Cannock Chase Clinical Commissioning Group

Cannock Chase CCG Joint Governing Body & Members Board Meeting

to be held on Thursday 4th April at **14:00**

in the Ball Room, Cannock Chase Council Offices, Beecroft Road, Cannock, WS11 1BG

AGENDA

A=Approval D=Decision I=Information

		Enc	Lead	A/D/I
1	**Welcome by the Chairman**		JM	
2	**Apologies for Absence**		JM	
3	**Conflicts of Interests**	Verbal	JM	I
4	**Minutes of the meeting held:** • Governing Body held in public 07.02.13	Enc 01	JM	A
5	**Quality Report**	Enc 02	VJ	A
6	**Chair Report**	Verbal	JM	I
7	**Chief Officer Report**	Enc 03	AD	A/D
8	**Finance and Performance** • **Finance Report – Month 11** • **Finance Plan Report 2013/14** • **Financial Strategy Presentation**	Enc 04 Enc 05 Enc 06	AD	D/I A
9	**Everyone Counts – Plans for 2013/14**	Enc 07	AB/AD	A
10.	**Questions from the public**	Verbal	ALL	I/D
	Any Other Business	Verbal	ALL	D
	Date of Next Meeting : • 4th July 2013 Venue TBC			

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Minutes of
Cannock Chase Governing Body Meeting
Clinical Commissioning Group
Held on Thursday 7th February 2013
At Cannock Chase Hospital

	Present		**Action**
	Dr Johnny McMahon (JM)	Chair, Cannock Chase CCG	
	Andrew Donald (AD)	Chief Officer	
	Andy Chandler (AC)	Chief Finance Officer	
	Val Jones (VJ)	Nurse Board Member, Director of Quality & Safety	
	Manjit Obhrai (MO)	Secondary Care Consultant	
	Dr Tim Berriman (TB)	Clinical Lead	
	Dr Mo Huda (MH)	Clinical Lead	
	Dr Anna Onabolu (AO)	Clinical Lead	
	Clive Cropper (CC)	Practice Lead	
	Lesley Powell (LP)	Practice Lead	
	Paul Gallagher (PG)	Lay Member for Patient & Public Engagement	
	In Attendance:		
	Peter Gregory (PGr)	LMC Observer	
	Jonathan Bletcher (JB)	CCG Director	
	Sally Young (SY)	Head of Strategic Compliance & Governance	
	Adele Edmondson (AE)	Internal Relationship Manager	
	Katie Woods (KW)	Executive Assistant	
1.0	**Welcome by the Chairman**		
1.1	JM welcomed members of the public to the Governing Body and reminded all that the meeting was a meeting held in public and not a public meeting.		
2.0	**Apologies for Absence**		
2.1	Neil Chambers, Beccy Smith, Pauline Scott.		
3.0	**Conflict of Interests & Presentation of Register of Interests**		
3.1	None identified.		
4.0	**Minutes of the Meeting held**		
4.1	**Governing Body held on 5th November 2013** P2. 1.4 P6 S3 Public Health with drive forward – will Agreed true and accurate record.		

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4.2	**Joint Quality Committee** The Governing Body discussed the membership of the Joint Quality Committee and agreed to extend invitations to the Lay Members for Patient and Public Involvement, Lay Member for Governance and the Secondary Care Consultant.	
4.3	The Governing Body received and noted the minutes.	
4.4	**Audit Committee** AC informed members that the Audit Committee held in December amended the Terms of Reference to include Conflict of Interests and business cycle in key areas. AD reported to the Governing Body that Grant Thornton have been named as the Clinical Commissioning Groups external auditors.	
4.5	The Governing Body received and noted the minutes.	
4.6	Action: AC to circulate paper on Conflict of Interest process, agreed by Audit Committee to Governing Body members and the Local Medical Committee (LMC).	**AC**
5.0	**Quality Report**	
5.1	The Quality report provided the Governing Body with assurance of the progress by the CCG in the development of its capacity and capability for the transfer of responsibility for commissioning quality, safe services from April 2013. The Report also: • Described the progress towards the transfer of commissioning responsibility and demonstrated how patient experience is used within the governance model for the CCG; • Advised the members on the role of the newly formed Quality Surveillance Groups in sharing vital information and intelligence on provider quality and safety performance; • Provided an update on key quality and safety matters as reported to the Clinical Quality Review Groups (CQRMs).	
5.2	The Governing Body discussed the present capacity of the Quality Team and the feasibility of managing the quality agenda. AD agreed that the team in its current form is under-resourced. Work is underway to identify how further development in the capacity of the Quality function can be achieved.	
5.3	The Governing Body agreed an increase in clinicians and Lay Members undertaking quality and safety visits would allow more proactive work in relation to patient experience and complaints.	
5.4	Action: If any members of the public were interested in becoming part of a Lay Member team involved in Quality and Safety visits they should leave their contact details with Katie Woods.	**ALL**

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5.5	AC advised the Governing Body that the Contract Management and Out of Area Teams lead on contracts and therefore can produce reports for peripheral hospitals creating further capacity.	
5.6	VJ highlighted the following: • Infection Prevention and Control – both Mid Staffordshire Foundation Trust and Stoke-on-Trent and Staffordshire Partnership Trusts were both at high risk of exceeding c-difficile trajectory; • Complaints – Burton Hospital has shown improvement; • There had been a focus on the number of Slips/Trips/Falls as this supported the reduction in avoidable pressure sores.	
5.7	The Governing Body received and noted the report.	
6.0	**Chair of the Governing Body**	
6.1	The Chair advised members of the public that questions may be raised at the end of the meeting. However, the Governing Body could not discuss the recent publication of the Robert Francis QC report or the Protected Services work that Monitor are carrying out at this time.	
6.2	JM assured both the Governing Body and members of the public that even though the issues cannot be discussed, the CCG do take the matters seriously.	
6.3	The Governing Body were informed that JM also co-chairs the Health and Wellbeing Board (HWBB) and he is working with Health and Wellbeing Board Members on the development of a Provider Forum. This forum would be a key conduit for information to the Health and Wellbeing Board on provider matters.	
6.4	JM informed the Governing Body of his disappointment that the Members Board in January was cancelled due to adverse weather. Therefore, additional Membership Boards will now also take place in August and December.	
6.5	Correspondence had been circulated to Clinical Leaders of CC CCG detailing the election process for Governing Body members. The closing date for applications is February 22nd.	
7.0	**Chief Officer Report**	
7.1 7.1.1	**Authorisation** In February, the CCG will receive a formal letter setting out its terms of authorisation and the CCG is likely to be authorised with conditions. From this date the CCG will be a statutory body.	
7.1.2	The Governing Body noted the update.	

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7.2	**Legacy & Transition**	
7.2.1	CC CCG will be meeting with Staffordshire Cluster of PCTs to formally handover the legacy and transition documents prior to the 1st April 2013. Further areas of work not initially identified as being the responsibility of CCG's are now being transferred to CCG's, these include: • the implementation of Choose & Book • the introduction of the Summary Care Record	
7.2.2	AD discussed that the new areas of responsibility may be a challenge given the current capacity of staff.	
7.2.3	The Governing Body noted the update.	
7.3	**Quality, Innovation, Productivity and Prevention (QIPP) 2013/14**	
7.3.1	The plan would be transformational and less reliant on hospital based care. The plan will also look at creating a paradigm shift the pattern of care to make better use of the Clinical Commissioning Groups allocated resources.	
7.3.2	Discussions have been held with Governing Body members and the QIPP plan will be presented for sign off at the April Governing Body meeting as part of the plan on a page and financial strategy.	
7.3.3	The Governing Body noted the update.	
7.4	**Policies**	
7.4.1	All policies are available on the members' area of CC CCG website for approval. The policies demonstrate how the CCG intends to fulfil these requirements.	
7.4.2	The Governing Body approved: • Information Governance Framework • Information Governance Policy • Information Governance Strategy • Guidance for Inclusion of Information Governance Requirements within Third Party Contracts • Confidentiality Staff Code of Conduct • Information Security Procedures • Information Sharing Code of Practice • Privacy Impact Assessment Guidance • Information Risk Assessment and Management Plan • Private Sector Sub Policy • South Staffordshire PCT – Terms and Conditions • South Staffordshire PCT – CRB Policy and Employment with Criminal Conviction	

7.5 7.5.1 7.5.2 7.6 7.6.1	**Petition 38°** 38° is a UK campaigning community with more than 1 million members. They are writing to all CCGs to ask for specific requirements to be included in each CCGs constitution. A petition signed by 240 people has been handed to the Staffordshire Cluster of PCTs on behalf of Cannock Chase CCG. The CCG had responded to the petition and AD reported that all the matters raised have been taken account of in the CCGs Constitution. The Governing Body noted the petition and the response. **Conversation Staffordshire** The Governing Body noted that the event would be taking place on 5th March for Cannock Chase residents.	
8.0	**West Midlands Quality Review Service Report into Long Term Conditions**	
8.1 8.2 8.3 8.4 8.5	The West Midlands Quality Review service undertook a review of how Long Term Conditions management was being undertaken in the Cannock area. The report identified four areas for improvement integration of services, information sharing and communication, documentation and care for people with multiple LTC. There were also a number of additional findings that relate to individual organisations. Each organisation will ensure it addresses the actions required to improve services and as commissioners the CCG will hold providers to account. However, where the improvements require a system wide approach the Commissioning Board that oversees the Clinical Services Implementation Programme (CSIP) will manage the response via the Clinical Working Groups. Some specific improvements require changes across multiple organisations, the report has been presented to the Clinical Services Improvement Programme Board last month where both providers and commissioners were present. The Governing Body were asked to note the review report and its findings. The Governing Body noted work to develop the action plan in response to the West Midlands Quality Review and noted that the action plan when complete will be brought back to the Governing Body for sign off in May 2013.	
9.0	**Finance Report**	
9.1	AC presented the report to members which sets out the in-year financial position at month 9, based on 8 months of Secondary Care data. The CCG is currently showing an over-spend of £1.6m against plan. The CCG planned position was break-even at the end of period 9. A number of significant pressures have been identified.	

9.2	The main areas of risk remain around the Acute Contracts which show an over-spend of £2.2m as at Month 9, which is forecast at c£4.2m at the year end. There is also an over-performance on Continuing Health Care at Month 9 of £0.6m with a forecast over-spend of £0.9m. QIPP achievement also remains a key area of risk.	
9.3	The Governing Body noted that it was encouraging to see a reduction in over-spend.	
9.4	AC discussed that there may be further reductions with finance provisions previously reported could be on the high side. There may be some benefit in the prescribing budget and continuing health care.	
9.5 9.5.1	**Audit Committee ToR** The Governing Body approved the revised ToR.	
9.5.2	The Governing Body noted the report.	
10.0	**Performance Report**	
10.1	AC summarised the highlights below where KPI's were not achieved in November 2012: • MSFT – Daily Discharges & Weekend Discharges; Diagnostic Waiting times >6 weeks; Cancer Waiting Time Patients receiving 1st definitive treatment for cancer, 62 days of an urgent GP referral. • SSOTP – Complaints - 100% responded to in timescale agreed with complainant; Delayed transfers of care Community Hospitals within SSOTP (3.5% of occupied bed days); Time from referral to Implementation of all services; Older people remaining at home at 91 post discharge. • SSSHFT – Delayed Transfers and 18 weeks non-admitted waiting times for Paediatrics. • RWHT – Delayed Transfers (local stretch target).	
10.2	The Governing Body agreed to include members on the circulation list for weekly performance dashboards.	
10.3	Thanks were extended to Alex Bennett, Head of Commissioning/18 Weeks for her work in support of the delivery of the 18 week standard.	
10.4	The Governing Body noted areas of performance where the present rating is red and the remedial actions being taken to improve performance and mitigate risk.	
10.5 10.5.1	**Performance Monitoring and Assurance Update** AC outlined the work underway to develop a performance dashboard covering all aspects of performance which will give Governing Body members a picture of performance across the whole CCG portfolio. The Performance Team will be working with all partners and providers in the Health Economy.	

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10.5.2 10.5.3	Data will also be published in the public domain. Future reports will include QIPP performance reports and comparative data from practices including practice referral data. The Governing Body noted the report.	
11.0	**Any Other Business**	
11.1	None identified.	
12.0	The Chair thanked all for attending the meeting and the meeting was closed.	
12.1	The next meeting shall be held on **4th April 2013 (14:00 – 16:00) Council Offices Cannock Chase.**	

Signed …….. Date ……..

Print …… (CHAIR)

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REPORT TO THE CLINICAL COMMISSIONING GROUP
Governing Body Meeting
TO BE HELD ON: Thursday 4th April 2013

Subject:	Quality and Safety Report					
Board Lead:	Val Jones					
Recommendation:	**For Approval**		**For Discussion**		**For Information**	✓

PURPOSE OF THE REPORT:

To update the Governing Body Board members on the current quality and safety issues

KEY POINTS:

Please see attached report which describes the key quality issue for local providers.

1. BHFT and MSHFT are both rated RED which indicates that there is a high level of concern relating to both the providers. The specific concern for MSHFT is the potential risk of destabilisation due to the Monitor report and the uncertainty for this provider until the Trust Special Administrator (TSA) is appointed.

2. BHFT continues to be a high level of concern although is being closely monitored by the commissioners and the Local Area Team (LAT). This Trust has been identified as one of the 14 following the Francis report that will come under scrutiny by the DoH for a high mortality rate and the quality paper includes a briefing on the action taken to address high rates for non-elective COPD.

Relevance to Key Goals

To reduce health inequalities across Stafford and Surrounding areas through targeted interventions.	Commissioning for quality will enable the CCG to put in place exemplary systems for commissioning intentions and provider performance management that will deliver its Key Goals
To identify and support patients with Long Term Conditions to ensure care delivery closer to home.	
To improve and increase overall life expectancy.	
To develop integrated services with simple, easy access.	

Implications

Legal and/or Risk	Enable the CCG to meet its statutory responsibilities for commissioning quality; reduce and mitigate risks to the organisation and to patients.	
CQC	Enable the CCG to meet commissioner responsibilities for CQC Essential Standards for Health including that providers have up to date registration with the CQC.	
Patient Safety	Integral element of the Quality Strategy which describes the systems that will be deployed to "keep patients safe."	
Patient Engagement	Integral element of the Quality Strategy which describes how the CCG will use patient engagement and experience to form the intelligence essential for effective and safe commissioning	
Financial	Following the baseline assessment of the CCG structure, systems and processes there maybe implications for additional funding.	
Sustainability	A three year plan which will be refreshed on an annual basis through the annual Quality Improvement Plan	
PBC/ CCG		
Workforce / Training	Organisational Development Plan for the CCG is in place to develop members, staff and leadership.	
Equality Delivery Strategy	N/A	

RECOMMENDATIONS / ACTION REQUIRED:

The CCG GOVERNING BODY is asked to note :

1. The use of the RAG rating to denote the current quality and performance status of each provider.
2. The RED status of three local providers and actions taken to improve this.
3. The key quality and safety issues reported to the Clinical Quality Review Groups (CQRM).

KEY REQUIREMENTS	**Yes**	**No**	**Not Applicable**
Has a quality impact assessment been undertaken?			✓
Has an equality impact assessment been undertaken?			✓
Have partners / public been involved in design?			✓
Are partners / public involved in implementation?			✓
Are partners / public involved in evaluation?			✓

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CC CCG Governing Body Quality and Safety Report
Date of Report: 4th April 2013

CSU Quality Lead: Lynn Tolley **CCG Lead Director: Val Jones** **GP Clinical Lead: Tim Berriman**

Developing CCG Capacity and Capability for Quality Improvement

- The Governing Bodies of the Stafford and Surrounds CCG and the Cannock Chase CCG will be holding a joint meeting on 11th April to discuss the findings and implications and actions to be taken following the publication of the second Francis report on the Mid Staffordshire Enquiry.
- Additional resource to develop the capacity of the CCGs to be able to fully implement the recommendations from the Francis report and deliver their responsibilities for quality and safety functions within the context of the continuing issues from the legacy of Mid Staffordshire have been agreed.
- Lay members are to be invited to attend one of the provider CQRMs to observe the crucial role undertaken by CQRMs in enabling Commissioners to hold providers to account for the delivery of high quality safe services.

Main Issues/Top Themes For Providers

1. **Mid Staffordshire Hospital Foundation Trust (MSHFT)**
   - a. Destabilisation risk
   - b. Breast Cancer Services
2. **Staffordshire Stoke On Trent Partnership Trust (SSOTPT)**
   - a. Pressure Ulcers
   - b. Diabetic backlog
   - c. Podiatric Service
3. **South Staffordshire Shropshire Healthcare Foundation Trust (SSSHFT)**
   - a. Suicide Strategy update
   - b. Serious incidents
4. **Walsall Healthcare NHS Trust**
   - a. No significant Issues reported
5. **Wolverhampton Foundation Hospital Trust**
   - a. Access to CQRM reports for associate commissioners - update
6. **Burton Foundation Hospital Trust (BHFT)**
   - **a.** Mortality Review
   - **b.** COPD
7. **University Hospital North Staffordshire (UHNS)**
   - **a.** Outpatient waiting time Backlog - update
   - **b.** A&E performance - update
   - **c.** Radiology
8. **Rowley Hall Hospital**
   - **a.** No significant issues
9. **Hospices**
   - a. No CQRM
10. **British Pregnancy Association (BPAS)**
    - a. No CQRM

Regulators involvement and issues

MSHFT - CQC visits

The CQC report of the responsive visit made on the 1st February is now available and reports that MSHFT is compliant with the Essential Standards of care.

Other Main Issues for Providers

MSHFT – Potential Destabilisation risk

The potential risk of stabilisation at MSHFT from staff migration as a result of the outcome of the Monitor review is being taken seriously by commissioners and regulators and a Risk Summit is to be organised to agree actions to mitigate this risk. Any impact on quality and safety is being closely monitored through CQRM, CCG Quality Committee and the newly established Quality Surveillance Group.

MSHFT – Breast Cancer Services Review

The Royal College of Surgeons (RCS) completed their review as scheduled on the 15th February and found no immediate safety issues or concerns. The report is not yet available and is scheduled for the June CQRM. The review by the West Midlands Cancer Peer Group is also being undertaken at this time

SSOTPT – Pressure Ulcers (PUs)

Pressure Ulcers contain to be the major reported issue for SIs and avoidable PUs have remained fairly static throughout the year despite a number of initiatives and a zero tolerance action plan in place. This has been comprehensively reported to members previously with regard to the CQUIN performance where they are meeting the targets set for this.

All PUs are subject to an RCA with the results scrutinised at the Tissue Viability Board which is attended by both the DNS and the CSU quality lead. There are issues around the completion of documentation and validation which the Trust have a zero tolerance approach to. The development and roll out of the PU Tracking Tool will facilitate better targeting of resources and a reduction in PUs.

SSOTPT –Suspension of the Podiatric Service – update

This matter has previously been reported to members. The Trust provided a report to the March CQRM on how they are managing the rescheduling of patients following the suspension of the service. The contracts with other providers Little Aston and Rowley have now been signed and patients will be reassigned this week unfortunately this has taken longer than expected. For those patients who have chosen MSHFT the contract is not yet agreed.

SSOTPT – Diabetic Backlog

Issues with the community diabetic service in the North in Dec 2011 as a result of an internal audit which identified significant team and clinic capacity and efficiency issues which were reported to commissioners. A number of remedial actions were taken to address this however these were not entirely successful and a repeat audit in Dec 2012 demonstrated that the situation had not improved. A waiting list audit conducted in February concluded that urgent appointments appear to be managed but that the follow up appointment backlog is excessive. A number of recommendations have been made which include the redesign of the diabetic team to develop more capacity and improvements in appointment scheduling.

SSOTPT- Heart failure Service – Update

An update was presented to CQRM on the actions the Trust has taken to address the capacity issue in the Stafford team due to sickness and maternity leave. Interim action has been taken to prioritise urgent cases with some support from the Cannock team with a new fully trained Heart Failure CNS recruited to start work on 15th April

SSSHFT – Suicide reduction - update

A representative from Public Health attended the CCG Joint Quality Committee to present the strategy for preventing and reducing the number of suicides in Staffordshire and to respond to the concerns reported previously by clinical commissioners regarding the number of suicides. It was reported that there is an increase locally in suicides but this is in line with increases reported nationally and Staffordshire is not thought to be an outlier in this regard. However the rep did report that there is no way of benchmarking suicides due to differences in the way in which providers categorise and report them.

UNHNS – Outpatient waiting list Backlog - Update
The backlog numbers have decreased very slightly and the lead commissioners have requested weekly reporting. Ophthalmology has the largest backlog and is now closed to new referrals and a new provider has been commissioned there are also plans to reallocate those who have been waiting the longest to the new provider. There are no reported safety issues relating to the backlog however additional protocols have been agreed to ensure the safe management of patients in the backlog.

UHNS – A&E Performance update
This has previously been reported to members. A contract query was raised and the Remedial Action plan forms part of the process. It is anticipated that if all the actions from the Local Health Economy Action Plan are delivered then performance will be at 95% from late February.

UHNS – Radiology
As a result of SHA regional review related to SI's reported within the region, the Trust have undertaken a local review and developed a new policy. During the review it was identified that they should be using the WHO Radiology checklist instead of the WHO Surgical checklist.

BHFT – Mortality
Following the Francis report the Trust is to undergo a review of their mortality data by a member of Sir Bruce Keogh's team.

BHFT – COPD Mortality
Following identification of a higher than expected mortality in non-elective COPD patients managed by the Trust, the COPD service was peer reviewed on 7th March 2012. In response, an action plan has been devised to address the peer review recommendations, and focuses on:

- A review of Structures and process in place for patients admitted with COPD
- A Review of the Non Invasive Ventilation Service and recommendations concerning further development.
- Consideration of concerns with specific reference to mortality in patients with COPD and the assessment of the service provided against NICE Quality Standards.

The Action plan is monitored through the CQRM

Infection Control

WALSALL
During December 2012 there were 3 cases of hospital attributable C.DIFF and no cases of community attributable C.DIFF. and 1 case attributable to the wider community. Of the 3 positive results, the RCA highlighted inappropriately prescribed antibiotics on ward 16. There were one case of MRSA within the acute during December 2012 and the Trust has reached its agreed trajectory of no more than two cases with quarter 4 outstanding. There were no cases reported within the community

UHNS, SSOTP, MSHFT
Please see attached economy wide infection control report from Alison Heseltine.

Patient Experience

MSHFT - Net Promoter

Although the Net promoter score had risen in January to 60 there were two wards which achieved a lower than expected score, which were the acute stoke unit and ward 11. Ward 11 is the winter pressures ward and the Trust has found it difficult to engage the staff in ensuring the net promoter needs to be completed. The lead on patient experience has been to see the ward managers in both areas and has educated them on the need to increase these responses for next month. In addition there were low numbers of patients which affected the response rate.

SSOTPT – Net Promoter

Net promoter score is improving month by month and 77.7 is the highest score yet.

BHFT – Net Promoter

In January the Trust achieved a score of 75.28 for the Friends and Family test which is 2 points lower than the previous month in December. This however the remains above the SHA average of 70.

WASALL

The net promoter score for November was 60 a decrease from October's score of 72.

UNHS – Net Promoter.

February score is not yet available.

Eliminating Mixed Sex Accommodation

No breaches reported for any provider**.**

Patient Safety

MSHFT - Serious Incident (SIs)

There have been 13 SIs reported in January. There was one never event which has resulted in a referral to the GMC for further investigation. There has been on avoidable event which occurred in A & E (retained venflon). The Trust has been challenged on the use of Venflons in A & E and a request has been made informally for a review. A formal request will be made at IRG if update not received prior to meeting.

There were 11 pressure ulcers reported in January, of which 8 were grade 2 (avoidable), 3 were grade 3 (1 avoidable, 1 unavoidable and 1 awaiting review completion)

SSOTPT- Serious Incident (SIs)

37 SIs reported in December the majority (29) of which were pressure ulcers and included 1 confidential information leak, an unexpected death of a patient and an allegation against HC non-professional.

UHNS- Serious Incidents (SIs)

There have been 4 SIs reported for January. These have included 2 Clostridium Difficile, 1 retained cannula and I retrospective drug error as a result of a Coroner's letter to the Trust.

BHFT – Serious Incidents (SIs)

There were 15 SIs reported in January. 6 were pressures ulcers, 3 unexpected deaths and two retained cannulas that bring the total of retained cannulas to 11 for this year so far. One SI relating to a retrieved body part of a male who had part of his ear bitten off was withdrawn as the body part was in saline by the side of the patient, when his friend took it and threw it away outside the emergency department. This was withdrawn as an SI as the actions of other people cannot be accounted for.

WALSALL – Serious Incidents (SIs)

Information not available

CCG Quality Meeting
March 2013
Infection Prevention and Control Report
Allison Heseltine - Head of Infection Prevention & Control

MRSA Bacteraemia
I have enclosed the attachment, 'Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2013' which is now finalised.

The purpose of this guidance is to support commissioners and providers of care to deliver zero tolerance on MRSA bloodstream infections, as set out in the planning guidance Everyone counts: Planning for Patients 2013/14.

The planning guidance sets out a requirement to institute a Post Infection Review in all cases of MRSA bloodstream infection and the purpose of the review is to identify how a case occurred and to identify actions that will prevent it reoccurring.

The outcome of the Post Infection Review will be to attribute responsibility for MRSA bloodstream infections. It relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA bloodstream infection.

The guidance also supports the identification, data exchange and reporting of cases of MRSA bloodstream infection to help Clinical Commissioning Groups (CCGs) and healthcare providers conduct the Post Infection Review.

Burton Hospital NHS Foundation Trust
BHFT have demonstrated their commitment to reducing Clostridium difficile with a reducing in the numbers in the recent months and are looking like they will come in under trajectory for 2012-13.

The target for BHFT MRSA bacteraemia was set locally which is 1 not 0 as stated on the SHA documentation.

Norovirus has hit BHFT during February and early March, prompt actions put in place to control the outbreak with minimal disruption.

In the Intensive Care Unit there have been a number of patients have been colonised with Vancomycin Resistant Enterococci (VRE), no infections due to this organism have been identified. All cleaning and precautions have been put into place.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

Mid Staffs Foundation Trust

MSFT have breached their annual trajectory for Clostridium difficile. The trajectory for 2013-2014 of 12 has been challenged at Department of Health, National Commissioning Board and NHS Midlands & East but with no result.

They have appointed a Locum Consultant Microbiologist until March 2013 who has an interest in Infection Control; there is no information of the permanent position being advertised. The permanent Lead Nurse 8a post has been advertised and interviews taking place mid-April.

During February they have had a cross Trust outbreak of Norovirus/D&V, all appropriate precautions have been put in place and outbreak meetings held. Amongst others MSFT has seen a different type of Norovirus this season; lasting longer than usual (72 hours) with increased numbers of patients have relapses.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

University Hospitals of North Staffs

A Clostridium difficile reduction strategy has been developed and is being worked through and the Trust is now within trajectory.

They have been continued wards affected by Norovirus from mid-February to current time; HIPC has been informed that precautions have been put in place. There have not been any formal outbreak meetings and this has raised this with the Trust who are using daily bed management meeting for this purpose. There continues to be delays in the reporting Serious Incidents.

They have an outbreak of 2 patients with Health Care Acquired Influenza A, one patient has died but not yet aware of contents of death Cert. Outbreak meeting called but delayed by a day as Microbiologist not available.

An additional decontamination has been reported (late) regarding the same scope being used on two patients without being decontaminated, investigation is underway.

A decontamination incident relating to the new scopes being introduced continues to be investigated following further development. The risks to individual patients continue to be very low.
The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

A meeting is being arranged with the Head of Infection Control and Prevention to discuss the infection control concerns.

Staffordshire and Stoke on Trent Partnership NHS Trust

Clostridium difficile action plan is in place and they have now reached the trajectory for the end of year.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

South Staffs and Shropshire NHS Foundation trust

Have had wards affected by Norovirus all precautions have been put in place.

The mother and baby unit has had cases of Rotavirus, precautions put in place.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

Combined Healthcare

Have had wards affected by Norovirus all precautions have been put in place.

HIPC has attended the ICC and has suggested their Infection Control Nurse attends an ICC at SSSNHSFT.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

Heart of England Foundation Trust

HEFT have had a number of wards affected by Norovirus across all sites.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

Independent Contractors and Independent Social Care Home Sector

A numbers of Care Homes have had Norovirus/ D&V outbreaks.

The Norovirus Strategy is being updated by the Health Economy Infection Prevention and Control Group.

Cannock Chase Clinical Commissioning Group

REPORT TO THE Clinical Commissioning Group Governing Body Meeting TO BE HELD ON: Thursday 4th April 2013

Subject:	Chief Officer's Report					
Board Lead:	Andrew Donald					
Officer Lead:	Andrew Donald					
Recommendation:	**For Approval**		**For Discussion**		**For Information**	✓

PURPOSE OF THE REPORT:

- To update members on progress to statutory go live date on 1st April 2013
- To update members on transition matters
- To outline the CCG's emergency planning responsibilities
- To update members on the action plans following authorisation
- To outline initial comments on the Francis report and proposals for action – Government response
- To give an update on the Monitor Review

KEY POINTS:

- CCG is now authorised with six conditions
- Transition / handover continues
- CCG Chief Officer proposed as Emergency Planning & Resilience Accountable Officer
- Progress on action plans
- Initial views on response to the Francis report
- Update on Monitor Review

Relevance to Key Goals

To reduce health inequalities across Cannock Chase through targeted interventions.	Not applicable
To identify and support patients with Long Term Conditions to ensure care delivery closer to home.	Not applicable
To improve and increase overall life expectancy.	Not applicable
To develop integrated services with simple, easy access.	Not applicable

Implications

Legal and/or Risk	Transition and handover not completed, this would be a risk to the CCG in undertaking its statutory duties
CQC	Response to Francis report is critical to ensure high quality safe services and building public confidence
Patient Safety	Response to Francis report is critical to ensure high quality safe services and building public confidence
Patient Engagement	Response to Francis report is critical to ensure high quality safe services and building public confidence
Financial	
Sustainability	
Workforce / Training	

RECOMMENDATIONS / ACTION REQUIRED:

The CCG Governing Body is asked to:

- **note** the report
- **note** the appointment of Tim Rideout to support the CCGs financial strategy work
- **note** the relevant transition matters
- **agree** that the CCG Chief Officer is nominated as the Emergency Planning and Resilience Accountable Officer
- **note** the proposed approach to the Francis Report and confirm their agreement
- **note** the update regarding the Monitor Review

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			✓
Has an equality impact assessment been undertaken?			✓
Has a privacy impact assessment been completed?			✓
Have partners / public been involved in design?			✓
Are partners / public involved in implementation?			✓
Are partners / public involved in evaluation?			✓

Report to Cannock Chase CCG Governing Body

Chief Officer's Report

1.0 Purpose

- To update members on progress to statutory go live date on 1st April 2013
- To update members on transition matters
- To outline the CCG's emergency planning responsibilities
- To update members on the action plans following authorisation
- To outline initial comments on the Francis report and proposals for action
- To give an update on the Monitor Review

2.0 Current Issues

2.1 Progress to Statutory Go Live Date

On the 20th February Cannock Chase CCG received their formal letter of authorisation. The CCG has been authorised with six conditions related to finance and risk management.

All these conditions can be reviewed at the end of March and quarterly thereafter. The conditions relate to the significant challenges facing the CCG financially next year.

To support the CCG in developing further the financial strategy the CCG has commissioned Tim Rideout, a former Chief Executive and Senior Director of finance, to work with the CCG on developing the financial strategy.

Since my last report significant work has been undertaken to demonstrate that we have a credible QIPP Plan which enables the CCG to deliver its statutory financial duties at March 2014.

Action: The CCG Governing Body is asked to **note** the appointment of Tim Rideout to support the CCGs financial strategy work.

2.2 Transition Matters

As we move into the last month of transition there are a number of significant matters which need to be addressed to ensure that from 1st April 2013 the CCG can take on its full responsibilities, these include:

- Staff transfers
- Remuneration Committee to confirm certain salaries and fees
- Completion of statutory requirements e.g. Information Governance, Data Protection
- Signing off of contracts for the 2013/14 financial year
- Receiving handover documents on a range of matters from the PCT Cluster

This work is being completed alongside day to day commissioning work. It should be noted that following the PCT Cluster Board meeting on the 20th March 2013 there will be an Extraordinary

Governing Body meeting to receive formal handover documents from the PCT, this will take place on 21st March 2013.

Action: The Governing Body is asked to **note** the relevant transition matters.

2.3 Emergency Planning and Resilience

The CCG will be a Category 2 responder under the Civil Contingencies Act (2004). This means the CCG must have an Emergency Planning and Resilience Accountable Officer. It is proposed that this is the CCGs Chief Officer.

The role of the CCG is as a co-operating body involved in planning and response to a major incident. The full document outlining the arrangements, role of the accountable emergency officer and a set of frequently asked questions are available at: http://www.commissioningboard.nhs.uk/ourwork/gov/eprr/

Action: To agree that the CCG Chief Officer is nominated as the Emergency Planning and Resilience Accountable Officer.

2.4 Update members on action plans following authorisation

All plans submitted for authorisation have been reviewed by the Lead Manager and updated. These will be added to the CCG website. In the near future to demonstrate progress.

2.5 The Francis Report

On the 6th February 2013, Robert Francis QC produced his report based on the public inquiry into Mid Staffordshire.

The report has 290 recommendations with a report totalling 1919 pages. Its significance for the NHS cannot be underestimated. NHS bodies have a duty to respond to this report.

There were a number of key themes related to culture, inspection and regulation, employees, Foundation Trust application and local accountability.

Robert Francis has suggested that:

- All organisations reflect on the report and recommendations
- Each organisation should announce at earliest practicable time its decision on the extent to which it accepts the recommendations and implementation and on at least an annual basis report on progress
- The Department of Health (DH) publish an annual report on progress collating all of the information
- The Health Select Committee use progress in implementation as part of their reviews of organisations in their normal business

The government has yet to respond and it therefore seems wise to wait for this response. However for the NHS it would be easy to take the recommendations and work through them. That is not the appropriate approach to such an important report.

Subsequent to the government response the following is proposed as action for the CCG:

- That a more detailed paper is written by the Clinical Lead for Quality and Safety supported by the Director of Quality and Safety and is presented to the next Public Governing Body for discussion
- That a briefing is produced for all staff and practices with an offer to present to all practices on the implications
- A Joint Governing Body Development session will be set up to enable Governing Body members to reflect on the report and its implications. (This has been arranged to take place on the 11th April 2013).
- A further review of present arrangements for managing Quality & Safety from a commissioning perspective will be undertaken
- Subject to the reflections of the Joint Governing Bodies a plan for action will be drawn up

We have now received the Governments response to the Francis Inquiry and this response will be reviewed alongside the report.

Following the 11th April a detailed plan will be developed on actions that the CCG proposes to take over and review its current approaches to Quality and Safety.

Action: The Governing Body are asked to note the proposed approach and confirm their agreement

2.6 Monitor Review

The contingency planning team appointed by Monitor has produced a report prior to Christmas outlining that over the longer term Mid Staffordshire Hospitals Trust was neither clinically or financially sustainable.

This has been followed by a recommendation that the Secretary of State should appoint a special administrator. This decision is expected immediately.

The report submitted by the contingency planning team was made public on the 6th March 2013. This outlined the potential future services that commissioners wished to commission alongside the services outlined as 'Protected Services' recently changed to 'Location Specific Services'.

The report outlines areas where services could potentially be no longer provided on the Stafford site:

- Obstetrics and Midwifery (delivery)
- Accident and Emergency (response by a 24/7 Emergency & Urgent Care service)
- Transfer of ITU/HDU Beds

However, over 80% of present patient pathways under the proposed model would remain locally at Stafford and Cannock.

The CCG will continue to work with the Trust and special administrators (if appointed) to ensure the best possible standard of clinical services at both sites subject to services being clinically safe and affordable.

The important point to make is that any changes made under a Trust Special Administration are subject to consultation.

The CCG also notes the report produced by Mid Staffordshire Hospital Foundation Trust outlines its position as the risks associated with the criteria of the Contingency Planning Team) CPT report with regard to Stafford. The CCG will continue to work with the Trust and the local community to achieve the best possible outcome even though there may be differences of opinion on certain services.

Subject to the appointment of a special administrator the CCG and the Commissioner will be continuing to work with the Trust to deliver its commissioning aspirations for the local community.

Action: The Governing Body is asked to note the above

3.0 Conclusion

There was a significant amount of activity during March to ensure that the CCG can take on its full statutory duties from the 1st April 2013 alongside day to day requirements. The above outlined some of the key elements of that work.

4.0 Recommendations

The Governing Body is asked to:

- **note** the report
- **note** the appointment of Tim Rideout to support the CCGs financial strategy work
- **note** the relevant transition matters
- **agree** that the CCG Chief Officer is nominated as the Emergency Planning and Resilience Accountable Officer
- **note** the proposed approach to the Francis Report and confirm their agreement
- **note** the update regarding the Monitor Review.

Cannock Chase Clinical Commissioning Group

Report to the Clinical Commissioning Group Governing Body TO BE HELD ON: Thursday 4th April 2013

Subject:	Finance Report as at Month 11 (28th February 2013)					
Board Lead:	Andy Chandler					
Officer Lead:	Anne Perry					
Recommendation:	**For Approval**		**For Discussion**	✓	**For Information**	✓

PURPOSE OF THE REPORT:

To present the finance position for the CCG as at Month 11 (28th February 2013) and forecast for 2012/13.

KEY POINTS:

1. This report sets out the in-year financial position at month 11, based on 10 months of Secondary Care data. The CCG is currently showing an overspend of £0.6m against plan. The CCG planned position was break-even at the end of period 11. A number of significant pressures have been identified, details of which are contained within the body of the report.
2. The CCG is still forecasting a balanced position at year end. This is, however, after factoring in the receipt of £2.5m of SHA support and delivering £2.0m of mitigating actions.
3. The CCG holds a £3.6m contingency reserve of which 11/12ths (£3.3m) has been phased into the year to date position.
4. Based on the information from Providers the main significant areas of overspend at Month 11 are with Walsall Hospitals (£1.8m), Royal Wolverhampton (£0.9m), Burton Hospitals (£0.4m), Rowley Hall (£0.4m) and Continuing Health Care (£0.9m).

Relevance to Key Goals

To reduce health inequalities across Cannock Chase through targeted interventions.	Financial Plan supports delivery.
To identify and support patients with Long Term Conditions to ensure care delivery closer to home.	Financial Plan supports delivery.
To improve and increase overall life expectancy.	Financial Plan supports delivery.
To develop integrated services with simple, easy access.	Financial Plan supports delivery.

Implications

Legal and/or Risk	Note the risks identified relating to delivery of Quality, Improvement, Productivity and Prevention (QIPP), Acute Trust Activity and Continuing Care
CQC	None.
Patient Safety	None.
Patient Engagement	None.
Financial	Note the year to date and year end forecast.
Sustainability	None.
Workforce / Training	None.

RECOMMENDATIONS / ACTION REQUIRED:

The CCG Governing Body is asked to:

- **Note** the year to date position of £0.6m deficit, and the value of contingency factored into the month 11 position.
- **Note** the overspend to date on a number of provider contracts and Continuing Health Care.
- **Note** the forecast year end position, associated risks and mitigating actions.

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?			✓
Has an equality impact assessment been undertaken?			✓
Have partners / public been involved in design?			✓
Are partners / public involved in implementation?			✓
Are partners / public involved in evaluation?			✓

1. Cannock Chase CCG Financial Position

1.1. The overall position for the CCG is included in table 1 below. There is a year to date deficit of £0.6m. The detailed position is shown at Appendix 1.

Table 1 - Cannock CCG	Current Performance			Forecast		
	YTD Budget £000	YTD Actual £000	Variance £000	Annual Budget £000	Forecast £000	Variance £000
Acute Contracts	85,969	89,647	3,678	91,693	96,962	5,269
Mental Health	12,512	12,600	88	13,642	13,743	101
Community Services	11,392	11,387	(6)	12,497	12,490	(7)
Other Commissioned Services	17,646	18,276	630	19,252	20,010	758
Total HCHS	**127,520**	**131,909**	**4,389**	**137,084**	**143,206**	**6,121**
Prescribing	19,950	20,347	397	21,685	22,070	385
HQ Recharges	1,492	1,577	85	1,625	1,728	103
Contingency Reserve	3,293	0	(3,293)	3,595	0	(3,595)
QIPP/Other	(1,291)	60	1,351	(1,408)	65	1,473
St HA	2,292	0	(2,292)	2,500	0	(2,500)
Mitigating Actions	0	0	0	0	(1,987)	(1,987)
CCG Total	**153,256**	**153,893**	**637**	**165,081**	**165,081**	**0**

1.2. The CCG is still forecasting a balanced position at the year end, based on 10 months contract information. This position, however, assumes delivering £2.0m of mitigating actions and containing current known risks as outlined at section 4.2.

1.3. The main areas of risk remain around Acute Contracts which show an overspend of £3.7m as at Month 11 which is forecast to increase to c£5.2m at the year end. There is also an over performance on Continuing Health Care at Month 11 of £0.9m with a forecast overspend of £1.0m. QIPP achievement also remains a key area of risk. QIPP achievement has not been good and the current finance forecast position has factored in the non-delivery of £1.9m.

2. Contract Performance

2.1 Walsall Manor Hospital – year to date overspend of £1.8m (forecast overspend £2.0m) with the main areas of pressure identified as Inpatient Emergency (General Surgery, T&O, General Medicine and Geriatric Medicine), Outpatient Follow-Ups (T&O), Inpatient Electives (T&O), Day-case Electives (T&O) and A&E.

2.2 Royal Wolverhampton Hospital – year to date overspend of £0.9m (forecast overspend £1.1m) with the main areas of pressure identified as Emergency Short Stay Non-Electives (Cardiology

& Paediatrics), Outpatient First Attendances (Cardiology, T&O and Ophthalmology), Outpatient Follow-ups (Ophthalmology) and A&E.

2.3 Burton Hospital – year to date overspend of £0.4m (forecast overspend £0.4m) with the main areas of pressure identified as Non-Electives Non-Emergency (specifically Obstetrics) and Non-Electives.

2.4 Rowley Hall – year to date overspend of £0.4m (forecast overspend £0.4m) mainly on Trauma & Orthopaedics and Gastroenterology.

2.5 Mid Staffs Hospitals – year to date underspend forecasting overspend of £1.0m, with the main areas of pressure identified as Day-cases (T&O, Rheumatology and Colorectal Surgery). Non Elective (specifically General Medicine and Obstetrics), Outpatient Procedures First Attendances (Gynae and Diagnostic Imaging)

2.6 Continuing Health Care – year to date overspend of £0.9m (forecast overspend £1.0m).

3. Quality, Improvement, Productivity and Prevention (QIPP)

3.1 The CCG Finance Plan, as previously presented to the Board, has a targeted delivery of £3.6m of QIPP savings. The required savings for each individual scheme have been added to the relevant budget line.

3.2 The current finance forecast position has factored in the non-delivery of £1.9m of QIPP.

4. Contingency/Risks

4.1 The CCG currently holds a contingency reserve budget of £3.6m, £3.3m of which has been released into month 11.

4.2 There are still a number of risks that need to be managed to ensure the CCG achieves a break even position at the end of the financial year namely containing current Acute and Continuing Health Care over performance at current forecast levels and delivering the remainder of the QIPP programme.

4.3 There is an additional financial risk facing the CCG that hasn't currently been factored into the position around the impact of activity flowing to other peripheral providers. This relates to the fact that Burton & Wolverhampton Hospitals have seen a marked increase in emergency admissions from Cannock Chase patients that they believe has caused a significant financial burden on their respective organisations as under PbR they only receive 30% of the tariff for these additional admissions.

4.4 In order to support the year financial position of the overall PCT, a number of actions have been agreed with the Cluster Finance Team in the form of an agreed action plan. In addition a formal financial recovery approach has been taken between now and the year end to ensure that the surplus position is achieved.

5. Mitigating Actions

5.1 As described above, in order for the CCG to break even at the year end, it needs to achieve £2.0m of mitigating actions. The table below shows the current plan as to how this will be delivered together with a RAG risk rating to assess likelihood of delivery.

Action	£m	RAG
Reduction in Prescribing Year End Forecast	0.3	
Continuing Healthcare Provision	0.7	
NHS 111 Service Delayed Implementation	0.1	
Cluster Support	0.9	

Appendix 1

Finance Position as at 28th February 2013

Cannock CCG	Current Performance			Forecast		
	YTD Budget	YTD Actual	Variance	Annual Budget	Forecast	Variance
	£000	£000	£000	£000	£000	£000
Hospital and Community Health Services						
Acute						
Mid Staffordshire Foundation Trust	54,287	54,284	(3)	57,090	58,174	1,085
Burton Hospitals Foundation Trust	4,093	4,495	402	4,462	4,903	441
Heart of England Founation Trust (HEFT)	833	857	24	908	939	30
Royal Wolverhampton Hospital Trust	7,766	8,689	922	8,453	9,570	1,117
Dudley Group of Hospitals	109	116	6	119	127	7
University Hospitals of Birmingham	1,600	1,806	206	1,745	2,006	261
University Hospital North Staffordshire NHS Trust	3,194	3,128	(66)	3,534	3,454	(81)
Derby Foundation Trust	352	374	22	384	395	12
Walsall Manor Hospital Trust	7,017	8,778	1,761	7,637	9,611	1,974
Birmingham Childrens Hospital	732	829	97	799	914	115
Row ley Hall	601	988	387	655	1,100	445
Other acute	5,384	5,304	(80)	5,906	5,769	(137)
Sub-Total Acute	85,969	89,647	3,678	91,693	96,962	5,269
Mental Health						
Sth Staffordshire & Shropshire Healthcare FT	10,573	10,569	(3)	11,528	11,516	(12)
Other Mental Health & Learning Disability Agreements	1,940	2,031	91	2,114	2,227	113
Sub-Total Mental Health	12,512	12,600	88	13,642	13,743	101
Community						
Staffordshire & Stoke on Trent Partnership Trust	11,208	11,186	(21)	12,269	12,237	(33)
Other Community Agreements	185	200	16	228	253	25
Sub-Total Community	11,392	11,387	(6)	12,497	12,490	(7)
Other						
West Midlands Ambulance	3,586	3,820	233	3,902	4,197	295
Continuing Care & Funded Nursing Care	9,983	10,920	937	10,890	11,938	1,048
Other Service Agreements	4,077	3,537	(541)	4,460	3,875	(585)
Sub-Total Other	17,646	18,276	630	19,252	20,010	758
QIPP/Other						
Reserves - Locality	0	0	0	0	0	0
Reserve - Cancer Semen Storage	0	0	0	0	0	0
Reserve - Healthw atch	28	28	0	31	31	(0)
Reserve - M&E NTL Safety Therm	12	12	0	13	13	0
Reserve - WM Perinatal Safety Therm	20	20	(0)	22	21	(0)
QIPP Savings	(1,351)	0	1,351	(1,474)	0	1,474
Contingency Reserve	3,293	0	(3,293)	3,595	0	(3,595)
Planned Surplus	0	0	0	0	0	0
Primary care Workers	0	0	0	0	0	0
StHA	2,292	0	(2,292)	2,500	0	(2,500)
Mitigating Actions	0	0	0	0	(1,987)	(1,987)
Sub-Total QIPP/Other	4,294	60	(4,234)	4,687	(1,922)	(6,609)
Total HCHS	131,814	131,969	155	141,771	141,284	(487)
Prescribing						
GP Prescribing - normal	18,902	19,387	486	20,539	21,035	496
GP Prescribing - High Cost	7	0	(7)	7	4	(4)
Home Oxygen	492	409	(84)	537	434	(103)
Central Topslice	468	434	(34)	511	481	(29)
Essential Shared Care	81	117	35	91	116	25
Sub-Total Prescribing	19,950	20,347	397	21,685	22,070	385
Locality Management						
Locality Management	1,492	1,577	85	1,625	1,728	103
Sub-TotalCCG Management	1,492	1,577	85	1,625	1,728	103
Total Locality	153,256	153,893	637	165,081	165,081	0

Cannock Chase Clinical Commissioning Group

REPORT TO THE Clinical Commissioning Group Governing Body Meeting
TO BE HELD ON: Thursday 4th April 2013

Subject:	Finance Plan 2013/14					
Board Lead:	Andy Chandler					
Officer Lead:	Anne Perry					
Recommendation:	**For Approval**	✓	**For Discussion**	✓	**For Information**	

PURPOSE OF THE REPORT:

To present the Finance Plan including QIPP 2013/14 for approval.

KEY POINTS:

1. This paper presents the process, underlying principles and assumptions used in generating the financial plan for NHS Cannock Chase Clinical Commissioning Group (CCCCG) in 2013/14.

2. The plan includes the plans to spend within our running cost allocation of £3.4m in 2013/14 which equates to £25 per head of patient population.

3. The paper outlines the plan to deliver a £1.4m (1%) surplus in 2013/14 against our programme costs allocation and notes key risks to the delivery of that plan as follows:
   a. Specialised Services allocation adjustment (£9.9m budget removed from CCG baseline which needs to be offset by equal cost reduction).
   b. Operational risks regarding continuing healthcare and emergency admissions growth.
   c. Risk of delivery against significant QIPP savings (c£7.4m) planned for 2013/14.

4. Mitigation is in place against these risks individually but also the CCG financial plan includes provision of the following funding in order to mitigate these and further risks:
   a. 0.5% (£0.7m) Contingency
   b. 2.0% (£3.0m) of the transformation fund will not be committed initially.

Relevance to Key Goals

To reduce health inequalities across Cannock Chase through targeted interventions.	Financial Plan supports delivery
To identify and support patients with Long Term Conditions to ensure care delivery closer to home.	Financial Plan supports delivery
To improve and increase overall life expectancy.	Financial Plan supports delivery
To develop integrated services with simple, easy access.	Financial Plan supports delivery

Implications

Legal and/or Risk	Note the risks identified relating to delivery of Specialised Services, Quality, Improvement, Productivity and Prevention (QIPP), Acute Trust Activity and Continuing Health Care.
CQC	None.
Patient Safety	None.
Patient Engagement	None.
Financial	Note the 2013/14 Financial Position.
Sustainability	None.
Workforce / Training	None.

KEY REQUIREMENTS	Yes	No	Not Applicable
Has a quality impact assessment been undertaken?	✓		
Has an equality impact assessment been undertaken?	✓		
Have partners / public been involved in design?	✓		
Are partners / public involved in implementation?	✓		
Are partners / public involved in evaluation?	✓		

RECOMMENDATIONS / ACTION REQUIRED:

The CCG Governing Body is asked to:

- **Note** the contents of this report.
- **Approve** the Finance Plan and budget for 2013/14 noting the risk contained within the report.

1. Background and Context

The NHS Commissioning Board advised Clinical Commissioning Groups in December of their 2013/14 allocations and in the document "Everyone Counts: Planning for Patients 2013/14" also published in December, the planning principles to be applied when commissioning services including levers and incentives.

The plan incorporates wherever possible local knowledge of developments and cost pressures and current negotiations with providers.

The NHS National Commissioning Board has advised CCGs of their growth uplifts for 2013/14 and specified over-arching financial requirements:

- **Growth** – CCG Growth uplifts and allocations have been announced with allocations increasing for all CCGs by 2.3% - this equates to £3.4m for the CCG.

- **Tariff Inflation** – Tariff inflation has been calculated at 2.7% and has been applied equally to services covered by both national PbR tariff and non-tariff services. This means that the unit cost of commissioned services will increase by 2.7%.

- **Tariff Cost Improvement** – a 4% cost improvement has been set for 2013/14 and will apply equally to services covered by both national PbR tariff and non-tariff services. This means that the unit cost of commissioned services will decrease by 4% (a net reduction of 1.3% in total when aggregated with tariff inflation).

- **Planned Surplus** – CCGs are required to plan for a recurrent surplus of 1% which will be carried forward at the end of 2013/14. This figure for the CCG is £1.4m.

- **Transformation Fund** - CCGs are required to hold a non-recurrent 2% Transformation Fund (headroom); this reserve may only be committed non-recurrently following business case approval by the Area Team. This equates to £3.0m for the CCG.

- **Contingency Reserves** – CCGs are also required to hold a minimum of a 0.5% Contingency Reserve to facilitate management of risks within the Health Economy. This figure for the CCG is £0.7m

2. Financial Principles

The following principles have been applied in constructing the financial plan 2013/14:

- **Population Growth** – this is the growth in services necessary to reflect the change in size and demographics of the population within Cannock Chase.

  In absolute terms, the population is forecast to grow by 0.64% in 2013/14.

- **Cost Pressures 2012/13** – In Year, the CCG has had to deal with levels of service demand greater than anticipated and contracted for, such as activity shifts to providers outside of South Staffordshire, increased emergency admissions and the knock on effect on emergency thresholds and additional ambulance costs as a result of the overnight A&E closure at Stafford Hospital. Some of these additional service demands are recurrent in nature and therefore have had to be funded to set contract levels at 2012/13 outturn levels. The cost of such pressures is calculated to be £4.4m and represents a call upon CCG resources.

  These pressures have previously been reported to both the Membership Board and Governing Body meetings in the forecast financial outturn element of the monthly Finance report.

- **Cost Pressures/Investments 2013/14** – drawing upon the knowledge of Finance and Contract Management Teams across Staffordshire, a number of cost pressures and investments for 2013/14 have been identified, shared and agreed. Using this approach means that when negotiating with a single provider on behalf of all associate commissioners, a common approach has already been agreed.

- **Continuing Health Care (CHC)** – in previous years the CHC budget has only been uplifted by about 3% each year to meet rising demand, however, indications have emerged that the actual forecast overspend has increased and that a higher uplift would be required. Accordingly, it was agreed, in conjunction with the CHC lead, that the budget uplift 2013/14 would be based on a review of actual requirements rather than applying a historic rate of increase. The review indicated that a minimum budget uplift of 7% was more reflective of current demand growth.

- **Specialised Services** – the list of services to be commissioned as specialised by the National Commissioning Board has now been finalised and the corresponding financial adjustments advised. The CCG's allocation has therefore been reduced by a further £9.9m compared to the original assessment when the dis-aggregation returns were first submitted in early 2012/13.

- **QIPP** – The QIPP programme which is a large scale transformational programme is essential in ensuring the NHS makes the best use of available resources and thereby ensuring financial balance is maintained. The QIPP for 2013/14 is circa £7.4m and the overarching schemes are:

Level One - Global Summary	
Date	19/03/2013
Version	0.7
QIPP Challenge	£7,434,928
Value	£7,434,928
Gap	**£0**

Programme	QIPP	Target £	RAG
Transactional	Various	504,500	G
Transactional		**504,500**	**G**
Planned	Reduction in 1st OPA		
Cannock	5% reduction in 1ST OPA	583,068	A
Total		**583,068**	A
Planned	reduction in elective admissions		
Cannock	5% reduction in elective admissions	1,153,745	A
Total		**1,153,745**	A
Planned		**1,736,813**	**A**
Unplanned	A&E attendances		
Cannock	6% reduction in A&E	272,506	R
Total		**272,506**	R
Unplanned	NEL admissions		
Cannock	6% reduction in NEL admissions	2,388,386	R
Total		**2,388,386**	R
Unplanned		**2,660,892**	**R**
Med Mgt	Medicines Mgt	750,000	A
Med Mgt		750,000	A
Other	Finance Strategy (TBC)	1,782,723	A
Other		1,782,723	A
Total		**7,434,928**	A

Details of the QIPP schemes have been outlined and are provided in Appendix 1.

- **CQUIN** – Nationally, the percentage of turnover which can be paid under the CQUIN arrangements remains at 2.5%. As this is based, however, on turnover and contract values have increased due to cost pressures etc., the CCG has had to commit additional resources to meet the increase in CQUIN payments.

- **Transformational Funds** – The Commissioning Board requires CCGs to set aside 2% of their recurrent baseline on a non-recurrent basis. This equates to £3.0m for Cannock Chase CCG. Although precise arrangements have yet to be notified, it is understood that funding will be released back to CCGs upon approval of business cases by their Area Team.

3. Summary Resource and Expenditure Plan

The Summary Resource and Expenditure Plan has been constructed using the growth uplift, Everyone Counts requirements and overarching principles and applying them to the 2012/13 rollover budgets.

The net result is a financial plan which is in balance and includes known cost pressures and developments.

The Plan is summarised below:

Sources	**£'000**	**Applications**	**£'000**
Recurrent Allocation	145,826	Outturn 2012/13	156,983
		Cost Pressures	4,371
		Contingency Reserve (0.5%)	745
		Specialised Services	(9,931)
Growth	3,354		
Sub Total	**149,180**	**2012/13 Rollover Budgets**	**152,168**
Running Costs	3,393	Net Provider Inflation / Efficiency	(226)
		Demographic / Non Demographic Growth	1,435
		2013/14 Cost Pressures & Developments	527
		Running Costs	3,393
Non Recurrent Allocations			
- Return of PCT Surplus 2012/13	177	QIPP Schemes	(7,435)
- Social Care Funding	1,573		
		Transformational Reserve (2%)	3,019
Total Sources	**154,323**	**Total Applications**	**152,881**
		Surplus (to meet NCB Requirement)	**1,442**

In regard to the summary, the following points should be noted:

a) The surplus of £1.4m represents the requirement for the CCG to deliver a 1% surplus.
b) The plan is in financial balance.
c) The CCG is required to hold a non-recurrent 2% Transformational Fund.

A more detailed plan is shown at Appendix 2.

4. Risks and Mitigation

The financial plan involves a degree of financial risk which has been assessed and included in the returns submitted to the Area Team over the last month.

The following areas of significant risk have been identified:

Specialised Services – The most significant risk to the CCG is the top slice of allocation (£9.9m) in relation to the Specialised Services algorithm and whether or not the apparent reduction in CCG expenditure will take place as a result. Initial analysis suggests it will be very difficult to transact the changes proposed to the specialised algorithm and as such a large proportion of specialised expenditure may continue to be charged to the CCG by Providers. The risk is further compounded for CCGs by the fact that the final specialised algorithm is different to that which was expected at the time that specialised commissioning colleagues completed their returns to the DoH in the summer. So far only £3.7m has been extracted from Provider contracts leaving £6.2m still unaccounted for.

QIPP Delivery – Given the scale of the QIPP challenge there is clearly a risk of deliverability of the full scale of the savings planned. The current QIPP plans have been RAG rated and an assessment made as to level of confidence of delivery.

Contracting – Key operational risks for the CCG involve containing growth in Emergency Admissions and Continuing Health Care expenditure. Many parts of the CCG's planned activities for the year revolve around actions to mitigate these risks including growth assumptions and delivery of QIPP schemes in these areas.

In mitigation of the financial risks within the plan, the CCG has the following reserves:

- Contingency Reserve £0.7m
- Transformational Fund (2%) £3.0m
- Planned Surplus £1.4m

5. Conclusion

The CCG has prepared and submitted a balanced financial plan to the Area Team.

In constructing the plan, the notified allocations have been incorporated, where allocations are anticipated these have been clearly described and the corresponding expenditure included in the plan.

Expenditure plans meet DoH requirements for reserves and includes all known forecast cost pressures, adjustments for efficiencies and Pay & Prices etc.

Inevitably, the plan includes an element of financial risk, though mitigation is in place, work will continue throughout the financial year to clarify further the degree and level of risks and ensuring additional mitigations are put in place as required.

6. Recommendations

The Cannock Chase Clinical Commissioning Group is requested to:

- **Note** the contents of this report
- **Approve** the Financial Plan and budget for 2013/14 noting the risk contained within the report.

Appendix 1

QIPP PLAN 2013/14

					£ Impact		Expected Impact				
		Lead	Clinical Lead	PID	Best	Investment	Q1	Q2	Q3	Q4	RAG
Transactional	Trigger point	Ashleigh Gibbs	NA	NA	198,000	No					G
	Wheelchair	Rebecca Johnson	NA	NA	60,000	No					G
	Nursing home	Tammy Lott	NA	NA	146,500	No					G
	Integrated Equipment	Rebecca Johnson	NA	NA	100,000	No					R
					504,500						
Planned	Vasectomies	Alex Bennett		Yes	10,000	No					A
	MSK Phase 1	Mel Savage	Gary Free	Yes	536,298	Net					A
	MSK Phase 2	Mel Savage	Gary Free	Yes	0	Unknown					A
	PLCV	Alex Bennett	Gary Free	No	210,162	No					A
	Planned Care Pathways	Alex Bennett	Gary Free	No	100,000	No					A
	Demand Management	Alex Bennett	Gary Free		880,353						A
					1,736,813						
Unplanned	EUCS	Alex Bennett	Sue Knight	No	234,233	No					R
	AEC	Alex Bennett	Sue Knight	No	0	Unknown					R
	Respiratory	Alex Bennett	Sue Knight	Yes	0	No					R
	Diabetes Paediatric	Alex Bennett	Sue Knight	No	0	Unknown					R
	UTI	Jonathon Bletcher	Tim Berriman	Yes	0	No					R
	Falls	Jane Chapman	Anna Onabalou	Yes	0	Net					A
					975,459						R
					1,209,692						
Coordinated Care	LTCs programme	Ashleigh Gibbs	Adel Adelfy	Yes	141,000	Yes					A
	Nursing Homes	Tammy Lott	Anne Marie Houlder	Yes	70,500	Yes					A
	Continence	Rebecca Johnson		Yes	4,700	No					A
	Dementia	Jonathon Bletcher		No	235,000	Outcome					A
					451,200						
Prescribing	HOS-AR	Ashleigh Gibbs	Dr Cooke	Yes	12,223	Net					G
	Med Mgt	Jane Chapman		No	681,868						A
	BGTS standardisation	Ashleigh Gibbs	Dr Cooke	Yes	45,909	Net					G
	Diabetes Procurement	Ashleigh Gibbs	Dr Cooke	Yes	10,000						A
					750,000						
Primary Care	Primary Care Incentive Scheme	Jonathon Bletcher	Mo Huda	No	1,000,000	Outcome					A
					1,000,000						
Other	Finance Strategy (TBC)				1,782,723						A
					1,782,723						
Total					7,434,928						

***Supported by:**

Clinical leadership programme

Practice support packs

Self Management programme

GP peer networks

Appendix 2

FINANCE PLAN 2013/14

Cannock Chase CCG	Annual Budget £000
Hospital and Community Health Services	
Acute	
Mid Staffordshire Foundation Trust	52,900
Burton Hospitals Foundation Trust	3,755
Heart of England Founation Trust (HEFT)	946
Royal Wolverhampton Hospital Trust	9,497
Dudley Group of Hospitals	168
University Hospitals of Birmingham	1,915
University Hospital North Staffordshire NHS Trust	2,790
Derby Foundation Trust	374
Walsall Manor Hospital Trust	9,965
Birmingham Childrens Hospital	874
Row ley Hall	1,259
West Midlands Ambulance	4,306
Other acute	3,804
Adjustment (Specialised Services)	(6,238)
Sub-Total Acute	86,315
Mental Health	
Sth Staffordshire & Shropshire Healthcare FT	12,017
Other Mental Health & Learning Disability Agreements	1,519
Sub-Total Mental Health	13,536
Community	
Staffordshire & Stoke on Trent Partnership Trust	12,149
Other Community Agreements	1,723
Sub-Total Community	13,872
Other	
Continuing Care & Funded Nursing Care	11,085
Other Service Agreements	4,884
Sub-Total Other	15,969
QIPP/Other	
QIPP Savings	(7,435)
Contingency Reserve	745
Other Reserves	0
Planned Surplus	1,442
2% Non Recurrent	3,019
Sub-Total QIPP/Other	(2,229)
Total HCHS	127,463
Prescribing	
GP Prescribing - normal	21,969
Other	1,498
Sub-Total Prescribing	23,467
Locality Management	
Running Costs	3,393
Sub-TotalCCG Management	3,393
Total Locality	154,323

Cannock Chase Clinical Commissioning Group

Financial Plan 2013/14

Background & Context

- CCGs advised of 2013/14 in Dec 12
- All CCGs received uplift of 2.3% (£3.4m)
- "Everyone Counts" – Planning Principles
  - Planned Surplus of 1% (£1.4m)
  - 2% Recurrent Funding for Non-Recurrent Expenditure (£3.0m)
  - 0.5% Contingency Reserve (£0.7m)
  - National Efficiency of 4% offset by Inflation of 2.7% (i.e. net deflator of 1.3%)

Financial Principles

- **Following Principles have been included in the plan:**
- Population Growth (0.64%)
- Cost Pressures 2012/13 - equates to £4.4m
- Cost Pressures / Investments 2013/14
- Continuing Health Care – 7% uplift
- Specialised Services – allocation reduced by £9.9m
- QIPP – Plan for 2013/14 circa £7.4m
- CQUIN – remains at 2.5%
- Transformational Funds – 2% of recurrent baseline set aside on a non-recurrent basis

Summarised Resource & Expenditure Plan

Sources	£'000
Recurrent Allocation	145,826
Growth	3,354
Sub Total	**149,180**
Running Costs	3,393
Non Recurrent Allocations	
- Return of PCT Surplus 2012/13	177
- Social Care Funding	1,573
Total Sources	**154,323**

Applications	£'000
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Specialised Services	(9,931)
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QIPP Schemes	(7,435)
Transformational Reserve (2%)	3,019
Total Applications	**152,881**
Surplus (to meet NCB Requirement)	**1,442**

Risks and Mitigation

Risk	Mitigation
Specialised Services – only £3.7m extracted from Provider contracts leaving £6.2m still unaccounted	• Involvement in SHA review process • SHA 'risk pool'
Delivery of QIPP financial savings	• Regular monthly monitoring of QIPP plans • Secure additional in year QIPP to ensure headroom in financial position • 2% Transformation Fund
Emergency Admissions & Continuing Health Care Expenditure	• Regular monitoring of contract performance • Apply contract terms in full • Contingency Reserve in place • Regular reporting to Board

QIPP Challenge

Level One - Global Summary	
Date	19/03/2013
Version	0.7
QIPP Challenge	£7,434,928
Value	£7,434,928
Gap	**£0**

Programme	QIPP	Target £	RAG
Transactional	Various	504,500	G
Transactional		**504,500**	**G**
Planned	Reduction in 1st OPA		
Cannock	5% reduction in 1ST OPA	583,068	A
Total		**583,068**	A
Planned	reduction in elective admissions		
Cannock	5% reduction in elective admissions	1,153,745	A
Total		**1,153,745**	A
Planned		**1,736,813**	**A**
Unplanned	A&E attendances		
Cannock	6% reduction in A&E	272,506	R
Total		**272,506**	R
Unplanned	NEL admissions		
Cannock	6% reduction in NEL admissions	2,388,386	R
Total		**2,388,386**	R
Unplanned		**2,660,892**	**R**
Med Mgt	Medicines Mgt	750,000	A
Med Mgt		750,000	A
Other	Finance Strategy (TBC)	1,782,723	A
Other		1,782,723	A
Total		**7,434,928**	A

Finance Plan 2013/14

Cannock Chase CCG	Annual Budget £000
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NHS

Cannock Chase Clinical Commissioning Group

Discussion & Questions

NHS Cannock Chase Clinical Commissioning Group

Report to the Clinical Commissioning Group Governing Body
TO BE HELD ON: 4th April 2013

Subject:	Everyone Counts – Planning for Patients					
Board Lead:	Andrew Donald					
Officer Lead:	Jonathan Bletcher					
Recommendation:	**For Approval**	✓	**For Discussion**		**For Information**	

PURPOSE OF THE REPORT:

In December 2012 the NHS Commissioning Board published its planning guidance for 2013/14, called "Everyone Counts – Planning for Patients", this document outlines the targets for the national and locally determined priorities. From 2014/15 the quality premium will be used to reward CCG's for measurably improving the quality of services commissioned, associated improvements in health outcomes and a reduction in health equalities.

Furthermore the guidance set out five offers from the Board to support commissioners to produce better health outcomes:

- Seven day working
- More transparency and choice
- Listening to patients and increasing their participation
- Better and more consistent data
- Safer care

KEY POINTS:

Supporting the Commissioning Process:

The Quality Premium will be available to CCG in 2014/15 if the CCG can demonstrate that it has improved or achieved a high standard of quality. The four national targets applied to NHS Cannock Chase are based on measures within the NHS Outcome Framework, these are:

1. To reduce or stabilise avoidable emergency hospital admissions based on a composite of four indicators.
2. Reduction in years of life lost form avoidable death.
3. Reduce health care associated infection.
4. Improve patient experience of hospital through the roll out of the friends and family test.

In addition to the national priorities and in accordance with Everyone Counts Planning Guidance Cannock Chase CCG has submitted three local targets. These have been identified and prioritised from the CCG's Integrated Plan and will be presented to the NHS Commissioning Board Area Team.

Local Targets - Proposed local priority target 2013/14

- Increasing number of patients accessing stop smoking services
- Increase the number of patients accessing NHS Health Checks
- Managing the unwanted variation in hypertension by increasing the reporting levels of this condition

This approach enables the CCG to respond to local needs and health challenges identified within our local plan.

In order to respond to the requirements of Everyone Counts and the NHS Outcome Framework the

CCG has prepared a 'strategic' plan on a single page. A copy of the NHS Cannock Chase CCG plan is presented in Appendix 1.

RELEVANCE TO KEY GOALS

To reduce health inequalities across Cannock Chase through targeted interventions.	Yes
To identify and support patients with Long Term Conditions to ensure care delivery closer to home.	Yes
To improve and increase overall life expectancy.	Yes
To develop integrated services with simple, easy access.	No

IMPLICATIONS

Legal and/or Risk	N/A
CQC	N/A
Patient Safety	N/A
Patient Engagement	N/A
Financial	Supports access to the CCG quality premium
Sustainability	N/A
Workforce / Training	N/A

RECOMMENDATIONS / ACTION REQUIRED:

The CCG Governing Body is asked to:
The Governing Body is asked to approve the Everyone Counts plan 2013/14.

Everyone Counts Planning – 2013/14

The proposed targets set for Everyone Counts planning for 2013/14, have been informed by the analysis of the data from the Atlas of Variation (Right Care), the need to reduce the variation across practices and to move towards National or Office of National Statistics (Peer Group) averages.

Whilst the targets are ambitious the majority of the schemes need to deliver these targets are either worked up or being developed to deliver the changes needed to deliver the proposed targets. Clinical engagement and cross agency working will also be essential in the delivery of these plans. It is recognised that support from primary care clinicians will be needed to support the use of referral pathway etc.

An overview of the targets can be seen in the table below.

Table 1: Percentage reduction for 2013/14 for NHS Cannock Chase CCG.

	Cannock Chase
1st OPA	5% reduction
Elective FFCE's	5% reduction
NEL FFCE's	6% reduction
A & E Attendances	6% reduction

Key:
OPA – Out Patients Appointment

FFCE's – First Finished Consultant Episodes

NEL – Non Elective Admissions

For first outpatient and elective admissions has been set at a 5% reduction to ensure the CCG is moving towards its national average (the actual reduction required to meet this lower target would be 9%). The A & E attendances and the NEL's have remained at 6% which is in line with the CCG's 5 year target within the commissioning intentions and on achieving the National or ONS (CCG Peer Group) average.

Local Targets - Proposed local priority target 2013/14

- Increasing number of patients accessing stop smoking services
- Increase the number of patients accessing NHS Health Checks
- Managing the unwanted variation in hypertension by increasing the reporting levels of this condition

National guidance has meant that a number of the more obvious local targets that the CCG would have wished to be included could not be used. The proposed local targets have been identified as they support the CCG desire to reduce the variation in QoF registers and increase prevention activities.

Two of the above targets will support the local public health priorities and are key areas that if addressed will reduce health inequalities. Although Primary Care will be important to delivery of these targets, a wider approach will also be developed this will include self-care and promoting service access. Funding for the NHS Health Check and Smoking Cessation activity will come via public health programmes.

Responsibility of the Membership Board and Governing Body:
The CCG Membership and Governing Body will need to drive the implementation of Everyone Counts. In particular the Governing Body will be annually assessed on how its plans have:

- Improved the quality of services
- Reduced inequalities
- Sought and used professional/clinical advice
- Involved the public
- Met its financial duties and take account of local health and wellbeing strategies.

Cannock Chase CCG Everyone Counts Planning 2013/14

Cannock Chase Clinical Commissioning

Needs Context & Challenges

Gaps in life expectancy and higher premature mortality rate particularly in cancer and CVD	Ageing population particularly in over 75 year olds	12% of CCG population live in the 20% most deprived areas in England	Problems with access and patient flow through urgent care system	Financially challenged acute Trust which is clinically and financially unviable	CCG significant QIPP Challenge

Goals (to be delivered by March 2018)	Programmes	Transformation Change Scheme 2013/14	Target 2013/14	Outcomes	Risk
The vision of Cannock Chase Clinical Commissioning Group is to commission high quality and safe services to ensure people live healthier longer lives **Our Values are**:- **Prevention**: Increasing the years of quality living through targeted provision **Quality**: Commissioning high quality, safe treatment and care focused on individual needs **Education**: Educating patients to improve self care **Innovation**: Responding to needs through engagement, innovation and change **As a CCG our goals are to:-** To reduce health inequalities through targeted interventions To identify and support patients with long term conditions to ensure care delivery is close to home To increase overall life expectancy To develop integrated services with simple, easy access **NHS Outcomes Framework** Domain 1: Preventing people from dying prematurely Domain 2: Enhancing quality of life for people with long term conditions Domain 3: Helping people to recover from episodes of ill health or following injury Domain 4: Ensuring that people have a positive experience of care Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	**Planned Care** The CCG is an outlier in relation to both the national average and ONS Median for GP first outpatient rates and elective admissions. A strategy for the reconfiguration of surgical pathways has been agreed with local providers. This will need to be undergo review following the outcomes of the Monitor Report at Mid Staffordshire Foundation Trust.	• Better care pathways and GP to Consultant communication reducing growth in hospital referrals and subsequent treatments • Reduction in outpatient follow ups and face to face consultations • Optimisation of treatment at the appropriate time avoiding unnecessary intervention	5% reduction = 1,435 1st OPA (target of 27,272) and 1,029 EL (target of 19,548) admissions 25% reduction = 198 procedures	• Reduction in first outpatient attendance **(CI)** • Reduction in elective admissions reducing unnecessary steps in the pathway and improving patient satisfaction **(CI, EC, OF)** • Improved New : Follow Up ratio's avoiding unnecessary appointments for patients **(CI)** • Reduction in procedures of low clinical value ensuring patients are not treated inappropriately **(CI)**	Difficulties in changing embedded NHS culture Delays in redesign work Instability of healthy economy flow due to Francis Report and Monitor Review of Mid Staffordshire Foundation Trust
	Unplanned Care The CCG is an outlier in relation both the national average and ONS Median for non elective admissions There is local agreement to transform the emergency and urgent care system. This will include the development of an ambulatory care unit, review of MIUs, GP out of hours service and a model for integrated and social care The CCG is also exploring the introduction of a GP enhanced LES to reduce unnecessary hospital admissions from nursing homes.	• EUCS - modernising services which are sustainable and of high quality across the local health economy. Efficient access and rapid assessment as alternatives to hospital admissions. Implementation of NHS 111 AEC unit, review of MIUs and ICT/Social Care model. • Nursing Homes - targeted support to nursing homes to avoid unnecessary hospital admissions	6% reduction A&E attendances = 2,793 (target of 43,760) NEL admissions = 761 (target of 11,928) Included in numbers above	• Reduction in A&E Attendance / Emergency attendances & admissions (adults & children) (**EC, OF, CI**) • Delivery of care close to home, easy access and improved patient satisfaction • Reduction in A&E and emergency admissions through case management of patients to ensure optimal care in the home setting **(CI,OF,EC)**	Difficulties in changing embedded NHS culture Delays in redesign work Instability of healthy economy flow due to Francis Report and Monitor Review of Mid Staffordshire Foundation Trust
	Co-ordinated Care To develop a holistic integrated care model which encompasses a preventative, anticipatory and whole person approach to ensure patients with LTC, Dementia and mental health problems feel supported to manage their condition, they have improved functional ability and can access care close to home. It will also ensure that care across all sectors are integrated and seamless	• LTC - Provision of high quality integrated care through roll out of risk stratification and case management. Care pathway reviews and patient self management • Dementia - Increased diagnosis rates and improve access to treatment. Ensuring there is sufficient capacity for step down and on-going management • Mental Health - Improve access to services	6% reduction A&E attendances & NEL admissions included in unplanned care figures 60% - increase to 992 on register (from 710 cases) 13% - increase by 182 patients (1,458 patients receiving treatment) 50% target CC currently achieving 45%	• Reduction in A&E Attendances / Emergency admissions. Delivery of care closer to home, easy access and improve patient self management and satisfaction **(CI,OF,EC)** • Increased number of diagnosed patients on the register accessing services and support **(OF,CI,C)** • Increased patients receiving first treatment **(M, EC, CI, C)** • Increased number of patients in recovery within 2 years **(M, EC, CI, C)**	Difficulties in changing embedded NHS culture Delays in redesign work. Instability of healthy economy flow due to Francis Report and Monitor Review of Mid Staffordshire Foundation Trust Insufficient IAPT compliant capacity to meet demand Ability to capture robust data
	Primary Care Clinically appropriate evidence based performance of care linked to local quality premium under development	• Increase number of diagnosed patients with hypertension reducing long term complications associated with undiagnosed disease **(local priority)** • Increasing life expectancy - increasing the number of patients accessing stop smoking services and quitters at 4 weeks and increasing the number of health checks for all patients **(local priority)** • Improve patients health and well being and increase number of patients on disease registers and ensure access to appropriate treatment **(local priority)** • Management of unwarranted variation across practices to include practice level peer review in relation to referral management, and optimisation of community services across both planned and unplanned care	Increase number of patients on register in 2011/12 by 3% (target 21,040 on register) 8.5% access - increase by 231 patients (target 2,153 patients accessing service) 49% quitters - increase by 188 patients (target 1,055 patients quitting) 10% target (National average) increase by 1,443 patients to 3,936 accessing health checks To achieve peer group and/or national average in line with planned care/unplanned activity above - 5% & 6% reduction respectively	• Increased number of patients diagnosed with hypertension improving health and well being and reducing health related comorbidities **(OF, CI, M, C)** • Increased numbers accessing smoking cessation service and increase in quitters at 4 weeks **(OF,CI,M,EC)** • Increase number of health checks promoting health and well being, self management and early diagnosis leading to improved outcomes • Reduction in referrals and activity on secondary care **(OF, CI, M)**	Difficulties in identifying patients. Accurate coding in General Practice. Difficulties in changing embedded NHS culture Public Health delivery of services Difficulties in changing embedded NHS culture. Difficulty in identifying patients and accurate coding in General Practice Difficulties in changing embedded NHS culture. Delays in redesign Instability of healthy economy flow due to Francis Report and Monitor Review of Mid Staffordshire Foundation Trust

Key Principles

Choice **Quality & Equality** **Evidence based - need lead** **Information & Performance management** **Risk Management Strategy** **Partnership working** **Patients Voice** **Risk Management Strategy**

Key: OF = outcomes framework M = mandate CI = commissioning intentions C = NHS constitution EC = everyone counts 2013/14