, with GP practices working more closely together, integrating with other providers of care to achieve effective community health and social care services.

2.1 The new Model of Care
As described in Simon Stevens ‘Five Year Forward View’, the plan sets out the need to work jointly and collaboratively, moving towards a Multi-specialty community provider model (MCP).
The proposed model of Primary Care is intended to:

- Support the population to stay as well and as healthy as possible;
- Overcome difficulties in recruitment and retention of Primary Care staff;
- Better manage increased patient demand;
- Improve performance of Primary Care services across the area and ensure that access to appointments and services is equitable;
- Deliver key health and wellbeing outcomes and create healthier communities;
- Empower patients to better manage their own care;
- Enable early intervention and prevention with an increased focus on wellbeing;
- Ensure that primary care works in collaboration with other services such as community services to ensure that care is joined up in the community; and
- Deliver agreed outcomes for the lowest cost while staying within budget.

Securing and sustaining GP services in this way now and for the future will make General Practice an attractive career choice are integral to the successful delivery of this vision.

The Primary Care team will work alongside localities to create joint working in groupings of practices with between 30,000 – 50,000 patients. Working towards a health system which represents the three characteristics of care that matters the most to patients; 1) proactive, 2) accessible and 3) co-ordinated.

Across North Staffordshire and Stoke on Trent there will be 10 MCPs:

- NEB MCP
- ANEW MCP
- South Stoke:
  - Longton MCP
  - Meir MCP
  - Stoke MCP
- Newcastle North MCP
- Newcastle Central MCP
• Newcastle South MCP
• Moorlands Rural & Werrington MCP
• Leek & Biddulph MCP

2.2 Strategic Drivers
The Strategic Drivers with the delivery plan include:
• Meeting Local Need - Addressing the challenges identified by the Joint Strategic Needs Assessment
• Workforce - a workforce plan that analyses the needs, identifies workforce requirements, gaps and implements solutions; putting in place systems which enable clinical time to be focused on patient need Co-commissioning – opportunities under delegated commissioning
• Medicines Optimisation – ensuring that patients get the best possible outcomes from their medicines
• 7 Day Working – Introduction of Primary Care Access Hubs across Northern Staffordshire

2.3 Sustaining General Practice
Locally and Nationally it is recognised that General practice is under significant strain. 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.
The GP Forward View, ‘NHS England April 2016’ outlines the plans of support to strengthen and redesign general practice, including:

1. Investment – Accelerating funding of Primary Care – an additional £2.4bn identified
2. Workforce – Expanding and supporting GP and wider Primary Care staffing
3. Workload – Reducing practice burdens and releasing time
4. Practice Infrastructure – Developing the Primary Care Estate and investing in better technology
5. Care redesign – Providing a major programme of improvement support to practices – see the introduction of a new voluntary Multispecialty Community Provider (MCP) contract from April 2017

2.4 Financial Model
The Delivery Plan sets out the development of 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.
In summary, the 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.

3.0 Commissioning Framework
To oversee the programme of work a commissioning framework is currently being drafted. The framework is intended to build upon and implement the strategic objectives set out in the Strategic Delivery Plan and reflected in the operation plan for 2016/17. These objectives are aligned to the strategic direction and
priorities agreed by the Health and Wellbeing Boards, supporting the Staffordshire Transformation Programme ‘Together We’re Better’.

4.0 Implementation plan & Governance
The work to take forward implementation of the Strategic Delivery Plan will be through a robust implementation plan. This will be led within the CCG by the Clinical Director Primary Care and the Head of Primary Care Commissioning, supported by members of the primary care team. The Primary Care Strategic Delivery Group will continue to agree the high level principles and ensure all stakeholders are engaged in achieving our vision for primary care. The Primary Care Delivery Group will focus on how the primary care/general practice elements are operationalised.

Externally oversight of the primary care implementation plan will continue to be through the Primary Care Delivery Plan Steering Group for Northern Staffordshire and the Primary Care Joint Co-Commissioning Group for the Staffordshire Transformation Programme.

4.1 Work to date supporting Out of Hospital Urgent Care
4.1.1 Primary Care Access Hubs
Work is ongoing to develop Primary Care Access Hubs across Northern Staffordshire which will support weekend opening across Primary Care. The hubs will be linked to the Out of Hospital Urgent Care work and will compliment GP Out of Hours and Front of House.
Initial scoping includes:

- Improved access to primary care services (initially on Saturdays)
- At 3 – 4 location across Northern Staffordshire (options appraisal is currently being developed)
- Extended hours of access for the whole population
- Accessed via NHS 111
- Hubs having full access to GP Medical Record
- Future opportunities could include an ‘overflow’ function for acute care in core hours
- Separate from the urgent care offer, the PCAH may provide some MCP functions during core hours

5.0 Role and Function of Northern Staffordshire GP Federation
The CCGs continue to support General Practice working at scale through the North Staffordshire GP Federation.

Northern Staffordshire GP Federation 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 primary and community services
beyond those traditionally offered from individual practices.

6.0 ECIP Support
Four areas have been identified for support for Primary Care in support the system. These include
1. Primary Care Data – what data could support the new model of care
2. Support to develop the GP Federation
3. Actions required to support a clinician to clinician conversation between Primary and Secondary Care
   before referral
4. Admissions Avoidance DES – How can the system link up to ensure the right systems are in place to
   ensure the best outcomes from the Admissions Avoidance DES voidance DES
**ENCLOSURE:** 9.3

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>REPORTING OFFICER /DIRECTOR</th>
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<tbody>
<tr>
<td><strong>Name</strong></td>
<td>Sally Parkin</td>
</tr>
<tr>
<td><strong>Title</strong></td>
<td>Clinical Director for Partnerships and Engagement</td>
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**REPORT TO**
Stoke-on-Trent Clinical Commissioning Group Governing Body

**TITLE OF REPORT**
Patient and Public Involvement Update

**DATE OF THE MEETING**
7th June 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>The information contained in this report was presented to the Joint Quality Committee on 11th May 2016</td>
<td>Margy Woodhead, Lay Board Member for Patient and Public Involvement</td>
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</tbody>
</table>

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

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

1. The Governing Body is asked to **consider** the ongoing PPI work of the CCG and to **note** the actions being taken to strengthen the CCG’s capacity for this work
2. The Governing Body is asked to **approve** the proposal to delay the development of a joint Communications and Engagement Strategy until the new Head of Communications and Engagement is in post (August 2016).

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

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<thead>
<tr>
<th>STOKE ON TRENT CCG</th>
<th>YES</th>
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PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY

This report is aimed to provide assurance to the Governing Body that the CCG has measures in place to fulfil its duty to engage with our local population in Stoke on Trent.
It provides:
- An outline of the commitment of the CCG to Patient and Public Involvement
- Details of the actions being taken to build capacity and capability
- An update regarding the Patient Congress
- Future plans

SUMMARY OF RISKS RELATING TO THE PROPOSAL

None

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

Appropriate patient and public involvement is a statutory responsibility as set out in the NHS Constitution and NHS Mandate.

QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

The paper references the plan to create a stakeholder group to represent people from the 9 protected characteristics.

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

This report focuses on the CCGs’ work with patients and the public

ACRONYMS

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<tr>
<th>CCG</th>
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<tr>
<td>PPI</td>
<td>Patient and Public Involvement</td>
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<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
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<td>EDS</td>
<td>Equality Delivery System</td>
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<td>NS</td>
<td>North Staffordshire</td>
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<tr>
<td>S-o-T</td>
<td>Stoke-on-Trent</td>
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An outline of the CCGs’ commitment to Patient and Public Involvement

Effective patient and public involvement is not only an obligation under the NHS Constitution and the NHS Mandate; it is also the right thing to do. However the most compelling reason to get this aspect of our work right is that it makes us better commissioners so that the people of Stoke-on-Trent can receive the right care. There is no doubt that by harnessing the lay wisdom of patients and the public in the commissioning of healthcare, we make wiser decisions. Patient and public involvement is a central component of quality monitoring and the commissioning of safe, high quality health services. Stoke-on-Trent CCG is fully committed to meaningful patient engagement at each stage of the commissioning cycle:

- Strategic planning – assessing the needs of our population and deciding on priorities
- Procuring services – designing services, influencing supply and managing demand
- Monitoring and Evaluation – gathering patient experience information and managing performance

Capacity for Patient and Public Involvement

Stoke-on-Trent CCG commissions its communications and engagement function from the Midlands and Lancashire Commissioning Support Unit, with a Clinical Director and Board Lay Member overseeing this function. In S-o-T CCG this function was initially supported through the Primary Care team and then on an interim basis by the Senior Planning and Development Manager. This support is no longer in place.

Since January 2016 NS and S-o-T CCGs have had a single Clinical Director for Partnership and Engagement and work has begun to co-ordinate the PPI work across both CCGs to make most effective use of our shared resource.

The following actions have been put in place to develop the CCGs’ capacity and capability for this work in 2016 and beyond:

- A weekly operational meeting with the CSU senior partner and account manager to consider requests from commissioners for engagement support, prioritise actions and develop and review the communications and engagement work plan.
- We have successfully recruited an in-house Head of Communications and Engagement, to provide expertise on a full-time basis, to build the capacity of the CCGs and to enable the CCGs to be an intelligent customer of the CSU and other external providers.
- An externally facilitated PPI steering group workshop was undertaken on 26th April to enable the two existing PPI steering groups, which have a different, history, culture and membership, to come together as a single group and agree shared principles, purpose and priorities. This is being progressed at speed as the S-o-T CCG PPI steering group was suspended temporarily due to difficulties with quoracy.
- The recruitment of 5 new members of S-o-T CCG’s Patient Congress was successfully completed in April. These new members have received their first induction session, and were welcomed by the Clinical Accountable Officer.
- S-o-T and NS CCG Patient Congresses have agreed to align their meeting structures, with planned bi-monthly meetings, two of which each year will be joint meetings to focus specifically on the major issues for our Health Economy.
- We continue to work closely with Healthwatch Stoke and Healthwatch Staffordshire; pooling our intelligence and collaborating around a shared purpose and goals.

Governance arrangements

Under the new terms of reference and cycle of business of the Joint Quality Committee, there is a quarterly focus on patient experience and engagement. At this meeting the PPI steering group(s) report on the CCGs’ engagement activities, outcomes, impacts and future plans and this intelligence is correlated with information from the two Healthwatch organisations and the CCGs PALs and complaints report. The first PPI update report was received at Quality Committee on 11th May 2016.
**Patient Congress**

The Patient Congress met in April, and received feedback from the My Care My Way – Home First Engagement and Consultation. The Congress also received a copy of the Strategic Delivery Plan for Primary Care. Key themes from the engagement were around access to appointment; GPs can be seen as a barrier to accessing other services; there were issues for those people with disabilities in accessing care; there were differences in the provision of services in different localities; the concept of a core co-ordinator in Primary Care was welcomed. Change management also emerged as a theme – although there was broad support for the principles and vision of the strategy, there were concerns about how this would be managed.

Patient Congress members from S-o-T and NS continue to provide a patient voice at over 30 groups and committees and provide patient leadership in the places where they live.

**Current Engagement**

S-o-T and NS CCGs are currently undertaking a patient experience survey of the wheelchair service, ahead of the re-procurement of this service.

**Equality Delivery System (EDS)**

At the EDS Public Grading Event on 17th May it was heartening to see patient representatives giving evidence alongside CCG commissioners and provider organisations, demonstrating the CCG’s commitment to meaningful engagement with protected groups. We are currently developing a forum for the 9 protected groups to provide advice and support to the CCGs about how best to engage with people from protected groups and to ensure we give due regard to the needs of these citizens in our commissioning work.

**Future plans**

The CCG’s current Communications and Engagement Strategy is due to be reviewed; this was initially planned for Q1/2 of 2016/17. However the Governing Body is requested to agree to delay this revision until Q3 of 2016/17 so that the new Head of Communication and Engagement can lead this work and create a joint strategy across S-o-T and NS CCGs. This strategy will make explicit our principles and approach and provide a structure for our future plans including the use of social media.

Stoke and NS CCGs will jointly host 4 Community Conversations over the next year, the first of which will be on July 5th. We are planning to focus on prioritisation as a key theme for this event.

At the request of both Congresses, North Staffordshire and Stoke-on-Trent CCGs’ Governing Boards have approved the proposal to undertake a second Citizens Jury, this time focusing on Mental Health. The Jury will be convened in the summer of 2016 under the leadership of the Stoke-on-Trent and North Staffordshire CCGs’ Lay Board Members for PPI.

Ongoing liaison with the Director of Commissioning and staff has been established to ascertain a timeline of engagement to support the commissioning cycle, so that engagement can be more systematic and focused.

We consider it a priority to ensure the PPGs across practices in Stoke-on-Trent are supported and encouraged to enable patient involvement at a local level. PPG awareness week runs from the 6th to the 11th June 2016. We used our May edition of the patient newsletter to highlight the benefits of PPGs to practices and to patients, to encourage patients to get involved and to publicise some of the local events being organised by our PPGs.

We will focus on the outcomes of patient engagement, the influence and impact of the patient voice and refer to best practice examples, both local and national.
To be completed by each chair of the Committee/Meeting:

**Name of Committee/Meeting:**

**Name of Chair:**

**Date:**

<table>
<thead>
<tr>
<th>Question</th>
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<td>1. Did we achieve what we set out to do; linking back to the agenda</td>
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<td>2. Have we taken the actions forward from the previous meeting for which we considered the minutes?</td>
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<td>4. Do we need to escalate any issues elsewhere?</td>
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<td>5. Do we need to inform any of our decisions / actions? Sub Committees / Staff / NHSE etc.,?</td>
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<td>6. Are we assured?</td>
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<td>7. Do we need any more information / require a further progress report at a future date?</td>
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