NSCCG GOVERNING BOARD – PUBLIC SESSION

Meeting to be held on the 2nd March 2016 from 2.00pm until 4.30pm
Churnet Room, Staffordshire District Council, Moorlands House, Stockwell Street, Leek, Staffordshire, ST13 6HQ

AGENDA

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<th>NO</th>
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<tr>
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<td>PROCEDURAL ITEMS</td>
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<td>1</td>
<td>Chairs welcome and to receive apologies</td>
<td></td>
<td>Dr M Shapley</td>
<td>Verbal</td>
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<td>2</td>
<td>New Conflicts of interest (available on website)</td>
<td>Additions/Amendments</td>
<td>Dr M Shapley</td>
<td>Verbal</td>
<td>2.00pm</td>
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<td>3</td>
<td>Minutes of the meeting held on Wednesday 2nd March</td>
<td>Approve</td>
<td>Dr M Shapley</td>
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<td>4</td>
<td>Matters arising</td>
<td>Update</td>
<td>Dr M Shapley</td>
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<td>6</td>
<td>Accountable Officers Report</td>
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<td>Mr M Warnes</td>
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<td>EPRR</td>
<td>Assurance</td>
<td>Mr M Warnes</td>
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<td>8</td>
<td>Equality and Inclusion</td>
<td>Assurance</td>
<td>Mr M Warnes</td>
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<td>QUALITY AND SAFETY</td>
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<td>Quality Report</td>
<td>Assurance</td>
<td>Mrs J Downey</td>
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<td>10</td>
<td>Patient Congress</td>
<td>Information</td>
<td>Prof N Chambers</td>
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<td>STRATEGIC</td>
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<td>11</td>
<td>Primary Care Strategy</td>
<td>Approve</td>
<td>Mrs S Blenkinsop in attendance</td>
<td>Enclosed</td>
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<td></td>
<td>COMFORT BREAK</td>
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<td>FINANCE AND PERFORMANCE</td>
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<td>12</td>
<td>Integrated Performance Report</td>
<td>Information</td>
<td>Ms N Dowd</td>
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<td>13</td>
<td>Finance Report</td>
<td>Information</td>
<td>Mr I Stoddart</td>
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<td>14</td>
<td>Financial Planning 2016/17</td>
<td>Information</td>
<td>Mr I Stoddart</td>
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## GOVERNANCE

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<td>15</td>
<td>Audit Committee Report</td>
<td>Information/Assurance</td>
<td>Mr N McFadden</td>
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<td>16</td>
<td>Terms of Reference – Joint Quality Committee and Audit Committee</td>
<td>Approve</td>
<td>Mrs J Downey</td>
<td>Enclosed</td>
<td>4.35pm</td>
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<tr>
<td>17</td>
<td>Governance Template</td>
<td>Completion</td>
<td>Dr M Shapley</td>
<td>Enclosed</td>
<td>4.40pm</td>
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## QUESTIONS FROM THE PUBLIC

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<td>18</td>
<td>Questions from the public</td>
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<td>Dr M Shapley</td>
<td>4.50pm</td>
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## DATE AND TIME OF NEXT MEETING

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<tr>
<td>19</td>
<td>Wednesday 4th May, Seminar Rooms 2 - 5, Medical Institute, Hartshill, Newcastle, Staffordshire</td>
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**Note**

The Clinical Chair and Members of the Governing Board will be glad to meet with members of the public and representatives of the press following the meeting to discuss and comment on any agenda items, or other issues which may be of current interest.

Members of the press/media are asked to contact the Communications and Marketing Department, tel: 01782 401048, with any requests for further information and comment.
NORTH STAFFORDSHIRE CLINICAL COMMISSIONING GROUP

GOVERNING BOARD - PUBLIC SECTION

Minutes of the meeting held on Wednesday 6th January 2016
Council Chambers, Merrial Street, Newcastle, Staffordshire
Commencing at 2.00pm

Present:
Dr M Shapley Clinical Chair (CHAIR) (MSh)
Dr A Bradley Non Executive GP Board Member (ABr)
Prof N Chambers Lay Member, Patient Experience (NC)
Mrs J Downey Director of Nursing and Quality (JD)
Dr L Hussain Non Executive GP Board Member (LH)
Mr N McFadden Lay Member, Governance (NMcF)
Dr R Page Non Executive GP Board Member (RP)
Mrs S Parkin Clinical Director - Partnerships & Engagement (SP)
Dr D Robertson Secondary Care Doctor (DR)
Mr I Stoddart Chief Finance Officer (Joint) (IS)
Dr E Sutton Clinical Director - Primary Care (ES)
Mr M Warnes Accountable Officer (MW)

In Attendance:
Mr G Young Communications Team (RC)
Mrs L Ellis Board and Committee Manager (LE)
Mrs A Palethorpe Head of Governance (AP)
Ms R Symons Staffordshire Transformation Director (agenda item 12) (RS)
Mrs K Lawrence Head of Transformation (KL)

Observers
Mrs T Cork Local Pharmaceutical Representative (TC)
Mr D Hardy Patient Representative (DH)
Mr P Scott Local Medical Council Representative (PS)

5 members of the public present

2016.001 Chairs welcome and apologies for absence

Apologies for absence were received from:
Mrs N Dowd Interim Director of Strategy, Planning and Performance (ND)

A quorum of the Board was present and members had been given formal written notice of this meeting in accordance with the CCG’s constitution.

2016.002 Declarations of Interest

No additional declaration or conflicts of interest were received.
2016.003 **Minutes of the last meeting held on the 4th November 2015**

The minutes from the meeting held on the 4th November, were approved as an accurate record of the meeting.

2016.004 **Matters Arising**

In addition to the action noted on the action tracker, the following:

At a previous meeting member of the public Bas Pickering referred to Kniveden Hall and requested an update on the current status. LE agreed to obtain an update and liaise with Bas Pickering outside of the meeting. Postscript, response received from the Local Authority on the 12th January stating “yes we are still progressing plans for our dementia centres of excellence”.

**Accountable Officers Report**

At a previous meeting MSh referred to the quarterly assurance meeting and asked if a formal report will be shared with members of the Governing Board. MW agreed to share the formal report with colleagues. He advised that the assurance process has changed, in which there will be monthly assurance meetings, together with a full annual assurance meeting.

**Prioritisation Programme – hearing aids**

At the last meeting, members of the Governing Board received communication from Staffordshire County Council, in which a response was requested from the CCG. MW confirmed a response was sent and agreed to circulate to members for information.

RP referred to the prioritisation information, which had been previously agreed to be included on the CCGs website and advised that this still has not been uploaded and expressed concern that this is against the transparency upheld by the organisation. SP stated that there is a delay with regard to ensuring the correct wording is used, which needs to be aligned with the PAN Staffordshire prioritisation programme and agreed to follow up so this can be action asap.

2016.005 **Matters Discussed within the Closed Session**

MSh advised that the Governing Board in closed session discussed the financial position, quality and safety, cancer and end of life.

2016.006 **Accountable Officers Report**

MW presented the Accountable Officers report and advised that following a final interview on 9th December 2015, his application for the post of Accountable Officer for the CCG was successful and supported by NHSE and he commenced in post with effect from the 10th December.

MW stated that further progress has been made since the last Board meeting and advised that the CCG continues to work closely with neighbouring CCGs, in particular Stoke-on-Trent CCG and advised that a shared structure has been implemented with a number of shared posts between the two CCGs.
MW advised that the CCG continues to face close scrutiny from NHS England due to our financial position and performance against our Financial Recovery Plan, performance against NHS Constitution standards and our leadership capacity and capability and these remain the reasons for our ‘not assured’ status and must remain the focus of our collective attention.

It was reported that the urgent care system continues to attract national attention due to the continued failure to achieve the A&E 4 hour target, contractual processes are being followed with performance notices issued and remedial action plans requested and through the monthly System Resilience Group (SRG) and recovery plans have been submitted. It was also noted that referral to treatment continues to be a concern, especially in relation to the cancer and 18 week target, in which all the targets have not been met with the last quarter.

MW advised the CCG continues to make good progress on the delivery of its financial plan and at month 8 is on track to deliver its £2 million deficit control total and added that the CCG continues to focus on its financial position through a fortnightly Financial Recovery Group, which is run jointly with Stoke CCG and in addition the CCG have voluntarily commissioned an internal Turnaround Director, Alistair Mulvey, who will be in post until the end of March 2016 and will provide increased focus and support the North Staffordshire GP Federation, which was established on 1 August 2015. He added that the Staffordshire CCGs’ will be working towards Level 3 delegated commissioning across Staffordshire by April 2017. MW advised that the Federation will play a key role in the northern Staffordshire provider landscape and the CCGs will work ever more closely through co-commissioning with the NHS England North Midlands Area Team to enable primary care to play an even more pivotal and effective role in shaping and providing healthcare services, recognising that it is critical given the increasing pressure on primary care that practices are adequately resourced to do so.

MW referred to “my care, my way – home first” and advised that the formal consultation exercise commenced in September and will end in mid-January. He added that six public consultation meetings were held during October and November and were independently chaired by Stoke and Staffordshire Healthwatch representatives, supported by commissioning managers and our communication team.

MW stated that a high level draft Case for Change was shared with NHS England on 23 December 2015, which sets out the challenging transformation programme that will be delivered across Staffordshire and Stoke on Trent over the coming years and added that Rita Symons, Programme Director will present an update report later in the meeting.

MW advised that Noreen Dowd will continue as Interim Director of Strategy, Planning and Performance until at least the end of March 2015 or until a substantive appointment has been made. This will ensure that we have the required senior leadership through the forthcoming annual planning round. He also added that the post of Director of Commissioning has been advertised internally to senior staff on an interim basis until a substantive appointment is made. He was pleased to announce that Cheryl Hardisty has been appointed interim Director of Commissioning.

NC welcomed the report and referred to the issues within Primary Care and advised that it is the responsibility of the whole organisation.

Member of the public, Mr Pickering referred to management of change and requested a copy of the revised staffing structure.
AP stated that the revised staffing structure will form part of the new revised constitution and a number of issues are being confirmed and advised that information will be in a suitable format as from April.

Member of the public, Mr Syme referred to the recurring underperformance at UHNM and stated that for the first time NHS England are underperforming and stated that NHS Scotland are reporting a better position. He added that it has been reported that patients at UHNM have been waiting in the corridors and that there have been a number of 12 hour trolley waits in December. He stated that A&E performance is substandard and no improvements have been made. MSh assured members of the public that the CCG is working hard to rectify the issues and added that it is a whole health economy issue. MW stated that robust plans are in place and acknowledged that the issues are frustrating and reiterated that it is a system wide issue and there are measures in place which are now having an impact on the “front door pressures” and work is progressing to improve the “back door pressures”. He added that £12.5 million has been invested over the past 2 ½ years, including recruitment of additional staff. He acknowledged that further work is required to improve primary care and work is progressing.

JD advised that she has introduced regular meetings between herself and Provider Director of Nursing colleagues and stated that regular visits are being undertaken to provider organisations to ensure patient safety and to ensure that systems are working. She added that the CCG is working with colleagues in the South to ensure that systems are working across the whole of the health economy.

NC shared the frustration from members of the public and provided assurance that the CCG is totally committed and is working with all partners to rectify the issues. She asked colleagues if the CCG is capturing evidence where good performance has been identified. MW stated that the health economy is one of 26 which have an improvement care programme and stated that more work is required. He added that a significant amount of best practice has been applied and improvements are being made. He stated that staff are working extremely hard in difficult circumstances and it is essential that staff continue ensuring that patients remain safe. He provided assurance that as commissioners the CCG is supporting the provider trusts as this is a whole system issue. NMcF stated that it would be beneficial for the provider organisations if there was an outside body to take an interest.

Members of the Governing Board received and noted the report.

2016.007 Emergency, Preparedness, Resilience and Response (EPRR)

MW provided a verbal update and advised that an EPRR update Paper is being presented to the next Joint Organisational Development Committee on the 19 January, which will provide a summary of the revised EPRR Framework, which was released in November 2015.

MW advised that preparations for Exercise Aurora (a pan-Staffordshire multi agency Business Continuity emergency) will be taking place from the 16th May 2016 to the 19th May 2016. He added that the CCGs are active participants and stated that the exercise will also be an opportunity to test local business continuity plans.

MW stated that the Business Continuity Plan and Incident Response Plan will be revised by February 2016 and also stated that all Silver and Gold responders will receive updated EPRR training during February and March.
It was noted that the CCGs will lead a local health economy Gold Desktop Training and Exercise Event during January/February 2016, which will be supported by the Staffordshire Urgent Care Team, Regional Capacity Management Team and Civil Contingencies Unit.

Members of the Governing Board noted the update.

2016.008 Equality and Inclusion Progress Report

MW presented the report and advised that the CCG held its first EDS annual grading event jointly with Stoke CCG on the 27th October 2015 and senior clinicians and staff presented summarised evidence to a group of 12 volunteer EDS informal stakeholders and focused on EDS Goals 1- Better Health outcomes and Goal 4-inclusive leadership at all levels, and both CCG scored well.

Members of the Governing Board:

- Noted the outcome of the joint EDS annual Public Grading and in particular the: EDS Grading Report
- Noted the progress in relation to WRES in particular the approval of the WRES action Plan

MW thanked Julia Allen, Equality and Inclusion Business Partner for her ongoing support to the CCG and for providing the report.

Members of the Governing Board requested that the acronyms are explained within the report. MW agreed to feedback to Julia Allen.

2016.009 Annual Equality and Inclusion Report

MW presented the report and advised that the CCG’s Annual Equality and Inclusion Publication was reviewed and approved by the Joint Organisational Development Committee at its meeting in November 2015 and subject to approval from the Governing Board the report will be made publicly available on the CCG website by 31 January 2016.

Members of the Governing Board:

- Ratified the Annual Equality and Inclusion Publication following review by the Joint ODC and note this will be made publicly available on the CCG website by 31 January 2016.
- Note that Equality and Inclusion is delegated to the Joint ODC who review and monitor progress on a regular basis and report to Governing Board as appropriate

Member of the public, Mr Pickering noted the significant time to complete documents and noted that staffing numbers continue to reduce and asked the CCG if it is worthwhile.
NC stated there is an important principle in relation to reaching out and supporting all people in the nine protected groups.

2016.010 Quality Report

JD presented the report and advised that since the last Governing Board meeting the Quality Committee (joint meeting with Stoke-on-Trent CCG) met on the 11th November and 9th December and received reports outlining the quality assurances for the CCG’s main providers and updates from its subgroups, which include Infection Prevention & Control Group, Safeguarding Group and Primary Care Subcommittee. She added that the Quality Committee discussed the Insight (Patient Experience & Membership Feedback) Report 2015/16 Quarter 1 (July – September); 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 168 feedback contacts in the quarter by the following methods: PALS (66), Soft Intelligence – patient based (59), Complaints (25), MP Letters (11), Compliments (3) Media (2) and Social Media (1).

Combined Healthcare NHS Trust (NSCHT)

It was noted that the Safety Thermometer ‘harm free care’ rate for November 2015 is 92.96% and 95.77% and no ‘new harms’ have been recorded.

JD advised that 8 serious incidents during October and November 2015 have been reported and all were categorised as ‘unexpected death’. She added that all serious incidents are investigated in accordance with the National Framework and using National Patient Safety Agency best practice guidance. She assured members that the CCG has an opportunity to challenge the provider’s investigation findings at the monthly Serious Incident Subgroup.

JD referred to the latest Friends and Family Test (FFT) results, which highlights that 82% of patients would recommend the Trust, 63% of staff would recommend the Trust as a place to receive care and 42% of staff would recommend the Trust as a place to work.

Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP)

It was noted that the Safety Thermometer ‘harm free care’ rate for November 2015 is 91% and 97% and no ‘new harms’ have been recorded.

JD advised that the Trust has reported 51 serious incidents during October and November 2015; of these 44 were within the ‘pressure ulcers’ category. She added that all pressure ulcer serious incidents are reviewed, challenged and scrutinised. She added that SSOTP have not yet adopted the new serious incident definition and are therefore reporting all grade 3 or grade 4 pressure ulcers and will continue to report high numbers of serious incidents within the ‘pressure ulcers’ category, until the end of the financial year. Plans are in place to make the change as from April 2016.

University Hospital North Midlands NHS Trust (UHN)

It was noted that the Safety Thermometer ‘harm free care’ rate for July 2015 is 91% and 98% and no ‘new harms’ have been recorded.
JD advised that the Trust has reported 16 serious incidents during October and November 2015; of these 8 were ‘slips, trips & falls’ and a further 5 were ‘pressure ulcers’. She added that all pressure ulcer serious incidents are reviewed, challenged and scrutinised at the Tissue Viability Panel.

JD referred to the FFT which lighted that 97% of inpatients would recommend the Trust, 73% of A&E attenders would recommend the Trust, 83% of staff would recommend as a place to receive care and 62% of staff would recommend as a place to work.

Infection Prevention and Control (IPC)

JD advised that a health economy wide group has been established, which she chairs and advised that the group will target all action plans to ensure that progress is made and trajectories are back on track. She added that the Head of Infection Prevention & Control presented the C-Difficile Recovery Plan at the Quality Committee in November, which highlighted the actions undertaken as part of the work plan. She advised that an event has been scheduled for January to bring together all stakeholders, including NHS England, the NHS Trust Development Authority and commissioners to focus on the work being undertaken and the actions required as a local health economy.

Safeguarding Adults, Children & Young People

JD advised that “my next patient may lack capacity” Prompt Cards have been distributed to all local GPs, which specifically address the principles of the Mental Capacity Act and its application and have been funded by NHS England North Midlands and developed by Asist Independent Mental Capacity Advocates (hospital service).

Colleagues referred to the FFT for UHNM in particular the response rate and suggested that through the quality visits targeting patients to gain feedback.

MW referred to the “my next patient may lack capacity” Prompt Cards which have been distributed throughout Primary Care and asked if feedback can be received to establish if the cards have been beneficial.

MSh referred to infection, prevention and control and asked how we compare with other areas. JD stated that the situation is similar, however UHNM is particularly challenging and reiterated that it is challenging for the whole of the health economy, however, she added that the situation does fluctuate, but is remaining constant nationally.

NC referred to the FFT test in which a number of provider organisations have been highlighted as not a good place to work and asked if there is any information available regarding what members of staff are stating. JD indicated that information can be requested and added that it would be helpful to have a comparison against better performing trusts and offer support if needed. JD agreed to feedback via the Quality Committee. SP advised that through the LETC there is a leadership group, which consists of leaders from local provider organisations looking at improving morale amongst staff.

Member of the public, Mr Syme referred to recent media attention regarding a primary care provider within the region and the number of unexpected deaths reported and asked how the CCGs Serious Incident Group takes on the
recommendations to ensure that the issues are not recurring. JD advised that she has regular meetings with Director of Nursing colleagues from all local provider organisations and stated that the CCG is a member of the Serious Incident Group and assured members that the Group will take on board all the recommendations.

Members of the Governing Board received and noted the report.

2016.011 Patient Congress / Second Citizens Jury

NC provided a verbal report and on behalf of the Patient Congress thanked Dr Paul Unyolo for his support to the congress and excellent steer.

NC advised that at the last Patient Congress meeting, members received an update regarding the Five Year Strategy and were asked to consider how best the CCGs could engage with the public and what areas are problematic around access to services.

NC referred to the Citizens Jury and the benefits to the CCG and reminded colleagues that the jury focused on diabetes last year and generated many recommendations, which have been accepted by the CCG and work is progressing towards implementing them, together with regular updates received at the Patient Congress and at Board.

NC recommended that a second Citizen’s Jury is established jointly with Stoke on Trent CCG and suggested that the jury focus on mental health, with the jury deciding on the scope of the enquiry.

JD asked if the provider organisations are engaged and included. NC assured JD that provider organisations are included and invited where necessary and stated that the jury welcome input from all partners.

ABr referred to the initial jury and the working party established to lead and implement the recommendations and requested feedback on progress. NC stated that feedback is regularly received. She added that 15 recommendations were agreed and the working group continue to track progress and implementation. She added that not all recommendations have been implemented fully, however, progress is being made. ABr asked if an update report should be received from the working group to provide the Governing Board with an update. Members of the Governing Board agreed that an update would be provided to the Quality Committee at the next meeting.

DH advised that the first Citizens Jury was very successful, which was mainly due to the leadership of the jury and stated that the selection must be of great importance.

Members of the Governing Board:

- Supported a second Citizens Jury investigation
- Agreed that the topic for the second Citizens Jury would be mental health

Agreed that the next Citizens Jury will be jointly sponsored by both North Staffordshire and Stoke on Trent CCGs
PAN Staffordshire Transformation Programme “together we are better”

MS welcomed Rita Symons Staffordshire Transformation Director to the meeting.
RS provided a PowerPoint presentation regarding the Transformation Programme and stated copies are available for the Governing Board and members of the public.
She advised that the Transformation Programme was established as a system wide response to the challenges facing the Staffordshire and Stoke on Trent health and care economies. She advised that the Programme is developing at pace and there is emerging clarity on what the transformational projects are and how this links to individual CCG plans and business.

It was noted that a number of workshops have been held to introduce the concept of Logic Models at a workstream level and a clear process is in place with workstream leads to carry out the logic modelling at a project level.

RS added that a number of meetings have been held with colleagues around the case for change development and a provider workshop took place on the 10th December to clarify scope of the workstream and discuss the broader case for change process and engagement in the other workstreams. She also added that a Leadership Summit was held on 15th December to follow on from a previous Summit on 20th October and shared the outline of the Case for Change and which required informal sign up from Local Authorities, CCGs and providers and was a very positive debate and feedback will influence the final submission to the Tripartite.

RS advised that the Case for Change which outlines the context, financial background and what we are going to do through the programme is close to completion. The content has been through iterative discussions through the Congress, Clinical Leaders Group and through broader Leadership Summits. A session is planned in the New Year to discuss with both Health and Wellbeing Boards. The Case for Change will be presented to Governing Bodies and Cabinets for sign off. She advised that during the programme there will be significant patient and public engagement.

NMcF referred to logic modelling and asked for further details. RS provided the details, which identifies what is required to be commissioned and looks at evaluating and supporting tools.

SP noted that patient and public involvement will be undertaken and asked if there is any risk of duplication, as the CCG has a good embedded engagement infrastructure and stated that the CCG can provide assistance to ensure that all parties are reached. RS welcomed the assistance.

SP referred to working with the GP Federation and developing new models of care, but acknowledged that this is not featured on the “programme on a page”. RS provided assurance that new models of care and the work undertaken by the GP Federation will be included.

NC welcomed the programme on a page and reiterated SP comments regarding engagement and highlighted that both CCGs have well established Patient Congress Groups. She referred to a previous Governing Board meeting, in which the Board referred to the period of time and stated two years for completion was ambitious and suggested three years. She also asked if lessons are being learnt from Manchester, who have undertaken a similar programme. RS stated that the scope of change is huge, the programme has been agreed for two years, but added that there is an established work stream for five years and stated that the planning horizon will be undertaken over five years.
She added that learning has been taken from the Manchester programme and stated that colleagues are looking at the decision making framework.

MSh stated that the programme should not only focus on finance, but also needs to look at poor patient experience and improving the quality of care, rather than bridging the financial gap. RS assured that funding should be spent wisely and work is progressing.

PS referred to the programme timeframe of two years and stated that this is not long enough and expressed concern regarding the ongoing difficulties and issues in primary care, particularly the GP workforce in two years. RS stated that there are actions which can be taken now, which can achieve results and stated that discussions are taking place across the patch. PS stated that there is an urgent need to plan for the potential lack in workforce and the limited funding within primary care. RS stated that funding will be re-allocated appropriately and stated that there is a need to drive change and a need to reduce hospital expenditure. She added that there is potential for more change if the Local Authority is involved and all parties are working together.

ES stated that the team are looking at primary care implementation and along with this there is a need to look at funding, as it is essential that the money moves with change to ensure efficiencies.

DR stated that the workforce is changing and stated that funding is being wasted and it is essential to ensure better care.

MW stated that the programme is about improving outcomes and quality and stated that there is an opportunity to review the whole picture and have a joined up approach to ensure better quality of care for patients.

**Members of the Governing Board received and noted the update and noted the timelines and process for developing the case for change.**

**2016.013 Integrated Performance**

IS presented the report and advised that the format is developing and changing and in future will include outcome measures.

On behalf of ND, KL presented the constitutional targets and referred to the referral to treatment pathways and advised that Commissioners have raised a Contract Performance Notice (CPN) relating to the failure to deliver the incomplete target and agreed the trajectory which indicated overarching delivery of the 92% standard by the end of October 2015. She advised that UHNM failed to achieve against this remedial action plan (RAP) and as a result, the CCGs withheld 2% of the contractual value for a period of one month.

It was noted that the CCGs made the decision to close the CPN to enable a further submission of a revised CPN with the intention of UHNM providing a RAP with overarching actions at a specialty level to deliver the constitutional target of 92%. This RAP was received by the CCGs on the 20th December 2015 and was not agreed, therefore the CCGs are following the contractual process and UHNM have up to the 8th January 2016 to resubmit a revised RAP. In addition, UHNM are required to deliver a RTT Improvement Plan to the TDA and NHSE highlighting specialty actions to deliver the overarching target.
KL referred to the A&E four hour waiting time and advised that the 95% quality metric has not been attained within this financial year and as a result, Commissioners raised a Performance Notice and the RAP was agreed on the 5 October 2015 and planned to deliver the 95% quality metric by the end of November 2015. She added that the performance during October 2015 failed to meet the projected trajectory of 90% and consequently commissioners have withheld 1% of the contract.

KL advised that CCG has failed both 2 week wait indicators in October 2015 and the urgent GP referrals have decreased to 91.7%. She added that the performance in October 2015 for breast symptom referrals was 43.8%, which is the worst performance during the reporting period.

It was noted that there has been a significant increase in referrals for all CCGs and all sites (particularly breast) and the breast two week wait service at UHNM is currently experiencing an influx of referrals which is beyond the capacity of the service.

KL advised that the CCG achieved all four 31 day Cancer standards in October but has failed two on a year to date (YTD) basis and the subsequent surgery standard has a YTD performance of 91.1% and the drug treatment standard has just failed on a YTD basis with performance to October of 97.9%. She advised that UHNM have revised their trajectory and are now predicting achievement of all 31 day targets by January. As part of the contractual process for under performance against standards in Cancer two Remedial Action Plans (RAP) have been agreed. These are the 31 days diagnosis to first definitive treatment and the 31 days for subsequent treatment where the treatment is surgery.

It was noted that the CCG failed the Urgent GP referral standard in October with performance at 68.8% and a year to date performance of 73.6%. The Screening Service referral standard also failed in October with performance of 57.1%. In addition to poor performance in October, both 62 day targets have now failed on a Year to Date basis.

As a result UHNM have revised their trajectory and are now predicting achievement of all 62 day from GP referral by March 2016. Actions specific to the breast pathway have been agreed and incorporated into the 62 day cancer improvement plan.

KL stated that one of the three ambulance targets were breached in October 2015 as Red 19 just failed the target with performance of 94.95%. She advised that key risks are job cycle times, handover delays and delivery of the profiled outcomes. She added that commissioning intentions are agreed across Stoke and North Staffordshire and these have been shared with the Regional Team for circulation to West Midlands Ambulance Trust.

IS referred to the provider analysis contained within the report and also referred to the quality premium and asked that as a result the CCG will receive £375,000 for achieving partial elements of the quality premium last year.

NC referred to the ongoing underperformance in achieving the four hour A&E target and noted that it is forecasted that the projection will be 3% under trajectory at year end. IS stated that there has been a delay with regard to the step up /step down initiative contract, together with the delivery of the QIPP and advised that adjustments and contract challenges have an impact on the monthly baseline position. He advised that at the end of January the year end outcome will be agreed which may have an impact on the forecasted position.
NC referred to the underperformance in relation to the two week cancer wait, as it has been reported that the performance in October 2015 for breast symptom referrals was 43.8%, which is the worst performance during the reporting period and noted that there has been a significant increase in referrals and asked if patients can be diverting to other providers who are not as challenged and also asked if local GPs are aware of the issues. KL agreed to obtain further detail.

NMCF referred to the A&E four hour wait performance during October 2015 which failed to meet the projected trajectory of 90% and consequently commissioners have withheld the 1% of the contract and asked if this will be withdrawn continuously. IS stated that further guidance is expected from NHS England and advised that the CCG invoked penalties where required. He added that fines and penalties are re-invested and details are provided to NHS England on a regular basis.

Members of the Governing Board received and noted the report.

2016.014 Finance Report

IS presented the Finance Report and advised that at the month 8 reported position stands at £2.454 million deficit and the basis of the financial position is through receipt of activity and costs up to month 7 for acute data and to month 6 for prescribing data. He added that the overall forecast outturn remains at the planned level of a £2 million deficit at year end and to achieve this position the CCG needs to mitigate the current level of risk and fully deliver to QIPP programme levels in the last 4 months of the financial year. He added that there is a necessity to fully apply any remaining contingencies (predominantly the 0.5% “headroom” contingency of £1.3 million and all sums in budget now assessed as contingent).

Members of the Governing Board received and noted the report.

2016.015 Allocations

IS presented the report and advised that running cost allocations are likely to reduce due to the proportion of registered population for North Staffordshire as a percentage of the total England population reducing, however the actual figures are not yet confirmed. He added that the provider sector cost pressures are estimated at 3.06% and the efficiency requirement is 2% and would result in the tariff being uplifted in 2016/17 by circa 1.06%.

IS advised that the Finance Team will work through the plan once guidance has been received and will ensure that plans are aligned to the strategic and annual plans. He added that the final CCG allocations for the next 3 years (firm) will only be confirmed after the 8th January 2016 and due to the tight timescale by which plans will have to be agreed and submitted there are key decisions that will need to be made and regular updates will be provided to the Governing Board.

MSh asked if the plans reflect the PAN Staffordshire position. IS advised that the footprint will extend wider than North Staffordshire and stated that in making progress it is envisaged that it will bring North Staffordshire back into surplus.

IS advised that the relevant documentation circulated highlights the requirements for CCGs and providers and the need to ensure that investment is aligned.

Members of the Governing Board received and noted the report.
Staffordshire County Council (Care) update

MSH advised that notification has been received from the Local Authority that no representation is available to attend the Governing Board and also advised that the Local Authority do not attend any other CCG Governing Board meeting.

DH stated that there is a significant amount of information which needs to be shared with the Governing Board and Local Authority colleagues need to attend the Governing Board.

SP expressed concern regarding the lack of public health representation and asked if there are other forums in which information can be shared to ensure that all colleagues are updated.

MW stated that historically Local Authority colleagues attended as the CCG partially funded work undertaken by the Joint Commissioning Unit (JCU), however the JCU no longer exists, but the CCG continue to make a financial contribution and stated that it is essential that the CCG continues to receive an update and agreed to liaise with Helen Coombes at the Local Authority.

PS stated that public health contribution is critical and stated that within primary care there has been a significant lack of communication and colleagues should be held to account.

Members of the Governing Board supported MW to raise concerns with the Local Authority.

Audit Committee Report

NMCF presented the report which outlines the activity of the Audit Committee and highlights from its last meeting, which took place in November. He advised that the Committee discussed the existing membership with a view to strengthen existing processes and it was agreed that the JD would be invited to attend future meetings, but would not become a formal member.

NMCF advised that the Committee noted the progress made in relation to the work undertaken with Stoke CCG to align the assurance framework and risk register and training on the new system will be provided to all staff involved. He added that the Risk Management Strategy will be updated once the review is complete.

NMCF stated that the Committee received and noted the Freedom of Information report and noted that there have been a significant number of requests which are predominantly made up of commercial, media and public. It was noted that even though applicants do not have to provide personal/company details and are ‘applicant’ blind, the Committee requested information as it would be useful to understand recurring themes.

NMCF advised that the Committee received a progress report against the internal audit plan for 2015/16, which included operational budgetary control, delivery of the CCG financial plan, better care fund and delivery of the CGG financial recovery plan. He advised that there has been one addition to the audit plan following a recent letter to Stoke CCG from HMRC regarding payments to GPs and as a result a review has taken place to ensure that processes meet with normal standards and expectations across both CCGs.
NMcF advised that the Committee received an update regarding local counter fraud, specifically following a Proactive Fraud Review report prepared for Stafford and Surround CCG on Continuing Health Care. Following the review a number of control weaknesses were identified, which resulted in inappropriate payments made to providers. He added that an action plan has been developed and will be reviewed by the Committee on a regular basis.

NMcF advised that IS provided the Committee with a preliminary response to the independent functional review carried out by USL Consultants, on behalf of both NHS North Staffordshire and NHS Stoke-on-Trent Clinical Commissioning Groups and added that remedial work to address the issues continues and a further update will be provided to the Committee on completion.

Member of the public, Mr Syme referred to the FOI progress report and expressed concern regarding the lack of communication between the Commissioning Support Unit and the CCGs, following a request made by himself and stated that legal duties are being failed. NMcF stated that the Committee received an update and stated that performance was highlighted as good. IS acknowledged that there have been delays and has requested a review to highlight any signs of weaknesses and advised that an action plan has been put in place following the review. IS agreed to liaise with Mr Syme outside of the meeting to gain further information.

postscript – the FOI request was submitted to Stoke CCG, not NSCCG, however processes in place across both CCG’s and within the CSU have been reviewed, and will where necessary be strengthened.

Members of the Governing Board received and noted the report.

2016.018 Governance update (includes Constitution and terms of reference updates)

AP presented the report and advised that the CCG submitted proposed changes to the constitution to NHS England in October 2015 which reflected the revised Governing Board and subcommittee structure as a consequence of working more collaboratively with Stoke CCG. AP advised that NHS England have approved and support the changes and the revised constitution will come into effect following approval at today’s Governing Board meeting and will be published on the website shortly.

AP advised as part of the collaborative working with Stoke CCG it has been proposed that a number of Committees operate as one and therefore terms of reference are required to be reviewed and requested that the Governing Board approve the revised terms of reference for the following Joint Committees:

- Joint Planning Committee
- Joint Commissioning Arrangements (including scheme of delegation)
- Joint Finance and Performance Committee

Members of the Governing Board approved the revised terms of reference for all the Joint Committees and noted the approval of the Constitution.

2016.019 Any Other Business

No issues raised.
2016.020 **To receive additional questions from the members of the public**

Mr Blackhurst referred to the Audit Committee report, specifically the local counter fraud update in which it refers to an investigation, which concluded that there was insufficient evidence to prosecute and asked if further details can be shared. IS stated that the report was commissioned on behalf of the other CCG and stated that any potential fraud issues would be discussed and appropriate action taken. On this occasion there was no claims of a fraudulent nature and stated that added assurance has been gained from NHS England.

IS advised that since the host CCG received the report the CHC team have implemented new systems and processes to address the weaknesses highlighted.

Mr Williams referred to the second Citizens Jury and welcomed mental health as the next topic for the Jury.

Mr Syme referred to Childrens Safeguarding Board and the publication of two reports following two local serious case reviews in Stoke and noted that a number of recommendations and criticisms have been made, however expressed concern that there are no actions for the Local Authority.

Mr Syme referred to the comments made earlier from PS regarding the crisis in primary care. MSh referred to the PAN Staffordshire Programme and stated that there is a workforce plan aligned with the strategy and colleagues are working extremely hard.

2016.021 **Date and time of next meeting**

The next meeting will take place on Wednesday 2\(^{nd}\) March, Churnet Room, Stockwell Street, Leek, Staffordshire.

*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 action carried out promptly without waiting for the issue of the minutes*

These minutes are signed as being a true record of the meeting

Signed: ........................................................................................................

Position: .................................................  Date: .................................
## Meeting Action Tracker - CCG Board – HELD IN PUBLIC

**Actions from the meeting held on the 6th January, update to be provided at the meeting scheduled on the 2nd March**

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
<th>Lead</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Matters Arising</strong></td>
<td>Prioritisation Programme – hearing aids</td>
<td>MW</td>
<td>Circulated to colleagues</td>
</tr>
<tr>
<td><strong>Accountable Officers</strong></td>
<td>At the last meeting, members of the Governing Board received communication from Staffordshire County Council, in which a response was requested from the CCG. MW confirmed a response was sent and agreed to circulate to members for information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Report</strong></td>
<td>RP referred to the prioritisation information, which had been previously agreed to be included on the CCGs website and advised that this still has not been uploaded and expressed concern that this is against the transparency upheld by the organisation. SP stated that there is a delay with regard to ensuring the correct wording is used, which needs to be aligned with the PAN Staffordshire prioritisation programme and agreed to follow up.</td>
<td>SP</td>
<td>Completed – website updated</td>
</tr>
<tr>
<td><strong>Equality and Inclusion</strong></td>
<td>Members of the Governing Board requested that the acronyms are explained within the report. MW agreed to feedback to Julia Allen.</td>
<td>MW</td>
<td>Completed</td>
</tr>
<tr>
<td>Staffordshire County Council (Care) update</td>
<td>MSh advised that notification has been received from the Local Authority that no representation is available to attend the Governing Board, MW agreed to raise concerns with the Local Authority and report back to the Governing Board.</td>
<td>MW</td>
<td></td>
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</table>
AUTHOR | REPORTING OFFICER /DIRECTOR
---|---
Name | Marcus Warnes
Title | Accountable Officer
Name | Marcus Warnes
Title | Accountable Officer

REPORT TO | North Staffordshire CCG Governing Board

TITLE OF REPORT | Accountable Officer’s Report

DATE OF THE MEETING | Wednesday 2 March 2016

WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT? | None.

COMMITTEE/GROUP | INDIVIDUAL

ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD (please identify all applicable and provide details below) | Approve | Assurance | Discussion | For noting | X

RECOMMENDATION
The Board is requested to note the contents of the report.

STRATEGIC GOALS SUPPORTED BY THIS PAPER (identify appropriate goals) | YES | NO
---|---|---
1. Increase life expectancy and reduce inequality | X | 
2. Improve prevention, early detection and effective management of those at increased risk | X | 
3. Enhance quality of life and improve health outcomes for people with LTCs | X | 
4. Ensure people receive the right care in the right place | X |
In this report I provide some context about the environment we have been operating in over the last two months as well as describe progress with regard to NHS Constitution Standards, financial recovery and the pan Staffordshire transformation programme.

I provide an update about the new model of care as well as matters of local and national interest. In addition I describe how we are progressing with collaborative working and strengthening our executive structure.

<table>
<thead>
<tr>
<th>SUMMARY OF RISKS RELATING TO THE PROPOSAL</th>
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<table>
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<tr>
<th>ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS</th>
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<tr>
<th>QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT</th>
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<tr>
<th>ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT</th>
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<tr>
<th>ACRONYMS</th>
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<tr>
<td>Explained in the report.</td>
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</table>
1.0 Introduction

1.1 It is no exaggeration to say that the NHS is facing one of the most challenging periods in its history, and North Staffordshire is not immune to the pressures felt across the country. NHS finances are front page news, along with strikes, workforce recruitment and retention, quality issues, performance against NHS Constitution standards and general concerns about the future of the NHS in its current form.

1.2 The CCG continues to work effectively with its system partners and in what has been a very difficult year for the CCGs, wider health and social care economy and nationally for the NHS, I would again like to acknowledge the outstanding efforts across the CCG and our partners. We continue collectively to respond to the pressures on urgent care, NHS constitutional standards, our financial position, delivery of our financial recovery plan, and the Pan Staffordshire Transformation Programme. These continue to be our key priorities, with reports for information and discussion within this Board meeting.

1.3 Further progress has been made since the last Board meeting on collaborative working with our neighbouring CCGs, and with NHS Stoke-on-Trent CCG on integrating our workforce and executive teams. Following the conclusion of the CCGs’ Management of Change process, from 1 January 2016 staff have transitioned into the new structure and organisational arrangements.

1.4 As ever, I am grateful to the hard work and dedication of our staff and those in the front line in primary, community and hospital settings. I would like to thank everyone for their professionalism and for the support that is being offered to colleagues and myself; it makes me really proud to be a member of this CCG and makes my job as Accountable Officer whilst challenging, an enjoyable one.

2.0 NHS Constitution Standards

2.1 A&E Performance

2.1.1 The urgent care system continues to attract national attention due to the continued failure to achieve the A&E 4 hour target. Contractual processes are being followed with performance notices issued and remedial action plans requested and through the System Resilience Group (SRG), recovery plans submitted.

2.1.2 You will note from the Integrated Performance Report that performance has not improved significantly and whilst fluctuating week to week, performance against the target of 95% remains around the high 80s% mark. The Recovery Plan requires a performance of at least 90% so we are behind trajectory.

2.1.3 As a result, a refreshed urgent care system improvement plan has been agreed at SRG, which is based on the Emergency Care Improvement Programme (ECIP) diagnostic and key actions. The high impact actions for improvement and initiatives are:

2.1.3.1 Assess to Admit – primary care development plan, exemplar front door, frailty pathway, step up services, ambulatory pathway;

2.1.3.2 Doing Today’s Work Today – SAFER patient care bundle, therapies support;

2.1.3.3 Discharge to Assess – Home First, step down services, domiciliary care development plan, development of multi-specialist community provider model, system demand and capacity review.

2.1.4 Implementation and delivery of the plan will be driven through SRG to ensure the sustained improvements necessary to bring the system back into balance are achieved.
2.2 Referral to Treatment (RTT)

2.2.1 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.

2.2.2 You will note from the Integrated Performance Report that performance falls short of the required standard, which at 90.3% was not achieved in January. An improvement plan was submitted to NHS England on 19 February 2016, with a number of key actions and an improvement trajectory to achieve the target. The CCGs will continue to work with UHN and our other providers to ensure this is successfully implemented and delivers the required improvements.

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

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

2.2.5 Cancer RTT standards also remain a continued cause for concern, although we are on trajectory to deliver all standards by the end of March 2016. A cancer Remedial Action Plan (RAP) is in place with clear actions, trajectories and targets for improvement detailed. This is being monitored through the contract management arrangements with UHN.

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

3.0 Financial Recovery

3.1 The CCG continues to make good progress on its financial recovery and QIPP plans and the delivery of its financial plan and planned £2m deficit control total. As has been reported previously there remain risks to delivery given that many of our QIPP/financial recovery schemes impact in the second half of the year. As such, the CCG continues to maintain a tight grip on its financial position through a fortnightly Financial Recovery Group, which is run jointly with Stoke CCG and chaired by myself. This enables close scrutiny of performance against the Financial Recovery Plan (FRP) and provides the opportunity for deep dives into areas of concern.

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

3.3 A comprehensive review of this year's financial position and plans for next year is contained within Ian Stoddart's report.

4.0 My Care, My Way – Home First

4.1 The formal consultation exercise on My Care, My Way – Home First ended on 17 January 2016. The evaluation report is expected on 29 February 2016. The report will be considered by commissioners and recommendations will come to Board for consideration. The report will also go to the local authority scrutiny committees as requested.
4.2 The step down contract was signed by UHNM and commissioners and was implemented from 1 December 2015. Further updates on progress will be provided in the contract update in the Integrated Performance Report.

5.0 Collaborative Working

5.1 The strengthening of collaborative working between the CCG and NHS Stoke-on-Trent CCG continues and plans for closer working and shared structures and workforce between the CCGs are being implemented. Alongside this, the CCGs are exploring options for co-location of the shared workforce and these will be shared with the Board at the earliest opportunity.

5.2 Following the recent Management of Change process and all CCG employees having been consulted on the proposed shared structure and changes to roles and responsibilities, implementation of the shared structures commenced from 1 January 2016.

5.3 Whilst the executive, clinical and managerial workforce and committee structures will be shared by both CCGs, this is not a merger and both CCGs will remain sovereign bodies with their own governing bodies and accountable officers.

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

6.1 We have received feedback for NHS England and NHS Improvement on the case for change and whilst in a number of areas positive, there is further work to be done in several areas to provide the required level of assurance. The system response over the coming weeks and months is critically important and there will be some refocusing on key areas of improvement and strengthening of governance arrangements.

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

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

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

7.0 Update on Executive Staffing

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

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

7.3 Noreen Dowd will continue as Interim Director of Strategy, Planning and Performance until at least the end of March 2015 or until a substantive appointment has been made. This will ensure that we have the required senior leadership through the forthcoming annual planning round.
9.0 Recommendation

9.1 The Board is requested to:

9.2 Note the contents of the report.
ENCLOSURE:

North Staffordshire
Clinical Commissioning Group

REPORTING OFFICER /DIRECTOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Cheryl Hardisty</th>
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</thead>
<tbody>
<tr>
<td>Title</td>
<td>Interim Director of Commissioning</td>
</tr>
</tbody>
</table>

REPORT TO
North Staffordshire CCG Governing Board

TITLE OF REPORT
Equality & Inclusion: EDS update (Equality Delivery System)

DATE OF THE MEETING
2 March 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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<tr>
<td></td>
<td>Record which committee/group have already seen this report, note date and comments (if applicable)</td>
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<tr>
<td></td>
<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 (please identify all applicable and provide details below)

<table>
<thead>
<tr>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
<th>x</th>
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</table>

RECOMMENDATION

1. Note - Sally Parkin, Cheryl Hardisty and Heads of Commissioning Services to meet in February to agree on key priority care pathway focus of evidence gathering for EDS Goal 2: Improved patient access and experience. (ie the NHS should improve accessibility and information, and deliver the right services that are targeted, useful, usable and used in order to improve patient experience.)

2. Note - Nominated staff to collect (and present) a balanced set of evidence of good Outcomes and challenges encountered, from a range of engagement and consultation opportunities - leading to mitigation or reshaping of services for inclusion, by CCG.

2.1 Note - Required evidence is specifically for people from local protected groups and is summarised onto two summary slides / EDS template by 15 April 2016. Evidence will then be proof read, and displayed on CCG 2016 EDS evidence webpage a week before the grading event. In 2016 CCGs are looking to include different ways of presenting anonymised patient stories / vignettes.

3. Note - 2016 EDS annual public grading of Goal 2 required Outcomes, is taking place on Tuesday 17 May (am) in the Brampton room, NSCCG at 9.30 until 1pm. EDS stakeholders, CCG senior clinicians and nominated staff to attend by invite.

4. Note - The 2016 EDS event will include April 2015 to 31 March 2016 equality performance joint evidence for both North Staffs CCG and Stoke-on-Trent CCG, as the second joint EDS event for North Staffs localities. We will also include lessons learnt from the 27 October 2015 joint public grading. The overarching Equality and Inclusion Action Plan includes a section showing EDS actions for 2015-17 from findings and recommendations for improvements made to CCGs by EDS stakeholders in October 2015. This action plan will be presented to Joint ODC meeting on 29 March 2016.

5. Note - Larger provider compliance with an EDS annual public grading of equality performance evidence is being monitored by CCG Contracts Lead. The new National Provider Contract 2016-17 when available should
have this mandated EDS NHS framework embedded as a requirement.

5.1 Note - Contracts Lead will also ensure CCG focus on broader compliance issues ie: this is what you have to do for equality and human rights compliance; and this is how you do it; into contracts in 2016-17. EDS provides evidence of providers meeting their Public Sector Equality Duty or PSED. It is worth noting that if our providers are not compliant in this area (as mandated by NHS England) then neither is their lead commissioner.

6. Note – Fair access to (key) information for protected groups: EDS grading report (27 October 2015 public event) has been précised into 2 sides of A4 and has been sent to ASIST (North Staffordshire locality) - who produce clear information with involvement from people with learning disabilities, on 17 February for an initial estimate re producing an Easy Read document suitable for people with learning disabilities / literacy issues. This document is intended for display on CCG EDS webpage alongside the full EDS grading report and could be requested in other formats to aid ‘fair access’ to this information for patients.

### STRATEGIC GOALS SUPPORTED BY THIS PAPER

<table>
<thead>
<tr>
<th>(identify appropriate goals)</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1. Increase life expectancy and reduce inequality</td>
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</tr>
<tr>
<td>4. Ensure people receive the right care in the right place</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

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

Equality Delivery System (EDS v2) requires all commissioner organisations and their larger provider partners to carry out an annual public grading of their equality performance evidence. An annual summary EDS report should then be submitted to NHS England and displayed on CCG EDS webpage. Provider lead commissioners also require a report confirming their provider’s current annual EDS compliance status. This report can be received at any time during the financial year, usually via the Contracts Lead.

CCG are required to build up the capacity of an EDS volunteer (trained) stakeholder group who will work with the CCG as a ‘critical friend’ in publicly grading equality evidence for each of the 4 Goals and 18 required Outcomes, over a 4 year delivery cycle (2013 to 2017). EDS stakeholders should represent each of the 9 protected groups across both localities, as well as local communities of interest eg from the voluntary sector.

This EDS update report seeks to draw Board’s attention to CCGs own compliance journey throughout the year and CCGs vigilance re their larger provider partners’ compliance with NHS England requirements including meeting the PSED. EDS guidance and reporting template is available on NHS England website for both commissioner and their larger providers, who are both subject to the requirements of the Equality Act 2010 and the Public Sector Equality Duty 2011.

### SUMMARY OF RISKS RELATING TO THE PROPOSAL

Highlight any implications, including finance, quality, reputation, governance, strategic workforce, clinical, medicines optimisation, equality related or other

The NHS EDS v2 equality performance framework is mandated by NHS England from April 2015. Failure to comply could lead to reputational risk for CCG, and their larger providers. The Equality and Human Rights Commission (EHRC) could also serve a notice of non-compliance with the Public Sector Equality Duty.

If the EHRC decides to take enforcement action against discriminatory practices, it can do this by conducting a formal investigation and issuing an unlawful act notice, or going to court to seek an injunction.

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

**Equality Act 2010** – evidence of giving ‘due regard’ according to the Brown principles, to local people from groups protected by the Act

**Public Sector Equality Duty 2011**

On 5 April 2011, the public sector equality duty (the equality duty) came into force. The equality duty was created under the Equality Act 2010.
The equality duty replaced the race, disability and gender equality duties. The first of these duties, the race equality duty in 2001, came out of the Macpherson Report on the murder of the black teenager, Stephen Lawrence. Following failures of the investigation of Lawrence’s murder, the report revealed institutional racism in the Metropolitan Police. It was clear that a radical rethink was needed in the approach that public sector organisations were taking towards addressing discrimination and racism.

Prior to the introduction of the race equality duty, the emphasis of equality legislation was on rectifying cases of discrimination and harassment after they occurred, not preventing them happening in the first place. The race equality duty was designed to shift the onus from individuals to organisations, placing for the first time an obligation on public authorities to positively promote equality, not merely to avoid discrimination.

Following the introduction of the race duty, it was clear that progress could also be made on other areas of equality through the introduction of similar duties. The disability equality duty came into force in 2006, followed by the gender equality duty in 2007.

**The equality duty**
The equality duty was developed in order to harmonise the equality duties and to extend it across all of the characteristics protected by the Equality Act 2010. It consists of a **general equality duty**, supported by **specific duties** which are imposed by secondary legislation. In summary, those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims or arms of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the duty may involve treating some people more favourably than others.

The equality duty covers the nine protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status. This means that the first aim of the duty applies to this characteristic but that the other aims (advancing equality and fostering good relations) do not apply.

**Purpose of the duty**
The broad purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities. If you do not consider how a function can affect different groups in different ways, it is unlikely to have the intended effect. This can contribute to greater inequality and poor outcomes. The general equality duty therefore requires organisations to consider how they could positively contribute to the advancement of equality and good relations. It requires equality considerations to be reflected into the design of policies and the delivery of services, including internal policies, and for these issues to be kept under review.

Compliance with the general equality duty is a legal obligation, but it also makes good business sense.

**QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT**
Date completed, please highlight any direct or indirect implications
N/A as EDS update report to Board.

**ANY RELATED WORK WITH STAKEHOLDERS/PRACTICES/PUBLIC AND PATIENT ENGAGEMENT**
Provide further information, including dates if applicable
Links closely with the new Patient Engagement Strategy being developed.

**ACRONYMS**
If not listed in the report, please list
CCG Clinical Commissioning Group
## AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Lee George</th>
<th>Name</th>
<th>Jayne Downey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Head of Quality</td>
<td>Title</td>
<td>Director of Nursing &amp; Quality</td>
</tr>
</tbody>
</table>

## REPORT TO

North Staffordshire (NS) Clinical Commissioning Group (CCG) Governing Board

## TITLE OF REPORT

Quality Report

## DATE OF THE MEETING

Wednesday 2nd March 2016

## WHAT OTHER CCG COMMITTEE OR GROUP HAS CONSIDERED THIS REPORT?

Record which groups/committee have already seen this report, the date and comments (for example agreed this report should go to the governing board for approval)

N/A

## ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD (PLEASE TICK)

<table>
<thead>
<tr>
<th>Approve</th>
<th>✓ Assurance</th>
<th>✓ Discussion</th>
<th>✓ Information</th>
</tr>
</thead>
</table>

The CCG Governing Board is asked to:

- Note the key quality and safety matters reported to provider’s Clinical Quality Review Groups and the CCG’s Quality Committee and actions taken in response.

## STRATEGIC GOALS SUPPORTED BY THIS PAPER (tick appropriate goal)

1. Increase life expectancy and reduce inequality ✓
2. Improve prevention, early detection and effective management of those at increased risk ✓
3. Enhance quality of life and improve health outcomes for people with LTCs ✓
4. Ensure people receive the right care in the right place ✓

## PURPOSE OF THE REPORT/SUPPORTING INFORMATION (if applicable)

This report aims to provide North Staffordshire CCG Governing Board assurance that structures and processes are in place to promote, monitor and ensure safe, high quality health services for the people of North Staffordshire.

Care Quality Commission inspection reports are published on the following website: [www.cqc.org.uk](http://www.cqc.org.uk)

## KEY POINTS/EXECUTIVE SUMMARY

North Staffordshire CCG has breached its annual tolerance at Month 9 with 84 CDI cases reported against an annual tolerance of 55. The Head of Infection Prevention & Control presented to Quality Committee assurance of the range of actions being undertaken in relation to HCAIs; namely the CCG HCAI Work Plan, C Difficile Recovery Plan, along with individual Provider Work Plans which are monitored and reviewed at each Trusts Infection Prevention and Control (IPC) Committee and at the local IPC Forums held in the North and South of Staffordshire.

## Risks relating to the proposals in this paper

N/A

## Summary of any finance/resource/medicines management /workforce implications

N/A

## Any statutory/regulatory/legal/NHS Constitution/Assurance/Governance implications

N/A
1. **Developing CCG Capacity & Capability for Quality Improvement**

1.1 Since the last Governing Board meeting the Quality Committee (joint meeting with Stoke-on-Trent CCG) met on the 13th January and 10th February. The Committee received reports outlining the quality assurances for the CCG’s main providers and updates from its subgroups; Infection Prevention & Control Group, Safeguarding Group and Primary Care Subcommittee.

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

North Staffordshire CCG directly received 13 complaints; this in line when compared with the previous quarter (12). The organisations that the complaints were about include: CCG commissioning decisions (3), Royal Stoke University Hospital (3), Continuing Healthcare (2), Out of Hours (2), and a further three relating to separate services. The CCG is not aware of any complainants contacting the Parliamentary and Health Service Ombudsmen requesting an independent review of their complaints.

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

During Quarter 3 292 events were submitted for both North Staffordshire CCG and Stoke-on-Trent CCG. 170 of the events recorded were regarding ‘safe, high quality co-ordinated care’; this consistent with previous quarters. The highest themes under the domains of patient experience are: ‘discharge issues’, ‘medication issues; and ‘clinical care/treatment’ and key words used are ‘emergency medicine’, ‘pharmacy’, ‘GP practice medicine’ and ‘general surgery’. The joint Datix Newsletter is circulated to all in a ‘you said, we listened, we did’ style to provide them with some additional feedback, highlighting themes and what outcomes have been achieved in direct response to the concerns they are raising.

2. **Quality Monitoring of Main Providers of Clinical Services**

A. **North Staffordshire Combined Healthcare NHS Trust (NSCHT)**

2.1 The Safety Thermometer ‘harm free care’ rate for January 2016 is 97.14% and 97.14% had no new harms recorded. This is based upon 70 patients surveyed. In January 2016, 1.3% of reported patients had a pressure ulcer and 1.3% had a fall with harm. The highest rate of harm over the twelve month period is falls and the next highest rate of harm is pressure ulcers. The rolling twelve month performance at NSCHT is:
<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feb</td>
<td>Mar</td>
</tr>
<tr>
<td>No Harms (%)</td>
<td>98.48</td>
<td>93.67</td>
</tr>
<tr>
<td>No New Harms (%)</td>
<td>100</td>
<td>97.47</td>
</tr>
<tr>
<td>Patients</td>
<td>66</td>
<td>79</td>
</tr>
</tbody>
</table>

NSCHT has reported 15 serious incidents during December 2015 and January 2016; 13 of these were categorised as ‘Apparent/actual/suspected self-inflicted harm meeting SI criteria’ and a further two were ‘slips, trips & falls’. All serious incidents are investigated in accordance with the National Framework and using National Patient Safety Agency best practice guidance. The CCG has an opportunity to challenge the provider’s investigation findings at the monthly Serious Incident Subgroup.

2.2 The latest Friends and Family Test results highlight that 88% of patients would recommend NSCHT, 63% of staff would recommend NSCHT as a place to receive care and 42% of staff would recommend NSCHT as a place to work. The FFT results are broken down below:

<table>
<thead>
<tr>
<th>Patients</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan</td>
</tr>
<tr>
<td>Recommend</td>
<td>82%</td>
</tr>
<tr>
<td>Not Recommend</td>
<td>0%</td>
</tr>
<tr>
<td>Total Responses</td>
<td>39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS England (Peer) – Not Recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oct</td>
<td>Nov</td>
</tr>
<tr>
<td>Recommend – Care</td>
<td>50%</td>
<td>69%</td>
</tr>
<tr>
<td>Recommend – Work</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>Not Recommend – Care</td>
<td>15%</td>
<td>7%</td>
</tr>
<tr>
<td>Not Recommend – Work</td>
<td>Not Applicable</td>
<td>32%</td>
</tr>
<tr>
<td>Total Responses</td>
<td>100</td>
<td>90</td>
</tr>
</tbody>
</table>

The Staff FFT NHS England averages for all Trusts are as follows: Recommended – Care 79%, Recommended – Work 62%, Not Recommended – Care 7%, Not Recommended – Work 19%. The disaggregated England average scores for acute, community and mental health provider trusts are not published.

2.3 The Care Quality Commission carried out a comprehensive inspection which included an announced inspection visit week commencing the 7th September 2015. Following the comprehensive inspection we are currently awaiting the publication of the final report from the CQC which will be presented and discussed at the Quality Summit; date to be confirmed. The Trust is already working on a number of actions highlighted to them.

2.4 There is currently a waiting list within the Child & Adolescent Mental Health Service for initial assessments and further interventions; some of these service users have been waiting longer than 26 weeks. These waiting times have developed over a period of time due to demand and the level of resource available. The Trust has implemented a number of initiatives to improve waiting times and ensure that no patients come to harm whilst waiting. These include: all referrals are reviewed on the day of receipt by a Senior Practitioner, an internal waiting list protocol has been developed including a risk assessment and plan of care at the initial assessment, waiting lists have been amalgamated into one which is monitored on a weekly basis and all families/carers have been contacted to inform them that the young person remains
on the waiting list and remind them of the details of who to contact should circumstances for the young person alter.

**B. Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP)**

2.5 The Safety Thermometer ‘harm free care’ rate for January 2016 is 91.67% and 96.95% had no new harms recorded. This is based upon 1837 patients surveyed. In January 2016, 6.64% of reported patients had a pressure ulcer, 0.76% had a new venous thromboembolism, 0.71% had a urinary tract infection with a catheter and 0.6% had a fall with harm. In January 2015 these percentages were 5.41%, 0.37%, 1.56% and 0.27% respectively. The highest rate of harm over the twelve months is pressure ulcers and the majority of these are existing Grade 2 pressure ulcers. The number of new harm pressure ulcers remains constant between a high of 2.03% in July 2015 and a low of 1.2% in May 2015. The rolling twelve month performance at SSOTP is:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feb</td>
<td>Mar</td>
</tr>
<tr>
<td>No Harms (%)</td>
<td>92.66</td>
<td>91.76</td>
</tr>
<tr>
<td>No New Harms (%)</td>
<td>97.28</td>
<td>97.28</td>
</tr>
<tr>
<td>Patients</td>
<td>2058</td>
<td>2172</td>
</tr>
</tbody>
</table>

SSOTP has reported 21 serious incidents during December 2015 and January 2016; of these 14 were within the ‘pressure ulcers’ category and a further 4 were ‘slips, trips & falls’. All pressure ulcer serious incidents are reviewed, challenged and scrutinised at the Tissue Viability Panel, chaired by SSOTP’s Director of Nursing & Quality and attended by the CCG’s Quality Manager, a decision is made whether the pressure ulcer was avoidable/unavoidable and any learning identified.

SSOTP continue to work towards the elimination of avoidable pressure ulcers refreshing their zero tolerance action plan, launching the pressure ulcer campaign ‘React to Red’. For the period April to October 2015 there have been 20 grade 3 and 4 avoidable attributable pressure ulcers; for the same period in 2014 there had been 18. There have been no community hospital acquired avoidable attributable pressure ulcers between February 2014 and November 2015.

2.6 The latest Friends and Family Test results highlight that 97% of patients would recommend SSOTP, 78% of staff would recommend SSOTP as a place to receive care and 48% of staff would recommend SSOTP as a place to work. The FFT results are broken down below:

<table>
<thead>
<tr>
<th>Patients</th>
<th>2015</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan</td>
<td>Feb</td>
<td>Mar</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
<td>Oct</td>
<td>Nov</td>
<td>Dec</td>
</tr>
<tr>
<td>Recommend</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Not Recommend</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Total Responses</td>
<td>1779</td>
<td>1467</td>
<td>1613</td>
<td>2306</td>
<td>2701</td>
<td>3206</td>
<td>3413</td>
<td>2955</td>
<td>3088</td>
<td>3037</td>
<td>2808</td>
<td>3328</td>
</tr>
</tbody>
</table>

| NHS England (Peer) – Recommend | 96% | 95% | 95% | 96% | 95% | 95% | 95% | 96% | 95% | 95% | 95% | 95% |
| NHS England (Peer) – Not Recommend | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 2% | 2% | 2% | 2% |

<table>
<thead>
<tr>
<th>Staff</th>
<th>2014</th>
<th>2015</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oct</td>
<td>Nov</td>
<td>Dec</td>
<td>Jan</td>
<td>Feb</td>
<td>Mar</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
<td>Jul</td>
<td>Aug</td>
<td>Sep</td>
</tr>
<tr>
<td>Recommend – Care</td>
<td>64%</td>
<td>76%</td>
<td>77%</td>
<td>78%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommend – Work</td>
<td>50%</td>
<td>51%</td>
<td>51%</td>
<td>48%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Recommend – Care</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Recommend – Work</td>
<td>26%</td>
<td>25%</td>
<td>27%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Responses</td>
<td>1876</td>
<td>1826</td>
<td>803</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.7 The Care Quality Commission carried out a comprehensive inspection which included an announced inspection visit week commencing the 3rd November 2015. Following the
comprehensive inspection the Trust were issued a warning notice and a steering group has been set up to monitor the actions in the improvement plan which needs to be completed by 29th February 2016. These have been discussed at the CQRM and in meetings with the Trust’s Director of Nursing & Quality. The CQC have not yet issued draft reports and we await further confirmation of publication dates.

C. University Hospital North Midlands NHS Trust (UHNM)

2.8 The Safety Thermometer ‘harm free care’ rate for January 2016 is 89.91% and 98.46% had no new harms recorded. This is based upon 1169 patients surveyed. In January 2016, 7.27% of reported patients had a pressure ulcer, 2.82% had a urinary tract infection with a catheter and 0.68% had a new venous thromboembolism. In January 2015 these percentages were 8.4%, 2.1%, 0.7% respectively and 0.54% of surveyed patients had a fall with harm. The highest rate of harm over the twelve months is pressure ulcers and the majority of these are existing Grade 2 pressure ulcers. The rolling twelve month performance at UHNM is:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feb</td>
<td>Mar</td>
</tr>
<tr>
<td>No Harms (%)</td>
<td>90.71</td>
<td>87.78</td>
</tr>
<tr>
<td>No New Harms (%)</td>
<td>97.66</td>
<td>97.01</td>
</tr>
<tr>
<td>Patients</td>
<td>1195</td>
<td>1170</td>
</tr>
</tbody>
</table>

UHNM has reported 22 serious incidents during December 2015 and January 2016; of these 13 were ‘slips, trips & falls’ and a further 5 were ‘pressure ulcers’. All pressure ulcer serious incidents are reviewed, challenged and scrutinised at the Tissue Viability Panel, chaired by UHNM’s Director of Nursing and attended by the CCG’s Quality Manager, a decision is made whether the pressure ulcer was avoidable/unavoidable and any learning identified.

Falls Bundle (92.7%) scores and Falls Risk Assessment (98.1%) completion continues to exceed the 90% target across UHNM. Further, 98.78% of all patients had a Pressure Ulcer Risk Assessment completed upon admission. UHNM continues to implement the “Stop the Pressure” initiatives to eliminate hospital acquired pressure ulcers.

2.9 The latest Friends and Family Test results highlight that 97% of inpatients would recommend UHNM, 73% of A&E attenders would recommend UHNM, 83% of staff would recommend UHNM as a place to receive care and 62% of staff would recommend UHNM as a place to work. The FFT results are broken down below:

<table>
<thead>
<tr>
<th>Inpatients</th>
<th>2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td>Recommend</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Not Recommend</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Total Responses</td>
<td>1214</td>
<td>1559</td>
</tr>
<tr>
<td>Response Rate</td>
<td>33%</td>
<td>45%</td>
</tr>
</tbody>
</table>

| NHS England (Peer) – Recommend | 94% | 95% | 95% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% |
| NHS England (Peer) – Not Recommend | 2% | 2% | 2% | 2% | 1% | 1% | 1% | 1% | 2% | 1% | 1% | 2% |

<table>
<thead>
<tr>
<th>A&amp;E</th>
<th>2015</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan</td>
<td>Feb</td>
</tr>
<tr>
<td>Recommend</td>
<td>83%</td>
<td>84%</td>
</tr>
<tr>
<td>Not Recommend</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Total Responses</td>
<td>1218</td>
<td>964</td>
</tr>
<tr>
<td>Response Rate</td>
<td>18%</td>
<td>15%</td>
</tr>
</tbody>
</table>

NHS England (Peer) - 88% 88% 87% 88% 88% 88% 88% 88% 88% 87% 87% 87%
2.10 As members will be aware, the local health economy urgent care system has been under varying degrees of pressure since December 2015. There have been a number of 12 hour trolley breaches reported, particularly in January and February 2016; prior to these no breaches had been reported since 1st July 2015. Therefore, the 12 hour breach quality framework agreed last year has been re-enacted. In summary the frame-work includes the following:

- Each patient experiencing a 12 hour breach is interviewed
- An A&E breach report is received weekly for review and feedback and submitted to the Clinical Quality Review Meeting for UHNM on a monthly basis
- UHNM hold a 12 hour Breach Panel to review the Root Cause Analysis’, which the CCG, as the Commissioner attends.
- Unannounced visits to the outlier wards have been scheduled to try and better understand the main issues with patient flow and medically fit for discharge within the hospital. Members received assurance that there were no major quality issues to highlight following these visits.

In addition, patient safety visits to Accident and Emergency with UHNM and the CCG are undertaken to seek assurances with regards to the safety of care delivered in A&E and to provide constructive recommendations and support for improvement. There have so far been no immediate concerns to raise and a range of good practice was evident and noted.

3. Infection Prevention & Control (IPC)

4.1 Since the last Governing Board meeting the Infection Prevention & Control Group (joint meeting with Stoke-on-Trent CCG) met on the 21st January 2016.

4.2 NHS England has set a challenging trajectory for Clostridium Difficile Infections (CDI) and a zero tolerance approach to avoidable Methicillin-Resistant Staphylococcus Aureus (MRSA) blood stream infections (BSI) for 2015/16. The Month 9 (April 2015 – December 2015) performance data for the CCG and our main providers is included below:

<table>
<thead>
<tr>
<th>Year to date</th>
<th>YTD target</th>
<th>Annual tolerance</th>
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<tr>
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</tr>
<tr>
<td>CDI</td>
<td>82</td>
<td>55</td>
</tr>
<tr>
<td>MRSA</td>
<td>3</td>
<td>0</td>
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</table>
4.3 North Staffordshire CCG has breached its annual tolerance at Month 9 with 84 CDI cases reported against a cumulative tolerance of 46. Of the 84 CDI cases, 22 occurred within an acute setting and 62 in a non-acute setting (e.g. sample sent from a Nursing Home, General Practice or within 48 hours of admission to an acute or bedded community facility other than a Care Home).

4.4 The Head of Infection Prevention & Control presented to Quality Committee a detailed presentation in respect of the current position in relation to MRSA and CDI within the CCG and its main providers, along with comparative information for other CCGs within the West Midlands. Members received assurance of the range of actions being undertaken in relation to HCAIs; namely the CCG HCAI Work Plan, C Difficle Recovery Plan, along with individual Provider Work Plans which are monitored and reviewed at each Trusts Infection Prevention and Control (IPC) Committee and at the local IPC Forums held in the North and South of Staffordshire.

Further assurance was provided in relation to the key areas currently being addressed through the IPC Strategy which include:
- Prevention of avoidable infection – Short life working group to address the high incidence of CDI across the health economy but particularly in the north of the county.
- Improvement in standards of IPC in the Care Home setting.
- Reduction in the incidence of catheter associated infection in the care home setting.
- Support improvement of IPC in Primary Care.
- Reduction in Antimicrobial Prescribing across the Health Economy.

In addition, a key area of priority is to further enhance antimicrobial stewardship with the following areas of focus identified:
- Re-establish the Health Economy antimicrobial prescribing forum. Identify a Chair and vice Chair for this forum.
- Implement the UK 5 year antimicrobial resistance strategy across the Staffordshire Health Economy.
- Assessment of Acute prescribing of antimicrobials in accordance with guidelines.
- Promote completion of the antimicrobial stewardship competences by all prescribers as part of the implementation of the UK 5 year antimicrobial resistance strategy.

This year there are a small number of new key performance indicators pertaining specifically to infection prevention and control in nursing homes, with which each home across the health economy must comply. These are as follows:
- Every home will be required to complete and submit an Infection Prevention Society audit which will be scrutinised for deviation from the baseline results. The top and bottom 10 performers will receive an unannounced inspection visit, in addition to homes with any unexplained deviation from the baseline audit result.
- Every home must identify at least one IPC link practitioner, one of whom must be a registered nurse able to agree competence.
- All patient facing staff must complete the competency based educational framework (to be added as a contract variation when launched).

4. Safeguarding Adults, Children & Young People

5.1 Since the Safeguarding Group (joint meeting with Stoke-on-Trent CCG) meets quarterly it has not met since the last Governing Board meeting. The next meeting will take place on the 18th March 2016.

5.2 The CCGs have strengthened our Adult Safeguarding function by appointing an Adult Safeguarding Specialist Nurse.
ENCLOSURE: 11

<table>
<thead>
<tr>
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<th>REPORTING OFFICER /DIRECTOR</th>
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<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Liza Pursey</td>
<td>Emma Sutton</td>
</tr>
<tr>
<td>Title</td>
<td>Title</td>
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<tr>
<td>Interim Primary Care Strategy Manager</td>
<td>Clinical Director Primary Care</td>
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<th>Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan</th>
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<th>2nd March 2016</th>
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WHAT OTHER CCG COMMITTEE/GROUP/INDIVIDUAL HAS CONSIDERED THIS REPORT?

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<th>COMMITTEE/GROUP</th>
<th>INDIVIDUAL</th>
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<tr>
<td>Joint Planning Committee 9th January – Approved Northern Staffordshire Primary Care Steering Group 2 February 2016 – Approved Stoke-on-Trent Patient Congress 5th January 2016</td>
<td>All GP members, practice managers and other members of the wider primary care team have been actively engaged in the development and ‘sign off’ of this document through direct representation and through a number of engagement events. A programme of patient and public engagement events commenced in January and will be completed in March</td>
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<tr>
<th>ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD</th>
<th>Approve</th>
<th>X</th>
<th>Assurance</th>
<th>Discussion</th>
<th>For noting</th>
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RECOMMENDATION

The Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan describes a vision for primary care over the next five years and recognises that primary care is a key enabler to support the delivery of models of care which will reduce unwarranted variation, ensure sustainability and improve health outcomes of the local population.

This strategy acts as a local vision to support the 5 Year Primary Care Strategy for the ‘Together We’re Better’ Staffordshire Transformation Programme.

North Staffordshire CCG Governing Board are asked to approve the overall vision and key principles described within this strategy to enable a detailed implementation plan to be developed.

STRATEGIC OBJECTIVES SUPPORTED BY THIS PAPER

<table>
<thead>
<tr>
<th>NORTH STAFFORDSHIRE CCG</th>
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<td>1. We will commission safe effective and high quality sustainable services</td>
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</tr>
<tr>
<td>2. We will deliver better patient outcomes through effective federated and collaborative arrangements with key partners</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. We will improve patient experience through patient engagement, feedback</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. We will reduce health inequalities and inappropriate clinical variation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Governance &amp; Statutory Requirements</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. We will achieve all of the above while remaining within financial balance and achieving best value</td>
<td>X</td>
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</table>
The Northern Staffordshire Primary Care Strategy sets out Stoke on Trent and North Staffordshire CCG’s vision for Primary Care for 2015-2020. It is aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire, supports the Staffordshire Transformation Programme, ‘Together We’re Better’ and builds on the new opportunities provided through primary care co-commissioning.

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

The strategy proposes that Northern Staffordshire and Stoke-on-Trent CCGs in partnership with the Shropshire and Staffordshire Area Team begin supporting GPs in working collaboratively, to develop a sustainable, holistic and high quality model of Primary Care and ensure that all patients have access to the full range of enhanced locally available primary care services. The CCGs will continue to work closely with the Northern Staffordshire GP Federation to achieve this ambition.

In addition, in order to achieve our vision, over the next the next five years, the strategy proposes to develop a Multispecialty Community Provider (MCP) model of care. This model will initially incorporate enhanced Primary Care and Community Services, and will subsequently support integration and joint working across other out of hospital services across the area.

An Implementation Plan is being developed which will oversee

1. An implementation plan for the Development of the Northern Staffordshire Primary Care Commissioning Strategy; and
2. The development of a Multispecialty MCP Model of Care

The strategy will be supported by a number of enabler work streams which will be developed through the Staffordshire Transformation Programme and aligned to our local implementation plan for primary care:
- An Organisational Development and Workforce Plan;
- A Commissioning Framework which will address the contracting, performance and payment approaches required to enable new approaches to integrated working; and
- Estates and IT development plans

In addition a localised financial model is being developed to enable better understanding of the impact on investment and the release of savings through the development of primary care and the creation of an MCP model of delivery.

It is recognised that the progression of a primary care strategy and implementation requires transformation across the wider primary care team and across the health and social care system and with this in mind the Primary Care Delivery Plan Steering Group with representatives of the wider primary care team and all stakeholders, which developed the strategy, will continue to be used to oversee plans for implementation.

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### SUMMARY OF RISKS RELATING TO THE PROPOSAL

High level risks have been described within the Primary Care Strategy. Having a Primary Care Strategy is a key requirement of Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21.

Key risks will be identified within the implementation plan.
<table>
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### QUALITY IMPACT ASSESSMENT AND/OR EQUALITY IMPACT ASSESSMENT

An EIA has been developed to support this work. In addition a series of public and patient engagement have been organised across Northern Staffordshire. Focus Groups are being used to ensure the views of people from protected groups are captured.

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

The Primary Care Steering Group is composed of stakeholders from the wider health and social care economy and includes representation from UHN, SSOTP and the North Staffordshire Combined Healthcare Trust. In addition attendees include Public Health and Social Care. GP views are represented by two locality leads and the LMC attend. Other members of wider primary care team such as nursing and pharmacy are invited and the Shropshire and Staffordshire Area Team participate. Dr Emma Sutton chairs this group. In addition GP, Practice Managers and the wider primary care team have participated in a programme of direct engagement including an online survey. An event for GPs to actively engage with this strategy was held on the 11th February. Healthwatch have organised a series of engagement events with members of the public and patients throughout January and February. This work has been led by Dr Emma Sutton and although planned to end in March, followed by an evaluation report, engagement will be ongoing.

### ACRONYMS
DRAFT

Northern Staffordshire

5 Year

Primary Care

Strategic Delivery Plan

Final Version
Executive Summary

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

The key aims of the strategy are to:

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

This is an ambitious programme of large scale change recognising the importance of primary care at the heart of our entire health system. Most health system contact begins and ends in primary care with nine out of ten NHS contacts taking place in primary care, of which eight are in general practice. The GP record is the only place where an individual’s complete health history is recorded, thus enabling the delivery of integrated and coordinated care. The CCGs have valued and developed engagement via localities since their inception and more recently have asked practices to consider the transformation agenda. This strategy builds on this approach and sets out a vision for Northern Staffordshire with primary care at the centre of system transformation.

Our future vision for care has the patient and their GP at the heart of a multi-disciplinary model of provision where General Practice remains an attractive career choice and practices can flourish and work together, integrating with other providers of care as a part of a truly effective community health and social care system.

Throughout this document, the reference to patient care and wellbeing refers to both the patients physical and mental health needs, and by delivering a holistic approach we aim to achieve improvements in population wellbeing and ensure primary care sustainability. This multi-speciality community provider (MCP) model will enable patient-centred coordinated care, which will be provided in a locality; achieving improvements in health, developing resilience and supporting the population to stay as well and as healthy as possible. The development of our current localities to work together across a footprint of delivery of around 30-50,000 patients, and to obtain economies of scale through collaboration, will bring opportunities at practice level that cannot be achieved by individual practices alone.

The development of the MCP model will take into account the needs of our diverse population; empower patients to self-manage their care; improve population health and wellbeing by focussing on early intervention and prevention; encompass the three characteristics of care that matter most to patients, (proactive, accessible and coordinated care) and work across the system to develop a hub and spoke model to meet the requirement to provide 7 Day Access and winter resilience.

Enablers within this strategy will support the development of MCPs and the benefits that can accrue from integrating services around registered list based populations. Enablers include new technologies, organisational development, and financial modelling that will support emergent organisational structures and opportunities, acknowledging that the new MCP based delivery structures have the potential to maximise new ways of working such as care coordination and integrated systems around the registered lists.
It is clear that local primary care as we know it is under threat from significant workforce and economic pressures, a substantial increase in the number of appointments required, the complexity of presenting problems, increased bureaucracy and a transfer of unfunded work from secondary care. Any new model of care will need to address these issues and rapidly develop enabling work streams around workforce, estates and infrastructure (including IT) and robust financial modelling.

To this end, the CCG’s are committed to developing a **workforce plan** that analyses need, identifies workforce requirements, identifies gaps and implements solutions; in addition the work force plan will enable clinical time to be focused on patient need; resolve the issue of indemnity fees for all primary care professionals; support practices to develop and implement workforce models; enable greater use of the voluntary sector; place an increased emphasis on learning and development and promote work opportunities and the message that Stoke-on-Trent and North Staffordshire are good places to live and work.

We will develop a **financial model** which will identify current spend on primary care services and will explain how Northern Staffordshire will invest in primary care, mental health and community services. This investment strategy will enable practices to achieve the organisational capability required to deliver scale. It will support a viable workforce plan, deliver a viable estates portfolio and achieve technological solutions which enable data to be shared across the system. In addition there will be a shift to an outcome based approach, developing contracts which enable primary care to achieve outcomes and remain financially stable. This will be achieved through an implementation plan which enables change and maximises the use of all sources of funding so that we are able to provide the best services for our patients, in the right place, at the right time for the lowest cost.

In summary, this strategy will allow us to address the diverse needs of our population, promote primary care now and in the future whilst continuing to recognise the importance of the doctor patient relationship. It grows and develops the concept of locality working, by integrating services with and around primary care in a MCP model. It reflects the national ambition of working to scale and makes local primary care ‘future proof’ by providing a viable primary care provider model that can be supported by the emerging GP federation.

In addition by giving voice to primary care through one vision we are ensuring that the contribution that primary care makes in delivering good health for our populations is universally recognised and places primary care at the heart of our healthcare system.
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1.0 Summary on Two Pages

Our vision for primary care is to build a clinically and financially sustainable model for primary care services, in partnership with the wider health and social care system. The patient and their GP will be at the heart of a multidisciplinary model of care enabling patient-centred coordinated care, which will be provided in a locality, achieving improvements in health, developing resilience and supporting the population to stay as well and as healthy as possible.

Our Proposed Model

The Key Aims of Our Strategy are aligned to the strategic direction and priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire which describes the outcomes that health, social care and public health are committed to achieve. In addition we are working to support the Staffordshire Transformation Programme, ‘Together We’re Better’. Our aims are:

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

We will develop a commissioning framework which will enable us to agree a future model of primary care taking into account the needs of our diverse population:

- Placing increased emphasis on the integration of mental health services into a primary care model of care which is essential to support holistic wellbeing
- We will progress an MCP Model of Care which will act as a catalyst for the transformation of primary care
- Empowering patients to self-manage their care
- Encompassing the three characteristics of care that matter most to patients; proactive, accessible and coordinated care
- Creating a shift from treatment to a model of improving population health and wellbeing focusing on early intervention and prevention recognising the importance of good mental health and social prescribing in overall well being
- Work across the system to develop a hub and spoke model to meet the requirement to provide 7 Day Access

Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan Final Version 22 February 16
Author: Liza Pursey Interim Primary Care Strategy Manager
We will continue to engage with our patients, members, our primary care teams and our other key stakeholders to develop a Primary Care Implementation Plan that:

- Gives voice to primary care
- Reflects local diversity
- Delivers success as defined by the achievement of aims
- Is supported in principle
- Harnesses expertise to achieve a valued and sustainable vision for the future
- Taking into account the needs of our diverse population but better managing demand
- Recognising that no one model of primary care will be advocated
- Empowering patients to self-manage their care
- Encompassing the three characteristics of care that matter most to patients; proactive, accessible and coordinated

Northern Staffordshire Primary Care Strategic Delivery Plan Outline Timescales

**Alignment of System Views**

**Stakeholder Engagement**
2.0 Introduction to Northern Staffordshire

This strategy reflects our vision for primary care for the next five years. We need a clinically and financially sustainable model for primary care services which places all that is good about general practice at its centre.

Most contact between local people and the NHS occurs within primary care yet planning too often centres around secondary care services. We need to design services that meet the individual needs of those that are unwell, providing care in the place that is the most appropriate, delivered by those that are best placed to provide it. We believe that this will be more often in community settings than formerly.

The focus of our Primary Care Strategic Delivery Plan is on the primary care services that are in place to meet the needs of the population of Northern Staffordshire; Northern Staffordshire being defined as the geographical areas served by North Staffordshire Clinical Commissioning Group (NSCCG) and Stoke-on-Trent CCG. We have ensured that the strategy is aligned to the priorities agreed by the Health and Wellbeing Boards in both Stoke-on-Trent and Staffordshire and which both CCGs are committed to achieve.

Our intention is to:

- develop specific solutions that meet the needs of the populations of both Stoke-on-Trent and Northern Staffordshire CCG
- identify key principles that will enable the development of a model of care that is scalable across Staffordshire

We see general practice as sitting at the centre of our future plans, but to be truly effective GPs and their teams have to work very effectively with the many other Health and Social Care professionals, third sector organisations and community groups that exist within North Staffordshire. The challenge is to keep what is good, but to use the opportunities that are offered by considering different ways of shared working to improve the health of the communities we serve.

In addition this strategy aims to focus not just on the contribution made to population wellbeing by General Practitioners but also aims to recognise the value and importance of the extended primary care team composed of GPs, Dentists, Opticians, Pharmacists, nurses, administrative and managerial staff. This is vital if we are to develop models of care that are both sustainable and able to meet the clinical needs of patients both now and in the future. The extended primary care team is therefore what is meant by ‘primary care’ within this Strategic Delivery Plan.

The actually practicalities of implementation will be developed in our Primary Care Implementation Plan which will be developed in early 2016.
3.0 The Need to Change

There are many good things to say about primary care; 72% of people say that it is easy to get through to someone at their GP practice on the phone, nine out of 10 patients find the receptionists at their GP practice helpful and the majority of patients think the service provided by their GP and practice staff is good (Source: Access to GP Appointments: Healthwatch Telford and Wrekin, Healthwatch Stoke-on-Trent, Healthwatch Staffordshire and Healthwatch Shropshire).

General practice is, however, under significant strain. There are areas within Northern Staffordshire where remedial action is needed quickly to prevent breakdown of the current system. It is also clear that difference in both quality and access needs further investigations, to understand the reasons and implications of this variation.

Challenges include an increasing workload; an expanding population; people living longer and with increased care needs. These have occurred whilst investment in general practice has fallen significantly as a proportion of total health spend. General Practice has become a much less popular specialism for doctors at the end of their training and there are many fewer doctors permitted to work as GPs in the country from South Asia than formerly. As the challenge increases, significant numbers of experienced GP principals are opting to retire early or are reducing their commitment to their practices. This comes at a time when primary care nursing posts are also increasingly difficult to fill.

The net effect is that there are unlikely to be enough UK general practitioners willing to work in Staffordshire to sustain our existing delivery structure in the medium term.

The pressures on primary care are described in the diagram below:

**Diagram 1 The Pressures on Primary Care**
### 4.0 Challenges within the Northern Staffordshire Health and Social Care System.

A strategic needs assessment produced jointly by the public health departments of Staffordshire and Stoke highlighted the following key issues.

<table>
<thead>
<tr>
<th></th>
<th>North Staffordshire CCG</th>
<th>Stoke –on-Trent CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Older population compared with England; fewer children and people under 40 with exception of student population</td>
<td>Younger population; otherwise generally similar structure to England</td>
</tr>
<tr>
<td>Deprivation</td>
<td>Around 11% of people live in the most deprived areas across North Staffordshire CCG. However pockets of deprivation are also hidden in rural areas.</td>
<td>High deprivation with over half of its population living in the most deprived areas. Ranks as 24th (of 211) most deprived CCG in England (and 16th / 326 LAs)</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>Inequalities in life expectancy: – Stoke men and women and Newcastle men have shorter lives than average – inequalities by deprivation. There is gap in life expectancy of nearly 10 years between people living in our most affluent and disadvantaged localities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Both men and women across the two CCGs spend more time in poor health than average</td>
<td></td>
</tr>
<tr>
<td>Preventable Mortality</td>
<td>North Staffordshire have similar rates to England although some localities (e.g. Newcastle Central) have higher than average death rates. Rates for liver disease are stable</td>
<td>Higher than average early death rates of cancer, respiratory disease and liver disease in Stoke-on-Trent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer survival rates poor across both CCGs</td>
</tr>
<tr>
<td>National Issues</td>
<td>Mental ill health accounts for over a third of all illness in Britain and 40% of all disability</td>
<td>People with severe mental illness are less likely to have their physical health problems diagnosed and treated and as a result die on average 15 - 20 years sooner than the general population</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ageing population and increasing life expectancy – however healthy life expectancy is not keeping up adding burden to finite health and care resources</td>
</tr>
</tbody>
</table>

Source: Joint strategic workshop – Public Health analytics, Commissioning Intentions
5.0 Primary Care in Northern Staffordshire

The CCG is a clinical membership organisation with 32 GP practices in North Staffordshire and 52 GP practices in Stoke-on-Trent CCG. These member practices are geographically based in a total of eight localities; five localities across North Staffordshire which are Newcastle North, Central and South, Moorlands Rural and Leek and Biddulph and three localities in Stoke-on-Trent which are ANEW, Stoke South and NEB.

Each of our localities has responded to the unique needs of patients in their respective areas. This local knowledge and responsiveness is one of the benefits of a locality model for clinical commissioning. Each of these localities engages closely with its respective member practices and patient groups, and holds regular locality meetings. The locality meetings are supported by the CCG’s Primary Care team but remain autonomous of the CCG.

Clinical leadership in each locality is provided by an experienced GP and practice manager lead. Locality leads help to shape and influence CCG strategy, commissioning intentions, service redesign and implementation of the commissioning cycle. The locality meetings also provide the platform for peer review.

5.1 Northern Staffordshire GP Federation (NSGPF)

General Practice is largely based around independent contractors serving relatively small populations. It has proved to be a very effective and appreciated service since its inception as a list based service from the birth of the NHS in 1948. Everyone person living in the country has a right to a GP and that GP is expected to be able to offer a view on any social, psychological or physical problem that their patient presents with.

Northern Staffordshire GP Federation exists to transform the local delivery of primary care. Its published aims are: -

- To protect the future of primary care by creating a united, resilient and sustainable general practice that will benefit the entire Northern Staffordshire Community.
- To provide enhanced, integrated, patient centred care.
- To provide a means for practices to work together
- To contribute to county wide solutions to the problems of recruitment and retention
- To ensure that General Practice is appropriately rewarded for the work that it does.
- To develop and extend the traditional values of General Practice in order to foster healthier local communities
- To enhance the capacity of practices to compete with external private sector companies
- To strengthen clinical governance and improve the quality and safety of services
- To develop training and education capacity

Practices have recently joined together to form this federation and are looking for shared ways that they can work more effectively. Practices see the federation as a credible provider for community services beyond those traditionally offered from individual practices. This is described in the diagram below.
Many elements of this strategy require movement towards the development of Multispecialty Community Providers (MCP). The GP federation provides necessary skills and organisational resource for these developments and will be supported. As commissioning organisations, North Staffordshire and Stoke-on-Trent CCGs cannot and should not determine the precise make up of a provider organisation. However, in line with their duty to support improvements in the quality of primary care, the CCGs are actively encouraging the development of federated working across Northern Staffordshire.

6.0 The Vision for Primary Care

This strategic delivery plan sets out an ambitious and attractive vision of general practice that provides primary care where it is needed, and in partnership with the wider health and care system. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This should occur in general practices which are recognised as centres in each neighbourhood, developing community resilience and supporting the population to stay as well and as healthy as possible.

The Strategic Delivery Plan focuses on ‘function’ not ‘form’ and sets out a new patient offer that can only be delivered by primary care teams working in new ways and by practices coming together when it makes sense for them to do so. How this looks will differ from area to area and will need to be designed and owned locally. It will require an environment which supports innovation; shares best practices and new technologies; and is recognised as an attractive place to work for a variety of healthcare professionals.

It is clear that for primary care to deliver a new patient offer and to make the changes required, additional financial investment is necessary.
There will be elements that only make sense for practices in localities to deliver between them, so joint working to get the economy of scale will be required.

There is no one-size-fits-all solution and given the diversity of our populations we know that we need to develop different solutions. However there are key principles that need to be addressed to reach a model that suits our local needs. These are set out below.

1. **The way we deliver care**: Inside and outside of the practice; how we best use skill-mix; how we work in and out of hours; how we work with others – not confined by our individual consulting rooms, practices and organisations; and how we work best with the primary, secondary, mental health, community, voluntary and charity sectors.

2. **The way we organise ourselves**: This applies to normal working hours and out of hours; how we deliver unscheduled care and how we organise our physical environment – the buildings we work from. Individual practices may want to form part of something bigger.

3. **How we work together to deliver** personalised care for certain groups of patients across a wider population for example:

   - finding creative ways of connecting with the vulnerable, isolated and socially marginalized who are at highest risk of becoming ill and least likely to seek out support to stay well.
   - developing services across groups of practices where the complexity of care and range of professionals involved is such that it requires a central focus for higher intensity care coordination and frequent specialist input (e.g. complex frail elderly, people living with learning disabilities, people in care homes and prisons).
   - creating alternative access points for high volume, low complexity care services for minor ailments in order to free-up additional capacity in each GP surgery for the patients who need us most.
   - Clinicians in primary and secondary care need to work better together so the latter become a resource for groups of practices, enhancing the level of care and support offered in specific areas and providing additional training and development activities for GPs locally. Conversely secondary care clinicians need to be encouraged to think more widely about those with multiple morbidity so that care becomes uniformly patient centred rather than disease centred. In addition we need to enhance and utilise the skills that other members of the extended primary care team are able to offer so that clinical expertise is directed to appropriately.

4. **How we meet the different access needs**: By allowing patients to choose from a range of service options (length of appointment, rapid access, booking ahead, GP of choice); accessing different professionals, enabling choice in the way patients access general practice (in person, online, by phone, email or video conference); and looking at how we meet any personal accessibility requirements (e.g. physical or sensory disability, language, chaperone/advocacy).

5. **How we use data.** Not simply to identify different patient needs but also to inform us; to provide intelligence that will improve the quality of clinical care; to provide early warning for system failure;
to enable us to see patients on different sites; and to help us deliver care in different ways, for example through remote care (e-health and telecare).

In addition we know that many patients want to manage their own care and therefore we need the develop the systems that enable patients to access their own data and source information that will empower patients and better enable them to manage their own care.

6. How we improve ourselves and become a learning environment through a well-developed infrastructure and the implementation of a wide range of factors to ensure that primary care develops as an effective learning medium for all healthcare practitioners

7. How we disseminate innovation.

8. How we develop a vibrant, attractive workplace with career prospects for clinical and non-clinical staff

9. How general practice can support patients, families and communities to stay well and cope with minor illness so that the system moves from one of perceived dependence on clinical consultation towards self-reliance and positive lifestyle choices. We want resilient healthier communities. To enable this to be achieved and empower patients to manage their own care we know that patients need access to better and targeted information.

It is clear that changes are needed to support primary care in delivering a new vision to develop solutions that will better meet the future needs of the populations of Northern Staffordshire and provide a sustainable model of primary care for the next 5 years. Our vision is for integrated working between Primary Care, Community Services, Social Care, the Voluntary Sector, Public Health and Mental Health providers to develop a model of care that will meet the needs of our population, address current and future challenges and develop a strong mandate for the overall direction of primary care development. Vital to the success of our model is to place the patient at the centre of our model so that care is delivered on the basis of patient need.

6.1 Patient Expectations

The aspects of care correlating most closely with good patient experience are relational. Patients want to be listened to, to be given explanations that are meaningful to them, to have their questions answered, to share in decisions, and to be treated with empathy and compassion.

People want many other things from healthcare, including continuity of care and smooth transitions. These require planning and co-ordination. They may not require organisational ‘integration’, but by efficiently deploying multi-professional resources, co-ordinated care systems are better able to deliver the other things patients require: fast access, effective treatment, respect for their preferences, support for self-care, and the involvement of family and carers. Hence ‘integration’ is the top demand from patient, service user and carer organisations. Patients have little interest in organisational/institutional priorities or mergers. They want organisations not to argue between themselves or send conflicting messages.
They expect professionals to work together as a ‘team around the patient’, and they want services to work together likewise: that is, to come together at the point they are needed, and to meet people’s needs in the round.

People understand that there are resource limitations, and indeed are often self-limiting in the use they make of services and professionals’ time. But they want to know clearly what their entitlements are (not just to care, but to support and finance), and what costs they might incur, at any key point on their journey. They want services easily to agree on these and not to argue between themselves. They want obvious efficiencies to be achieved – not least in use of their own time – for example by making it possible for multiple appointments to happen on one day; or by linking diagnostics and consultations seamlessly together. They want agreed packages of care to be delivered without delay.

‘Care is care is care’ for the person who needs it. Divisions into ‘primary’, ‘secondary’, ‘community’ and ‘social’ care are relatively meaningless. The people for whom integration is most relevant, especially those with long term conditions, consistently say that they are looking for the ‘system’ to combine two things in one place:

- knowledge of the patient/service user/carer as a person, including their home circumstances, lifestyle, views and preferences, confidence to care for themselves and manage their condition(s), as well as their health status and symptoms

- knowledge of the relevant condition(s) and all options to treat, manage and minimise them, including knowledge of all available support services

People know they may need a variety of professionals and support services, but within this they want a single trusted point of liaison, to which they can have recourse as necessary, where the above knowledge is held. They expect this person/service to advise them on how to take next steps and, ideally, to co-ordinate their care or to help the patient/carer to co-ordinate it. (Source: Integrated care: what do patients, service users and carers want? A paper commissioned by the Integration work stream of the NHS Future Forum)

6.2 Delivering High Quality Equitable Care

In terms of the current quality of care, the majority of care provided by general practice is good, but our aspiration is to bring all up to the standard of the best. Practices need support to encourage them to seek out and address variable performance, including: appropriate data and information; skills development; protected time; and appropriate rewards for excellence (as well as consequences for poor performance that does not improve despite the offer of support).

Nationally specific variations in quality exist as described below:

- There is considerable scope to improve the quality of care co-ordination for patients with long-term chronic and mental illnesses, for those at the end of life, and in maternity care. Links between general practice and other services need to be strengthened in areas where patients with complex problems receive care from multiple providers.
• There is considerable scope for improvement in ensuring that all patients receive appropriate care as defined in clinical best-practice guidance.

• There are wide variations in patient experiences in terms of access to care, continuity of care, and patient engagement. Patients remain poorly engaged in making decisions about their own health and more could be done to support patients to make choices, to be engaged in decision-making, and to care for themselves.

Delivering high-quality care requires effective team working within general practice. The skill-mix in general practice will need to evolve, to include a wider range of professionals working within and alongside it. The GP should no longer be expected to operate as the sole reactive care giver, but should be empowered to take on a more expert advisory role, working closely with other professionals.

Delivering high-quality care also requires new models of shared care to be developed with other care providers, including those working in the community, in hospitals, and in care and well-being services. Multi-specialty local clinical partnerships need to develop that integrate services across boundaries. Such models of care will need to articulate the roles and responsibilities of general practice clearly to ensure that care for patients is well co-ordinated.

7.0 Strategic Drivers

To meet the challenges described above requires a transformation in the way our health and social care system delivers services, both in the quality and the cost-effectiveness of care. To do this our vision for primary care must address some significant drivers which are described below. For the future the health service must be built on a foundation of integrated, community-shaped, generalist healthcare services. This will require a greater number and diversity of skilled, generalist-trained professionals, able to care for patients in their homes and communities, both in and out of hours. It will require investment, not just in people but also in premises, to provide high-quality services, education and training and to enable GPs to spend more time with those patients who have complex needs. The future health service will see more person-centred systems of care and less division between primary, secondary and social care organisations.

7.1 Meeting Local Need

To address the challenges identified by the Joint Strategic Needs assessment, our CCG aims are:

• Commission safe and effective, high-quality, sustainable services prioritising the principle of ‘home first’;
• Deliver better patient outcomes through effective collaboration between key partners;
• Improve patient experience through patient engagement, feedback and involvement in decisions throughout the whole commissioning cycle;
• Reduce health inequalities and unwarranted clinical variations; and
• Achieve all of the above while remaining within financial balance and delivering cost effective care.

7.2 The Workforce

Primary care in England is under pressure as a result of multiple drivers of demand. There is evidence that demand for primary care has been rising significantly over time, with the number of general practice consultations having risen by 75 per cent between 1995 and 2009, resulting in an increased clinical workload of over 40 per cent when compared to 1998 (Securing the future of general practice: new models of primary care. The Kings Fund July 2013).

The general practice workforce including GPs and practice nurses and community based primary care nurses is under significant workload pressure with many staff considering early retirement. The number of mid-career doctors (under the age of 50 years) considering leaving the profession is also rapidly rising. Nationally the growth in GP numbers has not kept pace with that of hospital consultant numbers (per Whole Time Equivalent) and boosting numbers entering GP training is proving difficult.

In addition practice nurses are becoming increasingly difficult to recruit and whilst the existing nursing workforce is made up of very experienced staff, here too there is a need to create a succession plan to ensure the development of the nursing workforce in the future.

These demands, coupled with technological advances and the adoption of best practice across care settings have important implications for how to develop and train primary and community clinicians and the wider workforce of the future.

Implementation of a new model of care will require localities to offer an extended scope of services; more convenient opening times; personalised care; and further development of access options to match the desires of the population. Practices of all sizes will be faced with the challenge of how to:

• configure the workforce to ensure safe practice, ongoing training and development
• maintain continuity of care; and harness the potential of temporary and locum staffing
• expand flexible working arrangements
• prevent professional isolation
• ensure staff are up to date on evidence based practices, treatment developments,
• efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.
• effectively manage the risk of providing clinical services through multidisciplinary workforce teams

Effective clinical governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings.
Delivering integrated primary care using multidisciplinary models of working in community settings will require new approaches to support safe clinical practice whilst ensuring staff are supported to continually learn and develop.

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- expand flexible working arrangements
- prevent professional isolation
- ensure staff are up to date on evidence based practices, treatment developments,
- efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.

Different roles and responsibilities are likely to evolve in each local area as experience grows. Broadly it is anticipated that the roles detailed below will be required:

- **within each practice**: GPs, practice nurses, advanced nurse practitioners, matrons, practice nurses, healthcare assistants, volunteers, receptionists, managers, physician associates, pharmacists, medical secretaries and other administrative staff.
- **aligned to each practice but working across a wider geography/at-scale primary care organisations**: prescribing advisors, care coordinators, wellbeing teams, community support teams (as an extension of the current matron services) and managerial staff with sufficient skill to lead the development and operational management of larger primary care organisations that wrap around or integrate existing practices.
- **as part of, for example, a wider Multispeciality Community Provider (MCP)**: secondary care specialists, social care, mental health and community services teams, and community pharmacy.

A number of extended roles are appearing in the general practice setting enabling the delivery of high quality care, improved patient experience and improved clinical outcomes. These are additional to what is now considered a core team of GPs, practice nurses and advanced nurse practitioners, managers and reception staff. A few examples are provided below to illustrate the functions these new roles are performing and how they are supporting new ways of working both within general practice and across a wider primary care team. These new roles include:

- **Clinical personal assistant.** The Primary Care Clinical PA (PCCPA) is an administrative worker trained to support GPs with their day to day clinical work as an extension of traditional secretarial or administrative roles. As an example they can help process clinical letters coming into the practice. By using a clear and agreed workflow, the PCCPAs can carry out delegated work where it safe to do so, leaving GPs to deal with those letters requiring medical input or oversight.
• **Practice pharmacists** Practice pharmacists can consult with and treat patients directly, relieving GPs of casework and enabling them to focus their skills where they are most needed, for example on diagnosing and treating patients with complex conditions. As part of the multidisciplinary team, practice pharmacists can advise other professionals about medicines, resolve problems with prescriptions and reduce prescribing errors. They can work with GPs to resolve day-to-day medicine issues and with practice teams to provide advice on medicines to care homes, as well as visiting patients in their own homes when needed. There are many opportunities for practice pharmacists and these must be matched to the experience and qualifications of the pharmacist and linked to practice plans for the pharmacist’s professional development.

• **Healthcare assistants (HCA)/Assistant Practitioners:** provide clinical support to the primary care team to enable staff to allocate their time appropriately to patient need.

• **Health and wellbeing coordinators:** enable patients to maintain their health and wellbeing and improve self-management of their condition.

• **Physician associates:** work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.

• **Care coordinators/navigators:** provide a central coordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

We already have some examples of innovative workforce developments in Northern Staffordshire but it’s clear that we need to put in place a comprehensive workforce plan to deliver the requirements of our model.

### 7.3 Co-commissioning

On 1st May 2014, Simon Stevens announced new opportunities for CCGs to co-commission primary care services in partnership with the NHS England. The NHS Five Year Forward View describes primary care co-commissioning as a key enabler in developing seamless, integrated out of hospital care,

It will also drive the development of new models of care such as multi-specialty community providers and primary and acute care systems.

Co-commissioning is essential to the delivery of transformed primary care by:

• Facilitating the development of a clearer, more joined up vision for primary care, which is aligned to wider CCG plans for improving health services.

• Encouraging clinical leadership and public involvement in primary care commissioning, enabling more local decision making.

• Giving more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services.

• By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained.
The CCG is a level 2 joint commissioning organisation and expects to achieve full delegation in 2017. Given this the CCG is committed to working closely with Member practices, NHS England and the LMC to ensure primary care services are developed over the coming months to ensure that primary care is in a state of readiness to take forward a delegated commissioning agenda.

In addition it is vital that these key stakeholders are actively engaged in how the primary care strategy is developed and how the local delivery plan is shaped and implemented. The CCG continues to engage with member practices to ensure productive relationships with GPs as both commissioners and providers of services.

7.4 Medicines Optimisation

The CCGs Medicines Optimisation team role is to focus on introducing systems which support medicines adherence as a proxy of treatment outcome, so that pharmacist knowledge, skills and experience in commissioning and their analytical expertise is re-focussed to support waste reduction and the safe prescribing of medicines which can transform patient outcomes.

The broad aim of medicines optimisation is to ensure that patients get the best possible outcomes from their medicines. The Medicines Optimisation Team therefore promotes good quality, evidence-based prescribing, which involves the use of medicines which are safe and clinically and cost-effective, working closely with local GP practices, community pharmacies, CCG colleagues and other NHS organisations to achieve this. This helps to ensure that patients and the NHS get better value from the investment in medicines.

The key strategic aims of the Medicines Optimisation Team are as follows:

- To deliver the medicines optimisation QIPP agenda and effectively manage the CCGs’ prescribing budget
- To commission safe, clinically appropriate and cost-effective medicines
- To contribute to the development and redesign of clinical services involving medicines
- To work in partnership with key stakeholders to ensure that patients receive seamless care regarding medicines across the primary/secondary care interface
- To promote evidence based medicine in order to ensure quality outcomes
- To obtain value for money when procuring medicines
- To improve communication around medicines with all key stakeholders
- To support care homes to improve medicines processes and patient outcomes
- To ensure that there are robust governance arrangements in place for the commissioning, prescribing and use of medicines
- To minimise the amount of medicines that are wasted

7.5 7 Day Working

Northern Staffordshire recognise that there is a need to understand and define exactly what patient access requirements are, and in response, undertake a review of current capacity and access to GPs as part of a system wide approach to care. This work aims to identify barriers to access together with potential solutions to ensure that patient are seen in the right place at the right time.
Consideration also needs to be given to the requirement to deliver 7-day care for all patients by 2020.

However, evidence suggests overall satisfaction with our practices is good, with Healthwatch finding that very few patients were waiting for excessive periods of time to be seen.

However it is difficult to determine a relationship between opening hours and patient satisfaction and this research may mask key issues such as:

- if access to appointments is equitable and length of appointment
- if surgery opening times are matched to population need
- whether the process for making an appointment is clear
- if patients are being seen in the right place at the right time by the appropriate health professional
- the demand for a same day appointment may be placing undue pressure on surgeries

To ensure that every patient has access to 7-day services by 2020, the model of care we develop needs to take stock of our existing primary care provision, the system wide provision for care specifically urgent care and use this information to determine how to best use the resources we have to meet patient need. This means that rather than asking every GP Practice to open extended hours we will need to develop a hub and spoke approach taking into account our locality models.

We need to recognise the importance of developing a whole systems approach using our other primary care resources such as our GP led health centres, our walk in centres and the Out Of Hours service. In addition we need to work with our key partners who provide other health care services such as A&E, to develop a whole system approach to better manage demand and access requirements.

Finally we need to recognise the expertise that existing within the workforce. Extended access does not necessarily have to be medically led and nurses, pharmacists and other community professionals have much to add in developing an extended service for patients.

In essence we need to look at what we do currently and do things better to ensure the service best serves the rural and geographically diverse population that live in Northern Staffordshire. However it is clear that providing 7 day access will require additional investment and this factor will be considered as part of the development of a primary care investment plan.

8. Meeting Patient Expectations

National policy focuses on improving the productivity and sustainability of all health services with a strategic shift of activity from hospitals to the community by providing care closer to people’s homes. This will mean that primary care will become all the more important, making it essential that the CCG works in a supportive and collaborative way with wider primary care, including its member practices, as well as social care, housing, education, leisure services and other determinants of health.
Alongside this, the health needs and expectations of our population are changing and inequalities exist. In order to address these, the whole health and social care sector will need to move towards a system of integrated care, where clinicians work flexibly around the needs of the patient, their families and the communities in which they live not only providing health care services but coordinating social care and advocating for social prescribing.

Public Health services have a key role to play in placing increased emphasis on health promotion, early intervention and wellbeing services.

We need to work closely with our patients and populations to achieve a primary care system that refocuses on wellbeing, prevention and restorative health, empowering patients to take greater responsibility for their health.

Conversely, when in need of health care, it must be accessible and equitable and within a system in which our patients are valued and involved in shared decision-making.

Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health care. Given that the provision of social care services is based on needs assessment and eligibility criteria, there are significant challenges in moving towards an integrated model of care. The principles of sustainability are aligned with the policy direction in the health and care sector: more integrated health and social care service provision, integrated connections between service providers, empowered patients, improved use of information and communications technology (ICT), supported self-care and management of long term conditions.

Primary care is a key player in delivering these principles, which are reflected in our local primary care priorities of: Improving the quality and performance and reducing inequalities and unwarranted variation in primary care.

Developing a model with closer integration of services provided out of hospital in the community

Improving access to primary care and managing workload

These principles are supported by:

- Member practice engagement and citizen participation
- Development of the workforce and meeting the educational and premise needs of our practices in order to deliver a sustainable healthcare system.

### 8.1 The Patient at the Centre

There are six guiding principles that drive our strategy and put patients at the centre. These are the important things that we know our patients and the public want from primary care.

#### 8.1.1 Improving quality and performance and reducing inequalities and unwarranted variation in primary care

Whilst the quality of most primary care services is good, there are wide variations in performance. The CCGs believes that all patients should have access to the same range of and quality of services to
meet their health needs. Patients should be able to get the care they need when they need it, as close to their home as possible. At the same time we need to put in place measures to reduce any unwarranted variation so that patients the public and our professional colleagues across health and social care system are assured that primary care services are consistently of the highest quality.

8.1.2 Achieving equitable access

Access encompasses a range of circumstances including availability, ability to source services and ease of finding services and subsequently using these services. Variations exists in all types of access especially for people from vulnerable groups. To ensure a sustainable primary care system it is critical that practices are supported to provide responsive primary care services for those that most need it, when they need it. This will involve improving access through increased capacity in the right place, provided by the right person at the right time.

8.1.3 Local people are supported to stay well, preventing ill health

There are huge advantages in focussing on keeping people well rather than waiting for them to become ill. By doing this, people will be healthier and we will reduce the overall costs of care. Good primary care is fundamental to managing the health of populations and reducing health inequalities. By developing high quality, strong primary care services it will be possible to build healthier and more resilient communities. Tackling the root causes of ill health will be achieved through developing an emphasis on providing universal, preventative services which have a focus on patient centred care and supporting people to be more in control of their health.

Empowering patients is key to enabling patients to stay well and manage their own wellbeing if patients do become ill and the voluntary sector have a valuable role in supporting patient and their carers with information, signposting, support and advocacy.

8.1.4 Patients and carers of all ages are empowered to take an active part in their own care

Evidence shows the benefit of engaging patients, their carers and families about their care and treatment – they are likely to experience greater satisfaction, have fewer unwanted treatments and achieve better outcomes. In addition 6.5 million people in the UK are carers and with this number continuing to rise the specific needs of this group need to be addresses.

8.1.5 Patients will receive their care and treatment in the right place – at home or as close to home as possible

People would often rather receive healthcare in their own home or in their local community, and older people lose their independence if they spend long periods in hospital. So it makes sense to help people to stay at home and stay as independent if possible.

8.1.6 Patients will experience services that are joined-up

Organising health and care services around the needs of patient’s means that they will be better signposted, coordinated and delivered. This will ensure that providers focus on quality and dignity for patients and on getting the results that really matter to them. A more joined-up way of doing things will help us to reduce gaps and duplication.
How we intend to put patient’s health and wellbeing at the centre of our model is described below.

**Diagram 3 Patient Centred Care**

9.0 The Future of General Practice in Five Years

The central function of the GP in the NHS, which will remain fundamental to its success in the future, is to provide comprehensive, compassionate medical care within the community setting, to an identified population of patients with whom the general practice team has a continuing relationship and responsibility. This involves managing a wide range of health problems; making accurate risk assessments; dealing with multimorbidity; leading a multidisciplinary team; coordinating long-term care; and addressing the physical, social and psychological aspects of local patients’ wellbeing, in the context of their individual needs, their families and their communities.

There is strong evidence that high-quality, well-led general practice results in better and more cost-effective patient care. However, to continue to carry out this key role effectively in the future, the role of the GP will need to be adapted to meet the challenges confronting the NHS. In the NHS of the future GPs will play a vital role in preventing disease, reducing health inequalities, developing community resilience and delivering high-quality, cost-effective care. They will do this by further developing their core professional skills and expertise as generalist clinicians but some will choose to become the leaders of the larger scale organisations that will develop.

Northern Staffordshire 5 Year Primary Care Strategic Delivery Plan Final Version 22 February 16
Author: Liza Pursey Interim Primary Care Strategy Manager
9.1 Definition of Primary Care

The National Association of Primary Care (NAPC) identifies Primary Care as both a level in a health system (its form) and a strategy or philosophy for organising approaches to care (its function). The NAPC regards effective Primary Care as having five central features:

1. The first point of contact for all new health needs;
2. Provide care to an optimum, registered population of between 30,000 and 50,000; Practical configurations are subject to CCG commissioning requirements recognising that there is no one size fits all model and local issues could determine scale.
3. Person-centred (holistic), rather than disease-focused, continuous lifetime care;
4. Comprehensive care provided for all needs that are common in a population; and
5. Co-ordination and integration of care when a person’s need is sufficiently uncommon to require special services or provision from another sector (secondary or tertiary care).

9.2 Core Principles

No one organisational model of primary care provision should be advocated. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population. However to deliver the core principles of care, in a form that is sustainable and achieves improvement in health any model of primary care must:

1. Be the first point of contact to enable access to health and health related wellbeing services
2. Operate as single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals.
3. Encompass an integrated workforce, with a strong focus on partnerships spanning primary, community, secondary and social care
4. Maintain a combined focus on personalisation of care with improvements in population health outcomes
5. Achieve equity and in terms reaching all people equally including people who do not routinely access services and who may be at higher risk of ill health
6. Deliver universal access to primary care services which achieves defined constitutional standards of care
7. Enable access to primary care health professional across seven days of week in their local area, for pre-bookable and unscheduled care appointments

9.3 Key Characteristics of Care

At the heart of this strategy is a new service compact for general practice. This supports the need to define and commission a consistent service for the population including adults, children, young
people, carers and families; reducing variations in access, patient experience and clinical outcomes. The strategy provides a single definition of high quality care.

For primary care provision to thrive and deliver a specification for care that patients need and value, the model of care needs to encompass the three characteristics of care that matter most to patients:

**Proactive coordination of care** – Primary care works with key stakeholders within the community to co-design approaches to improve the health and wellbeing of the local population. This is planned together with people, particularly patients with long term conditions so that people use their own capacity for improving their own health and their health improvement goals and are empowered to remain healthy. Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing.

**Accessible care** – There is universal access to primary care services which delivers constitutional standards of care. Patients will be given a personalised, responsive, timely and accessible service which ensures fast responsive access to care and prevents avoidable emergency admissions and A&E attendances.

**Coordinated care** – Primary care is often the first point of contact for patients, coordinating care to ensure that patients experience services that are truly seamless and through partnership working with other providers organise high quality cost effective care in the right place at the right time. Continuity between patient and GP is paramount. Care is personalised by involving and supporting patients, their carers and supporters in managing their own healthcare.

### 9.4 What Will Patients Notice

- Patients and the public will be able to have the right length of consultation, provided by the most appropriate health professional, in better premises, using up-to-date technology. There will be more responsive care which will be delivered in a range of ways, for example online, email and telephone rather than just face-to-face consultations. People will only need to make one call or click to book their appointment and won’t be told to call back the next day. There will be no need to take a day off work to see a GP as there will be the choice of early or late appointments or telephone consultations. Those who need to, will be able to book appointments up to several weeks ahead at a time to suit them. Care will be centred around each person so they won’t need to have multiple appointments about different long term conditions; they will be arranged around them.

- Patients will experience better management and care of long-term diseases; when they are frail and elderly; and at the end of life. General practices will be encouraged to organise themselves so that all patients have a named GP accountable or care coordinator for their care. The need for continuity of care should be defined by the patient and has the potential to be regarded as important irrespective of age. This care might be delegated to other GPs or healthcare professionals in the practice team as appropriate.
• Continuity of the personal care relationship is especially important for those patients with complex and chronic health care needs. The future practice will provide improved continuity of care for these patients and for those that require more coordinated care.

• Multidisciplinary teams will work together to deliver care in- and out-of-hours, and in- and out-of-hospital.

• There will be safer, less (unwarranted) variability and better quality care delivered closer to home by highly trained GPs, nurses and other professionals. Patients will not necessarily see 'their' healthcare professional for all care at 'their practice'. They may choose to access an extended range of services at convenient opening times either in their own practices or in those practices linked to it. There will be no gaps for patients who are unregistered to fall through.

10.0 Model of Primary Care

The model proposed is an integrated one. The Royal College of General Practitioners champions integration of care as crucial to patient-centred practice, seeking approaches that improve patient care and experience as well as being efficient and effective.

For general practice, the integration of care should be ‘Patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational boundaries to deliver the best possible health outcomes.’

Primary care will have at its heart active collaboration between healthcare professionals and the people they care for. This patient-focused approach will require collaboration between professionals and strong team working, both within and across organisational boundaries. Primary care practices will include a wider range of disciplines. As well as GPs, nurses and administrative support, primary care teams may include healthcare assistants, physician associates, paramedics, allied health professionals, social workers and others. Pharmacists will increasingly become a core part of the practice team.

How roles and teams fit together in delivering future care will need to be determined and different roles and responsibilities are likely to evolve in each local area as the model of care is implemented.

10.1 New Models of Care for General Practice

The health system needs to be primary care orientated so that it is focused on improving population health and wellbeing. In order to ensure that patients receive the maximum benefit from this, general practice needs to have a collaborative approach involving, for example, voluntary and community organisations; community health services; community pharmacies; mental health services; public health, social care and other partners. Some elements of the model can only be delivered by working with patients and other partners to deliver high quality care.

This will give groups of practices the opportunity to focus on population health and provide extended opening hours whilst protecting the offer of local, personal continuity of care. What begins as a conversation about greater collaboration will move towards formation of practice networks that
increase joint working and will then go further towards shared teams and infrastructure requiring a single primary care organisation.

While the ability to extend the scope and scale of primary care is important, no one organisational model of primary care provision is advocated. Local context plays an important role in determining organisational form, and the precise mix of functions will likewise depend on the nature and priorities of the local population.

However given the challenges that primary care faces including the changing workforce, the desire to improve quality, and the need to respond to rising patient demand, staying the same is not an option.

10.1.1 Multispecialty Community Provider (MCP)

The NHS Five Year Forward View describes the development of a Multispecialty Community Provider (MCP) which could offer increased efficiencies through wider collaboration and integration. These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable provision of a wider range of services including diagnostics; shared infrastructure, expertise and specialists e.g. for mental health or children; create new career paths; training and learning together. Shared systems for peer review, developmental and supportive learning should improve patient safety, clinical quality and outcomes for all practices involved.

The organisations will contain teams that support care coordination and will have arrangements in place for closer partnerships with a wider range of practitioners and specialists beyond general practice.

How this all looks will vary across our diverse areas and the development of a model will need to take into account the issues that affect access such as public transport and car ownership for example. Given this the CCGs will involve our members, local communities, patients and other key stakeholders to develop and agree how models of care will be developed and implemented.

Patients will benefit through receiving care from a greater range of generalists, more specialist care and improved access to services in a better environment. We need to work together to achieve this ambitious specification to ensure we can deliver the future requirements of our population.

In addition, committing to the development of an MCP will form a catalyst for the CCGs to begin supporting GPs in working collaboratively, to develop a sustainable, holistic and high quality model of Primary Care and ensure that all patients have access to the full range of enhanced primary care services locally. In this way, development of the MCP will enable the CCGs to deliver a number of its ambitions around Primary Care Transformation; supporting General Practice to deliver on the specifications set out in the Northern Staffordshire Strategic Delivery Plan and address identified variations in the range and quality of the primary care services delivered.
The figure below illustrates the proposed model of care for a Multispecialty Community Provider (MCP) model.

**Diagram 4 Proposed Model of Care Multispecialty Community Provider (MCP) model**

![Diagram of Multispecialty Community Provider Model]

**10.2 Primary Care at Scale**

However just working collaboratively will not be enough to enable both primary care and the health and social care system to meet the challenges that are faced and continue to deliver care consistently to the majority of patients in the NHS. Patients’ needs are different and keep changing and the systems that are in place to care for them have to evolve to keep pace with this change.

The CCG is committed to supporting general practice in all its forms, to ensure it remains the cornerstone of patient care in the UK and a specialty of choice for future healthcare professionals.

However it is clear that to achieve significant economies of scale and in light of the current political and contractual landscape - particularly in the wake of the Five Year Forward View – there is a clear move towards 'at scale' delivery.

The table below describes the various advantages and disadvantages of different levels of sale working.

**Table 2**

**Description of Different Sizes of ‘At Scale’ Working with Advantages and Disadvantages**
### At Scale Levels

<table>
<thead>
<tr>
<th>Practice Level</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>Practice Level</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>
</tbody>
</table>

| Locality | GP Practices work together to deliver one agreed specification but retain own identity within the locality.<br>Practices share access to other services.<br>Back office functions are rationalised. | Community services are aligned to identified local need<br>Efficiencies achieved by contracting for back office services and sharing of other resources<br>All patients within the locality have equitable access to appointments and services<br>Access to 7 day services is through a hub and spoke approach which could be locality based | Variation between localities<br>Acute services continue to be contracted centrally resulting in inefficiencies in pathways.<br>Social care is commissioned separately so health and wellbeing not necessarily aligned | Investment<br>IT solution to enable sharing of records across primary and community care<br>Workforce plan for all members of primary care team |
### At Scale Levels

#### Commissioned Locality
- 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.

#### MCP Model
- GP Practices work together to deliver one agreed specification.
- The MCP directly commissions all health and social care services on the basis of local need.
- GPs oversee and manage the work of fully integrated multidisciplinary health and social care teams.
- Hospital consultants are based in the community and provide acute in-reach services.
- Care is fully integrated and commissioned as a single integrated pathways.
- Back office functions are directly commissioned at scale by the MCP.

### Description of Model of Care

<table>
<thead>
<tr>
<th>At Scale Levels</th>
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<th>Disadvantages</th>
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<tbody>
<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 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>Community 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>
<td></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 pathways. Back office functions are directly commissioned at scale by the MCP.</td>
<td>Community services are commissioned on the basis of population health. Efficiencies achieved by rationalisation of pathway. All patients within the locality have equitable access to appointments and services. Patients can expect the same outcomes. GP taking lead responsibility for care coordination, management of multi-morbidity, risk management and holistic approach. Patient enabled to provide self-care with coordinated care across pathway supported by community consultant.</td>
<td></td>
<td>Finance aligned to population needs. Investment in primary care system. Fully integrated health and social care system in place. Contractual framework in place. Workforce plan for all members of primary care team. Rationalisation of estates.</td>
</tr>
</tbody>
</table>
Whilst the principles described above describe a model of care, it is sufficiently flexible and adaptable for groups of practices to design how a model of care might be delivered consistently for all patients. Delivering the model of care described above will require local planning and customisation in order to ensure that these are provided in the best possible way for the whole population.

The key drivers for at scale working are based on a desire to improve patient care – to extend services for patients, to improve clinical outcomes and to improve access to primary care – as well as to create efficiencies in back office function and to maximise the development of clinical and non-clinical staff. However further work will need to consider the key discussion points including the role of the federations, the importance of considering function before forming at scale organisations, the role of training and education in workforce evolution, motivators for working at scale and the impact GPs can have in a leadership role.

11.0 Quality

In his report ‘High Quality Care for All’, Lord Darzi defined Quality in the three domains of patient safety, effectiveness and patient experience (DoH 2008). The NHS Constitution describes the NHS Value of ‘Commitment to quality of care’ in which;

“We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes’ (page 5)

The Health & Social Care Act (2012) gave NHS England a statutory duty to improve the quality of care in the NHS. In the modern, patient-centred NHS, improvements in quality will be driven by the new clinically-led, local commissioning system.

Northern Staffordshire hold overall responsibility for the quality of commissioned health services and provide assurance through the Quality Strategy. Specifically for primary care, under joint commissioning arrangements, the CCGs in Staffordshire have a joint responsibility with NHS England for monitoring quality and responding to concerns arising from general practice. NHS England has the responsibility to monitor the quality of the primary care services it directly commissions; dental, pharmacy and optometry.

In discharging our duties and responsibilities for quality, the CCGs in Staffordshire and NHS England – North Midlands have identified key priorities for quality improvement in this strategy:

- To support the ambitions in the NHS England Five Year Forward View (2014) to deliver primary care services that are safe, effective and give an excellent patient experience
- Ensure patients have equitable access to services throughout Staffordshire when they need it
- To reduce clinical variation in quality
- To encourage all providers to report and learn from untoward incidents
- To publish quality metrics so patients can easily compare their service to others
We will address these priorities by focusing on the following areas:

- Access
- Variation in outcomes
- Constitutional Standards

**Access**

Research cited in the local Healthwatch report ‘Access to GP appointments’ has identified that nine out of ten public interactions with the health and social care systems are through primary care services. Following local concerns regarding access to GP’s, Healthwatch Telford and Wrekin, Healthwatch Stoke-on-Trent, Healthwatch Staffordshire and Healthwatch Shropshire commissioned a piece of research to consider the experiences of patients in booking and accessing their GP practice.

Despite concerns about the delays in being able to access appointments the research found that very few patients were waiting for excessive periods of time to be seen. Those people who stated they had waited weeks to be seen were of a similar number to those who indicated this was what they needed at the time of booking the appointment. The report identified areas for consideration to improve access and these are being progress with stakeholders.

There are several quality metrics that collect data to monitor issues relating to access to GP’s; GP Patient Survey, Healthwatch feedback, NHS Choices feedback and CQC inspection reports.

**Variation in outcomes**

This will be monitored through various metrics including; Primary Care Web Tool and QoF. Our CCGs have already developed a suite of tools used to generate intelligence, evaluate for performance and drive peer review with the ultimate intention of reducing unwarranted variation. The professional forums and Quality Leads Group will provide a mechanism for sharing and promoting best practice to support improved clinical outcomes.

**Constitutional Standards**

A Primary Care Joint Commissioning Quality Leads Group has been established to support and drive quality improvements across primary care in Staffordshire. The group is developing a quality dashboard which will be used by the CCGs and NHS England to monitor quality in General Practice using the following quality metrics:

- Primary Care Webtool
  - General Practice Outcomes Standards
  - General Practice Higher Level Indicators
- Quality Outcomes Framework CQC visit status and outcome
- Incident reports/serious untoward incidents – STEIS/Controlled Drug incidents
  - Patient Experience feedback
  - GP Patient Survey
  - Friends & Family Test
  - Complaints
• Performance against CCG outcome priorities
• Practice vulnerability
• Breach of contract/remedial notices

A risk matrix will support implementation of the quality dashboard. It will provide a structure for the interpretation of the findings from use of the quality metrics in the dashboard and guidance on what action should be taken to support improvement.

A key indicator in quality surveillance is the report and findings from a practice visit by the Care Quality Commission (CQC). This approach dovetails with the model agreed by the CCGs in Staffordshire focusing on; urgent care, Long Term Conditions and Complex & Frail Elderly.

Practices are rated as either; outstanding, good, requires improvement or inadequate in the areas of care; safe, effective, caring, responsive and well-led. This assessment is completed for all population groups:

• Older people
• People with long term conditions
• Families, children and young people
• Working age people (including those recently retired and students)
• People with poor mental health (including people with dementia)

Practices identified as ‘inadequate’ or ‘requires improvement’ will receive support from the CCG and NHS England to develop an action plan for improvement. The action plan will be monitored by the CCG & NHS England until actions have been implemented.

The aim of the strategy will be in reducing the number of practices identified as ‘inadequate’ and increasing the number of practices graded as ‘outstanding’.

12.0 Consultation and Engagement

12.1 Members

During the summer of 2015, member practices were asked, through the use of a brief questionnaire, their views on the future of primary care. This was followed by a primary care workshop, to which all member practices were invited. The intention was to discuss the development of primary care services of the future. The outcomes of this workshop have been used to build on and provide direction for the development of the Primary Care Strategy.

Practices are at the heart of delivering a transformational strategy for primary care and, supported by the Primary Care Team, will, together with the Local Medical Committee (LMC), be actively engaged in the development of the strategy at a locality level.
All localities will be consulted on the development of the strategy during December and we have sought the views of every member through the use of an electronic questionnaire and the circulations of the Strategic Delivery Plan to each and every GP member.

We will use the feedback we receive to consolidate the vision and ensure that there is wide support from member practices to proceed to implementation stage.

12.2 Stakeholders

Although strongly focused on the role of general practice in primary care, the strategy recognises that successful implementation of a future model of care for primary care will require the support of the extended primary care team; optometrists, pharmacists, nurses and other allied health professionals. In addition transforming primary care will require everyone to look at the way care is provided so we can ensure that we provide care in the most cost effective way possible and in a way that best meets people’s needs.

To harness the expertise of our stakeholder organisations, ensure professionals work together from the beginning to deliver coordinated care, a Northern Staffordshire Primary Care Delivery Plan Steering Group, with membership from a wide range of stakeholders and professional bodies has been set up. This group meets monthly. This Task and Finish group has been established to provide expert comment on the development and implementation of a Primary Care Strategy for Northern Staffordshire making recommendation to ensure the effective delivery of a model of care. Our Local Medical Committee is actively engaged in this group with the intention of supporting good working relationships and a strong sense of partnership with practices. Terms of Reference for the group are included in Appendix 1

An initial review of the challenges and threats to the future provision of primary care was carried out by members of the Steering Group with potential solutions proposed. The rich data that was obtained by this group will be used as a bases for the development of the onward development of models of care through the delivery plan. A summary of this review can be found in Appendix 2.

In addition we sought the views of all members of our Steering Group on a version of our draft Primary care Strategic Delivery Plan and again we have used the comments that we received to guide the development of this document.

12.3 Public and Patient Engagement

Work has already taken place using both the existing patient networks and a one off engagement event that took place in the summer. The intention is to build on the patient views expressed through these forums to carry out further public and patient engagement, in three main ways:

- Inform and listen events across the local areas followed by review, evaluation and acceptance of the draft Primary Care Strategy. These events are supported by Healthwatch Stoke and Engaging Communities, Staffordshire.
- Development of a comprehensive consultation and engagement strategy using the CSU communications team

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• Harnessing of patient expertise and knowledge through the existing patient engagement processes such as Patient Locality Groups, Patient Congress, Patient Membership Scheme again supported by the CSU

13.0 Key Measures of Success

Phrases such as ‘improving the quality of primary care’ are used frequently, but in order for this to be meaningful for practitioners and patients there is a need to define what is meant by ‘good’ or ‘high quality’ and identify how this would be measured or demonstrated.

National Assurance Framework

There are now some performance indicators from NHS England which apply to all practices and Area Teams nationally and allows for comparisons to be made across CCGs or practices. This data will be used to measure quality in primary care, with additional measures being included as they are developed.

• A reduction in the variation of clinical outcomes across primary care in Staffordshire
• A reduction in the number of practices being graded ‘inadequate’ or ‘requires improvement’ following an inspection from the Care Quality Commission
• Patients reporting they feel safe in the care they receive and they would recommend their service to a friend or relative
• Greater opportunities to learn from untoward incidents through an increased reporting of incidents, near misses and errors

14.0 Enablers

As Making Time in General Practice notes in a report commissioned by NHS England there are clearly things within primary care that we need to do better and a number of issues that simply need to change to strengthen primary care and release capacity to introduce new care models. In addition there are a number of other key factors which need to be considered in order to deliver successful change. These enablers are described below

14.1 Clinical Leadership

The transformation of primary care is challenging, and the role of the general practitioner is at its heart in creating co-ordinated care close to the communities where patients live, with the patient experiencing seamless and frictionless care no matter where it is practiced. General practice will lead the redesign programme, designing integrated care pathways for patients that span primary, secondary and social care. GPs will co-ordinate care, and integrate information and knowledge derived from many sources for a single patient.
The principal interactions between the patient and health care will therefore be through general practice: the practice will be both the starting and the ongoing reference points for most patients.

Consequently, general practitioners will need to build working relationships with all aspects of health and social care, including local authorities and secondary care. Such relationships are new for general practice, and new leadership capabilities are needed to prepare GPs for them.

We are already benefitting from the contributions of our GPs and their practices – our members. Clinicians are now at the forefront of local decision-making and we will harness this clinical leadership to:

- Spearhead the necessary changes to clinical and operational models and forge new ways of working across professional boundaries. This recognises the role of local clinical involvement in service redesign and engaging with clinicians across our providers and partners in health and social care to develop the most appropriate services
- Implement and embed clinical innovation. This might include being more rigorous and systematic about the way in which care is delivered (reducing unwarranted variation) or introducing new technologies and approaches to delivering care, such as telemedicine and telehealth
- Produce a comprehensive workforce strategy that matches the needs of this clinical strategy covering, for example, clinical leadership development, health and care skills development and the promotion of research to support the delivery of our guiding strategic principles.

However we recognise that in order to develop the clinical leadership required to develop and implement new models of care there is a need to ensure that the future development of primary care remains a central focus off the CCG and receives an appropriate share of time and resources to develop models for the future.

### 14.2 Organisational Development

To deliver a transformed model of primary care there will be a need to establish place-based ‘systems of care’ which will support the need to work together to improve health and social care for the populations they serve. This means organisations collaborating to manage the common resources available to them. These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

However in developing new models of care, the focus should not just be on primary care but will also need to focus on the ability of organisations to work together to achieve better care. For example evidence indicates that unnecessary demand created by hospitals (failure in the booking of outpatient appointments for example) account for a total of 4.5% of appointments in GP practices. In addition other providers continue to enforce a medicalised model of care by only accepting appointments from a GP rather than other appropriately qualified professionals.

It is clear that organisations will need to develop internally but in addition to ensure systems work effectively there is a need for investment in time for clinical colleagues to talk and learn together.

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14.3 Financial Plan

The overall share of the NHS budget for general practice has reduced by nearly 20% over the last decade (Source: Making Time in General Practice). Whilst 2015 has seen the introduction of additional monies into primary care through the Prime Ministers Challenge Fund, for example, it is important that any financial investment is targeted at the areas where more money will make a difference and where sustainability is assured.

In addition, funding can be released through working more effectively both in terms of the way things are done but also in ensuring that valuable professional clinical expertise and time is directed to where it is most needed.

Finally in delivering transformational change, it is likely that money will need to shift from other parts of the system into primary care. This is likely to require an investment in terms of transitional funding but also additional investment into primary care to enable primary care to develop the models, leadership and systems to enable new ways of working.

The CCGs will therefore be working closely with NHS England, the Staffordshire Transformation Programme and with key stakeholders within the system to develop a financial strategy to support the implementation of this Primary Care Strategic Delivery Plan.

Priorities for investment in primary care are seen by the Steering Group as,

**Workforce**

- Short term critical investment to support immediate staffing solutions
- Staffing costs e.g. indemnity costs
- Investing in learning and development

**Infrastructure Costs**

- Estates – specifically LIFT building
- Information Technology Solutions

**Organisational Development**

- Clinical leadership
- Supporting working together
- Reducing unwarranted variation

**Mechanisms to support new ways of working**

- Investing in the existing workforce and investing in developing the workforce of the future
- Facilitating 7 Day access

It is worth noting that in developing a community service specification based on outcomes and commissioned on a capitated budget basis, primary care is an essential component of this vision and will need to be resourced to meet both capability and capacity requirements.

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14.4 Market Development

In light of the challenges that primary care services are facing and the complexity in developing solutions across a range of services and a wide stakeholder base there is clearly a need to ensure that Staffordshire and Stoke-on-Trent CCG work together to harness the expertise from within the system and develop one agreed vision. Therefore there is a need to work with NHS England, North Midlands who have a key role for setting the national context and the Staffordshire Commissioning Congress who are implementing a whole system transformation programme.

Secondly, there is a need for shared local commitment from commissioners (CCGs supported by their CSU and Local Authorities), local hospitals, community services and practices to own and work together to fix the obstacles that patients and members of the primary care team encounter every day.

Finally, there is a need for individual practices, or practices working together in groups, to work together to determine solutions that could improve the system.

Subsequently this learning needs to be harnessed into the development of practical solutions for new models of care and which will then need to be implemented. Therefore there needs to be a shared agreement about the best approach to be taken in commissioning and procuring services that will meet the needs of patients through the most cost effective means.

Significantly one area of market development could be to use the learning from programmes such as Better Together to activate the full potential of Community Health Champions to improve the health and wellbeing of their communities with positive results.

14.5 Workforce Plan

- The Strategy aims to maximise the skills that are available within primary care to ensure that primary care has the capability and capacity to meet the needs of local populations now and in the future. This will require the alignment of workforce planning (recruitment, retention and development) alongside education, learning and development programmes across the system and those that already exist in primary care. In an integrated model of care it is important to ensure that all agencies understand and are equipped to support and implement different ways of working. For example, currently, in some cases other agencies will not accept referrals from primary care non-medical staff even those these professionals are highly skilled and have been enabled to deliver constitutional care. Therefore the CCG will work with the Deanery, the Federation, stakeholder organisations and other workforce development and planning agencies to: Improve recruitment and retention of medical staff, nurses and administrative staff within primary care
- Continue to work with Health Education England and Health Education West Midlands to develop and implement training and education programmes which support primary care nursing.
- Utilise the existing training programmes and expertise available at Keele University School of Medicine to develop and retain primary care expertise
• Develop new workforce models using different skills and professions that is focused on prevention and wellbeing as well as treatment
• Maximise the use of the voluntary sector integrated with the primary care team
• Align social care provision alongside health provision to create a holistic model of care
• Map required skills (clinical and management) and develop workforce to deliver at scale. With time, develop major functions on locality (rather than practice) footprint e.g. HR function, pensions, nurse specialist role, investigations, GPSC or equivalent
• Instigate a system of patient education to understand skill mix/ use of personnel. Supported self-care.

In addition it clear from discussions with professionals working within the primary care system that the rising costs of indemnity fees are becoming a real barrier to both the recruitment and retention of staff but also to the expansion of individual professional roles. It is clear therefore that as part of our workforce plan there is a need to put in place mechanisms to control and manage the issue of indemnity fees and thus reduce personal liability and risk.

One way of doing this would be, for example for providers to employ and indemnify staff and absorb the risk and centralise risk, hence reducing the total cost to the health and social care economy. In addition groups of GP practices could be aligned with partner organisations buddy scheme enabling the sharing of risk. Such options will need to be explored further.

Finally a key indicator of success is that primary care in Northern Staffordshire is seen as an attractive career proposition. There is a need to utilise the very real growth in co-operation across the economies to support promotion of work opportunities accompanied by the message that Northern Staffordshire is a good place to live and work.

14.6 Information Technology and Data Sharing

The ability to implement common systems and provide integrated care has been complicated by the NHS’s poor record on developing integrated information systems. It is vital that the right information technology and data sharing infrastructure is in place to promote integrated care records and robust systems for data sharing between practices and other health and social care professionals. The CCGs are aiming to introduce a shared clinical record across the health and social care system that is entirely accessible to the patient by 2017. This will put patients at the centre of their care and create shared responsibility for their own health.

The CCGs will adopt innovative approach to the development of Information Management and Technology in primary care to ensure right electronic infrastructure is in place to enable more integrated working.

This will include systems and processes to enable the sharing of clinical information between health and social care professionals that will deliver better clinical outcomes for patients. Key outputs will include the introduction of:

• Consistent practice systems which enable the management and sharing of data
• Systems that enable patients to have a greater role in accessing their own notes and sharing this information with everyone involved in their care across organisational and professional boundaries.
• Software (EMIS Web)
• Summary Care Records and locally shared records.
• E-Referrals
• Electronic Prescribing
• Single shared solution with providers for electronic discharge process.
• Electronic ordering of investigations and viewing of secondary care results.
• Improving Data Quality
• Increased patient access via online prescription ordering and appointment’s.
• Mobile working solutions

Responsibility for the operational management of primary care IT services is delegated to the CCG from NHS England. Funding to support this has also been delegated, currently at less than historic funding levels. It is unclear at the time of writing this strategy exactly how primary care IT will be commissioned and funded from 2015/16 onwards as national policy is awaited.

14.7 Estates

Across Northern Staffordshire, the quality of the general practice estate is highly variable and there is a real challenge to improve the primary care estate portfolio. A poor estate means poorer patient experiences, poor working conditions for GPs and the wider primary care team and lost opportunities to improve health and healthcare.

Strategic estate planning will assist the NHS to make better use of its estate and ensure that the management of these assets is aligned with the “Five Year Forward View” with its vision of more integrated community based services, offering a greater range of diagnostic and treatment services in local hubs.

The strategic estate plans are intended to support the health economy to create a fit for purpose estate portfolio at less cost, specifically addressing:

• changes in demography and population demand;
• changes in the way that health care services are provided - specifically reflecting plans for integrated health and social care, greater levels of care within communities and new commissioning models;
• challenges in funding and affordability.

14.7.1 The Primary Care Estates Portfolio

The current primary care estate is in a variable condition. It is not always in the right location to deliver local services to the population and it is often not fully utilised.

Significant issues include:

• insufficient space to meet demand
• void space in long-term core buildings.
• bookable space that is not fully utilised.
• inappropriate tenants – for example, core clinical space is often filled with administration and support services. These services could be relocated, in most cases more cheaply and the space could be used to accommodate integrated clinical services.
• space is often not fully utilised – for example, a treatment room may be used by one provider for one session a day, three days a week.
• lack of joint working across organisations - this can lead to parochial decisions, for example, where new buildings are commissioned close to existing estate, which could have been utilised, potentially negating the need for the new estate.

Specifically, the development of primary care premises through the Local Investment Finance Trust (LIFT) presents real challenges.

Whilst these buildings have delivered improved access into primary care facilities, particularly in areas of social deprivation, in some cases they have resulted in high costs, unaffordable rents and as a result underutilised buildings.

14.7.2 The Development of a Strategic Estates Plan

Recognising that the development of a robust estates infrastructure is vital to enable the transformation of primary care, NHS England (NHSE) is working with Northern Staffordshire CCGs, Community Health Partnerships (CHP) and NHS Property Services (NHSPS) to complete a strategic estates plan for primary care properties within the area. The aim of this review is to achieve the following:

• provide an overview of the existing health economy estate and related partners estate
• articulate the estates needs that fall-out from the commissioning plans
• create deliverable implementation plans to provide fit for purpose estate

And as a result will involve:

• committing to, and maximising use of the “Core Estate”
• rationalisation and disposal of surplus or “unfit” estate
• improving effective utilisation of the estate
• ensuring appropriate utilisation – for example, focus on core clinical space delivering integrated clinical services and not admin/support services
• using the estate to deliver new models of care, through more integration and a wider range of co-located services
• partnering across organisations to achieve maximum system benefits

14.7.3 Investment in Estates

Following the Primary Care Infrastructure Fund (PCIF) application process, it was identified by CCGs and NHS England that there was a need to develop a primary care strategy to help identify priorities for future PCIF funding. (Renamed: Primary Care Transformation Fund (PCTF)).

An estates task to finish group was established in August to develop a primary care estates strategy by December 2015. This group includes representation from CCGs, LMC, NHS England, NHS Property Services and Community Health Partnerships and Local Authorities have been invited from December onwards.
The December version will provide a stock take of the current position on primary care estate and will identify the known gaps in the strategy and the actions required to address these gaps, together with timescales, linking into the need to submit PCTF bids by February 2016.

In terms of update on progress a GP premises questionnaire has been developed and practices are to respond by 27th November. The CCG will continue to work with NHS England and the national team to develop a process to approve and allocate funds to bids which meet the priorities of the CCG.

### 14.8 Contract Management and Procurement

Making Time in General Practice notes that the chief sources of bureaucracy in general practice is getting paid with this becoming a huge burden for all contractors of primary care services. Streamlining practice payment systems to minimise bureaucracy and maximise speed of data entry and payment would have immediate positive effect on releasing capacity.

If we acknowledge that the specification described here can only be delivered in full by general practice working together at scale and with other parts of the stat system there is a need to align contractual incentives, removing the barriers for working together across a local area - including financial incentives that cut across effective collaboration.

Part of this approach must be to put all providers of care on an equal footing if an integrated care model is to be implemented successfully. For example if the voluntary sector is to be commissioned to provide specific services with agreed outcome then to enable this to be carried out efficiently and to be monitored a robust contract mechanism needs to be put in place equal to those awarded to the statutory sector.

The Framework proposes new funding, not at an individual practice level but delivered through wider population-based contracts. The exact nature of these arrangements will vary depending on the provider landscape, but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which investment will be made. However there is a need to review the way in which primary care is contracted for both within general practice and across the system with community nurses and other health and care professionals if contracts are to enable the provision of integrated seamless, person-centred care for patients.

Local approaches will be determined within each CCG area, supported by co-commissioning. It is likely that the contracting vehicle will need to ‘wrap around’ existing national contracts.

The contracting vehicle may also need to be flexible to wider collaborations and partnerships with other types of providers, for example where the strategic intent locally is for accountable care organisations that can hold capitated budgets and shared risk for whole populations.

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15.0 Implementation of the Northern Staffordshire Primary Care Strategic Delivery Plan

Clearly there are many issues that must be addressed in order to develop our vision for primary care and implement future models of care. It is recognised that one model might not meet the needs of our diverse communities and we need to continue to work with patients and our other key stakeholders to develop a model that is fit for purpose.

15.1 Project Plan

We are working with patients, our members and our stakeholders to agree the model of care and key principles of our proposed primary care strategy. However the mapping and more detailed work will take place in the New Year. The proposed timescales are described below.

Diagram 5 Northern Staffordshire Primary Care Strategic Delivery Plan Outline Timescales

Alignment of System Views
Stakeholder Engagement

15.2 Governance

The Primary Care team will support the delivery of the Primary Care Strategy, as well as ensuring the operational requirements of the CCG are delivered through each of the Primary Care Sub Committees and the overarching Northern Staffordshire Primary Care Delivery Plan Steering Group. The Sub Committees are made up of primary care representation from each practice locality (both practice manager and clinical lead) supported by representation from stakeholders from within each CCG; LMC and public health for example. The Northern Staffordshire Primary Care Delivery Plan Steering Group will hold responsibility for integrating comment from stakeholders and assuring the overarching Northern Staffordshire Primary Care Strategy for sign off by both CCG Governing bodies and ultimately by The Primary Care Joint Co-Commissioning Board.

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Led by the Clinical Director of Primary Care for North Staffordshire and Stoke-on-Trent CCG, the Northern Staffordshire Primary Care Delivery Plan Steering Group, through harnessing primary care expertise and stakeholder skills will ensure that the Northern Staffordshire Primary Care Strategy supports and underpins delivery of the CCGs vision and operational delivery plans. The approach will be through both direct engagement with key stakeholders, as and when required and via virtual engagement.

Integrated working with the Primary Care Team, NHS England, North Midlands will ensure a consistent approach to the development of key objectives across Staffordshire and upwards to the Staffordshire Transformation Programme.

Overall programme targets and milestones will be monitored on a monthly basis by the Primary Care Strategy Group and reported to the Primary Care Joint co-Commissioning Board.

This board provides the governance link for the Staffordshire and Stoke-on-Trent CCGs to the Transformation Programme. These governance arrangements are described below.

**Diagram 6 Governance Structure Northern Staffordshire Primary Care Strategic Delivery Plan**

15.3 Stakeholder Development

Although strongly focused on the role of general practice in primary care, the strategy recognises that the implementation of the strategy will require the support of all independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care. Community-based services such as district nursing, health visiting, community mental health services and therapy services are partners as members of the Extended Primary Care Team. In addition organisations which provide other care services such as local authorities and voluntary organisations will continue to be key partners in the commissioning of integrated models of care.

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It will be essential that the CCG works closely with the Local Medical Committee to ensure good working relationships and a strong sense of partnership with practices.

In addition, the CCG will work with partner organisations such as the Local Pharmaceutical Committee and Local Optometry Committee to develop new models of care.

The CCG will work closely with patients and service users to ensure primary care services are person-centred, taking into account the aspirations of individuals alongside the diversity of the community.

15.4 Public and Patient Engagement

Patients are at the heart of every decision we make as commissioners. Our aim is to ensure that we have regular and ongoing dialogue with North Staffordshire residents and patients and, as part of his, work with as many people as possible to make sure everyone in North Staffordshire receives the best possible NHS services.

This year we have engaged and involved people through our patient membership scheme, the Patient Congress and through our GP practice patient groups to shape our future commissioning plans.

15.5 Monitoring and Evaluation

This strategy will be approved by The Northern Staffordshire Primary Care Delivery Plan Steering Group who will then be responsible for its implementation and delivery reporting on a quarterly basis to the Joint Planning Committee. Twice yearly updates reports will be provided to the Member Council and Stakeholder Council. In addition ongoing reports will be made to both the Staffordshire and Stoke-on-Trent Health and Wellbeing Boards to ensure that the development of primary care services is aligned to the strategic partnership priorities.

15.6 Risk and Mitigation

A full Risk Register for this project will be developed as part of the corporate risk register. Risks will be monitored by the Primary Care Board. A summary of the key emerging risks are described in the table below.
Table 3 Key Risks Primary Care Strategic Delivery Plan

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
<th>Rag</th>
</tr>
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<tbody>
<tr>
<td>Critical workforce issues are identified and managed within an</td>
<td>Working with the Area Team key workforce risks are identified and a range of solutions developed and implemented</td>
<td></td>
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<tr>
<td>appropriate timescale</td>
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<tr>
<td>Competing priorities and limited resources in terms of staff, time</td>
<td>Continuing engagement of all stakeholders through Steering Group plus alignment of strategy to individual organisational aims with intention of delivering whole system outcomes – e.g. emphasis on prevention as well as treatment.</td>
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<tr>
<td>and resources mean that organisations are not able to work together.</td>
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<tr>
<td>GP and practices do not engage</td>
<td>Robust engagement strategy with use of Localities to enable good communication and engagement.</td>
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</tr>
<tr>
<td>Failure to engage extended primary care team and other</td>
<td>Expert Advisory Group in place with representation from all stakeholder organisations and professional networks.</td>
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<tr>
<td>stakeholders</td>
<td></td>
<td></td>
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<tr>
<td>Patients and public unaware of need to change</td>
<td>Full Public and Patient Involvement strategy being implemented, utilising existing patient forums such as Patient Participation Groups</td>
<td></td>
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<tr>
<td>Failure to develop agreed future primary care models of provision</td>
<td>Models developed with full engagement of members and LMC. Use of evidence based models and expertise developed through Prime Ministers Challenge Fund supported by Area Team</td>
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<tr>
<td>for example: 7 day working</td>
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<tr>
<td>Unable to implement agreed model of co-commissioning</td>
<td>Area Team actively engaged in both development of strategic primary care framework and development of local strategy</td>
<td></td>
</tr>
<tr>
<td>Key Enablers to achieve success will not be aligned to delivery</td>
<td>Programme management approach implemented alongside development of strategy to ensure success.</td>
<td></td>
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<tr>
<td>of outcomes</td>
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16.0 Appendices

Appendix 1 Terms of Reference

Northern Staffordshire Primary Care Delivery Plan Steering Group

Terms of Reference

1. Purpose

1.1 This Terms of Reference outline the purpose and accountability arrangements of the Northern Staffordshire Primary Care Delivery Plan Steering Group. The Steering Group is a time limited Task and Finish Group established to provide expert comment on the development and implementation of a Primary Care Delivery Plan for Northern Staffordshire making recommendation to ensure the effective delivery of a model of primary care that improves coordination of care, access to services and enables a proactive approach to health and wellbeing with the intention of making care better.

1.2 The Staffordshire Commissioning Congress has been formed with the six NHS Clinical Commissioning Groups (CCGs), Staffordshire County Council, Stoke-on-Trent City Council and NHS England to identify and drive delivery of a collective transformation programme to ensure citizens in Staffordshire and Stoke-on Trent have high quality, sustainable services going into the future. A key element of this transformation programme is the development of a Primary Care Strategic Commissioning framework, which will enable the transformation of primary care across the pan Staffordshire economy.

1.3 The Steering Group will ensure that the Primary Care Delivery Plan developed for the Northern Staffordshire health and social care locality acts as a local delivery plan, enabling the members to make collective decisions on the review, planning and development of a framework for primary care services describing what best meets the needs of the local community. This group will ensure that this plan delivers the strategy framework for primary care, setting out a new patient offer for the people of Northern Staffordshire.

2. Definition of A Primary Care Service

2.1 A primary care service operates as the patient's first point of entry into the health care system for health (excluding emergency treatment) and wellbeing needs and as the continuing focal point for all necessary health care services providing continuity and integration of health care services to ensure improvement in individual health and wellbeing outcomes. A key principle is that the principal aim is to provide an easily accessible route to care, whatever the patient's need. Primary health care is based on meeting an individual's wellbeing needs rather than treating specific diseases.

3. Function and Duties

3.1 The key responsibilities of the Steering Group will be in the planning and coordinating of a consistent approach to the commissioning of primary care, acting as an expert advisory body to ensure the development of a Primary Care Delivery Plan that delivers quality, efficiency, productivity and value for money through:

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• Developing new models of care for primary care, to align with national strategic direction set by the Commissioning Congress;

• Identifying local models of primary care provision based on the views of patients, carers, and the local community, as well as evidence from the stakeholder community; and

• To co-ordinate a common approach to the commissioning of a primary care framework enabling the support of key stakeholders as represented by the Steering Group to improve care outcomes.

3.2 Specifically, to work together to direct a model of delegated commissioning which enables the development of a model of integrated care which supports the needs of local people and delivers the following benefits:

• Improved access to primary care and wider community centred provision with more services available closer to home
• High quality, consistent care
• Improved health outcomes, better access to services and reduced health inequalities.
• A better patient experience through more joined up services.

3.3 To work together to ensure the engagement of the stakeholder community across Northern Staffordshire, specifically identifying opportunities for effective public and patient contribution to discuss, debate and develop the key proposals of the Primary Care Delivery Plan commending appropriate mechanisms to support providers in optimum delivery, including:

• Supporting the development of GP networks and federations;
• Succession and resilience plans; and
• Strategies for providing additional financial investment in primary care

3.4 A key part of delivery is that members of the Steering Group will work together to ensure that the enablers required to deliver new models of care are aligned and managed through systematic review and evaluation, developing solutions to ensure models of care achieve outcomes and are sustainable. Specifically these enablers are recognised as:

• Clinical Leadership;
• Workforce;
• Information Management and Technology;
• Estates; and
• Contracts.

3.5 To achieve a local vision for Primary Care it is recognised that co-commissioning is a key enabler to deliver a primary care transformation Delivery Plan. Therefore the Steering Group will work to develop a model of co-commissioning which facilitates the development of primary care and maximises the benefits of a Primary Care Delivery Plan.

3.6 The Group will work in an advisory capacity to support the development of primary care commissioning proposals and ensure that milestones are achievable.

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The Group will also identify and log key risks which will be escalated and managed as part of the implementation stage in developing a primary care strategic framework.

3.7 The Group will ensure that the Primary Care Delivery Plan is locally designed and best meets the needs of the local community, but will work collaboratively as part of the Commissioning Congress to enable the transformation of Primary Care across Staffordshire.

4. Governance and Accountability

4.1 The Steering Group does not have any delegated authority in relation to primary care commissioning and as such does not have the ability to make formal decisions. However the Primary Care Steering Group will act as the group responsible for overseeing the primary care work programme across Northern Staffordshire. As such members have a duty to enable the group to direct, coordinate and manage the delivery of all work streams that enable the transformation of primary care by ensuring that primary care developments are governed through the Steering Group.

4.2 Members have a collective responsibility for the operation of the Steering Group. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

GOVERNANCE STRUCTURE TO BE REVISED

5. Membership

5.1 This is a complex programme of work and its delivery will require all of those involved, in the care of Northern Staffordshire patients to work together. The Steering Group membership has been designed to reflect the breadth of organisations and professions involved in care of patients across the local health economy, as well as reflecting the geography of the area.

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<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name</th>
<th>Designation</th>
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<tbody>
<tr>
<td><strong>Northern Staffordshire GP Federation Limited</strong></td>
<td>Dr Paul Roberts</td>
<td></td>
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<tr>
<td><strong>Clinical Locality Reps</strong></td>
<td>Dr Jag Boyapati</td>
<td>Stoke Locality Lead</td>
</tr>
<tr>
<td></td>
<td>Dr Barry Edwards</td>
<td>Northern Staffordshire Locality Lead</td>
</tr>
<tr>
<td><strong>Local Medical Committee</strong></td>
<td>Dr Paul Scott</td>
<td>LMC Chair</td>
</tr>
<tr>
<td></td>
<td>Dr Harold Van Der Linden</td>
<td>LMC Secretary</td>
</tr>
<tr>
<td><strong>Northern Staffs and Stoke Local Pharmaceutical Committee</strong></td>
<td>Tania Cork</td>
<td>Chief Officer</td>
</tr>
<tr>
<td><strong>Local Optical Committee</strong></td>
<td>Stewart Townsend (Chair):</td>
<td>Chair, Staffordshire</td>
</tr>
<tr>
<td><strong>Local Dental Committee</strong></td>
<td>Ms Carole Hollins</td>
<td>Chair, Northern Staffordshire</td>
</tr>
<tr>
<td><strong>Primary Care Nursing</strong></td>
<td>Kellie Johnson</td>
<td>Primary Care Nurse Lead - CCG Quality and Improvement</td>
</tr>
<tr>
<td></td>
<td>Charlotte Harper</td>
<td>Primary Care Nurse Lead, Northern Staffordshire</td>
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<tr>
<td><strong>NHS England</strong></td>
<td>Rebecca Woods</td>
<td>Primary Care Lead</td>
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<tr>
<td><strong>Provider Organisations</strong></td>
<td>James Shipman</td>
<td>Medical Director</td>
</tr>
<tr>
<td></td>
<td>Kieron Murphy</td>
<td>Director of Operations</td>
</tr>
<tr>
<td><strong>Staffordshire and Stoke-on-Trent Partnership NHS Trust</strong></td>
<td>Claire Holmes</td>
<td>Interim Head of Directorate – Adult Community</td>
</tr>
<tr>
<td><strong>Northern Staffordshire Combined Healthcare NHS Trust</strong></td>
<td>Helen Lingham</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td><strong>University Hospitals of Northern Midlands NHS Trust</strong></td>
<td>Sean Coleman</td>
<td>Area Manager</td>
</tr>
<tr>
<td><strong>Social Care</strong></td>
<td>Melanie Dunn</td>
<td>Strategic Manager for Commissioning</td>
</tr>
<tr>
<td><strong>Social Care Stoke-on-Trent City Council</strong></td>
<td>Leanne Eardley</td>
<td>Area Manager, Stoke-on-Trent</td>
</tr>
<tr>
<td><strong>Public Health</strong></td>
<td>Professor Zafar Iqbal</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td><strong>Public Health Staffordshire County Council</strong></td>
<td>Dr Chris Weiner</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td><strong>Voluntary Organisations</strong></td>
<td>Garry Jones</td>
<td>Chief Executive Support Staffordshire</td>
</tr>
<tr>
<td></td>
<td>Lorien Barber</td>
<td>Strategic Liaison Manager VAST</td>
</tr>
<tr>
<td><strong>Patient Representation</strong></td>
<td>Dave Rushton</td>
<td>Engagement Officer</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Engaging Communities Staffordshire</th>
<th>Sue Baknak</th>
<th>Engagement Manager</th>
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<tr>
<td><strong>In Attendance by Invite</strong></td>
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<tr>
<td>Health Intelligence CSU</td>
<td>Sarah Glover</td>
<td>Business Insight Manager</td>
</tr>
<tr>
<td>Nick Dunaway</td>
<td></td>
<td>Strategic I.T Lead Midlands &amp; Lancashire CSU</td>
</tr>
</tbody>
</table>

5.2 When not able to attend, members may send a deputy to participate and advise on their behalf. Each member must nominate a deputy at the start of the appointment period. In case the nominated deputy is also unable to attend the meeting, the member will not be able to send any other person on his/her behalf. Deputies must have similar expertise and be of similar level of seniority as the member they substitute.

5.3 Chair - Dr Emma Sutton  Clinical Director of Primary Care North Staffordshire and Stoke-on-Trent CCG

6. **Frequency of Meetings**

6.1 The Steering Group is established as a focused task and finish group for a 6 month period. Meetings will be held monthly on a Tuesday from 12 pm until 2 pm

7. **Operation of Meetings**

7.1 The Steering Group will be supported by the Primary Care Team of the Northern Staffordshire CCGs. A secretary will produce minutes and be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than seven days before the meeting.

8. **Declaration of interests**

8.1 The Code of Conduct and Accountability in the NHS and the Code of Conduct for NHS managers requires all Directors and staff to declare interests which are relevant and material. The declaration should be made on the declaration of interests form. Members are asked to inform the Secretariat before each meeting of any change in their relevant interests. The minutes of each meeting will record declarations of interest, and whether members took part in discussion and decision making.

8.2 Where the Chair of any meeting of the group, including committees, sub Committees of the Governing Board, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting.

8.3 Where arrangements have been confirmed for the management of the conflicts of interests or potential conflicts of interest in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy Chair may require the chair to withdraw from the meeting or part of it.

Northern Staffordshire Primary Care Strategy
Author: Liza Pursey Interim Primary Care Strategy Manager Final Version 10th February 2016
### Appendix 2 Key Challenges, Threats and Potential Solutions to the Future Provision of a Model of Primary Care

<table>
<thead>
<tr>
<th>Key Challenges</th>
<th>Key Threat</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.0 Funding</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1</strong> Insufficient funding within primary care to meet increased demands and key objectives such as 7 day working</td>
<td>Reduction in Public Health funding results in increase risk to primary care to delivery outcomes Move of funding from secondary care to primary care is based on transfer of activity NOT additional investment Current system includes significant unfunded ‘non-core’ elements of primary care</td>
<td>Ensure key message of primary care strategy linked to overall strategic plan both locally and Staffordshire wide is increased investment in primary care system Ensure all delivery is commissioned, costed and paid for or remove from primary care</td>
</tr>
<tr>
<td><strong>1.2</strong> Back room / overheads increasing for GP practices</td>
<td>Multiple overheads for corporate function with limited resilience</td>
<td>Other organisations to provide Corporate functionality support and or delivery in terms of HR, Finance, estates, informatics, Comms, support to GP practices.</td>
</tr>
<tr>
<td><strong>1.3</strong> Efficiencies are implemented to generate savings but result in a reduction in quality / access</td>
<td></td>
<td>Funding strategy needs to recognise that improving quality / access may require investment</td>
</tr>
</tbody>
</table>
## 2.0 Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Outcomes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong></td>
<td>Outcomes are defined by system rather than need</td>
<td>Comprehensive <strong>LOCAL</strong> needs assessment to be developed / built on shaped by all partners including voluntary sector and influenced by community</td>
</tr>
<tr>
<td><strong>2.2</strong></td>
<td>Patient voice not always ‘heard’ within the system</td>
<td>The way feedback is sourced from patients not always incorporated into needs assessment or is used to improve pathways or care Ensure that patients views are incorporated into needs assessment and utilised to create improvement</td>
</tr>
<tr>
<td><strong>2.3</strong></td>
<td>Lack of emphasis on health promotion, prevention, patient empowerment</td>
<td>System is predicated towards treatment Integration of the community &amp; voluntary sector into primary care to maximise potential around early intervention &amp; meeting the wider determinants of health. Public Health needs to work collaboratively with primary care to identify and target hard to reach groups. Health promotion work to be carried out by pharmacists, dentists, opticians. Children to have access to healthy lifestyle messages. Increased uptake of immunisations amongst children and increased uptake of all the screening programmes E.g. - breast, cervical and bowel cancer. Patient education to self-manage long term conditions as much as possible-raising awareness of websites like British Heart foundation, diabetes UK, arthritis UK, asthma UK, access to expert</td>
</tr>
</tbody>
</table>
### Models of Care

<table>
<thead>
<tr>
<th></th>
<th>models of care</th>
<th>Many experienced and skilled clinical leaders retiring</th>
<th>Financially support and develop the skills of local clinicians who want to take on managerial or leadership roles. Strategy to recognise that GPs will be central to the provision of any future models</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Primary care not seen as a ‘real player’ in the system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>Continuing with ‘corner shop’ model not sustainable</td>
<td></td>
<td>Amalgamate practices providing time and space to develop ‘Matchmaking’ between practices to support existing localities.</td>
</tr>
<tr>
<td>3.3</td>
<td>Social care provision vital to ensure delivery of effective health and wellbeing</td>
<td>Social care facing increasing pressures</td>
<td>Health providers to link with LAs to align social care provision in line with health needs as defined by GP practices.</td>
</tr>
<tr>
<td>3.4</td>
<td>Social care provision vital to ensure delivery of effective health and wellbeing</td>
<td>Social care facing increasing pressures in terms of ability to meet demand and increase costs pressures.</td>
<td>Work with local authorities to fully understand pressures and agree approach in addressing issues and / or gaps in provision as appropriate’ and ‘consider funding issues facing LAs and ensure the local health economy work collectively to protect provision.</td>
</tr>
<tr>
<td>3.5</td>
<td>Mental health treatment and wellbeing takes up significant amount of primary care resources</td>
<td></td>
<td>NSCHT keen to align community teams around GP practices with continuity of workforce and in reach clinics into practices relevant to need of population.</td>
</tr>
<tr>
<td>3.6</td>
<td>Voluntary Sector ‘invisible’ within primary care system</td>
<td></td>
<td>Integrating volunteering, fundraising, community activity into primary care to support practices, leverage in funds, develop community &amp; support workforce.</td>
</tr>
</tbody>
</table>
### 4.0 Commissioning

| 4.1 | Primary care system being asked to respond to increased demand, deliver more activity and deliver an increased number of health outcomes | Agree delivery plan and capacity targets. Increase investment in primary care |
| 4.2 | Voluntary Sector not always aware of commissioning strategy and voluntary sector needs support to adapt to changing environment | Missed opportunity for Voluntary Sector to change and adapt to local need Lack of clarity about area covered by model of care Voluntary Sector should be seen as an equal partner in commissioning strategy and treated the same as other providers Key commissioned geographical area to be defined Proactive communication with voluntary sector |
| 4.3 | Avoid denominator commissioning. “We have x pounds for the service and want y levels of activity with z quality” so we will pay X/Y per unit | |
| 4.4 | Current system doesn’t allow for identification and sharing of risk across the pathway | Disproportionate risk management within primary care Bench mark against national indicators. Incorporate into toolkit / commissioning system |
### 5.0 Workforce

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1</strong></td>
<td>Reduction in GP numbers with difficulties in recruiting and retaining GPs</td>
<td>Rise in indemnity costs making GP posts unattractive</td>
</tr>
<tr>
<td><strong>5.2</strong></td>
<td>Develop extended primary care workforce</td>
<td>Potentially more costly, more difficult and is equally off putting for potential GP trainees</td>
</tr>
<tr>
<td><strong>5.3</strong></td>
<td>Voluntary sector commissioned on an ad hoc basis on short term contracts</td>
<td></td>
</tr>
<tr>
<td><strong>5.4</strong></td>
<td>Lack of integration with other primary care contractors</td>
<td></td>
</tr>
</tbody>
</table>
### 6.0 Information Technology

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Information systems that support primary care are developed on an ad hoc basis without recognising specific needs of primary care</td>
<td>Develop primary care IT strategy that supports development of primary care. Should be EMIS Web based and include email. Requires skilled IT staff to support. Should be linked to commissioning strategy so only providers able to data share via EMIS are used. Needs to be an integrated solution across health and social care. Must be underpinned by data sharing protocols which all stakeholders <strong>MUST</strong> sign up to.</td>
</tr>
<tr>
<td>6.2</td>
<td>Integrated model requires ability to share patient information</td>
<td>Current system has multiple patient records both paper and Digital. NSCHT contracted national expertise for rollout of new electronic patient record. Supported by HSCIC (health and social care information centre). Broaden development from organisational electronic patient record to a patient solution starting with the patient and their record needs and then link to current to provider EPRs a fit for purpose population based solution that doesn’t dictate every provider to use the same system.</td>
</tr>
<tr>
<td>6.3</td>
<td>Current IT systems mean it is difficult to evaluate performance or identify risk</td>
<td>IT solution needs to be developed to enable evaluation of performance and management of risk in terms of specific clinical groups.</td>
</tr>
<tr>
<td>6.4</td>
<td>Technology doesn’t currently enable innovative practice</td>
<td>Ensure strategy enables increased use of technology e.g. Video /Telephone consults to create efficiencies.</td>
</tr>
</tbody>
</table>
### 7.0 Delivery

<table>
<thead>
<tr>
<th></th>
<th>Pace of change to great and cannot be implemented without alignment to enablers e.g. money</th>
<th>Develop a delivery plan with realistic timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### 8.0 Access

<table>
<thead>
<tr>
<th>8.1</th>
<th>Access to appointments / services currently inequitable</th>
<th>Commissioning approach needs to recognise that improving access and quality may require additional investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.2</td>
<td>Lack of clarity within community about which services are available and how to access them</td>
<td>LAs in line with care act requirements are currently working to develop a joint information and advice strategy. The LAs are proposing that this incorporate CCG’s as IAG (information, advice and guidance) has been identified as one of four big tickets under Workstream 2 of commissioning congress. The strategy won’t include children but will refer to IAG in transition from children’s to adult services.</td>
</tr>
<tr>
<td>8.3</td>
<td>Community transport is commissioned on an ad hoc basis</td>
<td>Inequitable access</td>
</tr>
</tbody>
</table>
**AUTHOR**

<table>
<thead>
<tr>
<th>Name</th>
<th>Leesa Murray</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Planning and Strategy Manager</td>
</tr>
</tbody>
</table>

**REPORTING OFFICER**

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

**REPORT TO**

Governing Board

**TITLE OF REPORT**

Integrated Performance Report

**DATE OF THE MEETING**

2nd March 2016

**WHAT OTHER CCG COMMITTEE OR GROUP HAS CONSIDERED THIS REPORT?**

Record which groups/committee have already seen this report, the date and comments (for example agreed this report should go to the governing board for approval)

**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD (PLEASE TICK)**

<table>
<thead>
<tr>
<th>Approve</th>
<th>Assurance</th>
<th>Discussion</th>
<th>Information</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**STRATEGIC GOALS SUPPORTED BY THIS PAPER (tick appropriate goal)**

1. Increase life expectancy and reduce inequality
2. Improve prevention, early detection and effective management of those at increased risk
3. Enhance quality of life and improve health outcomes for people with LTCs
4. Ensure people receive the right care in the right place

**RECOMMENDATION**

Members are asked to:

1. Note the performance and quality metrics contained in the report, which highlights certain performance features including constitutional and contract targets.

2. To note that the finance report which records financial performance for the period ending 31st December 2015, 9 months of the financial year should be viewed in conjunction with any further financial performance outlined in this report.
<table>
<thead>
<tr>
<th>PURPOSE OF THE REPORT/SUPPORTING INFORMATION (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This report seeks to inform the CCG of its performance against key constitutional and quality metrics to month 9 of 2015/16.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KEY POINTS/EXECUTIVE SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG continues to fail on constitutional targets around A &amp; E waiting times, referral to treatment times and some cancer wait targets.</td>
</tr>
<tr>
<td>The CCG’s cumulative financial position and metrics are in line with plan to the end of December 2015 (Month 8). The finance report will outline key risks and anticipated delivery to plan by the year end.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks relating to the proposals in this paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of the constitutional targets will have an impact on the assurance level of the CCG and in terms of service delivery to the public which are below the nationally mandated levels.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary of any finance/resource/medicines management /workforce implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk scenarios are developed together with risk management and mitigation plans as appropriate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any statutory/regulatory/legal/NHS Constitution/Assurance/Governance implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remedial actions relating to adverse performance against the NHS constitutional targets remains a key focus of attention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equality Impact Assessment (Are there any direct or indirect implications)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any related work with stakeholders/practices/public and patient engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acronyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set out in the body of the report.</td>
</tr>
</tbody>
</table>
Integrated Finance and Performance Report - Contents

Overview

Section 1: NHS Constitution (Exceptions)

Section 2: Contract Plan Performance
- UHNM Contract Summary - North Staffordshire CCG
- UHNM Contract Summary - Stoke on Trent CCG
- SSoTP Contract Summary - North Staffordshire CCG
- SSoTP Contract Summary - Stoke on Trent CCG
- Nuffield Contract Summary - North Staffordshire CCG
- Nuffield Contract Summary - Stoke on Trent CCG

Enclosure 12 - Integrated Performance Report
Report Overview

Section 1: NHS Constitution Exception Reporting

This report contains the latest published data for the NHS Constitution indicators for North Staffordshire CCG and Stoke on Trent CCG. Indicators included here are only those which the CCG is failing on a Year-to-Date basis or has failed in the reporting month. For a complete list of indicators, including those the CCG has passed please see the Monthly Performance Assurance Report on the BI Portal: https://aristotle.northstaffs.nhs.uk/Pages/int_perf.aspx

Section 2: Contractual Plan Performance

This section covers performance at the main providers - UHNIM, SSOTP and Nuffield and these will be sourced from Provider SLAM's. The information provided covers performance for the current month, year-to-date and forecast outturn at POD level. The UHNIM performance report includes penalties and other financial adjustments as agreed with CCG Finance colleagues.
Comments:
Commissions raised a Contract Performance Notice relating to the failure to deliver the incomplete target and agreed the trajectory which indicated overarching delivery of the 93% standard by the end of October 2015. The Trust failed to achieve against this RAP and as a result, the CCGs withheld 2% of the contractual value for a period of one month. However, the CCGs made the decision to close the CPN to enable us to submit a further contract performance notice with the intention of the Trust providing a RAP with overarching actions at a specialty level to deliver the constitutional target of 92%. This RAP was received by the CCGs on the 20th December 2015 and was not agreed due to a number of terms and conditions requested by the Trust. The CCGs followed the contractual process outlined under GC9 of the contract for failure to agree a RAP and are currently withholding 2% of the monthly contract which will be permanently withheld should the target not be met before the end of this contract year. At present, UHNM have informed commissioners that they are unable to model a date for recovery and we continue to work with the Trust to understand this. The issue has also been escalated to NHSE and the TDA.

Comments:
SLA activity levels for ED and non-elective admissions. Stoke CCG at M9 ytd: ED is 2% under plan and non-elective admissions are 4% over plan. North Staffs CCG at M9 ytd: ED is 3% under plan and non-elective admissions are 1% under plan. There were 47 more Ambulance conveyances per week compared to the last 13 wks. The Remedial Action Plan was not achieved for December and consequently a 1% penalty will be applied to UHNM.
Section 1: NHS Constitution Reporting (Exceptions)

### Constitution Report (Exceptions)

**North Staffordshire CCG**

**Cancer - 2 Week Waits**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current</th>
<th>YTD</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP Referrals</td>
<td>92.2%</td>
<td>96.5%</td>
<td>Dec-15</td>
</tr>
<tr>
<td>Breast Symptoms Referrals</td>
<td>48.3%</td>
<td>61.2%</td>
<td>Dec-15</td>
</tr>
</tbody>
</table>

**Cancer - 31 Days**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current</th>
<th>YTD</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent surgery</td>
<td>85%</td>
<td>89.4%</td>
<td>Dec-15</td>
</tr>
<tr>
<td>Radiotherapy Treatments</td>
<td>91.8%</td>
<td>96.3%</td>
<td>Dec-15</td>
</tr>
</tbody>
</table>

**Cancer - 62 Days**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current</th>
<th>YTD</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP referral</td>
<td>75.0%</td>
<td>73.2%</td>
<td>Dec-15</td>
</tr>
</tbody>
</table>

**Stoke on Trent CCG**

**Cancer - 2 Week Waits**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current</th>
<th>YTD</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP Referrals</td>
<td>86.5%</td>
<td>92.6%</td>
<td>Dec-15</td>
</tr>
<tr>
<td>Breast Symptoms Referrals</td>
<td>29.5%</td>
<td>32.8%</td>
<td>Dec-15</td>
</tr>
</tbody>
</table>

**Cancer - 31 Days**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current</th>
<th>YTD</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent surgery</td>
<td>96.3%</td>
<td>98.4%</td>
<td>Dec-15</td>
</tr>
<tr>
<td>Radiotherapy Treatments</td>
<td>100%</td>
<td>93.2%</td>
<td>Dec-15</td>
</tr>
</tbody>
</table>

**Cancer - 62 Days**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Current</th>
<th>YTD</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent GP referral</td>
<td>75.4%</td>
<td>77.6%</td>
<td>Dec-15</td>
</tr>
</tbody>
</table>

---

Comments:

- **Breast Symptoms Referrals**: Standard 95%, Current 88.9% YTD 92.5%
- **Urgent GP referral**: Standard 93%, Current 96% YTD 93%
- **Subsequent surgery**: Standard 96%, Current 98.4% YTD 98%
- **Radiotherapy Treatments**: Standard 100%, Current 100% YTD 100%

---

**Treatments**: (E.B.11) Treatment Course. (E.B.9) Treatment is Surgery. (E.B.12) Treatment is a Radiotherapy Treatment Course. (E.B.13) NHS Cancer Screening Service.
Key risks:
Stoke-on-Trent – failure to achieve 2ww, breast 2ww, 62 day (GP referral & screening). There has been a significant increase in referrals for all CCGs and all sites (particularly breast). However conversion rates suggest that GP referrals are comparably appropriate to other areas of the country. The breast two week wait service at UHNM is currently experiencing an influx of referrals which is beyond the capacity of the service to absorb.

North Staffordshire – failure to achieve 2ww, breast 2ww, 62 day GP referral

Actions:
Following the publication the NHS England Publication Gateway Reference: 03614 on 14th July 2015 and subsequent letter dated 30th July 2015 UHNM was required to submit a Cancer Improvement Plan and Assessment against the 8 key priorities identified by the Cancer Waiting Times Taskforce (CWTT) and Intensive Support Team (IST). Remedial action plans are in place for 31 day (overall and surgery) and 62 day from GP referral target; Nov (31 days – achieved both trajectories (overall & surgery)); 62 days GP referral - achieved 3 of 4 trajectories (overall, lung, urology, failed colorectal marginally)
Breast 2ww: Contract Performance raised 15/01/2016. Agreement to complete Joint Investigation 28/02/2016.TOR of JI agreed 11/02/2015 - main issues capacity (review of pathway with a view to using resources better – implementing pain management clinic). NB All patients have been appointed by 14 days since 31 Dec 15.Pilot of under 30s breast clinic has increased capacity as have additional clinics.

North Staffordshire CCG

Stoke on Trent CCG

North Staffordshire CCG

Stoke on Trent CCG

Enclave 12 - Integrated Performance Report
Comments: Performance of the ambulance related NHS constitution targets discussed at the Staffordshire Divisional WMAS meeting on the 4th February 2016. WMAS indicated an increase in call volume from patients and increased activity from NHS 111. Commissioners requested an action, improvement and sustainability plan with a detailed trajectory for all Red Ambulance Performance Indicators across Staffordshire (including Stoke-on-Trent). This will be presented at the next Divisional Meeting on the 4th March 2016.
## Finance Variance to Budget:

<table>
<thead>
<tr>
<th>Year to Date</th>
<th>Current Month</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>-0.45%</td>
<td>2.07%</td>
<td>-2.85%</td>
</tr>
</tbody>
</table>

### University Hospitals of North Midlands Contract Summary

#### Finance Variance to Budget:

- **Var** to **Budget**:
  - £31,466
  - £240,839
  - £1,870,275

#### Actual vs. Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Var %</th>
<th>Vol %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A and E (Inc Front End)</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Daycase</td>
<td>-10%</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>-4%</td>
<td></td>
</tr>
<tr>
<td>Regular Day Attendees</td>
<td>-8%</td>
<td></td>
</tr>
</tbody>
</table>

#### Current Month

<table>
<thead>
<tr>
<th>Activity</th>
<th>Var %</th>
<th>Vol %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A and E (Inc Front End)</td>
<td>-31%</td>
<td></td>
</tr>
<tr>
<td>Daycase</td>
<td>-71%</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>-14%</td>
<td></td>
</tr>
<tr>
<td>Regular Day Attendees</td>
<td>-3%</td>
<td></td>
</tr>
</tbody>
</table>

#### Forecast Outturn

<table>
<thead>
<tr>
<th>Activity</th>
<th>Var %</th>
<th>Vol %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A and E (Inc Front End)</td>
<td>-45%</td>
<td></td>
</tr>
<tr>
<td>Daycase</td>
<td>-4%</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>-2%</td>
<td></td>
</tr>
<tr>
<td>Regular Day Attendees</td>
<td>-1%</td>
<td></td>
</tr>
</tbody>
</table>

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### Commentary

The above position is sourced from the UHNM SLAM which has had the Spec Comm IR applied correctly for the YTD month 9 reporting. The YTD and Current Month positions include the MRET plan value, the FOT section excludes the MRET plan value and includes a figure based upon FOT calculations.

Data Queries

- MRET
- T&O Coding & Counting
- A&E Front of House
- Drugs Query
- Daycase to Regular Day
- Daycase to OP Procedure
- Days Query
- A&E Front of House
- & T&C Coding & Counting

Penalties

- MRET
- Data Queries

**Total UHNM Position**

- 262,585 697,670,262

**Adjustment to SLAM**

- 22,085 21,714 -371 -3% 284,464 -7,081 -3% 199,049,878 -2,792,635 -3%

---

**Total UHNM Position**

- 262,585 697,670,262

**Adjustment to SLAM**

- 22,085 21,714 -371 -3% 284,464 -7,081 -3% 199,049,878 -2,792,635 -3%

---

### University Hospitals of North Midlands Contract Summary

#### Finance Variance to Budget:

- **Var** to **Budget**:
  - £31,466
  - £240,839
  - £1,870,275

#### Actual vs. Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Var %</th>
<th>Vol %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A and E (Inc Front End)</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>Daycase</td>
<td>-10%</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>-4%</td>
<td></td>
</tr>
<tr>
<td>Regular Day Attendees</td>
<td>-8%</td>
<td></td>
</tr>
</tbody>
</table>

#### Current Month

<table>
<thead>
<tr>
<th>Activity</th>
<th>Var %</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A and E (Inc Front End)</td>
<td>-31%</td>
<td></td>
</tr>
<tr>
<td>Daycase</td>
<td>-71%</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>-14%</td>
<td></td>
</tr>
<tr>
<td>Regular Day Attendees</td>
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</table>

#### Forecast Outturn

<table>
<thead>
<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>A and E (Inc Front End)</td>
<td>-45%</td>
<td></td>
</tr>
<tr>
<td>Daycase</td>
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<tr>
<td>Regular Day Attendees</td>
<td>-1%</td>
<td></td>
</tr>
</tbody>
</table>

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### Commentary

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The Forecast Outturn section includes the Adjustments to SLAM (that are shown above) as part of the overall calculation that is why they are not shown within the FOT section.

The YTD and Current Month positions include the MRET plan value, the FOT section excludes the MRET plan value and includes a figure based upon FOT calculations.

**Total UHNM Position**

- 262,585 697,670,262

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- 262,585 697,670,262

**Adjustment to SLAM**

- 22,085 21,714 -371 -3% 284,464 -7,081 -3% 199,049,878 -2,792,635 -3%
Staffordshire Stoke on Trent Partnership Trust Contract Summary - NORTH STAFFORDSHIRE CCG

Finance Variance to Budget:

- **Year to Date:** 0.11%
- **Forecast:** 0.34%

**Commissioner:** NHS North Staffordshire CCG  
**Data:** SLAM  
**Month:** Dec-15  
**Include Adjustments:** As Listed

<table>
<thead>
<tr>
<th>NHS North Staffordshire CCG</th>
<th>Annual Plan £</th>
<th>YTD Plan £</th>
<th>YTD Actual £</th>
<th>YTD Variance £</th>
<th>Total Forecast Contract Value 2015/16 £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haywood PBR Tariff Based Services</td>
<td>£1,730,146</td>
<td>£1,297,608</td>
<td>£1,345,484</td>
<td>£47,876</td>
<td>£1,793,834</td>
</tr>
<tr>
<td>Hospital Services - Non Tariff Based</td>
<td>£635,146</td>
<td>£476,361</td>
<td>£532,669</td>
<td>£56,308</td>
<td>£710,193</td>
</tr>
<tr>
<td><strong>Total - Specialised Services</strong></td>
<td><strong>£2,365,292</strong></td>
<td><strong>£1,773,969</strong></td>
<td><strong>£1,878,153</strong></td>
<td><strong>£104,184</strong></td>
<td><strong>£2,504,027</strong></td>
</tr>
<tr>
<td>Childrens Services - North</td>
<td>£2,200</td>
<td>£1,650</td>
<td>£2,252</td>
<td>£602</td>
<td>£3,028</td>
</tr>
<tr>
<td>Community Services - North</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Community Services - South Staffs</td>
<td>£16,480</td>
<td>£12,361</td>
<td>£12,911</td>
<td>£550</td>
<td>£17,349</td>
</tr>
<tr>
<td><strong>Total - All SSOTP Services</strong></td>
<td><strong>£2,383,972</strong></td>
<td><strong>£1,787,980</strong></td>
<td><strong>£1,893,316</strong></td>
<td><strong>£105,336</strong></td>
<td><strong>£2,524,404</strong></td>
</tr>
<tr>
<td>Pass Through Costs - High Cost Drugs - Rheumatology [Anti TNF]</td>
<td>£1,370,013</td>
<td>£1,027,510</td>
<td>£1,215,461</td>
<td>£187,951</td>
<td>£1,370,013</td>
</tr>
<tr>
<td>Pass Through Costs - High Cost Drugs - Other</td>
<td>£0</td>
<td>£0</td>
<td>£43,228</td>
<td>£43,228</td>
<td>£0</td>
</tr>
<tr>
<td>Pass Through Costs - High Cost Drugs - Botox</td>
<td>£27,242</td>
<td>£20,432</td>
<td>£23,053</td>
<td>£2,621</td>
<td>£27,242</td>
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<tr>
<td>Pass Through Costs - Limb Fitting</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total including Pass Through Costs</strong></td>
<td><strong>£3,781,227</strong></td>
<td><strong>£2,835,922</strong></td>
<td><strong>£3,175,059</strong></td>
<td><strong>£339,137</strong></td>
<td><strong>£3,921,659</strong></td>
</tr>
<tr>
<td>Shadow Cost &amp; Volume and Block</td>
<td>£36,070,433</td>
<td>£27,052,825</td>
<td>£27,052,825</td>
<td>£0</td>
<td>£36,070,433</td>
</tr>
<tr>
<td>CQUIN</td>
<td>£959,562</td>
<td>£719,672</td>
<td>£719,672</td>
<td>£0</td>
<td>£959,562</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>£40,811,222</strong></td>
<td><strong>£30,608,419</strong></td>
<td><strong>£30,947,555</strong></td>
<td><strong>£339,137</strong></td>
<td><strong>£40,951,655</strong></td>
</tr>
</tbody>
</table>

**Indicative FOT Variance** | £140,433

**Commentary:**

**Quality**

The Clinical Quality Review Meeting (CQRM) held on 25th January identified key quality and safety matters reported by the provider as:

- An independent comprehensive quality inspection was conducted week commencing the 3rd November 2015. A verbal update was received from SSOTP and the formal report is expected during this month, February 2016.

- Community Hospitals safe staffing has been maintained during October/November 2015 across the community hospital in-patient wards. Fill rate for registered nurses has increased by 2% to 98.1%; care worker fill rate remains unchanged at 101.3%.

- There were no patient safety incidents, during the month, as a result of staffing issues.

- Workforce KPI’s continues to be under trajectory however a steady increase in improvement can be seen in most indicators.

- Pressure ulcers. Compared to this time last year there were eighteen. There have been no hospital acquired/attributable grade 3 & 4 pressure ulcers between Feb14 and Nov15.

- An announced visit was carried out by the CCG Quality Team during December 2015 to the inpatient wards at Bradwell Hospital; there were no concerns requiring escalation at the time of the visit.

- Sepsis Q3 CQUIN - Re-submission being reviewed by Quality team. All other CQUINS met.

**Contract**

Month 8/9 report highlighted over-performance in Rheumatology for North Staffs and Stoke this impact was noted by the CCGs. Over performance in Rheumatology Drug Monitoring, Pass Thru and HCD Rheumatology Anti TNF has been identified as having a continued negative impact. Over performance in Intermediate Care readmission rate referrals and End of Life Percentage of patients who achieved their preferred place of death has also been identified which is being further investigated with respective Joint Investigation Teams.

Enclosure 12 - Integrated Performance Report
## Nuffield North Staffs Contract Summary

### Finance Variance to Budget:
- **Year to Date:** 17.01%
- **Current Month:** 17.01%
- **Forecast:** 17.01%

**Commissioner:** NHS NORTH STAFFORDSHIRE CCG  
**Provider:** Nuffield North Staffs

#### Under budget:
- **Commissioner:** NHS NORTH STAFFORDSHIRE CCG  
- **Provider:** Nuffield North Staffs

#### On budget:
- **Month:** Data  
- **SLAM**

#### Over budget:
- **As Listed**

### Activity Plan

<table>
<thead>
<tr>
<th>Point of Delivery</th>
<th>SLA</th>
<th>Activity</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daycase</td>
<td>680</td>
<td>510</td>
<td>£834,602</td>
</tr>
<tr>
<td>Elective</td>
<td>262</td>
<td>196</td>
<td>£1,081,246</td>
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<tr>
<td>Outpatient 1st</td>
<td>1,075</td>
<td>807</td>
<td>£147,297</td>
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<tr>
<td>Outpatient Follow Up</td>
<td>2,469</td>
<td>1,851</td>
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<tr>
<td>Radiology</td>
<td>227</td>
<td>170</td>
<td>£24,658</td>
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</table>

### Year to Date

<table>
<thead>
<tr>
<th>Activity</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>Actual</td>
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<tr>
<td>Plan</td>
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</tr>
<tr>
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<table>
<thead>
<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>Plan</td>
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<tr>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>Plan</td>
<td>Actual</td>
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### Current Month (indicative)

<table>
<thead>
<tr>
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<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOT</td>
<td>Var</td>
</tr>
<tr>
<td>FOT</td>
<td>Var</td>
</tr>
</tbody>
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### Forecast Outline

<table>
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<tr>
<th>Activity</th>
<th>Finance</th>
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<tbody>
<tr>
<td>FOT</td>
<td>Var</td>
</tr>
<tr>
<td>FOT</td>
<td>Var</td>
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</table>

**Total Nuffield Position**

<table>
<thead>
<tr>
<th>SLA</th>
<th>activity</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,733</td>
<td>£2,294,782</td>
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</tr>
</tbody>
</table>

### Comments

The above position is sourced from the Nuffield Contract Monitor.  
The reporting is currently on a YTD basis only but the CSU are looking to access a breakdown by month.  

**Enclosure 12 - Integrated Performance Report**

**Exhibitory:**  
No performance issues identified from contract performance and quality dashboard.
AUTHOR

<table>
<thead>
<tr>
<th>Name</th>
<th>Gill Gardiner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Assistant CFO</td>
</tr>
</tbody>
</table>

REPORTING OFFICER

<table>
<thead>
<tr>
<th>Name</th>
<th>Iain Stoddart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Chief Finance Officer</td>
</tr>
</tbody>
</table>

REPORT TO

| Governing Body |

TITLE OF REPORT

| Month 10 Financial Position |

DATE OF THE MEETING

| 2nd March 2016 |

WHAT OTHER CCG COMMITTEE OR GROUP HAS CONSIDERED THIS REPORT?

| FRG 24th February 2016 Joint Finance and Performance Committee 24th February 2016 |

Record which groups/committee have already seen this report, the date and comments (for example agreed this report should go to the governing board for approval)

| Challenge on assumptions and risk scenarios. Challenge around QIPP delivery and mitigating actions to deliver to planned positions. Risks noted and ongoing assurance sought. |

ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD

| Approve | Assurance | Discussion | Information | x |

Members are asked to note:

1. The CCG’s cumulatively reported position for the year to Month 10 (January 2016) stands at £1.84m deficit albeit, indicating a marginal difference from the planned year to date position of £1.957m, there remains a significant challenge to close the current position to planned out-turn levels.

2. The CCG’s forecast outturn position which is held at the planned deficit of £2m in line with the control total.

3. The current and forecast performance against the original £7.66m QIPP programme levels together with risk scenarios highlighting the potential risk levels being managed that could impact on the out-turn performance.

4. The contract performance at University Hospitals North Midlands (UHNMI) and other provider performance.

5. A significant level of risk mitigation actions are being taken through the Financial Recovery Group regime, but the forecast surplus is held at plan on the basis of satisfactory agreement of final contract values with providers around performance and contract levers. Further actions are being taken through the internal turnaround regime to deliver against plan in line with the gross level of assessed risks.
STRATEGIC GOALS SUPPORTED BY THIS PAPER
(identify appropriate goals)

<table>
<thead>
<tr>
<th>Financial resources underpin delivery of all the strategic goals of the CCG</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase life expectancy and reduce inequality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Improve prevention, early detection &amp; effective management of those at increased risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Enhance quality of life and improve health outcomes for people with LTCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ensure people receive the right care in the right place</td>
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</tr>
</tbody>
</table>

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

The month 10 reported position is a £1.84m deficit. This is a marginal (£117k) improvement from the planned deficit of £1.957m 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 artificially high levels and that underperformance would arise naturally 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.

The above expectation has not proven to be true, as the broad acute performance is at a break even level.

The basis of the financial position is through receipt of activity and costs up to month 9 for acute data and to month 8 for prescribing data. These latest details are now built into Programme expenditures.

All contingencies have been applied in full (predominantly the 0.5% contingency of £1.359m and “headroom” of £2.133m, plus all sums in budget now assessed as contingent).

At this stage the overall CCG forecast is being held at £2m cumulative deficit at the year end. To achieve this position the CCG needs to:

- mitigate the current level of risk which also incorporates the recovery and delivery of the QIPP programme levels over the last 2 months of the financial year (delivery of £4.12m between February to March)
- Reach final year end agreements with our main providers (in particular UHNM) on a number of performance issues including activity forecasts, sanctions and application of contract levers.

SUMMARY OF RISKS RELATING TO THE PROPOSAL

The position is based on initial month 9 activity data from Providers which is now providing a more reliable indication of activity and its trends. To date this shows both activity and costs to be below plan at our main provider, but at the overall acute level the forecast is over performing. Forecasts assume that current trends continue; albeit profiled to planned demand assumptions.

At a summary level the overall underspend in the main Acute contract at UHNM is attributable to the higher level plan figures which are before offsetting for planned Step Up activity reductions and also partly can be offset against over performance in other out of area Acute contracts. A number of activity coding issues have now been agreed and actioned in the UHNM contract; relating to specialised commissioning. Refunds expected for activity charged incorrectly to the CCG have been almost matched by charges made incorrectly to NHS England. This has then impacted upon the activity forecasting going forward.

The CCG is currently working through contractual processes with UHNM regarding various remedial action plans that may impact on the financial position over the last two months of the financial year. For financial planning purposes it is assumed that any recovery trajectories are incremental, rather than a step change increased delivery.

Discussions are taking place with UHNM and other providers to reassess and agree expected year-end financial positions. These discussions will take into account all outstanding matters relating to system resilience claims, sanctions and contract levers applied and other matters including 18 week backlog.
clearance.

The CCG position is based on 8 months Prescribing data reflecting the pricing process for prescriptions which has a two months lead time for the production of cumulative expenditure. Forecasts based on the information received indicate spending above plan at the year end. Forecasting methods use comparisons of spending in previous years and take into account the expected delivery of QIPP schemes through the remainder of the year. It is expected that expenditure will continue to be above plan but growth in costs will be avoided by delivery of the Prescribing QIPP programme.

To achieve the planned deficit position of £2m the CCG must deliver the bulk of the QIPP programme at £7.08m. This includes the substitute schemes to recover slippage on the Step Up scheme; arising due to the delay in fulfilling the expected sign up value relating to the Step Up and Step Down contract variation. This has adversely impacted on QIPP delivery and assumptions around the level of risk materialising.

A number of other risks are 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 and the payment for over performance. 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.

The CCG has fully applied the 0.5% contingency of £1.359m and its headroom of £2.133m against its forecast out-turn position. The risk is that no further “contingent funds” are available over the final 2 months of the financial year to cover any over performance in contracts.

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

Whilst the CCGs forecast outturn position is estimated at £2m deficit the management of financial risks gives rise to 3 assessments - an upside (optimistic) case; a downside (pessimistic) case and a realistic case. The CCG realistic case indicates the risk exposure to be managed through year end settlements, QIPP delivery and other measures stands at £3.36m to ensure delivery of the £2m deficit planning target. Clearly if this does not materialise then the CCG would be in breach of its set planning target.

A downside (pessimistic) case would require an additional £2m of risks to resolved. Through the process of tight fiscal control and financial turnaround the CCG is looking to mitigate identified risks and deliver the realistic scenario.

In addition to financial issues outlined above, concern still remains regarding the delivery of constitutional targets, regardless of the direct application of commissioner investment to promote access and patient flow across the system.

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

Concern still remains regarding the delivery of constitutional targets, regardless of the direct application of commissioner investment to promote access and patient flow across the system.

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

None

**ACRONYMS**

Set out in the body of the report.
Month 10 Financial Position 2015/16

1. **Background**
   North Staffordshire Clinical Commissioning Group (CCG) is required to report achievement against its key financial duties and plans on both a monthly and annually. This report discusses the position to the end of January 2016 (Month 10 of financial year 2015-16).

2. **Executive Summary**
   
<table>
<thead>
<tr>
<th>High Level Targets &amp; RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong> Total Revenue Allocation notified - £274.399m</td>
</tr>
<tr>
<td><strong>R</strong> Programme Allocation notified - £269.704m</td>
</tr>
<tr>
<td><strong>G</strong> Running Cost Allocation notified - £4.695m</td>
</tr>
<tr>
<td><strong>G</strong> Capital Allocation notified - zero</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Risks to Financial Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prescribing expenditure above original plan</td>
</tr>
<tr>
<td>• Elective activity below plan</td>
</tr>
<tr>
<td>• Non elective activity below plan but case mix costs higher than expected and activity over plan for December</td>
</tr>
<tr>
<td>• Out of Area Placement costs above plan</td>
</tr>
<tr>
<td>• Seasonal Resilience schemes significantly over committed against funding allocated, with a number of disputed claims received</td>
</tr>
<tr>
<td>• RTT Backlog clearance</td>
</tr>
<tr>
<td>• QIPP delivery planned for Q4</td>
</tr>
<tr>
<td>• Step Down QIPP delivery of targeted savings - no evidence of savings in the first month of operation</td>
</tr>
<tr>
<td>• Year end agreement of final SLA values with major providers</td>
</tr>
<tr>
<td>• Fines and penalties available to the step down scheme.</td>
</tr>
<tr>
<td>• Other mitigations available to achieve the control total.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other Areas of Focus</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussions are taking place with providers to agree final contract values taking account of activity to date including sanctions and penalties for under performance and outstanding matters relating to system resilience and service transfers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Overall Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The control total remains at £2.0m based on expectations that contract settlements with providers will deliver reduced expenditure following application of contract levers and sanctions.</td>
</tr>
</tbody>
</table>

3. **Financial Duties and Plans 2015-16**
   In 2015-16, the Income & Expenditure plans of the CCG are to:
   - Deliver a £3.3m in year and £2m cumulative deficit against allocated Revenue Resource Limit (RRL) [Against a mandated planning requirement of 1% surplus]
   - Contain expenditure within an overall cash limit
   - Contain expenditure within the Running Cost target of £21.80 per head of population
   - Deliver a QIPP of £7.66m

   Throughout the financial year the CCG has reported on its achievement against meeting its key financial duties and delivery against its financial plans.
A summary of financial performance is shown below:

<table>
<thead>
<tr>
<th>Description of financial duties</th>
<th>YTD</th>
<th>Forecast</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain expenditure within the revenue resource limit and deliver to a planned surplus (normally 1%)</td>
<td></td>
<td></td>
<td>The CCG is just ahead of its forecast deficit target to the end of Month 10. By setting a deficit plan the CCG is in breach of its statutory duties.</td>
</tr>
<tr>
<td>Maintain expenditure within a Maximum Cash Draw down Limit (cash limit).</td>
<td></td>
<td></td>
<td>The CCG has drawn down £199.718m to date with BSA requirements of £29.327m giving total cash requirement of £229.045m. This is behind the overall financial planning for 2015/16 primarily due to delays in payments to the Local Authority</td>
</tr>
<tr>
<td>Maintain capital expenditure within the delegated limit from the Area Team.</td>
<td></td>
<td></td>
<td>Nil allocation to the CCG. Capital expenditure is anticipated for GP IT and the CCG has planned commitments against this expenditure area. The CCG will recharge NHS England Area Team for these capital items which will be held on the NHS England balance sheet.</td>
</tr>
<tr>
<td>Ensure running costs are within the set allocation per head of population.</td>
<td></td>
<td></td>
<td>The CCG has an allocation of £4.695m for running costs. At Month 10, the running costs position was on plan.</td>
</tr>
<tr>
<td>Ensure a minimum of 0.5% contingency is held.</td>
<td></td>
<td></td>
<td>The CCG has 0.5% contingency within the financial plan this is expected to be fully utilised within the forecast positions reported at Month 10.</td>
</tr>
<tr>
<td>Ensure that 1% of funds are spent Non Recurrently on approved projects.</td>
<td></td>
<td></td>
<td>The CCG will utilise this fund against Risks identified against the Better Care Fund, clearance of Continuing Healthcare retrospective claims and additional pressure from Seasonal Resilience spending.</td>
</tr>
<tr>
<td>Delivery of QIPP targets</td>
<td></td>
<td></td>
<td>The original estimated QIPP plan totalled £7.66m. Delivery is off track year to date, and there is no evidence of delivery in the first month of the Step Up/Down arrangements</td>
</tr>
<tr>
<td>Ensure compliance with the Better Payment Practice Code (BPPC) – “Late Payment of Commercial Debt”</td>
<td></td>
<td></td>
<td>The CCG delivered 92.9% in 30 days against the number of NHS and 94.3% against non NHS invoices.</td>
</tr>
</tbody>
</table>

**Maintain expenditure within the resources allocated and deliver of planned deficit.**  
At the end of month 10 the CCG Financial Plan baseline resource level stood at £274.399m. This is built up of £269.704 for Programme expenditure and £4.695m allocation to meet Running costs. Within these figures is the non-recurrent return of prior year surplus at £1.326m and other non-recurrent allocations for items such as GPIT.

**Maintain expenditure within a maximum cash drawdown limit**  
The CCG manages cash flow on a monthly basis and draws down cash directly via NHS England. Net cash holding at the end of the month is within the 1.25% tolerance level. Payments are behind original plans due to some deferred remittances, but are expected to remain within planning parameters at the year end.

**Ensure running costs are contained within the allocated £21.80 per head of population**  
Running Cost allocation is £4.695m for the financial year against a population of 215,386. To date, running cost expenditure is within that planned value.

**Deliver QIPP savings targets.**  
QIPP saving schemes of £7.66m are planned for this financial year. These are a combination of transactional schemes and transformational schemes. Transactional schemes broadly fall in the first part of the financial year and transformational in the second part of the year. There has been concern expressed over several months regarding the high value phasing of schemes in the latter part of the year, especially where investment decisions are critically interlinked eg...
Step Up/Step Down. There is expected to be slippage on delivery, but with attendant response to mitigating financial risk and delivery of financial control totals.

**Ensure compliance with the Better Payment Practice Code (BPPC)**
The CCG is expected to comply with the Confederation of British Industry (CBI) Prompt Payment Code. This requires the CCG to pay 95% of valid invoices within 30 days of receipt. CCG performance up to 31st January stood at 92.9% based on count for NHS payables (95.4% by value), a deterioration on the December position. For non NHS payables the position was 94.3% based on count (87.3% by value), an improvement on the value measure from the previous month.

The CCG continues to press for improved compliance with the better payment practice code and has during the course of the year introduced a “Controlled Environment for Finance” which supports the controlled access to data allowing invoices to be paid more promptly. Further internal actions are on-going to press for a higher percentage of BPPC compliance.

4. **Position to Date**
The CCG key financial duties were achieved in the cumulative position to January 2016 (Month 10). Appendix 1 highlights a summary table of performance against the range of budget headings and financial performance, together with more granular narrative at Appendix 2. The financial position as at the end of January (Month 10) shows a cumulative overspend of £1.84m which is within the profiled target level for the CCG’s planned deficit at this point in the year. This has resulted in the achievement of financial duties against plan, but not against the NHSE planning rules, which require delivery of surplus.

The financial position set out within this report is based on external information provided to the CCG, e.g. acute activity initial month 9 data and Prescribing data for month 8 and also against a range of assumptions in compiling the position.

The Continuing Healthcare year end position is reflective of the forecast expenditure levels via the Commissioning Support Unit as at January 2016.

5. **Contractual Performance of Providers/Budgetary Performance**
Initial month 9 data received from **University Hospitals North Midlands NHS Trust (UHNM)** indicates that at the end of December, activity and costs are below contracted levels and would generate an underspending of £1.016m against plan. This data is subject to continuous validation processes relating to data queries, penalties and triggering of the Marginal Rate Emergency Threshold. After taking into account the likely outcome of these adjustments the forecast for this contract is an underspending of £2.576m. In order to deliver the Step up and Step Down Financial Recovery Plan (FRP) schemes, it is assumed that contractual fines, forecast at £1.0m will be reinvested in the delivery model for Step Down in 2015/16.

Monthly reporting data to the end of December has been received from **West Midlands Ambulance Trust** and this also indicates activity up to December to be under plan which is forecast to the year end as £133k under plan.

The CCG is now in receipt of SLAM reporting information for **out of area Acute contracts** with NHS and Private providers these are indicating year to date activity to be above plan by £1.654k with the forecast year end position being £2.150m above plan. Significant overspending is evident in contracts with Trusts in Cheshire and overspending in the majority of other contracts. Further work is required to fully understand the reasons for the year to date over performance and the forecasting methodology to determine to what extent this might be influenced by activity to clear 18 week backlogs and any link with activity at UHN or clear market share shifts.
The CCG has now received reporting information up to month 8 for **Prescribing** which indicates expenditure to be above plan. The forecast is that expenditure will continue to be at levels above plan but delivery of the QIPP programme savings in full would limit the forecast overspend to around £1.1m. Further information received at the time of this report for month 9 indicates a deterioration the forecast position – the details received are subject to analysis prior to being included in the financial position, however the data is suggesting additional forecast overspending of around £0.5m.

**Continuing Care** information has now been received for expenditure up to December which indicates that costs are currently under plan. This includes the transfer of £1.301m to NHS England national risk pools relating to the payment of retrospective claims for pre-April 2013 claims. Monitoring reports indicate that the Continuing Healthcare QIPP programme over achieved its November savings target, and based on current trends, which now include expenditure on personal health packages, expenditure would be £0.725m under plan at year end.

The CCG has continued to see a rise in the costs relating to a number of individual patients being placed in out of area settings with either other NHS or Private sector providers mainly relating to **Mental Health cases**. At month 10 the cumulative costs are £946k above plan, and they are forecast to be £1.111m above plan at year end taking into account the proposed QIPP scheme delivery.

6. **Quality, Innovation, Productivity and Prevention (QIPP)**

The final Financial Plan detailed a required QIPP programme of £7.6m net of investment (£8m gross) which is equivalent to 2.8% of the resource allocation.

The QIPP programme has a phased delivery with several of the larger schemes scheduled to deliver in the latter part of the year. The table below highlights the key assumptions being made in the month 10 report against the areas of focus for the 2015/16 QIPP programme.

<table>
<thead>
<tr>
<th>North Staffs</th>
<th>Annual Plan £000</th>
<th>Plan at Month 10 £000</th>
<th>Actual Delivered £000</th>
<th>Forecast £000</th>
<th>Year to date Variance £000</th>
<th>Forecast Variance £000</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step Up</td>
<td>2.99</td>
<td>1.99</td>
<td>0.00</td>
<td>1.50</td>
<td>-1.49</td>
<td>-1.50</td>
<td>Savings not yet evidenced since implementation on 1st December</td>
</tr>
<tr>
<td>Planned Care</td>
<td>1.00</td>
<td>0.83</td>
<td>0.83</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00</td>
<td>Delivery rephased from October</td>
</tr>
<tr>
<td>Emergency Activity</td>
<td>0.65</td>
<td>0.45</td>
<td>0.76</td>
<td>1.37</td>
<td>0.31</td>
<td>0.72</td>
<td>HM3 unplanned care under plan local data collected re schemes per FRG</td>
</tr>
<tr>
<td>Other Acute</td>
<td>0.09</td>
<td>0.04</td>
<td>0.04</td>
<td>0.06</td>
<td>0.00</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Mental health OOA</td>
<td>0.23</td>
<td>0.21</td>
<td>0.07</td>
<td>0.10</td>
<td>-0.14</td>
<td>-0.12</td>
<td>Savings rephased per workbook scheme being signed off by CCG</td>
</tr>
<tr>
<td>Other Programme Services</td>
<td>0.00</td>
<td>0.00</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
<td>0.11</td>
<td>£111 procurement</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step Down</td>
<td>0.59</td>
<td>0.39</td>
<td>0.00</td>
<td>0.59</td>
<td>-0.39</td>
<td>0.00</td>
<td>Delivery of savings planned from October, CV to be agreed in final settlement</td>
</tr>
<tr>
<td>Pathways</td>
<td>0.51</td>
<td>0.46</td>
<td>0.10</td>
<td>0.12</td>
<td>-0.34</td>
<td>-0.41</td>
<td>Delivery of savings planned from October</td>
</tr>
<tr>
<td>Other Community</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Continuing Care</td>
<td>0.76</td>
<td>0.66</td>
<td>1.01</td>
<td>1.53</td>
<td>0.35</td>
<td>0.74</td>
<td>April over delivered re profile</td>
</tr>
<tr>
<td>Prescribing</td>
<td>0.76</td>
<td>0.63</td>
<td>0.63</td>
<td>0.71</td>
<td>0.00</td>
<td>-0.05</td>
<td>Proposed re profile of delivery from Meds Opt</td>
</tr>
<tr>
<td>Total</td>
<td>7.66</td>
<td>5.66</td>
<td>3.54</td>
<td>7.08</td>
<td>-2.22</td>
<td>-0.59</td>
<td></td>
</tr>
</tbody>
</table>

The Month 9 savings target was £5.66m and actual reported delivery was £3.54m (37%), £2m under plan. A significant proportion of the savings relies on achievement of the Step Up/Step Down intermediate care plans – the scheme was delayed in its implementation until 1st December and the expected reduction in non-elective activity is not yet evidenced. Evidence of achievement is anticipated in the forecast outturn in the final three months of the year, although it is unlikely that the scheme will recover the savings expected in plans from October to December.
The ongoing monitoring and assurance of the programme takes place through the Finance Recovery Group (FRG) which continues to meet on a fortnightly basis and is in the process of refocussing its approach and priorities.

A further 2 schemes are now unlikely to deliver the planned levels of savings i.e. Physiotherapy and Mental Health. In order to mitigate these reduced savings, further plan B schemes have been identified to partially mitigate the schemes. The forecast plan is now valued at £7.08m with a balance of £3.54 to be delivered in the final quarter.

7. Audit Assurance

The CCG finance department will continue to work with Internal Audit to undertake assurance around various aspects of the CCG financials to provide audit opinion regarding accuracy of monthly accounts. In addition where further assurance work is required then this continues to be sourced as appropriate; predominantly from Internal Audit.

8. Strategic Support

The CCG was required to set aside 1% of its baseline recurrent allocation to be used each year on a non-recurrent expenditure basis, this equates to £2.7m.

This has been applied as Strategic Support to fund:

- Follow Up Backlog at UHN £600k
- Risk Reserve for Better Care Fund £800k
- Provider over performance £580k
- Accelerated clearance of Continuing Healthcare Retrospective claims £500k
- Minor Schemes £250k – Finance Recovery project management and Capacity and Demand modelling.

9. Balance Sheet

The CCG Statement of Financial Position as at 31st January 2016 shows the level of indebtedness between the CCG and other parties (mainly NHS providers). Significant entries include:

- Accounts Receivable £11.4m.
- Accounts Payable £18.5m including agreed claims with NHS bodies
- Cash £97k - this level of cash ensured the CCG delivered its obligations in relation to cash.
- Provisions £0.6m – provisions created relating retrospective continuing healthcare claims

<table>
<thead>
<tr>
<th>Statement of Financial Position</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Current Assets</td>
<td>0</td>
</tr>
<tr>
<td>Cash</td>
<td>97,346</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>11,356,449</td>
</tr>
<tr>
<td>Current Assets</td>
<td>11,453,795</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>11,453,795</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>18,451,621</td>
</tr>
<tr>
<td>Accrued Liabilities</td>
<td>641,374</td>
</tr>
<tr>
<td>Current Liabilities</td>
<td>19,092,995</td>
</tr>
<tr>
<td>Long Term Liabilities</td>
<td>0</td>
</tr>
<tr>
<td>Retained Earnings incl. In Year</td>
<td>(7,639,200)</td>
</tr>
<tr>
<td>Total Taxpayers Equity</td>
<td>(7,639,200)</td>
</tr>
<tr>
<td>TOTAL EQUITY + LIABILITIES</td>
<td>11,453,795</td>
</tr>
</tbody>
</table>
The CCG is required to agree and confirm the amounts payable and receivable with other NHS bodies as part of an NHS inter-indebtedness reconciliation process. This process is undertaken twice per year; once at December and then again at year end. This is undertaken across the NHS and includes values of those claims for payment which are disputed. Through the process the CCG has reported a number of disputed claims relating to systems resilience from UHNM and SSOTP totalling around £4.05m of the £5.6m disputed. The disputes are being worked through as part of year end settlements of final sums due under contracts and other expenditure.

<table>
<thead>
<tr>
<th>North Staffordshire CCG</th>
<th>Payables £000</th>
<th>Receivables £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Notified</td>
<td>Accrued</td>
</tr>
<tr>
<td>NHS STOKE ON TRENT CCG</td>
<td>2,863</td>
<td>-4</td>
</tr>
<tr>
<td>East Cheshire NHS Trust</td>
<td>678</td>
<td>217</td>
</tr>
<tr>
<td>Staffordshire &amp; Stoke on Trent Partnership NHS Trust</td>
<td>3,509</td>
<td>-642</td>
</tr>
<tr>
<td>University Hospitals of North Midlands NHS Trust</td>
<td>4,877</td>
<td>437</td>
</tr>
<tr>
<td>Others</td>
<td>1,527</td>
<td>1,623</td>
</tr>
<tr>
<td>Grand Total</td>
<td>13,454</td>
<td>1,631</td>
</tr>
</tbody>
</table>

NB: North Staffordshire CCG is the lead on systems resilience, initially the disputed invoices are within its payables totals.

10. Cash flow

The updated CCG plan for 2015/16 is £276.359m of cash for the period April to March including the requirements notified from the Business Services Authority. At the start of the year UHNM was advanced its March 2016 contract payment, resulting in the cash profile for the CCG being front loaded. This is consistent with the approach taken in previous years, but is not considered an "industry norm".

11. Main Risks

The CCG set a QIPP programme for 2015/16 of £7.66m (net) with the majority of the savings profiled to be achieved in the latter part of the year with a high percentage of the plan to be achieved through planned care changes and reduced non-elective activity following implementation of the step down intermediate care plans. Performance to month 10 is behind trajectory and the reduction in emergency admissions is not yet evident in the first month of operating the new arrangements. The QIPP programme continues to be monitored bi-weekly through the Finance Recovery Group, and a number of additional schemes are in development to deliver additional savings in year. Given recent challenges in QIPP delivery the CCG has moved towards strengthening its delivery through the appointment of a Turnaround Director.

Systems resilience planning is giving rise to potential expenditure pressures significantly above planned budget levels, and in addition there are a number of claims for payment from providers which have been disputed. This has the potential to increase the risk to the CCGs planned financial position and achievement of the control total. These issues are currently being worked through with the Systems Resilience Group and its individual member organisations.

Key Areas of Focus and Commissioning Implications

Tight fiscal control was undertaken to deliver Commissioning plans within budgetary allocations in the CCG’s last financial year. Prioritisation on spending plans is again necessary and Commissioning and Finance will work together to deliver the commissioning intentions within the available financial envelope. Part of the strategy objectives, are to review all aspects of commissioning to ensure value for money and achievement of the CCG’s financial targets both this year and in the future. The work of the Project Management Office is essential to this strategy.

12. Risk scenarios
The CCG has worked up 3 high level risk scenarios that stem from a base position as per the current forecast.

On an **upside (optimistic)** basis the level of budgetary pressures and risks to be mitigated is £1.2m. If this position is achieved the control total will be held or slightly improved. Significant improvement on the control total deficit is considered unlikely.

On a **downside (pessimistic)** basis the level of budgetary pressures and risks to be mitigated is £5.37m. Should the risks materialise, and steps taken to mitigate not cover these risks then the control total would be exceeded by this value. This assumes no further QIPP delivery arises. In this circumstance the year end position would decline to a £7.37m deficit at year end; a worsening of position from plan by £5.37m. The CCG cannot afford for any further deterioration of its financial position and practically this situation is unlikely to arise in full.

On a **realistic** basis the level of budgetary pressures and risks to be mitigated stands at £3.36m. These remain to be achieved by negotiated settlement of the two main provider contracts involved with transformation of step up and step down intermediate care and system resilience activities, and in agreeing performance issues.

**Recommendation**
The Governing Body is asked to note the contents of this report and executive summary regarding CCG performance against 2015-16 financial duties at the end of Month 10 of the financial year. In addition, the Governing Body is requested to note the risks to the 2015-16 financial plans and to support the actions being taken through the PMO to redress the financial shortfall against plans.
Appendix 1

Month 10 2015/16 and Forecast Outturn Financial Summary

<table>
<thead>
<tr>
<th>North Staffs CCG</th>
<th>CCG Current Performance</th>
<th>CCG Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YTD budget £000</td>
<td>YTD Actual £000</td>
</tr>
<tr>
<td>Acute</td>
<td>104,232</td>
<td>104,169</td>
</tr>
<tr>
<td>Mental Health</td>
<td>22,365</td>
<td>23,503</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>18,422</td>
<td>17,646</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>35,963</td>
<td>36,271</td>
</tr>
<tr>
<td>Primary Care</td>
<td>34,348</td>
<td>35,753</td>
</tr>
<tr>
<td>Other</td>
<td>7,662</td>
<td>7,667</td>
</tr>
<tr>
<td>TOTAL PROGRAMME</td>
<td>222,992</td>
<td>225,009</td>
</tr>
<tr>
<td>Running Costs</td>
<td>3,912</td>
<td>3,912</td>
</tr>
<tr>
<td>Reserves (Incl Contingency)</td>
<td>2,601</td>
<td>467</td>
</tr>
<tr>
<td>TOTAL SPEND</td>
<td>229,593</td>
<td>229,388</td>
</tr>
<tr>
<td>Surplus</td>
<td>-1,957</td>
<td>0</td>
</tr>
<tr>
<td>Total Locality</td>
<td>227,548</td>
<td>229,388</td>
</tr>
</tbody>
</table>

CCG Underlying position

<table>
<thead>
<tr>
<th>North Staffs CCG</th>
<th>£’m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resource</strong></td>
<td></td>
</tr>
<tr>
<td>Programme Allocation (month 9)</td>
<td>270.03</td>
</tr>
<tr>
<td>Running Costs Allocation</td>
<td>4.695</td>
</tr>
<tr>
<td>less non rec surplus return</td>
<td>-1.326</td>
</tr>
<tr>
<td>Less additional non rec allocation</td>
<td>-1.462</td>
</tr>
<tr>
<td>Total Recurrent Allocation</td>
<td>271.937</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Programme Spend</td>
<td>270.664</td>
</tr>
<tr>
<td>Contingency</td>
<td>1.366</td>
</tr>
<tr>
<td>Running Costs Spend</td>
<td>4.695</td>
</tr>
<tr>
<td>less non recurrent spend (1%)</td>
<td>-2.718</td>
</tr>
<tr>
<td>less non recurrent spend (CHC Topslice)</td>
<td>-1.301</td>
</tr>
<tr>
<td>less non recurrent spend (BCF Top Up)</td>
<td>-1.347</td>
</tr>
<tr>
<td>less non recurrent spend (Other)</td>
<td>-1.462</td>
</tr>
<tr>
<td>Total Recurrent Spend</td>
<td>269.897</td>
</tr>
<tr>
<td><strong>Underlying position</strong></td>
<td>2.04</td>
</tr>
</tbody>
</table>

In line with NHS England guidance the CCG is also reporting an underlying surplus position of £2.04m (0.75%) when removing non recurrent resource allocation and spend.
1. Contract Performance

University Hospital of North Midlands (UHNM)

The agreed contract value for UHNM stands at £97.87m following the protracted negotiation round earlier in 2015 and as a result of a contract variation relating to additional A&E activity signed off as part of the final plan approved by NHS England in May. The contract was set on a full Payment by Results (PbR) cost and volume basis where any activity carried out was paid for at tariff and the full National contract rules are applied.

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<th>Summary by Point of Delivery</th>
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<td><strong>Point of Delivery</strong></td>
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<td><strong>Outpatient First</strong></td>
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<td><strong>Non FCE</strong></td>
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<td><strong>SLAM Total</strong></td>
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At the time of finalising the Month 10 financial position the CCG was in receipt of the initial month 9 Service Level Agreement Monitoring (SLAM) information, this is shown within the table above and indicates activity levels across most Points of Delivery to be in line or below plan year to date. Month 9 saw a decrease in the planned care activity and outpatient procedures, and an increase in emergency activity. The SLAM report highlights under-performance at £1.016m at month 9 before data challenges, penalties and other contractual adjustments are applied.

Key variations for month 9
- A&E attendances 898 below plan (3%) and £129k under (4%)
- Elective / Daycases 365 below plan (2.2%) and £1.019m under (6.5%)
- Non Elective admissions 80 below plan (2%) and £134k under (1%)
- Out Patient First appointments 3644 below plan (9%) and £388k under (8%)
- Out Patient Follow Up appointments 2719 below plan (4%) and £25k under (1%)

Significant validation work continues on a monthly basis following receipt of the activity data. A number of coding issues have been worked through with UHNM relating to specialised commissioning,
and refunds expected for activity charged incorrectly to the CCG have been almost matched by charges made incorrectly to NHS England. The validation work also includes performance against contract penalties and the Marginal Rate Emergency tariff and consequences of failure would then be applied. Transfers of funding relating to the Step Down model and Planned Care initiatives have been transacted with the Trust. Around £1m of the Step Down scheme is funded from penalties levied for under-performance on targets. These QIPP schemes are intended to reduce activity and costs within the UHN contract, although in the areas of emergency activity this is not evidenced in the month 9 data.

The CCG is also working through a contractual process with UHN relating to clearance of the RTT backlog and the impact this will have on activity and costs; the current assumption is that activity and costs will return closer to planned levels for the coming months resulting in a forecast underspend of £2.576m at year end.

The CCG also spends £0.5m with UHN on services outside of the main acute contract at month 10 these are at planned levels.

Staffordshire and Stoke on Trent Partnership Trust (SSOTP)

The contract value for SSOTP is £39.43m. The contract operates predominantly on a block basis with cost and volume arrangements relating to PbR activity for Rheumatology and Anti-TNF drugs costs. The budget has been reduced by £0.435m to take account of the transfer of long term conditions management to UHN. The CCG is finalising the contract value reduction relating to the transfer of Step Down intermediate care which will see a further £1.35m being reduced from the block value of the contract.

Monitoring information for month 9 has been received from SSOTP with indications of overspending in cost and volume activities in rheumatology blood monitoring and administering of anti-TNF drugs. The forecast position is currently an overspending of £0.227m.

Combined Healthcare (CHC)

The contract value with CHC now stands at £22.35m and operates on a ‘block contract’ basis. Additional investments relating to the transformation of CAMHS services have now been included in the contract. Work continues with Combined Healthcare to deliver activity reporting on a ‘Cluster’ basis. Month 9 and forecast positions both reflect spend at planned levels.

West Midlands Ambulance (WMAS)

The contract value with WMAS for the Emergency Ambulance service is £6.27m. This operates predominantly on a cost and volume tariff basis; each Ambulance journey has a cost of £162. Some elements of the contract reflect wider West Midlands programmes which are funded on a block basis. At the time of finalising the month 10 position activity reporting up to the end of December has been received from the Provider, this indicates activity to be 716 journeys below plan (2.2%) this has been built in at month 10 as £116k below planned expenditure levels and forecast to year end as £133k under plan.

2. Other CCG Spend

Continuing Healthcare

The CCG has an annual budget for Continuing Care and Funded Nursing Care of £21.8m; this budget also covers the CSU costs relating to the assessment and nursing team. Monitoring information received at the end of January records expenditure below plan.
The CCG received written notification from NHS England that it will again be expected to contribute to a National risk pool relating to the payment in year of retrospective continuing healthcare claims, this equates to £1.3m for the CCG, this spend is now being accommodated within the planned budget.

As part of the 2014/15 Finance Recovery Plan the CCG approved a business case supplied by the CSU that through increased clinical and administrative support would result in reduced spend. This would be achieved through regular up to date case reviews and workload processing for 2015/16. The anticipated QIPP saving in the plan was £790k. The month 10 details received to date indicate savings will be significantly above target and a revised savings forecast is now included in the plan at £1.53m.

The reported month 10 position is an underspending of £0.776k. After taking account of personal health packages now built into forecasts, expenditure is now expected to be £0.725m under plan at the year end.

**Prescribing**

When compiling the month 10 report national Prescribing data up to the end of month 8 has been received for 2015/16. This indicates that to the end of November spend was £1.360m above plan. There has been evidence in recent forecasts that the growth in spending maybe levelling as a result of the full year increases in category M prices in October 2014 having been fully processed, however, at the time of writing, the December data has been received which indicates a significant increase in forecast. The latest details are subject to further analysis and challenge, but initially the data points to a further increase in overspending at the year end of around £0.5m. The assumption made in this report is that the forecast spend will continue at current levels with a forecast of £1.170m, but which could rise to £1.7m based on the as yet unanalysed data. This would put further pressure on delivering the control totals.

Within the financial plan there is an expectation that QIPP savings of £760k will be achieved and the Medicines Optimisation team have profiled delivery of these schemes. To date savings totalling £630k have been generated and the expectation is that around £710k will be achieved by year end.
**REPORT TO**
NS CCG Governing Board

**TITLE OF REPORT**
Approval of Terms of Reference - Joint Quality Committee & Audit Committee

**DATE OF THE MEETING**
2nd March 2016

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

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<thead>
<tr>
<th>COMMITTEE/GROUP</th>
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<tr>
<td>Joint Quality committee 10th February 2016</td>
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**ACTION REQUIRED FROM COMMITTEE/GROUP/GOVERNING BOARD**

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<tr>
<th>Approve</th>
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<th>Assurance</th>
<th>Discussion</th>
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**RECOMMENDATION**
The Board are asked to ratify the terms of reference of the following committees, to become effective from 1 April 2016:
- the Joint Quality Committee
- Audit Committee

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

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**PURPOSE OF THE REPORT, KEY POINTS, OUTCOMES, EXECUTIVE SUMMARY**
(supporting information to be included, if applicable)

Attached are the proposed terms of reference of the joint quality committee and the audit committee.

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

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

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

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

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

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

Enclosed are the proposed terms of reference of the joint Quality Committee developed following a self-assessment by the Committee of its effectiveness which was utilised to inform the production of fit and proper Terms of Reference to be adopted from the 1st April 2016.

The committee approved the terms of reference at its meeting on 10th February and agreed to ask the Governing Bodies of each CCG to ratify them at their next Governing Board meeting for adoption from 1st April 2016.

**Audit Committee**

The terms of reference for the above Committee were reviewed at the meeting on the 25th February 2015. Changes included:-

**adding** a paragraph in under purpose

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

**adding** the Lay member PPI to the voting membership

**removing** the secondary care specialist from the named membership

**adding** the Director of Nursing and Quality to the non voting membership

**adding** the following paragraph in under conflicts of interest

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

**adding** the following sentence under voting

The outcome of the vote should be clearly recorded in the minutes

other minor changes have been made

The committee approved the terms of reference and agreed to ask the Governing Board to ratify them at their next Governing Board meeting for adoption from 1 April 2016.
### SUMMARY OF RISKS RELATING TO THE PROPOSAL
Highlight any implications, including finance, quality, reputation, governance, strategic workforce, clinical, medicines optimisation, equality related or other
As outlined in the AGS

### ANY STATUTORY / REGULATORY / LEGAL / NHS CONSTITUTION/ASSURANCE / GOVERNANCE / PRESCRIBING IMPLICATIONS
Applicable to all staff and public

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

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

### ACRONYMS
If not listed in the report, please list
1. **CONSTITUTION**
   i. The Clinical Commissioning Group’s Governing Body/Board hereby resolve to establish a Committee of the Governing Body/Board known as the Quality Committee. The Committee is established in accordance with North Staffordshire Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation and Stoke-on-Trent Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   ii. Patient Experience
o To provide a strategic link between patient and public engagement and the delivery of high quality, safe health care and improved outcome for patients.

o To review the findings of national and local surveys, complaints, PALS enquiries, claims, serious incidents, soft intelligence and other forms of feedback about the experience of patients of local health services highlighting trends and advising appropriate actions and outcomes for patients.

o To review the events entered by General Practice / CCG via the Insight DATIX system, highlighting trends and advising appropriate actions and learning.

iii. Quality Assurance of Local Providers

o To receive, scrutinise and challenge the quality assurance reports from local providers, via Clinical Quality Review Meetings, highlighting any areas of concern in relation to quality within the health economy with particular reference to clinical performance and directing appropriate action.

o To review items of concern or exception which are being considered within the Clinical Quality Review Meetings. Taking an active role in reviewing and advising on appropriate actions.

o To scrutinise, challenge and review the systems in place within the CCGs to ensure, monitor and improve the quality of health care delivered to the patient.

o To seek assurance that the quality of service commissioned is appropriate and delivered, including confirmation of quality reports developed, discussed and actioned, escalating issues where appropriate.

o To review the registration status of providers against the requirements of the Care Quality Commission and highlight any concerns.

o To receive an overview in relation to Workforce Assurance (whilst noting that reports will be submitted to the Clinical Quality Review Meetings).

o To identify items that should be escalated to the Governing Body/Board or where themes or trends are evident across the wider health economy. In this, the Committee may explore issues in advance of discussion by the Governing Board/Body and will provide an oversight of the decision making processes for the various groups that monitor safety and quality on behalf of the CCGs.

o To ensure the engagement of appropriate external bodies on areas of concern.

o To ensure that quality assurance information is used to inform commissioning decisions and drive quality improvement.

iv. Clinical Risk Management

o To ensure that a robust strategy for clinical risk management is in place to manage the whole spectrum of risks associated with the CCGs business, that identifies and prioritises risks, describes action to be taken to mitigate each risk, identifies how risk is measured, challenges and moderates risk rating scores, identifies leaning outcomes.

o To review the clinical aspects of the CCG’s Corporate Risk Registers.

v. Safeguarding

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

vi. Infection Control

o To review and monitor progress with reducing/eliminating healthcare associated infections.

vii. National Publications / External Reports

o To provide a forum for the review & discussion of national/independent reports regarding quality, reports from the Department of Health arm’s length bodies or regulators/inspectors, professional and accreditation bodies, for local interpretation and ensure relevant actions are completed.

o To monitor and scrutinise the progress being taken by the CCGs in response to key national publications and highlight any risks/slippages to the Governing Body/Board as appropriate.

viii. Quality Related Strategies & Policies

o To receive quality related strategies & policies for expert view and approval prior to submission to the Governing Body/Board for ratification.
ix. **Quality Impact Assessments**
- To ensure that all service development and redesign, evaluation of services and decommissioning of services are subject to Quality Impact Assessment (QIA).
- To ensure that Quality Impact Assessments are undertaken for all Quality Innovation Productivity and Prevention (QIPP) schemes.
- To scrutinise and challenge the efficiency of the CCG’s QIA of QIPP schemes and provider’s QIA of Cost Improvement Programmes (CIP). This will be provided through a task and finish group with the results presented to the Committee.
- To receive a full copy of the Quality Impact Assessment for any scheme identified as high risk, either at the outset or during the delivery of the service, and further detail on how the mitigating actions being taken to manage the risks.

x. **Feedback / Assurance from Sub Groups and Wider Networks**
- To receive regular assurance and exception reports from groups aligned to the Committee.
- To receive feedback from the Quality Surveillance Group on local health economy quality related issues to ensure swift action is taken where risks have been identified or there is a reality of poor patient care.
- To receive an assurance and exception reports on the quality of primary care.
- To review and agree terms of reference for all subgroups that report directly into the Committee to ensure that membership and functions are satisfactory.

9. **REPORTING**
The Committee will have the following reporting responsibilities:

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

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

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

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

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

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

10. **RESPONSIBILITY OF COMMITTEE MEMBERS AND ATTENDEES**
Members of the Committee have a responsibility to:

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

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

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

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

11. **ADMINISTRATIVE ARRANGEMENTS**
The Secretary to the Committee will ensure:

a) Correct minutes are taken, and once agreed by the Chair; ensure distribution of the minutes to the members of the Committee.

b) Conflicts of interest are recorded along with the arrangements for managing those conflicts.

c) A record of matters arising is produced with issues to be carried forward.

d) An action list is produced following each meeting and distributed to members.

e) Ensuring any outstanding action is carried forward on the action list until complete.

f) They provide appropriate support to the chair and Committee members.

g) The agenda is agreed with the chair prior to sending papers to members no later than five working days before the meeting.

h) The annual programme of work of the Committee is up to date and agreed by the Committee.

i) The minutes of the meeting are distributed within five working days of the meeting taking place.

j) The papers of the Committee are filed in accordance with each CCG’s policies and procedures.
12. **REVIEW**

a) The Committee shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles and the Conflict of Interest policy.

b) The Committee will review its own performance, membership and terms of reference annually or sooner if required.

c) An annual report of its performance, membership and terms of reference with recommendations will be submitted to each Governing Body/Board for agreement and approval.

Date Agreed by Committee: 20th February 2016

Date Approved at North Staffordshire CCG Governing Board:

Date Approved at Stoke-on-Trent CCG Governing Body:

Review Date: September 2016
North Staffordshire Clinical Commissioning Group
Audit Committee
Terms of Reference
Revised Draft February 2016

1. Introduction

The Audit Committee (the Committee) is established in accordance with North Staffordshire Clinical Commissioning Group’s (CCG) constitution, Standing orders and Scheme of Delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the constitution and Standing orders.

2. Purpose

The purpose of the Audit Committee is to assist North Staffordshire 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 Board 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 North Staffordshire CCG for the period in question;
- Affairs are managed to secure economic, efficient and effective use of resources;
- Reasonable steps are taken to prevent and detect fraud and other irregularities.

3. Accountability

The Committee is a non-executive committee of the Governing Board and has no executive powers other than those specifically delegated in these Terms of Reference.

The Committee is authorised by the Clinical Commissioning Group’s Governing Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, or interim and temporary members of staff, who are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Governing Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

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

The Committee shall be appointed by the Governing Board as set out in the Clinical Commissioning Group’s constitution and may include individuals who are not on the Governing Board. The lay member on the Governing Board, with a lead role in overseeing key elements of governance, will chair the Audit Committee. Membership as follows:

Membership (voting Members)
- Chair - Lay member responsible for governance
- 2 members of the governing board
  - Lay member for patient and public engagement
  - Secondary care specialist
  - Non-Executive - GP Board member

Other attendees required (non voting):
- The Chief Financial Officer and/or Deputy Chief Finance Officer
- Director of Nursing & Quality
- Head of Governance
- Internal Audit,
- External Audit,
- Local Counter Fraud Specialist,

Accountable Officer, Executive Directors, Clinical Directors and other senior members of staff may be invited to attend (as appropriate), particularly when the Committee is discussing areas of risk or operation within their area of responsibility. This will be recorded as ‘in attendance’.

The Chair of the Governing Board will not be a member of the Committee, but may be invited to attend a meeting in order to form a view on, and understanding of the Committee’s operations.

5. Quorum

A minimum of two of the three members (including the Chair) will constitute a quorum.

However, if it has been identified that a planned committee meeting cannot take place as it would not be quorate, any of the following appropriate members may be called upon to attend that meeting of the committee to bring the meeting up to quoracy and enable the business of the committee to be transacted.

- non-executive GP board member
- secondary care specialist

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

A decision put to a vote at the meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

6. Frequency and notice of Meetings
Meetings shall be held not less than four times a year. The External Auditor(s) or Head of Internal Audit may request an additional meeting(s) if they consider it necessary.

The Local Counter Fraud specialist also has direct access to the Committee and or the Chair.

Members shall be given at least 14 working days’ notice to attend. Attendees will be given at last 7 working days’ notice of requirement to attend the meeting.

The Committee will approve a calendar of business and this will be updated on an annual basis.

The Audit Committee may also request on occasions to meet with Internal Audit and External Audit, prior to the formal committee meeting(s) taking place.

At least once a year the Committee should meet privately with the External Auditor and Internal Auditor without any senior officer present.

7. Secretary/Reporting arrangements

The Committee shall be supported administratively by the Board and Committee Manager, whose duties in this respect will include:

- Agreement of agenda with Chair and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward

The minutes of Audit Committee meetings shall be formally recorded and submitted to the CCG Governing Board for information when agreed as accurate by the Committee.

The Chair of the Committee shall draw to the attention of the Governing Board any issues that require disclosure to the full Governing Board, or require executive action in advance of the minutes being formally agreed via a written report by the Chair following each meeting highlighting:

- Issues
- Risks
- Assurance
- Recommendations

Commercially sensitive or sensitive information by their nature may have to be reported to the closed session of the Governing Board.

8. Conflicts of Interest

It is the responsibility of all members and all individuals in attendance to declare any conflicts of interest pertaining to the agenda.

Conflicts of interests are to be declared and recorded at the beginning of each meeting. The nature of the conflict of interest and the Chair’s decision based on consideration of this information will be formally minuted.

A register of members’ interests will be maintained by the Chair and submitted to the CCG Governing Board in accordance with the CCG’s Conflict of Interest policy.
If a conflict of interest arises, then the Chair may request members to withdraw at the appropriate discussion/voting point.

9. Voting

Voting will be by consensus. Where consensus is not reached, each voting member will be allowed 1 vote. The Chair (or vice Chair) will retain the casting vote.

The outcome of the vote should be clearly recorded in the minutes

10. Responsibilities

The Committee shall critically review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across North Staffordshire CCG for both clinical and non-clinical activities, including partnerships that support the achievement of the Group’s agreed objectives.

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

The key duties of the Audit Committee are as follows:

11. Integrated Governance, Risk Management and Internal Control

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

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

- all risk and control related disclosure statements (in particular the CCG’s governance statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the CCG Governing Board;
- the structures, underlying assurance processes and responsibilities for identifying and managing key risks facing the organisation, indicating the degree of achievement of corporate objectives, as laid down in the CCG’s annual governance statement and Assurance Framework;
- the policies for ensuring there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification;
- the operational effectiveness of policies and procedures;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect;
- Compliance with Information Governance legislation.
In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit, Counter Fraud and Security Management Service (NHS Protect) and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

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

12. Information Governance

The Committee will review the adequacy and effectiveness of the annual self-assessment against the information governance toolkit prior to endorsement by the CCG Governing Board.

13. Internal Audit

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

This will be achieved by receiving reports in relation to and considering the following:-

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management’s response), and ensuring coordination between the internal and external auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Clinical Commissioning Group;
- an annual review of the effectiveness of internal audit.

14. External Audit

The Committee shall review the work and findings of the External Auditors and consider the implications and management’s responses to their work.

This will be achieved by:

- consideration of the appointment and performance of the External Auditors, as far as the rules governing the appointment permit;
- discussion and agreement with the External Auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual plan, and ensuring coordination, as appropriate, with other External Auditors in the local health economy;
SCHEDULE 7- AUDIT COMMITTEE TERMS OF REFERENCE

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Clinical Commissioning Group and associated impact on the audit fee;

- review of all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Governing Board and any work undertaken outside the annual audit plan, together with the appropriateness of the management responses.

15. Other Assurance functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the Clinical Commissioning Group.

These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example the Care Quality Commission and NHS Litigation Authority etc) and professional bodies for the performance of staff or functions (for example, Royal colleges and accreditation bodies etc.)

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee’s scope of work. In particular, this will include the Quality and Performance Committee and any risk committees that are established.

16. Counter Fraud Provision

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

17. Management

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

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

18. Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Groups financial performance.

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

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

The Audit Committee shall focus particularly on:
• the wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
• changes in, and compliance with, accounting policies, practices and estimation techniques;
• unadjusted mis-statements in the financial statements;
• significant judgements in preparing the financial statements;
• significant adjustments resulting from the audit;
• letter of representation; and
• qualitative aspects of financial reporting

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

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

19. Policy and Best Practice

The Audit Committee shall approve key financial and governance policies prior to recommendation for ratification by the Governing Board. Addendums to the constitution shall be reported to the Committee. The Committee shall also receive regular reports detailing items including single tender waivers and losses and compensations.

20. Relationship with the Governing Board

The Committee will report to the CCG Governing Board at least annually on its work in support of the annual governance statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and ‘embeddedness’ of risk management in the CCG, the integration of governance arrangements.

21. Conduct of the Committee

The Committee shall conduct its business in accordance with national guidance, code of conduct for NHS boards and the seven principles of public life promulgated by the Nolan Committee.

These are:
Selflessness
Integrity
Objectivity
Accountability
Openness
Honesty
Leadership

22. Remuneration

Remuneration of members will be determined by the Remuneration Committee established by the CCG.

23. Review of Terms of Reference
The Audit Committee shall carry out an annual self-assessment to review its own performance, membership and terms of reference. Any resulting changes to the terms of reference or membership will be presented to the Governing Board for approval.

The Terms of reference will be subject to an annual formal review.

<table>
<thead>
<tr>
<th>Date Agreed</th>
<th>25 February 2016</th>
<th>Governing Board (Proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Date</td>
<td>31 March 2017</td>
<td></td>
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</tbody>
</table>
# Governance Template

To be completed by each chair of the Committee/Meeting:

**Name of Committee/Meeting:**

**Name of Chair:**

**Date:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did we achieve what we set out to do; linking back to the ToRs?</td>
<td></td>
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<tr>
<td>2. Was the information presented appropriate/easy to understand?</td>
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<tr>
<td>3. What were we requested to do with the information? Did we do this?</td>
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<tr>
<td>4. Are we getting the correct information?</td>
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<tr>
<td>5. Do we need to escalate any issues elsewhere?</td>
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<tr>
<td>6. Do we need to inform anyone of our decisions?</td>
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<tr>
<td>7. Have we seen something that we think would be more appropriate going to another committee?</td>
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<tr>
<td>8. Are we assured?</td>
<td></td>
</tr>
<tr>
<td>9. Do we need any more information?</td>
<td></td>
</tr>
<tr>
<td>10. Do we need less information?</td>
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</tr>
<tr>
<td>11. Agreed actions?</td>
<td></td>
</tr>
<tr>
<td>12. Do the Terms of Reference need to be amended?</td>
<td></td>
</tr>
</tbody>
</table>