Delivering the Five Year Forward View in East Staffordshire:

ESCCG Operational Plan 2016/17

Forward by East Staffordshire CCG Chairman: Dr Charles Pidsley

I am very proud to be the clinical leader of East Staffordshire CCG. I also feel very privileged to chair that same organisation with a team made up of so many hardworking, enthusiastic, innovative and energetic people. In the last twelve to eighteen months the team has been responsible for a procurement exercise that has contracted with a major nationwide health provider to transform and provide services that are integrated for people with frailty and Long term conditions. We have an outcomes based prime contract, with fixed financial envelope. This contract which will take effect from April 2016, will be amongst the first of its kind; certainly at a similar scale, to take effect in this country, and is already attracting a lot of positive interest from other commissioners. A major contributing factor to this initiative moving forward at pace, has been the engagement of clinical leaders and General Practitioners within the CCG. They have understood the need for such change and given it their support. This has been particularly evident in the considerable public engagement that has taken place over the last 3 years. That engagement has given us the incentive to introduce change. Patients have told us that they want to feel safe supported and informed as well as involved in their care. The existing services by and large did not provide this. These needs have become the core of the Improving Lives Programme and prime contract. Public engagement has also demonstrated that clinical leadership and direction is important to patients who are prepared to listen to those clinicians who step outside the safety of their consulting rooms and stand up in front of the public to listen and inform. To that end I am grateful to my GP colleagues who have served as executives on the CCG Governing Body, working outside busy practices to contribute to the CCG success.

This Operational Plan outlines how the Improving Lives procurement and other important work streams will progress. Key to this is the emphasis of joint collaborative working with our other CCG colleagues in the Staffordshire Together We're Better Transformation Programme. CCG team members and leaders are contributing to significant parts of the Programme particularly the planned care work stream. This is led by Tony Bruce our Accountable Officer and I continue to Co- Chair the Health and Wellbeing Board which provides oversight and direction to all elements of Staffordshire Health and Social Care. The area of provider engagement and involvement is one which will be developed further in the next 12 months.

East Staffs CCG understands the key elements of the Government's mandate to the NHS and the 2016/17 9 'must do's' our response to that is outlined within this document, with particular emphasis on improving outcomes, reducing inequalities, reducing unwarranted variability and implementing the recommendations of the Five year forward view.

Key to the success of the operational plan will be a strong and sustained primary care service. This document outlines how ESCCG will deliver this within the Staffordshire Primary Care Strategy.

Most importantly this document will outline how the CCG will achieve its commissioning aims within the strict financial envelope given to us with particular reference to the area of Mental Health expenditure and parity of esteem.

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1. Executive Summary

Our 2016/17 Operational Plan sets out our plan to secure delivery of the triple aims of the Five Year Forward View (FYFV) through improving health outcomes and reducing variation, improving the quality and experience of services patients receive and the financial health of NHS organisations locally.

As local system leaders we have led the development of a common vision for the future; through innovative extensive engagement and collaboration with patients, communities; our clinical membership, key provider colleagues and partners in Staffordshire.

East Staffordshire Clinical Commissioning Group (ESCCG) works very much within a "family" of NHS organisations and wider public service partners; through the Health and Wellbeing Board, the Collaborative Commissioning Congress, the East Staffordshire Systems Resilience Group (SRG), Local Strategic Partnership and the Better Care Fund (BCF) arrangements. We are an integral part of the Staffordshire Sustainability and Transformation Planning Footprint, however, we continue to work in collaboration with Derbyshire CCGs. This is to ensure an aligned commissioner view on the Burton Hospital Foundation Trust (BHFT) and Derby Hospital Foundation Trust sustainability plans respectively recognising the size of unplanned, planned and community care delivered by providers in Derbyshire.

Our CCG has played an active part in formulating the various governance processes for the Collaborative Commissioning Congress. The CCG's Head of Governance has actively led a number of governance task and finish groups in conjunction with the other participant CCGs and Staffordshire County Council. These have developed the Terms of Reference for the Congress and its associated sub-groups. One such task and finish group is currently shaping the core Decision Making Framework for the Congress going forward. This work has involved engaging with all CCG Governing Bodies and Council Cabinets to elicit their views on how the Congress can make quick but statutorily-appropriate transformation decisions. References have been made outside the Staffordshire Economy to the Manchester Devolution model to ensure that the key lessons learned elsewhere have been captured, and that all stakeholders' own sovereign governance requirements and statutory duties are protected as we shape the decision that will transform care services across the county.

We have been working with our public service colleagues for some time to develop both the Staffordshire Health and Wellbeing Strategy (HWS) and the pan Staffordshire Together We're Better (TWB) Transformation Programme (please see Appendix 3). Locally we have engaged extensively to develop both the East Staffordshire Delivery of Change Strategic Plan and the Improving Lives Programme which includes all unplanned care services for our adult population.

As a CCG we have been at the heart of developing joint working across Staffordshire and we are ambitious to realise the benefits it offers to local communities and the sustainability of NHS services; within the challenging financial climate we are operating in. We feel well placed to develop our part of the Staffordshire Sustainability and Transformation Plan (STP) and this will continue to drive our CCGs transformation of services.

As an NHS "family" we will be working together to develop the current HWS and the TWB Case for Change into a STP for Staffordshire and Stoke on Trent. Our CCG Chairman Dr Charles Pidsley Co- Chair's the Health and Wellbeing Board which provides oversight and direction to all elements of Staffordshire Health and Social Care. Our CCG Team lead on 3 work streams and are actively engaging and contributing to significant parts of the Programme including:

- Planned Care work stream led by Tony Bruce, Accountable Officer and supported by Nicky Harkness and Emily Davies
- Commissioning and Contract Models led by Wendy Kerr, Chief Finance Officer
- Quality work stream led by Heather Johnstone, Chief Nurse
- Governance systems and process support to Chair and Transformation Board, Paul Winter, Head of Performance and Governance.

Our 2016/17 Operational Plan outlines:

- How we are taking the transformation agenda forward locally as Year 1 of the emergent STP (building on the HWS and the TWB Programme) and how risks to delivery across our system have been jointly identified and mitigated through locally agreed plans.
- How we will address the 2016/17 operational planning requirements set out in the Planning Guidance: Delivering the Forward View 2016/17.
- How we address the small number of shortfalls in current quality and constitution standards.

As a CCG we recognise that times are challenging in the NHS locally but we remain optimistic and committed to achieve not only the constitutional standards but also the best possible outcomes, experiences and value for our citizens and our hard working NHS workforce.

This plan outlines the following:

- The strategic transformational programmes we are working on in 2016/17 to achieve the triple aims of the FYFV.
- The transactional and developmental change plans we have in place to deliver improved outcomes and reduce variation within our agreed financial envelope.
- The improvements in performance against the constitutional standards required and the actions we are taking along with the other non-constitutional performance standards we are focusing on to seek improvements.
- The finance and activity plans we have developed to underpin our transformational programmes and QIPP improvements to meet the national planning requirements and business rules specific to 2016/17.
- How we will be assured that the quality and safety of services in East Staffordshire is maintained.

- How we will continue to engage with our patients and local population to hear their views on how we can develop the best possible patient experience outcomes to commission our services against.

2. Delivering the Forward View: Year 1 of our 5 Year Sustainability and Transformation Plan

2.1 Introduction

ESCCG falls in the Staffordshire County Council area and is predominately covered by the area governed by East Staffordshire Borough Council with a small part of its population falling under Lichfield District Council.

Our CCG serves a population of 137,000 residents and has been formed by the 18 general practices within the East Staffordshire Borough Council Boundary that includes Burton on Trent and Uttoxeter.

Our membership GPs have historically worked very well together under the remit of Practice Based Commissioning and then following authorisation of the CCG. Our mission statement is:

'East Staffordshire CCG member practices will work together, and with stakeholders, sharing best practice and expertise. With this we shall strive for significant improvements in the overall health of the population we serve whilst at the same time achieve a sustainable local health economy and reduce health inequality.'

ESCCG has a current budget of £158 million per annum to improve the health of 137,000 local people and to reduce variation in outcomes and health inequalities by commissioning appropriate safe and high-quality health services.

We are have used the NHS Right Care approach to support the identification of operational productivity improvements that have to be made to make significant improvements in the overall health of our population along with the feedback from our patients/population, providers and partners. This has led us to use a transformational approach to the programmes of work we are progressing to ensure delivery against the 9 'must dos' for 2016/17. We are taking decisive steps to break down the barriers in how care is delivered and enable patients to have greater control and independence in managing their care. We have collaborated with our partners to align our CCG aims and set a strategic vision and develop the following programmes together:

- The Improving Lives Programme (unplanned care-adults)
- Together We're Better Transformation Programme including planned care and mental health
- Primary Care Local Delivery Plan
- East Staffordshire System Resilience Plan

We inherited a deficit budget and have been determined to address this using our Quality, Innovation, Productivity and Prevention Programme (QIPP) as the main vehicle to deliver the transactional and developmental improvements required to improve patient outcomes, reduce variation, increase value for money and efficiency whilst reducing costs.

Our progression of the emergent STP will be taken forward in 2016/17 through:

- Continued active engagement in the pan Staffordshire collaborative arrangements to shape and progress the STP across the Staffordshire footprint.
- Local implementation of the first stages of the transformation programmes will be driven through the 2016/17 QIPP Programme.
- Continued collaboration with Derbyshire CCGs and aligned commissioner view on the Burton Hospital Foundation Trust (BHFT) and Derby Hospital Foundation Trust sustainability plans respectively including their proposed collaborations and service plans.

2.2 Strategic Transformation

The Improving Lives Programme

We are taking forward the Pan Staffordshire Frail Elderly and Long Term Conditions (LTCs) Strategic Service model through mobilisation on 1 April 2016 of our innovative Improving Lives Programme with our Prime Contractor Virgin Care. Virgin Care, as the prime contractor and system integrator of all adult unplanned care services, will lead an integrated service network of providers and wider partners. They will implement the strategic model through integrated and collaborative leadership and through aligned goals and incentives; driving a transformation in care models and collaborative relationships. Virgin Care are contracted to achieve meaningful Outcomes; rather than undertake units of activity. This will enable the whole system to focus on doing what adds value to patient outcomes and reduce unnecessary and avoidable admissions into hospital. ESCCG and Virgin Care will be working collaboratively through the BCF arrangements and the TWB Programme to both aid achievements in ESCCG and to accelerate progress across Staffordshire through shared learning. Success will see health outcomes improved and a reduction in variation, reduction in emergency activity, reduction in avoidable admissions, patient satisfaction and activation increased and system costs reduced.

This innovative and ambitious programme will see emergency admissions for services in scope of the prime contract reduce by 10% in 2016/17 through joint system leadership, integrated care and up-front investment in new care models. Our right care data indicates that the average complex patient has 7 inpatient admissions per year across 3 conditions and that the majority of patients are aged 65 and over. Our benchmarked opportunity for increased value across unscheduled and emergency care system lies in improving the health outcomes in respiratory, genito-urinary (urinary tract), gastro intestinal conditions and trauma/ injuries.

There is significant overlap between Long Term Conditions and Frail Elderly provision, with multiple services supporting the same individual and services working in silos. Work with our patients, providers, and local communities indicated that a population based approach that is outcomes focused proactively encourages the delivery of holistic and integrated provision which is centred on the patient and their needs. This is what the 'Improving Lives Programme' looks to address.

The strategic programme of activity in 16/17 will involve the implementation and delivery of a single integrated acute and community services plan, which is jointly managed and is linked to evolving primary care provider organisations. The plan is multi-faceted and covers key aspects of the new models of care outlined in the Five Year Forward View.

The programme is being led collaboratively by all those responsible for leading the local system including Burton Hospitals NHS Foundation Trust, East Staffordshire Clinical Commissioning Group, the local GP membership and Virgin Care.

In their role as Prime Contractor, Virgin Care will be responsible for driving the change and integration across primary, community and secondary care through:

- Changing cultures, behaviour & beliefs of those working in the system at all levels.
- Integrating, transforming and managing the system across all sectors of provision.
- Modernising and innovating, through embracing digital technologies
- Achieving 'reach' and providing early support to educate and empower patients and their carers to self-care creating an increase in control of their care and independence.

Detailed implementation plans include:

- Proactive risk stratification of our population and management of patients through a large scale care coordination centre.
- Integrated management of patients with a long term condition/multiple conditions and who are frail across primary and secondary care.
- Integrated urgent care and emergency department services.
- Integrated information and technology management systems across all sectors within health, mental health and social care.

The Improving Lives Programme has a robust structure in place to mobilise and execute the implementation plan and continued development of the transformation programme. This includes the identification and management of risk. The following high level risks have been identified with mitigating actions agreed at our Joint Mobilisation Board and include:

Risk to Delivery	Mitigating Actions
Virgin Care terminate the Contract	ESCCG will commission services directly from subcontracts via PBR arrangement. Virgin Care has not yet withdrawn from a contract. Exit provisions are clearly defined between the 2 parties.
Non delivery against constitutional standards	NHS Standard Contract processes and levers used as with existing providers. These will be applied through standard procedures and an agreed governance structure that is in line with the NHS Standard Contract 16/17
Non delivery of outcomes framework (core of contract)	Virgin Care will not receive Payment for Performance. Percentage applied is on an increasing scale over the 7 years of the contract.
Demand is not managed appropriately	Virgin Care has a fixed price contract. Risk mechanisms within the contract that will enable us in a like-minded and trusted partnership jointly manage risk.
Impact on service continuity, patient safety and quality as a result of transition to Prime Contractor.	Safe Transfer of community services will be overseen by the CCG and Joint Mobilisation Board. Monthly assurance requested on workforce, premises, patient safety and protocols. No services are ceasing as a result of the Improving Lives Contract. Patient safety and quality continue to be monitored through existing contracts during the mobilisation phase and Virgin Care will be monitored against national constitutional quality and performance requirements applicable to all other NHS providers.
Disintegration of health and social care	Strong relationships have been formed with Social Care Commissioners and Virgin Care is agreeing protocols of integrated working. ESCCG will continue to work with Staffordshire County Council to ensure that monies invested in social care support delivery of improved care for patients and their families.

Key Lessons Learnt from the Improving Lives Procurement in 15/16

- Ensure you have a compelling case for change, which is centred on the views and experiences of patients and communities, alongside benchmarked performance data, views of clinical leaders and evidence and best practice.

- It is important to have a strong and diverse team of clinicians, managers and technical experts with the skills needed and behaviours expected, being particularly mindful of perceived peripheral but critical members e.g. legal experts from both procurement and contracting.

- In a genuinely collaborative, co-production process there are no pre-determined right answers but by commissioners, providers, front line staff/clinicians and patients working through this together you can achieve impressive solutions to difficult issues.

- Take the time to identify and manage key stakeholders starting conversations at the beginning of the process to engage, build trust and enable co-creation of the outcomes.

Together We're Better Staffordshire Transformation Programme

ESCCG operates as an active part of the Staffordshire (STP) footprint of NHS and public service partners and has been central to the development of both the Staffordshire Health and Wellbeing strategy and the pan Staffordshire WBT Transformation Programme and Case for Change. Over the next few months we will work together as local system leaders through the Collaborative Commissioning Congress and the TWB Programme to develop our current plans into the Staffordshire STP. We will share lessons learnt to date from our Improving Lives Programme along with best practice throughout the TWB Programme work streams.

We are leading the transformation of Planned Care work stream by working in collaboration and alignment with Staffordshire CCGs, providers, partners and patients aiming to:

- Lead a strategic transformation in the way that patients' needs from planned care are met, ensuring high quality clinical and patient/carer outcomes; embracing consistently best and innovative practice, thus reducing variation; whilst driving improved efficiency in the use of taxpayer's resources and reducing unit costs.

- Maximise the health benefit secured from the planned care budgets held by commissioners; through releasing efficiencies which can be used to meet growing needs.

- Avoid the need for undesirable reductions in access to NHS services due to financial and capacity constraints; by utilising scare medical. Clinical, estate and financial resources better.

- Facilitate the provider sector to respond to the above commissioning intentions in a way which addresses positively their clinical and financial sustainability challenges.

Our solutions will deliver the NHS quality and constitutional standards and be delivered within the existing (or in some cases a reducing) funding envelope while meeting the health and social care needs of the local population; having citizens, patients, carers and their families at the heart of our decisions.

Specific Benefits will include:

- Improved patient and carer self-reported satisfaction with the life/health improvement achieved.
- Improved patient and carer self-reported satisfaction with the service experience.
- Improved staff satisfaction with the service provided.
- Improved use of scare NHS resources including but not limited to reduced follow up appointments, reduced lengths of stay, increased outpatient and day case rates, reduced avoidable duplication of tests.

In 2016/17 we will focus on executing significant improvements in the way that follow up outpatient services are delivered through the use of an innovative CQUIN and through collaborative dialogue with providers to identify and seize win: win opportunities. This area was benchmarked as the biggest area of improvement opportunity within the planned care domain. This will build on the successful progress achieved in ESCCG in 2015/16 with Burton Hospital Foundation Trust (BHFT).

We are working will our colleagues in TWB, under the leadership of North Staffordshire CCG (NSCCG); to ensure that we deploy our resources on those health interventions which deliver the most significant benefit to patients; in return for their cost; maximising the health improvement from our use of taxpayers' money. Our clinical and managerial leaders are working to prioritise the treatments and care that all the Staffordshire CCGs will commission and to ensure the development of consistent commissioning policies which we will all adopt. This builds on the work already undertaken together in 2015/16 on "Procedures of Limited Clinical Value".

We are working within the TWB Programme to secure efficiency improvements in the way that both mental health services and Continuing Healthcare services are commissioned and procured; again building on successful joint work in 2015/16 to achieve our QIPP savings. ESCCG aims to provide parity of

esteem and will close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce) and support them to live full, healthy and independent lives. This will require great strides in improving care and outcomes through prevention, early intervention and improved access to integrated services to ensure physical health needs are addressed too. In particular, vulnerable children, homeless people, veterans and people in places of detention will receive high quality, integrated services that meet their health needs

The following risks to delivery and mitigating actions have been put in place to secure delivery in 2016/17:

Risk to Delivery	**Mitigating Actions**
Capacity and resource to deliver the programme particularly in light of other CCG organisational demands this could have a detrimental impact upon pace of delivery.	• Execution of the programme is aligned to ESCCGs corporate objectives and therefore deemed to be business as usual. • A small core team in place which is supported from the central PMO office. • Further capacity being secured from CCGs/ LAs and committed director time from provider directors.
Buy in to changes required across Staffordshire from patients, providers and commissioners.	• Development of comprehensive case for change which outlines the value opportunity that exists in the local health economy. • Extensive communications and engagement plan to be developed and deployed taking a population based approach to ensure engagement across all segments of the population in receipt of care. • Development of options appraisal based on evidence and engagement collated. • Alignment of contract incentives to obtain provider buy in and support the behaviour change required.
The current plan does not fill the estimated financial gap and actions required to do this may be unpalatable to the public and partners	• Gateway review to challenge assumptions. • Extensive public engagement. • Engagement with both Cabinets. • Joint scrutiny sessions arranged. • Meeting with MPs. • Share narrative around change through Communications Executive.

We will be working closely with BHFT in 2016/17 to build on previous work and to further support the Trust to develop and implement plans for clinical and financially sustainable local services; consistent with our transformation programme; commissioning intentions; and consistent with the finances available. We are supportive of the proposals for securing clinical and financial sustainability proposed by BHFT to Monitor in their January submission and supportive of their proposals for transformation support to assist them in taking this forward. The BHFT transformation plans are in alignment with our Improving Lives Transformation Programme and the TWB Staffordshire Transformation Programme. Partners including BHFT, ESCCG, Primary Care and Virgin Care across the East Staffordshire Local Health Economy have jointly submitted an expression of interest to NHS England to become a fast track, exemplar site in 2016/17 as requested by the planning guidance 16/17 to 20/21. This proposal is for a "Proof of Concept" (POC) exemplar programme, centred on BHFT, which could then be rolled out with pace and scale across the rest of Staffordshire.

BHFT are a key partner who have identified the need to innovate and change their models of working, operate in community based multi-disciplinary teams to break down barriers and silo working, work outside the hospital, reduce NELs and reduce inpatient capacity. BHFT are enthusiastic to do this, as evidenced in their recent plan to Monitor, but they have no resources to invest to help then make the necessary changes (staff development, IT development, and facilities changes) or to bridge them as they lose income faster than costs as they proceed down this path.

There is already a fully worked out transformation plan. It has two key outputs:

- To ensure the hospital reshapes into a smaller and more focused organisation that is "right sized" for the future sustainability of the health economy; and
- That the whole system, particularly acute, community and primary care become truly integrated and redesigned in terms of provision.

Supporting them through this proposal will deliver better care at reduced unit costs and reduced system cost; addressing organisational deficits by reducing costs not growing income, as required by the planning guidance.

In short, the plan aims to create "a system without boundaries" between the different providers – making them work "as if one organisation".

Primary Care

In 2016/17 we will continue to work with our local Practices, NHSE and with our Staffordshire colleagues to continue the development of the Staffordshire Primary Care Strategy for sustainable and high quality primary care service provision. We are working together with our local membership GP Practices, partner CCGs and with NHSE to develop our local plans for clinically and financially sustainable primary care providers that can deliver high quality care, over 7 days, consistent with our service Vision and Commissioning Intentions. ESCCG GPs are holding discussions as to how practices organise themselves to ensure resilient, sustainable and efficient working for the future and the options for working and interfacing with this new model of delivery.

We will take forward the Staffordshire Primary Care Strategy and its implementation locally alongside the preparations for the delegation of primary care commissioning within the agreed time. Our expectation is that delegated commissioning will be enacted in collaboration with Staffordshire CCGs.

The following risks to delivery and mitigating actions have been put in place to secure delivery in 2016/17:

Risk to Delivery	**Mitigating Actions**
Critical primary care workforce issues are identified and managed within an appropriate timescale.	Working with NHSE team to ensure key workforce risks are identified and a range of solutions developed and implemented.
Competing priorities and limited resources in terms of staff, time and resources mean that organisations are not able to work together.	Continuing engagement of all stakeholders through our membership Steering Group plus alignment of strategy to individual organisational aims with intention of delivering whole system outcomes.
GPs and practices do not engage.	Robust engagement strategy with use of localities to enable good communication and engagement.
Failure to engage extended primary care team and other stakeholders.	Expert Advisory Group in place with representation from all stakeholder organisations and professional networks.
Patients and public unaware to change.	Full public and patient involvement strategy being implemented, utilising existing forums such as Patient Participation Groups and the CCG Patient Board.
Failure to develop agreed future primary care models of provision for example 7 day working.	Models developed with full engagement of members and LMC. Use of evidence based models and expertise developed through the prime ministers challenge fund supported by NHSE.
Unable to implement agreed model of co-commissioning.	NHSE actively engaged in both development of strategic primary care framework and development of a local strategy.
Key Enablers to achieve success will not be aligned to delivery of outcomes.	Programme management approach implemented alongside development of a strategy to ensure success.

Digital Road Map

We are supporting the collaborative STP footprint approach in undertaking the implementation of the Digital Roadmap. This includes all working in partnership to identify the Digital footprint required to meet the challenge of becoming paperless at the point of care by 2020. The partnership has defined the digital footprint and this has been endorsed by NHSE. It includes the following providers:

- University Hospitals of North Midlands
- Staffordshire and Stoke on Trent Partnership Trust
- South Staffordshire and Shropshire Foundation Trust
- North Staffordshire Combined Healthcare Trust
- Staffordshire Doctors Urgent Care
- Burton Hospitals Foundation Trust
- Virgin Care
- GP Practices.

Four of the providers have been asked to complete a digital maturity assessment to date and to co-ordinate a response to the CCGs by the end of March 2016. The self-assessment will be used to determine the plans required by the providers to support the 2020 vision requirement. The timeline and milestones outlined below will be used to monitor progress towards achieving paper free at the point of care by 2020.

Timeline:

- Footprint template to be completed and sent out to Providers - October 2015 – Status completed.
- Guidance detailing content of a digital roadmap - end January 2016 – status - received.
- Maturity Index published – March 2016 – in progress.
- Submission of plans by CCGs - April 2016.
- Paper free at the point of care by 2020.

The following risks to delivery and mitigating actions have been put in place to secure delivery in 2016/17:

Key Risks to Delivery	**Mitigating Actions**
Inability to integrate IM&T provision across Pan Staffordshire due to lack of time resource and capacity	• Pan Staffordshire Lead for the programme identified • CCG leads identified.

	• CCG IM&T Strategies aligned to 2020 vision.
Insufficient capability and capacity of IT commissioning support services to project manage change required.	• Further capacity secured through Pan Staffordshire Transformation Programme. • Dedicated project team resource to be secured. • Alignment of CCG IM&T strategy and project management to ensure system enablement.
ESCCG System preparedness to accept IT connectivity insufficient	• Major programme of works already completed in ESCCG includes installation of DOCMAN; upgrades to Windows 7 capability; N3 connectivity; hosted clinical systems. • Major programmes of work in plan for 2016 include COIN migration for all GP Practices (currently 4 completed); Integrated GP Systems to support 7/7 working; remote working; SCR+. • Virgin Care Lumira system to support Care Co-ordination Hub across ESCCG to be implemented in 2016 to include integration of GPs systems to the HUB and other local health and social care providers. • eDischarge capability enabled between all local acute providers and GP practices in early 2016.
Capacity and resource to support delivery of IM&T programmes particularly in light of other CCG organisational demands this could have a detrimental impact upon pace of delivery.	• Execution of any programmes of IM&T work to be aligned to ESCCGs corporate objectives and therefore deemed to be business as usual. • Dedicated CSU IM&T project team resource to be secured as per IM&T strategic plan.
Compromised IT Governance and Data Quality	• Governance for Roadmap outlined in NHSE Guidance • Existing organisation IT Governance is well established • Any establishment of Project support will include Data Quality facilitators.
Buy in from patients in relation to consent to share records is limited.	• Extensive communications and engagement plan has been

	developed and deployed in conjunction with Virgin Care and GP Practices within ESCCG. • Targeted patient approach to ensure the cohort of frail and vulnerable patients have been Risk Stratified and informed consent obtained.

2.3 Quality, Innovation, Productivity and Prevention Programme (QIPP)

Our benchmarking analysis has consistently demonstrated that we would not be able to balance our finances by being "as good as the best" and we have therefore set high ambitions for QIPP; going first to and then beyond the current best performers; striving for true excellence and innovation. Our QIPP Programme has been the key delivery vehicle to execute transactional and developmental improvements required to improve patient outcomes, reduce variation, increase value for money and efficiency whilst reducing costs.

Our QIPP schemes for 2016/17 build on the progress we have made locally and the Staffordshire wide schemes in 2015/16. We have aligned our QIPP Programme where possible with contractual incentives across our local primary and secondary care providers to support the transformational change required in changing cultures, behaviour & beliefs of those working in our system. Our QIPP remains ambitious and each scheme has an upper and lower threshold target to achieve with a continuous programme of work to identify further opportunities.

The QIPP story Board can be found in Appendix 1 and reflects the QIPP gained from the Improving Lives Programme, TWB Transformational Programme (Year 1), contractual efficiencies across a range of providers (acute, community, mental health, continuing health care, independent contractors) and medicines optimisation efficiencies.

The QIPP Programme delivery is underpinned by a robust Programme Management function and governance structure to monitor delivery, manage and mitigate risk and identify further opportunities to improve outcomes, reduce variation and improve efficiency.

During 2015/16 QIPP Programme we learnt valuable lessons resulting in schemes being adapted for 2016/17 they include:

- Engaging with acute and primary care clinicians at the outset, sharing data on benchmarking, evidence and how the opportunity is defined.
- Align contractual incentives and processes to support delivery e.g. using the CQUIN as a driver and the Service Development and Improvement Plan to track the delivery by providers of key milestones.
- Align primary care Local Incentive Schemes to support the delivery of QIPP schemes.

The following risks to delivery and mitigating actions have been put in place to secure delivery in 2016/17:

Risk to Delivery	Mitigating Actions
The Programme fails to deliver the planned savings.	• Ensure that each scheme is phased in alignment with operational delivery. • Monthly review/reporting/assurance through the Financial Recovery Programme Board. • Ensure programme of work to continue the review of opportunity. • Ensure each scheme is delivering against PID plans. • Where a scheme is off track ensure approved action plan is in place to recover performance and is executed within the agreed timeframes.
The savings target for the Programme increases.	• Ensure continued programme of work is in place to review our opportunity Right Care, benchmarking, contractual performance data, feedback from membership and patient engagement. • Explore within the TWB Programme the opportunity to accelerate planned care and mental health transformational plans.
There is as yet unidentified QIPP driven by an addition £630,000 required.	• Ensure continued programme of work is in place to review our opportunity Right Care, benchmarking, contractual performance data, feedback from membership and patient engagement. • Undertake a programme of work with the Governing Body to explore bring forward 2017/18 Prioritisation Programme into 16/17

2.4 East Staffordshire System Resilience

We are responsible for system resilience for the Eastern Staffordshire footprint and have a robust partnership underpinned by a governance structure for delivery and assurance. Our System Resilience Group (SRG) and System Resilience Operations Group (SROG) bring together providers and partners from Health and Social Care to plan to collaborate and deliver an integrated system that provides high quality care all year round.

Our system is currently meeting the majority of constitutional standards and for those where we are an outlier Remedial Action Plans have been implemented and improvements are being seen. This is covered in Section 3 of this document: Performance against NHS Constitutional Standards.

Winter Plans 2015/16 Lessons Learned and Plans for Winter 2016/17

Review of our 2015/16 winter plan and the schemes described within it has continued throughout 2105/16 winter. This has enabled us to adapt our plans and abandon schemes that failed to mobilise or were having minimal benefit and use the funding to support alternative more productive schemes. This winter we have had difficulties recruiting to schemes requiring clinical posts this has enabled us to rapidly identify the schemes at risk of delivery and focus on schemes that we were able to launch and will deliver the most benefit.

Our review of the SRG Winter Plan performance for 2015/16 has been carried out in 3 stages:

1. Qualitative Grading of Winter Schemes by all Members of SROG

The System Resilience Operational Group are currently reviewing and grading all schemes including those funded by the CCG and Staffordshire County Council winter money and those mobilised independently by respective providers. The schemes will be graded in terms of impact on system flow. The group will reform in February 2016 to re-prioritise the schemes and assess the feedback. The results will be presented to the SRG in March 2016 with recommendations on those requiring extension to cover Easter holidays and the rest of the year.

2. Confirm and Challenge led by NHSE

We have invited a further independent review of our Delayed Transfers of Care (DToC) and winter schemes which will form a Confirm and Challenge and will be led by colleagues from NHS England. This confirm and challenge aim to identify new solutions, prioritise more effective schemes and integrate resources already available into a more effective model. All scheme leads will be invited to attend and talk about their individual schemes and how these have impacted on improved performance.

3. Independent Review of Pathways and Processes during implementation of “Getting People Home for Christmas” Initiative

In December 2015 ESCCG commissioned an independent clinical support for teams at Queens and Community Hospitals. The purpose of this was to mobilise an initiative “Getting People Home for Christmas” and also to provide more in-depth understanding of what is working well and what isn’t in the

system. The implementation of the "Getting people home for Christmas" initiative has been fundamental in identifying patients for discharge more quickly and efficiently, facilitating improved processes and increased integrated working between acute, community and voluntary sector teams.

Planning for Winter 2016/17

Winter Plans for 2016/17 will be formed using the outcomes of the independent review, SRG grading of CCG funded winter schemes and confirm and challenge session led by NHSE. The results will be shared with the SRG and Virgin Care who will commence the prime provider contract from the 1st April 2106. Representatives from Virgin Care are present on SRG and the SR Operations Group and they have been proactive in informing the work carried out to date and will continue to do so. Virgin Care will continue to work with the CCG as a like-minded and trusted partner to lead the system together as of April 2016.

We will bring together all key stakeholders either through SRG or an equivalent forum to align objectives across the system looking at data on activity, finance and performance and quality and safety.

The main challenge to our system continues to be DToC. Last year we collectively undertook a deep dive of data and National Guidance on DToC and have collaborated and agreed responsive actions we needed to execute to bring performance back in line within national benchmarks. In addition, in December 2015 we commissioned an independent review of processes. Recommendations from this review have prompted an approved action plan which includes:-

- Additional re-ablement social workers to support regained independence for elderly people.
- Single point of access to community intervention supporting rapid access for paramedics, nursing homes and GPs.
- Additional private domiciliary care broker who source appropriate social care or nursing support for people requiring help post discharge.
- Royal Voluntary Service Befriending Scheme to reduce isolation and loneliness.
- Discharge to assess beds in the community to facilitate fast discharge from hospital to an environment where de-compensation is less likely.
- Streamlining of internal processes and more integrated working between acute and community teams.
- Directory of Services to help paramedics, GPs and other teams to triage people to appropriate services to their needs.
- Integrated Crisis Resolution and Community Intervention Services to facilitate faster access to help in the community for people with mental health needs.
- First call Response Service providing support at home for people at risk of falling.
- Implementation of nurse led discharge process (pull function).
- Proportionate assessments that are focused on the first 2 weeks following discharge with rapid response services in place.
- Empowerment/ education of patients/families – Literature, demonstration and availability of care aids.
- Dedicated social care involvement on Ward Boards/Triage of Section 2 assessments.

- Changing behaviour/Culture to think and act upon 'Home First'

Our planned recovery trajectory is set out in the table below. We are awaiting validated data on our January performance and anticipate seeing a reduction since November:

DToC Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April
3.5%	7.5%	7.0%	6.5%	5.0%	3.5%

Our NHSE colleagues are supporting our plans and led a Confirm and Challenge session in the SRG (February 2016) which will drive forward delivery of the plan. The following risks to delivery and mitigating actions have been put in place to secure delivery on DTOC in 2016/17:

Risks to Delivery	**Mitigating Actions**
Limited domiciliary care providers in certain areas impact on increased length of stay.	• Implement discharge to assess trial to reduce risk of de-compensation and facilitate faster discharge home. • Focus on re-ablement to regain independence and reduce need for high prescribing of social care. • Consider hybrid solutions such as low level technology / voluntary sector to reduce need for high prescribing of social care. • Implemented new framework of domiciliary care providers.
High volume of people requiring social care support impacts on Social Care assessment capacity	• Integration of social care and ward teams to support faster and more efficient assessment. • Education of ward staff to manage patient expectations re discharge planning – aim for earlier discharge. • Recruitment of additional social workers.
Re-ablement Teams unable to discharge people to longer term social care support resulting in reduced availability for re-ablement support	• Re-structure prescribing process so that people receive the care they need rather than default to 6 weeks. • Recruit care coordinators to support re-ablement team.

Brokerage unable to cope with high volume of people requiring social care support at home or nursing home placements	• Extend private brokerage • Re-structure processes to ensure full benefit of the private broker service is received.

Staffordshire County Council has assessed domiciliary care provision and in response to gaps identified produced a new framework of providers which has provided additionally of service provision to our economy. The partnership is aware that further work is required to address gaps which remain in certain areas. We are therefore working with acute, community and mental health providers along with the voluntary sector to focus on prevention. We aim to integrate current services to ensure patients receive the right level of care at the right time and in accordance with their needs. Some services will be extended to cover weekends. This fully aligns with our Improving Lives Transformation Programme.

The Improving Lives Transformation Programme and the System Resilience Plans meet the first new national condition requiring local areas to fund NHS commissioned out-of-hospital services including locally agreed targets. These two conditions are designed to tackle the high levels of DTOC across the health and care system, and ensure continued investment in NHS commissioned out-of-hospital services, which for ESCCG include a wide range of services including social care.

Our strategic transformational programme (Improving Lives), QIPP plans 15/16 and SRG plans align with the Staffordshire Better Care Fund (BCF) plans aiming to reduce non-elective admissions and DToC. Further review of our current plans will be undertaken to ensure alignment of the BCF plans with our SRG plans, transformational programmes and operational delivery plans of our prime contractor: Virgin Care.

3. Performance Against the NHS Constitutional Standards

Our CCG continues to perform very well in terms of delivery of the headline NHS Constitution Standards. We also continue to benchmark favourably against both the regional and national averages for the principal measures of the NHS Constitution, such as 18 Weeks Referral to Treatment (RTT) and Cancer Standards.

We are a CCG with a very good track record of delivery in terms of CCG Assurance; and this is the thread running throughout our performance management regimes, which remain geared up to sustaining this good performance at all times.

Performance Context	Measures On Target	Measures Not On Target
NHS Constitution: latest month (M10)	**11**	**8**
NHS Constitution: year to date (at M10)	**12**	**7**

The table above confirms that the majority of NHS Constitution key standards are currently on track, and both the CCG and our major Providers continue to perform well in the main on these.

Where these are not currently being delivered, we have contractual Remedial Action Plans (RAPs) agreed, in place and are delivering the planned milestones and showing signs of performance recovery.

So while our cumulative year-to-date performance is relatively strong for these measures – with greater detail outlined in the tables below – we continue to have some delivery issues in terms of all elements comprising a national standard: e.g. not achieving 92% incompletes targets in all specialties, or not achieving national standards in every month of the 2015/16 financial year.

These are described in greater detail as Exception Reports below the table, and summarise the actions the CCG is leading on to improve performance in all areas.

Performance Tables

18 Weeks RTT Incomplete Pathways (standard: 92%) – achieved > 93% for all specialties at all providers in every month in the period January 2014 to January 2016, with the exception of May-14 (at 92.9%):

Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	YTD
95.1%	95.4%	95.1%	94.4%	94.4%	94.2%	93.9%	94.1%	93.5%	94.5%	94.5%

62 Day Cancer Waits (standard: 85%) – achieved > 85% for all patients at all providers throughout most of 2015/16 and achieving above 86% on a cumulative basis in 2015/16:

Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	YTD
100.0%	83.9%	92.0%	80.0%	87.0%	93.1%	72.7%	85.0%	88.9%	66.7%	84.6%

31 Day Cancer Waits (standard: 96%) – achieved > 96% for all patients at all providers throughout most of 2015/16 and achieving on a cumulative basis in 2015/16:

Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	YTD
97.9%	100.0%	100.0%	96.9%	92.6%	94.0%	94.3%	100.0%	97.8%	95.9%	96.8%

14 Day Cancer Waits (standard: 93%) – achieved > 93% for all patients at all providers throughout most of 2015/16 and achieving above 95% on a cumulative basis for all cancers in 2015/16:

Standard	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	YTD
14-d All	97.1%	93.9%	97.8%	92.8%	95.9%	94.6%	94.0%	94.5%	98%	92.2%	95.2%
14-d Breast	98.3%	97.7%	98.2%	94.1%	90.2%	94.1%	98.1%	87.9%	94.8%	54.5%	90.1%

3.1 Performance Issues to Address

RTT Delivery in all Specialties

We continue to see RTT delivered across all our principal acute providers (Burton and Derby Hospitals FT), however at CCG-wide performance levels, we continue to struggle at times with General Surgery, Rheumatology, Urology and T&O. These are all below 92% on a cumulative year-to-date (YTD) basis in 2015/16, April to January.

Rheumatology was a Burton-specific matter, subject to a RAP, which included actions relating principally to this provider experiencing local workforce capacity constraints that were largely due to national Rheumatologist recruitment issues which mostly lie beyond the CCG's and Trust's gift to remedy alone. The RAP set an improvement trajectory aiming to achieve 92% in this specialty by March 2016, which was delivered in February 2016. The principal ongoing action to ensure sustainable delivery involves the CCGs and NHS England as primary / secondary care Commissioners supporting Burton to ameliorate any future workforce restrictions by exploring the development of GP Shared Care Protocols.

General Surgery, T&O and Urology issues involve all our acute providers of choice, although many of whom are delivering at the whole-provider level (e.g. Burton), but not at East Staffs CCG patient level. This is normally owing to our patients choosing elective care at out-of-area providers where we are a low-volume Associate Commissioner, but when aggregated up to CCG level they contribute to our non-delivery. At provider level the under-performance for our patients is mostly experienced at Derby Hospitals FT. There is a Host Commissioner led contractual process in train (non-RAP), however there is a higher-level tripartite agreement between the Host CCG, NHS England and NHS Improvement to not apply contractual sanctions on specialty delivery issues where this Trust is delivering 18 Weeks at provider-wide levels, which is currently the case.

Cancer Delivery in all Standards

The CCG is delivering the majority of Cancer Standards from the Constitution; however there are three exceptions to this:

- *62 Day Waits from GP Referral to Treatment:* in the latest month of performance data (January 2016), there were an unusually high number of breaches of the standard. Year to date, there have been 37 breaches in total out of 241 patients treated, which has caused the CCG's performance to just dip below the 85% standard. The January breaches were due to a variety of causes, mostly as a result of clinical complexity (as evidenced by a higher-than-normal number of shared breaches among several providers). Because there is no discernible pattern of breaches or one affected provider, and owing to the fact that one fewer breach in the year to date would mean a compliant cumulative rate, the CCG is not yet issuing a RAP to affected providers. However should the January issue become an obvious trend, then the CCG will address this with the relevant provider.

- *62 Day Consultant Upgrades:* this standard is subject to a locally-agreed target of 95% (no national target is set). Under-performance is due to a very small but proportionately significant number of breaches at Burton FT, some of which are shared with tertiary providers like Derby. There have been three ESCCG-specific breaches reported YTD (one at Burton, and two shared at Burton / Derby), out of a total of 33 patients treated. Many of the Provider's breaches relate to other CCGs. As a result our CCG is below the locally-agreed 95% target; whereas Burton is significantly below at 86.6%, albeit with a low number of actual breaches recorded. As a result, the CCG as Lead Commissioner has agreed a RAP with the provider, which addresses the national "Backstop Process" about effective waiting list and breach management and ensuring that PTLs continue to be routinely managed to address long waits and bring patients in or refer to tertiary providers like Derby on a timely basis. We are currently reviewing the 95% local standard for the 16/17 contract with Burton, to look at the targets agreed by other CCGs with their providers to seek parity.

- *14 Day Breast Cancer:* until January 2016, the CCG was delivering the 93% standard on an YTD basis, with some headroom over the target. However January data showed significant failure of this standard for the third month this year at CCG level. Our main cancer providers show Derby compliant at provider level, but not Burton. There have been 56 patient breaches YTD out of a total of 565 patients seen (as at month 10). The majority of these were due to patient choice (declining compliant appointments offered within a 2-week period). However since the New Year, the CCG was made aware of issues developing at Burton caused by the loss of capacity they have arranged through a sub-contract with their symptomatic / asymptomatic screening service provider, University Hospitals North Midlands. The CCG has agreed a RAP with Burton that addresses some of the delivery issues. However there are a number of substantive commissioning and provision issues that will require the input of all Commissioners for the breast screening contract element. NHS England and Public Health England have commenced discussions with affected Providers and the CCG to explore alternate commissioning models. It is likely that performance in this standard will continue to be below target until a new sub-contracted service provider for Burton patients can be found. As such, we are unable to give a firm date for recovery as of yet.

Eliminating Mixed Sex Accommodation (EMSA) Standard

This is Constitution standard is expressed as National Quality Requirement within the Burton contract with a zero tolerance target. Performance over 2015/16 to date has been variable: the first three months seeing 16 breaches reported by Burton, who then recovered across Quarter Two, but reported a further 23 breaches reported in Q3. These are all Critical Care Unit breaches due to delayed transfers outside of the 4-hour CCU to ward bed requirement, usually experienced when the provider is on high escalation levels and experiencing patient flow pressures across the Trust. However the provider and the CCG remain fully assured that patient safety / quality is paramount at all times, and has not been compromised in any of these breaches. Furthermore, no complaints as a result have been recorded for any breaches; of which seventeen were ESCCG patients. The CCG applies the full contractual sanctions for any breaches that are not clinically justified. We are also assured that the policy approach adhered to by Burton is to be translated into a West Midland-wide revised EMSA policy to ensure consistent breach reporting and management.

Other Performance Issues (non-Constitution), as at January 2016

- Unplanned A&E Re-attendance Rate: Burton Hospitals FT: Whilst not a Constitution standard, this is a supporting measure for the national four-hour A&E wait target (currently being delivered by our two main providers, Burton and Derby, on a cumulative, year-to-date basis). This is an underlying supporting measure from the A&E Clinical Quality Indicator set with particular, historical performance issues at Burton. As such it is subject to a RAP with the provider, seeking recovery to the locally-agreed 5% target by year-end. The provider is currently on track to deliver all RAP milestones and is seeing improvements in its performance.

- Ambulance Handovers – 15 to 30 minutes, Burton & Derby Hospitals FT: This is another supporting (non-Constitutional) measure from the A&E / Ambulance Clinical Quality Indicator sets with historical performance issues at Burton and Derby. Both providers are subject to contractual actions and RAPs, via East Staffs CCG at Burton, and with a RAP in place at Derby with their Host CCG.

IAPT Access and Recovery Rate – South Staffs & Shropshire Healthcare FT: Whilst not a Constitution standard, this is a national priority measure for measuring "Parity of Esteem" policy. It also relates to supporting planning measures for the 15/16 and 16/17 years about IAPT access within 6 and 18 weeks. Our CCG has experienced particular, historical performance issues at its principal IAPT provider, South Staffordshire and Shropshire Healthcare FT. Owing to local dispute about the true nature of IAPT-compliant services and contractual service specifications; the performance of this provider has not been reported at CCG level until January 2016. The provider had been working on a Data Quality Improvement Plan throughout 2015/16 to ensure that IAPT-complaint activity is reported on the national Minimum Data-Set. Local agreements amongst the three affected CCGs led to this commissioning issue not being subject to contractual sanctions or a RAP with the provider. This was notified to both NHS England and IMAS routinely throughout this financial year. However the provider has begun reporting from January 2016 to inform the local contract meetings. In 2014/15, the CCG exceed its IAPT access target of 15%, so has historically we have performed in line with national expectations. Throughout the 2015/16 year, the provider has been on track with the delivery of all IAPT service activity and performance levels at whole-provider level. So while the CCG has not seen specific CCG-level detail until Q4 of 15/16, we have not encountered any service access issues reported by our Member Practices referring into IAPT services. Initial contract and national data-set information for the CCG has seen encouraging signs of delivery at mandated levels and the CCG expects further improvements to be made in the provider's performance going forward. The two additional IAPT measures required for reporting in 2016/17 have been raised with the Trus

4. Activity Planning 2016/17

The CCG and CSU Contracting team have modelled the activity demand plans based on 2014/15 trend and 2015/16 Year to Date information submitted by providers to SUS in line with national planning guidance. Table 1 bellow shows the start point, annual plan and growth.

Summary of Submitted Plans from 15/16 Forecast Outturn to 16/17 Submitted onto Unify Planning Template

Activity Line	CCG 15/16 Forecast Outturn	CCG 16/17 Annual Plan	Forecast Growth
Total Referrals (all specialties) – EM1	46,511	48,790	+4.9%
Consultant Led First Outpatient Attendances (total activity) – EM2	37,588	38,454	+2.3%
Consultant Led Follow-Up Outpatient Attendances (total activity) – EM3	72,095	73,753	+2.3%
Total Elective Admissions (total activity spells, ordinary electives & daycases) – EM4	15,892	16,179	+1.8%
Total Ordinary Elective Admissions (total activity spells, specific acute) – EM10a	2,917	2,970	+1.8%
Total Daycase Elective Admissions (total activity spells, specific acute) – EM10b	12,938	13,171	+1.8%
Total Non-Elective Admissions (total activity spells) – EM5	17,456	17,456	0%
Total A&E Attendances	40,782	41,517	+1.8%

CCG Forecast Outturns used in this Operational Plan are the same as those that were pre-populated by NHS England into the Unify planning templates. This is the base position using month 1-9 activity per national guidance. 18 Week RTT trends are applied to CCG commissioned activity base for 2015/16. Growth has been applied at individual Point of Delivery level based on a 2 year average trend from 2014/15 to 2015/16 forecast out-turn.

Other Key Points to Note:

- The CCG has modelled current 18 week Incomplete Pathway performance at Burton Hospitals FT and Derby Hospitals FT. The analysis was based on 7 specialties with sustainability challenges with a calculation based on an underlying 9 month trend from April 2015 of the volume of patients required to be seen for the Provider to ensure constitutional targets are achieved. 2015/16 conversion rates and average case-mix for the affected specialties was

applied to generate the associated outpatient and Day case/elective surgery forecasted to be required in 2016/17. The 7 specialties affected include General Surgery; T&O; ENT; Ophthalmology; Gynaecology; Urology and Rheumatology.

- The impact of the 2016/17 draft PbR tariff has been modelled based on analysis prepared by the Midlands & Lancashire CSU. This analysis, run at Provider level, shows the expected impact for scenarios where a Provider is using ETO in 2015/16; and also the movement from DTR in 2015/16 to the 2016/17 draft tariff. The resulting tariff impact at Point of Delivery level has been modelled by Provider in the CCG's plans.

- The Indicative Hospital Activity Model (IHAM) has been used to develop the CCG's plans. We have included growth rates that are roughly comparable to the benchmarks established in IHAM for the activity lines in the above table. The CCG is embarking upon a programme of work to explore the IHAM model in greater degrees of sophistication for the five year STP due in the June 2016. It is our intention that we will run the IHAM model and compare it with local CCG strategies, plans and levels of ambition for the forthcoming period up to 2021.

- The NHS England "Triangulation Tool" – a number of variances were reported in the initial analysis of our plans by NHS England, between what is reported by Burton Hospitals FT and Derby Hospitals FT for ESCCG and those we have submitted for them. As we do not have all the underpinning information from the models submitted by these Providers, on the basis of information available, we can confirm that highlighted variances will come from different approaches to activity reporting. The ESCCG model decided to split activity between our usual providers, with activity derived from the 2015/16 previous year to Virgin Care in line with what is in or out of scope for this programme. Therefore our view for each of the two named providers will be different to their views, as we plan to contract this activity from Virgin, but it appears that the providers have reported all that activity against ESCCG and nothing against Virgin Care (owing to limitations of the national templates not operating at such granular levels). Some CCG plans such as the NHS Constitution Endoscopy, Diagnostic and Cancer measures were not split by this sort of in / out of scope view, and are closer to what is reported by the providers. There may be also impact of service growth assumptions that these providers used, but we are not able to analyse it as they did not share this with us prior to submission.

5. Financial Plan 2016/17

Alongside being the first year of delivery of the Staffordshire STP this Operational Plan also gives assurance that the national delivery requirements and Business rules specific to 2016/17 have been recognised and that ESCCG is developing plans to achieve these. Please see Appendix 2: Financial Plan.

The NHS England Allocations paper shows the uplift received by the CCG for Commissioning Healthcare services for the population of East Staffordshire as being £7.5m, 5.1% growth. Guidance requires any funding above 3.05% to be attributed to supporting CCG's outturn position, for East Staffordshire this represents under £3m.

East Staffordshire CCG 2015/16 plans show an in year deficit of £1.5m forecast outturn, whilst the 2016/17 financial plans show an "in year "surplus of £1.6m, an improvement of £3.1m. Prior years the CCG has not had sufficient flexibility within it financial plans to have funds to meet the business rules with regard to holding a 1% non-recurrent fund, 2016/17 will be the first time that the CCG has been able to achieve this requirement. The two elements together demonstrate the CCG utilisation of the additional growth monies to support the CCG's outturn position.

The planning assumptions used to complete the financial templates are shown in Appendix 2, the growth % are gross and are therefore prior to applying QIPP schemes. The Prescribing and Continuing Health Care % increases are inclusive of both demographic (volume) and price changes.

As part of the planned expenditure, the planning guidelines have been taken into account, including PBR net inflator, Drugs and Continuing Health Care inflation, parity of esteem for Mental Health. Activity increases for 2016/17 reflect the growth trend that has occurred in 2015/16, excluding the Virgin activity that is in scope.

A number of risks remain and we have to recognise that contract negotiation discussions are on-going. Further work is currently being undertaken to assess the potential impact of accelerating actions being undertaken in the WBT Programme to gain additional impact in 2016/17.

6. NHS Planning Guidance 2016/17- Delivering the 9 'Must Do's' in 2016/17

The Nine Priorities	Implementation: Fully compliant with Business rules	Timescales	QIPP Alignment 2016/17 Target savings: £5,026M (Story Board: Appendix 1)
1. The Development of a high quality and agreed STP and 2016/17 Operational Plan with critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View	This Operational Plan describes how the development of new care models and proposals for the collaborative transformation of unplanned care, planned care and mental health care will be executed through our transformation programmes: Improving Lives, Together We're Better Programmes.	• As per North Midlands DCO Planning Timetable 2016/17	• Improving Lives Programme (NEL reductions, reduced length of stay, DTOC) • 1st:Fup Scheme • Reducing 1st Out Patient Appointments • POLCV • Prioritisation • CHC • Mental health contract efficiency saving • Contractual efficiency savings
2. Demonstrate that we achieve aggregate financial balance and tackle unwarranted variation.	• Demonstrated in our Financial Plan (Appendix 2) and monitored through CCG assessment framework. • Demonstrated in the case for change for Improving Lives, Together We're Better Programme and in the rationale for each	• As per North Midlands DCO Planning Timetable 2016/17	See Appendix 1 for rationale for QIPP scheme savings.

	QIPP scheme 2106/17.		
3. Develop and implement the Staffordshire Primary Care Strategy	GP working group established and Staffordshire Primary Care Strategy agreed. Exploration of new models underway and local delivery plans in development to address the sustainability and quality and will be delivered within the Staffordshire Primary Care Joint Commissioning Board requirements.	• As per North Midlands DCO Planning Timetable 2016/17	• A&E Attendance/NEL reductions aligned to Improving Lives Programme outcomes • Reducing 1st Out Patient Appointments • POLCV • Prioritisation
4. 95% wait less than 4 hours in A&E and 75% Category A calls within 8 minutes. Implement urgent and emergency care review.	• Delivered through East Staffordshire SRG Plan and monitored through CCG assessment framework. • Delivered through the Improving Lives Programme outcomes.	• Ongoing monitoring through SRG and Prime-Contractor.	• A&E Attendance/NEL reductions aligned to Improving Lives Programme outcomes. • GP Local Incentive Schemes (LIS).
5. Over 92% non-emergency wait less than 18 weeks	• Delivered through performance standard monitoring with Remedial Action Plans if required. • Delivered through the TWB planned care work stream and efficiency scheme.	• Ongoing contract monitoring. • Alignment of Primary Care LIS scheme continuation from April 2016.	• Reduction in 1st Out Patient Appointments • POLCV • Prioritisation

6. 62-day Cancer waiting standard, 2 weeks, and 31 days and improve one-year survival, reduce proportion of cancers diagnosed on emergency admission, improving proportion of cancers diagnosed at stage 1	• Delivered through performance standard monitoring with Remedial Action Plans. • Delivered in Partnership with PHE and local providers. • National CQUIN proposed to BHFT as part of contract negotiations.	• Ongoing contract monitoring and working with East Midlands Cancer network.	
7. Achieve the 2 new MH standards: 50% of people with 1st psychosis episode seen in 2 weeks and 75% with common MH treated within 6 weeks and 95% within 18 weeks. Dementia diagnosis rates to continue to improve	• Delivered through performance standard monitoring with Remedial Action Plans in place if required. • Delivered through the local implementation of the Staffordshire Mental Health Strategy. • Delivered through the primary care plans to improve Dementia diagnosis rates- monitored through Local Implementation Scheme review visits to practices.	• Contract negotiation for 2016/17 then ongoing contract monitoring with provider. • Ongoing monthly monitoring of Primary Care Dementia diagnosis rates.	Contract efficiencies and lower unit cost pricing for Mental Health services.
8. Learning Disabilities: Reduce inpatient capacity improve community care.	Delivery of local plans through the Joint commissioning Unit and collaborative commissioning with Staffordshire CCGS.	• To be confirmed.	

9. Quality improvement plan. Providers to publish avoidable mortality rates	The Quality Improvement Plan is monitored through the Joint Quality Committee and provider CQRM''s.	• Contract negotiation for 2016/17 then ongoing contract monitoring with all providers.	Aligned to all QIPP programmes. Quality Impact Assessment is an integral part of the development of each scheme.

7. Assuring Quality, Safety and Sustainability of Services in East Staffordshire

7.1 CCG Quality Strategy

Since authorisation, we have worked continuously to review and improve the quality functions delivered by the CCG and they are delivered in a model described in the CCG Quality Strategy which is currently under review. The Joint Quality Committee with South East Staffordshire and Seisdon Peninsula CCG has now operated very effectively for over eighteen months in a partnership with an agenda and business cycle structured to allow for detailed discussion of all commissioned services.

2016/17 is an exciting time for the CCG as it sees a vision of further alignment of Quality and Safety reporting of assurance in our Joint Quality Committee which will further enhance the grip that the Quality team has on delivering highly effective commissioning of Provider services. The 'virtual quality team' now works in a hub and spoke type model where we integrate our limited resources to absolute maximum effect.

The Quality Strategy refresh this year will describe a number of priority areas, which will include the following:

- Closer working with all CCGs in Staffordshire as part of the transformation work.
- The development of mechanisms for monitoring quality and safety in the delivery of primary care services, particularly in light of the CCG's evolving responsibilities in line with 'co-commissioning'.
- Better coordination of feedback from CCG member practices both via 'soft intelligence' reporting and feedback received as part of the business of the Joint Quality Committee.
- Ongoing improvements in data collection and presentation to continue to facilitate improved scrutiny of relevant data.
- Development of a centralised dashboard holding data for providers across the CCG, to be shared with other local CCGs.

2015 – 2020 A Five-Year View

Over the five-year period from 2015–2020 the CCG Quality and Safety agenda in East Staffordshire will principally focus on major commissioning changes, some of which relates to the introduction of the Improving Lives project, working closely with Virgin Care Limited in an innovative way to improve local services but also on the work to transform the commissioning and provision of health care in Staffordshire in partnership with other NHS organisations.

These changing responsibilities will need to be monitored closely if we are to achieve long-term resilience and avoid adverse quality and safety outcomes in the face of unsustainable demand, increased activity and financial pressures. The key enablers that will support these two strands of work are detailed below.

7.2 Key Quality Improvement Priorities

Learning from experience (The Francis Inquiry, Berwick, Keogh and others)

Learning from experience remains a key aim for us, with significant attention being paid to any relevant national publications. The action plan that was developed to ensure adoption of the recommendations of the Francis Inquiry has now been completed thanks to the concerted effort of a CCG Working Group which reported to the Joint Quality Committee.

We value the expert external review of all local providers by regulatory bodies such as Monitor, the Trust Development Authority (TDA) and the Care Quality Commission (CQC). Reports published by regulators in respect of local providers are used to triangulate local information and to inform assurance levels of providers at the Joint Quality Committee. The main local NHS acute Trust have been subject to Keogh reviews in the last couple of years, and subsequent follow up by the CQC highlighted further areas for improvement. Several other providers have been subject to announced or unannounced reviews by the CQC and a number have detailed CQC action plans which are their tools for improvement. We will continue to monitor all such external reviews over the coming years and to work to further strengthen their role in relation to the triangulation of patient experience and other information about providers.

The Morecambe Bay Investigation highlighted the risks to quality and safety of the constant cycle of restructuring in the NHS and in particular those for mergers between organisations. 2015/16 saw Providers assuring our CCGs on their progress against the learning outcomes of the report. In 2016/17 all maternity services commissioned will be monitored to ensure a high quality and safe service is delivered and work will commence to ensure increased personalisation and choice as part of the on-going review.

We remain an active member of the Area Team Quality Surveillance Group (QSG) and submit regular reports regarding Burton and where appropriate other providers where the Quality highlight issues that need escalation. The QSG is used as a two way communication forum and key messages relating to other providers, national and regional issues are highlighted at the Joint Quality Committee and opportunities to share best practice. The CCG remain committed to supporting this key forum.

Quality Impact Assessments (QIA)

Throughout 2016/17, one of the key quality priorities is to further develop and embed the quality governance systems, across the CCG, which support our quality and risk impact assessments. Quality leads have been specifically aligned to all of the QIPP programmes to support Commissioners completing the electronic Quality Impact Assessment tool, which will provide a more robust process. The Quality Team subsequently review the submitted QIA prior to their presentation at the overarching QIA Subgroup which feeds into the Joint Quality Committee meetings.

Primary Care

We are committed to working with NHSE to develop and expand the role and quality of care in general practice. The CCG and membership practices have made significant progress in the last 12 months to improve the quality of primary care, for example increased prevalence rates for dementia, improved flu uptake for the over 65s and reduced prescribing of antibiotics. We will continue to support practices to make further improvements to the quality of care and ensure that robust governance and assurance systems are in place to oversee delivery.

For 2016/17, the CCG will focus on developing quality improvement support to Primary care in line with our anticipated responsibilities as co-commissioner of these services.

Transforming Care (Accelerating Winterbourne)

The CCG will continue to deliver actions to transform care for people with learning disabilities, including implementing enhanced community provision, reducing in patient capacity, and rolling out care and treatment reviews in line with national plan 'Building the Right Support' and new service model for Commissioners of health and social care services to transform the way in which care and support is delivered to people with a learning disability and/or autism who display behaviour that challenges.

The Transforming Care Programme provides a framework to consolidate national ambitions and local priorities into a single Joint Transformation Plan, and enables the CCGs to build on the progress made in ensuring people with learning disabilities; complex needs and challenging behaviour are supported in community environments.

In line with national requirements, a Staffordshire Transforming Care Partnership with formal governance and reporting arrangements has been established and will be meeting on a regular basis. We are now working jointly with the two Local Authorities and NHS England Specialised Commissioners to produce a Joint Transformation Plan to work towards achieving the national service model for people with learning disabilities.

We are committed to working to move people with learning disabilities and/or autism in hospital settings to ensure they are moved appropriate community placements and our aims going forward are:

- To continue to reduce the numbers of people currently in in-patient hospital settings and move to appropriate community placements
- During 16/17, those learning disability patients that are in out of area placements are repatriated back into area and living in the community as far as possible

- To ensure there are robust, timely and quality services in place for the local Learning disability population that prevents their admission into hospital so that they can be treated in the least restrictive environment.
- 2016/17 is the start of implementing Staffordshire Transforming Care Partnership Plan to achieve the national service model for people with Learning Disabilities and/or autism who display behaviour that challenges

We are on target to meet the trajectory of one individual remaining in the cohort by the end of March 2016. We have recently received the information from NHSE on individuals likely to step down to local services. There is one individual who originates from East Staffs who is likely to transfer to local community services in the next 6 months. It is likely that this will not be for assessment and treatment and the move will be to the Stafford area in a residential placement therefore will not be East Staffs responsibility.

Transforming Care continues to be a priority work programme for the CCGs in Staffordshire and a number of Task and Finish Group work streams have been established under the new Transforming Care Partnership arrangements to deliver the key elements of the plan including a Communications and Engagement Task Group specifically involving people with learning disabilities, carers and families. We are currently looking at how we can commission the complex care service to better align our work to expediting the repatriation of service users within the Transforming care cohort and also ensuring there is a longer term plan for this work stream.

Caldicott Review

Our CCG has a named Caldicott Guardian and a Senior Information Risk Officer. We have a Caldicott Log for any actual or potential breaches of patient confidentiality. As we move towards more integrated commissioning and provision arrangements, we will continue to ensure we have robust systems in place.

Workforce Assurance – Safe Staffing

The relationship between safe staffing, safe care and the quality of patient experience is well known. Workforce assurance and safe staffing are both key factors highlighted in the Francis and Berwick Reports. More recently, the Keogh Reviews highlighted the need for many Trusts to improve nurse staffing. We recognise the local examples of SSOTP, SSFT, and Burton where workforce assurance has required additional scrutiny and support.

During 2015/16 providers in Staffordshire have been reporting against nationally required workforce assurance guidance. These have been scrutinised against other information to meet the new requirements for workforce assurance. This was to identify any impact on patient care and experience. This includes the guidance from the Hard Truths publication for ward-based staffing levels with shift-by-shift compliment levels displayed on each ward.

In 2015/16 providers implemented ward-based electronic boards for patient status and staffing levels. They have also demonstrated their commitment to providing staffing assurance against the guidance from NHSE Chief Nurse Jane Cumming in Feb 2015.

Each year the CCG takes part in work to review provider workforce plans to ensure that planned staffing levels are sufficient and any proposed changes as part of provider cost improvement programmes do not impact on the quality of care. The improvement of quality is paramount when considering the move towards integrated teams, use of digital technology and the development of new roles. The quality leads review provider publications in respect of Safe Staffing national guidance. This data is reviewed at CQRM meetings and issues identified are escalated to the Governing Body through the reports that are produced for each provider.

7.3 Patient Safety

Levels of Harm in Healthcare Services

There are a number of measures within the NHS National Contract that contribute to the understanding of provider levels of safety and harm including the Serious Incident Process, Safety Thermometer and mortality statistics. We use these reports to determine where we can learn lessons to improve practice.

In 2015/16, Providers have worked towards reducing harm from falls. With an ever growing elderly population Providers are looking at innovative ways of reducing falls. Regular reports on levels of harm enable the us to challenge, where necessary, the integrity of those results and to benchmark our position locally and nationally.

Learning from Incidents and Duty of Candour

All providers are required to report incidents which meet the Duty of Candour requirements via CQRM on a monthly basis, including demonstrating that patients and carers have been informed when something goes wrong. Providers are expected to demonstrate learning from serious incidents and are continuously challenged in respect of the quality of their investigations.

During 2015/16 we established a Serious Incident Review Group which all providers are expected to attend to present their Root Cause Analysis (RCA) investigations into all such incidents. These are closely scrutinised by quality staff, GP Quality Leads and lay representatives of the CCG. In the event that an RCA is found to be lacking clear evidence of learning and change, this will be rejected until further action is taken thus putting pressure on the limited timescale for investigation. This is intended to ensure that RCAs are adequate and fully completed prior to submission rather than to delay closure.

In addition the CCG receive routine notification of any death which results in a coroner's inquest and where the coroner issues a Regulation 28 report requiring a response and action from the Trust within 56 days. Evidence of learning from such incidents is required as part of the response to the report and these are reviewed at CQRM.

CQC Ratings & Inspection Reports

CQC inspection reports are a crucial tool in improving and evidencing quality of care and we have worked closely alongside CQC inspectors and NHSE sharing information and assurance visits. We do not currently commission services from any NHS provider with an inadequate rating by the CQC. We have played a pivotal role in driving improvements with Burton Hospitals helping to ensure an improvement with the Trust being taken out of special measures and an improvement in their CQC rating from "inadequate" to "requires improvement" and will continue to work with the Trust as they aspire to achieve a minimum "good" rating in the future.

Action plans following an inspection visit are monitored through the provider CQRM where the CQC risk ratings are routinely used to challenge the provider. In addition commissioners meet with the CQC on a bi-monthly basis along with other agencies in the Area Team Quality Surveillance Group where information is shared for assurance and a surveillance level for each provider is agreed. We also report on CQC Intelligent Monitoring data where each month this is included in provider reports presented to the Joint Quality Committee.

Healthcare Acquired Infections (HCAI)

Reducing the levels of Healthcare Acquired Infections (HCAI) and the associated high level of antibiotic prescribing and Proton Pump Inhibitors (PPIs) is a key area of preventable harm to patients.

The harm to patients from MRSA and Clostridium difficile infections is well known, as is the extra cost to the NHS that this incurs. The incidence of these infections is no longer used to calculate the quality premium. However, the reduction of HCAI remains an important quality improvement initiative in line with the CCGs vision, values and goals. The zero tolerance approach to MRSA and the downward pressure on Clostridium difficile objectives has resulted in a year-on-year reduction in the number of cases nationally.

Reduction of HCAI across Staffordshire remains a challenge, although significant Pan Staffordshire progress has been made during 2015/16 as the Head of Infection, Prevention and Control has worked with all Providers to share learning.

Throughout 2016/17, the county-wide Infection Prevention and Control Forum, chaired by NHSE, will continue to monitor the implementation of a programme of work to address the wider context of HCAIs, such as the interface between acute and Primary Care prescribing, patient flows and public awareness.

During 2016/17, all cases of MRSA bloodstream infection and Clostridium difficile across the health economy will continue to be investigated, to identify trends and common themes. The Head of Infection Prevention and Control will continue to work with Providers to investigate cases prior to admissions to see if this had any impact on the infection.

Antibiotic prescribing in Primary and Secondary Care

Antibiotics, when used in a targeted way, save lives. There are however, unintended consequences of antimicrobial use when not used cautiously which include:

- Selection of pathogenic organisms leading to health-care associated infections such as Clostridium Difficile.
- Emergence of resistance.

There is a now a working group to reduce antimicrobial prescribing across the county. This group sits as a subgroup of the Infection Prevention and Control Forum. Our CCG has a Medicines Optimisation Team (MOT) that is responsible for the implementation of a specific work strand to reduce antimicrobial prescribing.

One area of particular focus nationally has been on the subject of antibiotic prescribing. The Medicines Optimisation team continue to roll out the antibiotic prescribing campaign. The team continue to monitor prescriptions and pay particular interest to those for cephalosporins, quinolones and co-amoxiclav.

Reports are routinely presented to the quality committee, as a result of this the Quality Team has initiated a MOT prescribing meeting that brings together the CCGs, GPs, MOTs, Patient representatives to accelerate this work, subsequently the Quality Team now send updates out to the GPs of the work it is undertaking offering support and sharing positive practice. We continue to work closely with local providers, monitoring their antibiotic prescribing rates.

Named Doctor for Clinical Accountability

The specific challenges for our CCG, following service transfers in 2015/16 related to the number of medical outliers, as well as, for other reasons where patients are placed in outlying wards or different sites. In 2015/16 patient choice of location may also impact on named consultant where different consultants are employed by different Trusts and responsible for either outpatients or treatment. In 2016/17 we will be requesting further assurance from

providers on how they will comply with the recommendations of the guidance from the Academy of Medical Royal Colleges on "Accountable Clinicians and Informed Patients", especially going forward with the 5 year forward view and the impending changes in patient pathways which means patients care may be managed by differing providers, with one coordinator.

Reporting Harm in Primary Care

We plan to develop systems for quality reporting quality improvement in Primary Care, including reporting of harm that occurs in primary care. This will include enhancement of a Primary Care Quality Dashboard to include intelligence from NHSE and focus on those practices that need additional support. This will be further developed with the stated intention of NHSE Region to provide a standardised quality and safety dashboard for reporting purposes.

Currently Patient feedback is collected through the GP survey and soft intelligence and fed back into the CCG through the JQC. We will work with NHSE to agree how the results are triangulated with other sources of information and to ensure that work streams are complementary and contribute to a comprehensive profile of quality and safety of general practice.

Moving forward in 2016/17 we will be working with West Midland's Quality Review Service (WMQRS) to enhance GP soft intelligence to assist both GPs and the CCG to accelerate the work we have achieved so far. In addition to this a new introduction to the Joint Quality Committee has seen the introduction of an agenda item entitled 'GP 60 second reporting'. This involves the GPs scoping their GP colleagues to identify the current issues that are topical that reporting month, GPs then report back to the Committee. This gives the Quality Team early signals of the issues that are emerging, new and trending to address any inequalities or positive areas of healthcare.

Patient Safety Collaborative

Working with NHSE, the Patient Safety Collaborative (PSC) programme is led by the 15 Academic Health Science Networks (AHSNs) and intends to improve the way care is provided at a local level, enabling front line teams to involve patients and their families in making healthcare safe. Each PSC will be supported by NHS Improving Quality (IQ) to deliver safer care through finding and sharing their own local and innovative solutions. This will be further improved by pulling together key teams from across the AHSN regions to help leverage sustained improvement and spread this work locally and nationally across the system. The PSC programme will work alongside the national Sign up to Safety campaign.

Importantly we continue to commit passionately to delivering patient safety and has joined the 'sign up to safety' campaign 2015 and is regular involved in developments to support the collective and cumulative initiative to reduce avoidable harm by 50%, whole heartedly supporting the ambition of the national initiative to save 6,000 lives.

Patient Experience and Engagement

Our Communications and Engagement strategy has been key in supporting us to achieve our key goals and objectives over the past two years, in particular with regards to our Improving Lives programme. Our approach has been to make sure that all of our stakeholders have understood the challenges we faced and patients and carers have been asked for their views on what was important to them. We have made sure that stakeholders have been kept informed, have had the opportunity to be involved and help shape our plans, and have been kept up to date with what we were doing, when and why.

To this end, we developed a joint Improving Lives Communications and Engagement Strategy with Virgin Care, as our trusted partner, and this approach has proved very successful in maintaining consistent messaging and building confidence in our local community and with GPs and clinicians. To support the transformational changes which will be taking place over the coming year and beyond, this partnership working will continue to include regular stakeholder briefings and public events. Patients, carers and clinicians will continue to be involved in many ways, including in the co-creation of new long term condition pathways with input from Virgin Care's newly set-up Citizens' Panel.

We also have a broader communications and engagement strategy which encompasses all the work the CCG is doing. This involves working closely with our Lay PPI Member and our Patient Board, who are our link to our PPGs and voluntary sector and they will be helping to shape our overall communications and engagement plan for the coming year.

We are also working closely with other CCGs across Staffordshire to achieve many common aims and objectives. This joint working will increase with the Commissioning Congress' Pan Staffordshire transformation work streams.

We use the full range of national measures of patient experience (National Inpatient Survey, Internal surveys, Net Promoter). In addition, we include complaints, serious incidents and further intelligence from Health Watch or the CQC to target areas for further attention, a themed review and/or an assurance visit. This is then triangulated by Commissioners as part of an early warning system and used to form queries at CQRMs. The Friends and Family test scores are key metrics for patient experience that provide visible progress against national benchmarks and can often be the first indication of emerging problems. Soft intelligence, which does not meet the criteria to record as a complaint or an incident, is mapped to a specific area and red-flagged as more intelligence is reported. The collection of more detailed monitoring at ward level for acute providers, and locality level for community providers, enables the CCG to target specific improvements, which are reviewed at relevant CQRM and escalated if outcomes do not improve.

Our providers understand that the CCG expects patient feedback to include all patient groups including those who are harder to reach. Changes that have been made as a direct result of patient feedback are routinely reported to the monthly CQRMs via complaints, patient surveys and similar reports. These are then reported onward to the Joint Quality Committee and Governing Body as appropriate. Work continues to develop this further to ensure we are able

to demonstrate that providers make direct changes as a result of patient feedback. Importantly late 2015 introduced Healthwatch formally to the Joint Quality Committee as a core member, giving authority to make decisions and a voting right at a key Committee.

During 2015/16 the FFT methodology changed, including expansion of the areas covered meaning we gained a broader view of patient responses and recommendations. In 2016/17 we will continue to use the FFT to benchmark against other Providers, including the collection and scrutiny of other patient feedback to triangulate against other monitoring information which will reflect the organisational commitment to 'Compassion in Practice'.

Compassion in Practice Framework – The 6Cs

The CCG believes a true cultural change is required to significantly improve the quality of patient care. The 'Six Cs' are consistent with this belief and all providers continue to work in the compassion to practice framework, in 2015 we adopt the 6Cs + Principles = Care. In East Staffs this is explicitly written into the quality schedule of the contract and is being monitored via the CQRMs with providers expected to demonstrate periodically how they are fulfilling the requirements of the six Cs. Members of the quality team continue to work with commissioners outside of Staffordshire to ensure that they are also incorporating monitoring of the 'Six Cs' in their contracts. We are constantly seeking opportunities to further incorporate the Six Cs and a pilot project linking compassion in practice to complaints management is currently being considered.

Staff Satisfaction

The relationship between staff satisfaction and patient experience is clear. To that end, it is essential that we ensure that our staff feel motivated to deliver the best quality care and feel confident in raising concerns.

We triangulate the results of national staff surveys with quality and safety metrics to highlight any systemic or specific problems we need to address. Where we identify problems, improvements are monitored through the CQRM process. Quarterly staff survey updates will be provided to CQRM and FFT rolled out to staff, also reported on a monthly basis to CQRM. Staff satisfaction is used as part of workforce assurance metrics.

Staff FFTs offer a regular and timely barometer of the culture of the provider and the ability to target specific areas. Where there are levels of staff unable to recommend their organisation as a good place to work this should provide an early warning of potential quality and safety issues. Staff satisfaction is used as part of workforce assurance metrics. Throughout 2016/17, we will continue to review use staff surveys, staff FFTs and use announced and unannounced visits as opportunities to speak to staff and gain an insight into any impact service change have upon morale from organisational changes.

Nurse Revalidation

The new robust requirement for nurses to revalidate with the Nursing and Midwifery Council (NMC) will have significant implications in the coming years for all nurses and their employers. From December 2015 all nurses registered with the Nursing and Midwifery Council in England have been required to undertake revalidation through which every three years each nurse is required to demonstrate the following:

- Met the requirements for practice hours and continuing professional development (CPD)
- Reflected on their practice, based on the requirements of the Code, using feedback from service users, patients, relatives, colleagues and others
- Received confirmation from a third party.

The introduction of revalidation has implications for the CCG not only in terms of commissioned services but also in terms of the numbers of practice nurses working in member practices and all nurses currently working in non-clinical roles in the CCG. In 2015/16 we actively worked to ensure that the full implications of revalidation are understood and that providers have action plans in place to ensure that the nursing workforce are prepared for this new undertaking.

The CCGs have undertaken a collaborative piece of work regarding Nurse Revalidation that bought together the RCN, Wolverhampton University, CCG, and Practice Nurses that delivered workshops to GP practice Nurses and Managers that ensured organisational readiness for Revalidation. The CCGs have also ensured Nurse Revalidation has been discussed at CQRM and reviewed Provider readiness through their action plans and HR strategy.

The CCG continue to monitor our own internal action plan with a clear policy for internal Nurse Revalidation and we have a single lead Nurse who coordinates this on-going work.

Nursing Homes

Nursing homes will play an increasing role in commissioning strategies to address the need to reduce pressure on acute care. In 2015/16 a meeting took place to decide on the direction of Staffordshire Nursing Home Quality Assurance Group (NHQA). The outcome was to develop the group to work more collaboratively with the Local Authority (LA) by sharing information and streamlining quality assurance processes. In 2016/17, task and finish groups will review how processes can be streamlined, how information can be reported and shared. This will enable a more robust approach to NH assurance monitoring across Staffordshire.

During 2016/17 the LA and CCG contracts with nursing homes will be reviewed with a view to moving forward, an integrated contract.

Within Staffordshire there are 6 CCGs and they have a collaborative arrangement in place which delegates the responsibility for hosting and leadership of the individual complex care and CHC agenda to continue to be undertaken by Stafford & Surrounds (SAS) CCG, which is managed through the Individual Patient Activity (IPA) Program Board.

The Nursing Home Quality Assurance Group was established to have oversight of NHS contracts with Nursing Homes, working collaboratively with the Local Authority, and is required to report to the IPA Program Board. During 2015/16 SAS CCG increased capacity within their quality team to review the CHC provision from the CSU. In 2016/17 the CCG is to look at strengthening contractual agreements with the CSU to improve the service delivery. There will also be the full implementation of the new 'dynamic procurement system' (ADAM) which will standardise the procurement process and deliver efficient processes in relation to payment systems; and has the ability to produce a wide range of reports to support commissioning of services going forward. To register with the procurement system the NH will have to meet strict criteria covering areas such as CQC rating.

Safeguarding

Our CCG has strong and established systems and processes for safeguarding adults and children and work closely with the statutory partners of the Safeguarding Boards for both Adults and Children.

We have a robust governance framework in place for the reporting of safeguarding issues and PREVENT Agenda activity to the CCG Quality Committee and Local Safeguarding Board. In addition, we have a health sub group to address common areas of concern. Lessons from serious case reviews are disseminated through mandatory safeguarding training sessions and through the contract where required.

During 2014/15 we have worked Dashboard reporting was implemented for Quality and Safety Safeguarding Dashboard with agreed trajectories for each metric. This is now a contractual responsibility for providers to enable CCGs to view performance, trends and comparability and to target areas for action.

Following a successful bid for funding in 2014/15 a Lead for the Mental Capacity Act identified within the Safeguarding team who developed a training programme, and developed resources including an easy read resource provided to all practices to raise the profile of Act. The additional funding allowed for the development of an android and IOS APP for all clinicians which will provide guidance on the use of the Mental Capacity Act and Deprivation of Liberty Safeguards. The IMCA pilot has ran from June 2014 to January 2016 providing two full time advocates on site at QHB & UHNM to raise the profile of the IMCA service and ensure use of advocates as identified within the MCA.

We have identified a PREVENT lead who attends the Channel Panel and reports to NHSE quarterly in line with statutory requirements. Prevent training information is included within the dashboard reporting from all contracted partners.

A comprehensive programme of training events for safeguarding both adults and children is in place and has been delivered throughout the year. This training extends the previous work programme considerably and enhances this further with updates to "Working Together to Safeguard Children" and the publication of the Care Act and PREVENT now included to ensure all CCG staff and all clinicians in practice have a good understanding of the impact of each of these key work areas on a day to day basis.

Commissioning For Quality, Improvement and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of a provider's income to the achievement of local quality improvement goals. A KPI may be used in the following year in the provider's quality schedule to consolidate the initiative or where continuing improvement may be required.

There is a robust 2016/17 plan within our CCGs to align CQUINs with our QIPP ensuring where we can we apply a 'double lock' type approach to tie in QIPP and CQUINs that aims to enhance patient pathway by increasing Provider productivity, improving quality and impacting effectively on cost.

Seven-Day Working

In 2015/16 OUR CCG committed to delivering the seven day working program and whilst it has been automatically implemented where possible during 2015-16 through Contracts and New Procurements, there is still a significant volume of work to meet the expected outcomes of the guidance. Some of which is delayed due to the unavoidable requirement for additional funding in the already challenged economic climate.

We have previously concentrated on mapping current provision and producing a gap analysis to baseline the position of providers. This work has now been translated into an action plan and a pan Staffordshire group of both providers and commissioner has been established to agree priorities and jointly work to implement the requirements of the seven-day working plan.

Recently published Department of Health guidelines have highlighted the key expectations from seven-day services between now and March 2017.These priorities are being factored into the operational delivery plans with all providers via the Staffordshire wide group and 2016/17 will be focused on turning the whole strategy and plans into actual real changes.

The seven-day services program will continue to work in conjunction with the wider transformation agenda the Better Care Fund, primary care development and Other appropriate commissioning work streams. During 2016/17, locally we continue to receive updates from our Providers on their seven day action plans at CQRMs as an agenda item.

Research

We have a number of mechanisms for linking in to research. The CCG is an active member of the West Midlands North Primary Care Research Network and is a member of the Steering Group that oversees the work of the PCRN team. Their role is to support practices to deliver research and to ensure practices are research ready to enable them to take on and lead research projects. In addition the network ensures a balanced research portfolio; develops capacity to support industry studies and identifies sites in primary care where patients could be recruited.

Using practices as sites to identify patients (PIC sites) has been very successful with industry studies and increasing the number of patients involved with research studies. It has been agreed that in respect of patient and public involvement in research, that work will include raising awareness of research through media such as TV, newspapers and social media. In addition, work will include helping to identify research priorities and encouraging people to take part in research studies.

The PCRN is hoping that practices will sign up to the use of the research database and work is underway through the CCG Caldicott Guardians to gain endorsement for use of the database by local practices. The PCRN produces a quarterly newsletter that each CCG disseminates to practices as an electronic link.

The CCG Joint Quality Committee receives a quarterly update on progress with respect to research, including research active practice and a summary of this is submitted to Governing Body as part of the quality report. Our Quality Team Leads have attended the regional research meetings and have identified studies and local support for GPs which means West Midlands research group will be contacting practices directly with the CCGs support.

Areas of current work include:

- Excess Treatment Cost – Shared Arrangements

The shared arrangements in place in Staffordshire is working well, but that other areas are having difficulty identifying funds for excess treatment costs (ETC). The process has been shared as an area of good practice. The Staffordshire CCGs have a £10,000 levy on an annual basis for excess treatment costs as a shared arrangement.

- Research Capability Funding (RCF)

Joint Quality Committee has agreed to pool the £20,000 each CCG will receive as Research Capability Funding (RCF) to be held by Keele. The funding will be available from July 2016 and is expected to be £70k across Staffordshire.

- Research Governance for Primary Care

The process for obtaining research governance approval is set to change. A local arrangement will still be required for local studies. Currently this service is provided to the Staffordshire CCGs by BHFT under a service level agreement, but discussions are underway to move to a “pay as you go” arrangement.

- Optimising Recruitment

Earlier this year a proposal was put forward to introduce a “hub and spoke” model whereby one practice in each CCG is supported to undertake additional studies and act as a hub to support less research active practices. It is proposed that we pursue practices who are interested, even if they do not meet the 10,000 patient list size requirements laid down by CRN.

Appendix 1

NHS East Staffordshire Clinical Commissioning Group

QIPP Target 16/17 £5,026M

Risk Rating	2016/17 Outline Plan	16/17 Risk Adjusted Target £	Savings Rationale	Key Actions to Secure Savings Target	Contracted/Progress in Negotiation?	Delivery Date	Included in Finance/Activity Plan
	TRANSACTIONAL QIPP						
Low	CHC	340,000	Modelled on the review and assessment of what could be achieved in 14/15 -16/17. Reduced by £132,000 due to those savings being achieved in 15/16	The CSU Pan Staffs QIPP plan became effective in August 2014 and this is the 3rd year of savings based on: 1. Efficient management of patients with 1:1 nursing needs. 2. Improved case management in Children's services. 3. Review of high cost care packages. 4. Validation of patient stays in hospital. 5. Vac therapy equipment review. 6. Value based dynamic procurement system	**Yes**	Contracted and monitored on-going through the IPA Board. Phased equally for 12 months.	**Yes**
Low	Medicines Optimisation	490,000	Already in lowest quarter of CCGs in England for growth in costs + prescribing items - savings identified are: Further update of GP Prescribing software: £100K. 2. PrescQIPP Droplist 80K. 3. FYE from 15/16 schemes £80K. 4. Pharmacy rebate schemes £20K. 5. Patient Expires £10K	1.GP Practice audits on medicines of formulary compliance and using prescribing support software to review patients to stop or change treatments- audits scheduled throughout the year. 2. Self Care campaign continuation. 3. Review invoices against rebates using epact. 4.Medicines optimisation clinics -practice based and care homes. 5. Patent expiry-monitoring against drug tariff	**N/A**	Commencing April 2016 and continuation of 15/16 schemes on-going.	**N/A**
Medium	Audiology	50,000	South Staffs 15% reduction in total spend per annum on AQP. Upper decile saving based on North Staffs modelling.	1.Pan staffs programme of work led by SaSCCG CCG's. Work Plan delayed in 15/16 due to OSC review and request for further work up and engagement. We are reviewing all AQP contracts within this context, anticipate savings will be at year end	**No**	AQP Review underway with comms and engagement plan in development to take action from 1st April 2016 to ensure savings in quarter 4	**N/A**
Low	POLCV	200,000	Based on 15/16 scheme this will go above top decile savings of £549K for the top 6 procedures: Cataracts, (to remain bellow national average)Hips and Knees, Choleysystectomies, Tonsillectomies, Arthroscopies and Hysterectomies.	1. Aligned policy across BHFT and Derby with policies and service specifications in the contract. 2. OPCS codes will be used for monthly monitoring from April 2016 as HRG is still to high level for some POLCV. 3. Exploring the use of Bluteq for all POLCV as part of contract negotiation with BHFT. 4. Monthly audits of the top 6 across both main providers to assess compliance of Trusts and primary care. 5. Monthly review of primary care data shared with each practice and tied into LIS 1 payments. 6. Clarity in the policy and OPCS codes will be used to ensure excluded and restricted are clear. 7. Savings projection has not included any excluded procedures which will be reviewed monthly by BI and form part of contract challenges	**Yes**	Updated draft policy shared with Trusts in January 2016 for development of lead in plan from 1st April 2106. In BHFT contract negotiations will be included in BHFT, Derby with specification in contracts and commence 01/04/2016.	**Yes**
Low	BHFT Acute Contract Efficiencies / Challenges	540,000	Based on challenges in 15/16 and counting and coding reviews by BI.	1. Agreed: Blood/product transfusion price, glaucoma screening, multiple diagnostic, venous sampling, well babies, MIU, lucentis, oncolgy telephone advice.	**Yes**	01/04/2016 Contracted across BHFT, Derby, UHNM	**Yes**
		300,000	Balance sheet review of acute services	Contracted.	**Yes**	Contracted.	**N/A**
	LES/LIS Efficency	150,000	Based on efficency work undertaken in 15/16	Contracted.	**Yes**	Contracted.	**N/A**
Low	SSOTP Community Support Workers	180,000	Saving identified from a service line in the SSOTP contract that no longer existed.	1. Contracted in 15/16 - continuation.	**Yes**	Contracted.	**N/A**
	Sub-Total	**2,250,000**					

Appendix 1

NHS
East Staffordshire
Clinical Commissioning Group

QIPP Target 16/17 £5,026M

Risk Rating	2016/17 Outline Plan	16/17 Risk Adjusted Target £	Savings Rationale	Key Actions to Secure Savings Target	Contracted/Progress in Negotiation?	Delivery Date	Included in Finance/Activity Plan
	TRANSFORMATIONAL QIPP						
Low	Improving Lives Programme	1,446,000	1. Case for change includes all adults in receipt of unscheduled care and long term condition care.	1. Contracted from 1st April 2016-outcomes base, fixed price.	**Yes**	Contracted	**Yes**
Low	First Out Patients	180,000	1. Opportunity for adult specialities outside of Improving Lives: £470K (upper decile) 2. Opportunity for children's specialities is £63,342 (upper decile). The savings have been risk adjusted to reflect the assessed non-deliverability within children's specialties.	1. Monthy data shared with GP practice through visits and reports with an outcomes based plan generated. 2. LIS payment is tied into the development and delivery of the outcomes based plan and is monitored monthly. 3. Continued roll out of Map of Medicine and focus on high referring areas compliance with map of medicine (best practice/NICE guidance) 4. Align practice based outcomes plan with Virgin Care plans (January-April 2016) 5. GP Peer Review programme being worked up to support outcomes based plan development and support Map of Medicine implementation commencing April 2016. 6. Further scoping of dermatology tele-health scheme between January and April 2016.	**Yes**	Apr-16	**Yes**
Low	1:Fup Attendances	220,000	1. Opportunity is Upper Decile for specialities outside of the Virgin Contract at BHFT. 2. Work undertaken in 15/16 is forecast to achieve £269K across all specialities (opportunity was £985,200 at upper decile).	1.Specialities: Dermatology, ENT, Spinal surgery, Gynae, Paeds, Ophthalmology, Plastic Surgery. 2. Ophthalmology review identified 1: fups as a significant area for improvement. 3. CQUIN will be developed to encourage innovation/telehealth and will mirror 15/16 CQUIN.	**Yes 15/16-In negotiation 16/17, session in January**	Apr-16	**Yes**
High	Prioritisation	0	To be determined-awaiting further work up to identify specialities out of virgin scope and our 16/17 POLCV	1. Further CCG work up is underway to identify the opportunity in ESCCG- delivery date March 2016.	N/A	Mar-16	No
High	Mental Health	300,000	1. Alignment of SSSFT to a lower unit price which reflects a national average lower quartile and reduces community attributed overheads.	1. Contract negotiation to include reference cost reduction, re-negotiation of risk/benefit share/ non direct costs associated with transferred and pre-existing complex case managed cohort, no longer pay PICU nurse specialling costs across the contract. 2. Modelling to benchmark unit prices for PBR cluster charges and incremental improvements in community RCI values.	**In negotiation 16/17**	Apr-16	**Yes-Finance only**
	Sub-Total	**2,146,000**					
	Unidentified QIPP	630,000					
	TOTAL QIPP	**5,026,000**					

* All acute facing schemes are at 15/16 tariff/price

*All ESCCG schemes have full PID, QIA, clinical engagement and are modelled into the contract activity and financial values

Appendix 2: East Staffordshire CCG Financial Plan 2016/17

The NHS England Allocations paper shows the uplift received by the CCG for Commissioning Healthcare services for the population of East Staffordshire as being £7.5m, 5.1% growth. Guidance requires any funding above 3.05% to be attributed to supporting CCG's outturn position, for East Staffordshire this represents around £3m.

East Staffordshire CCG 2015/16 plans show an in year deficit of £1.5m forecast outturn, whilst the 2016/17 financial plans show an "in year "surplus of £1.6m, an improvement of £3.1m in prior years the CCG has not had sufficient flexibility within its financial plans to have funds to meet the business rules with regard to holding a 1% non-recurrent fund, 2016/17 will be the first time that the CCG has been able to achieve this requirement. The two elements together demonstrate the CCG utilisation of the additional growth monies to support the CCG's outturn position.

The planning assumptions used to complete the financial templates are shown in the table below, the growth % are gross and are therefore prior to apply QIPP schemes. The Prescribing and Continuing Health Care % increases are inclusive of both demographic (volume) and price changes.

As part of the planned expenditure, the planning guidelines have been taken into account, including PBR net inflator, Drugs and Continuing Health Care inflation, parity of esteem for Mental Health.

Activity increases for 2016/17 reflect the growth trend that has occurred in 2015/16, excluding the Virgin activity that is in scope.

Uplift Assumptions	**2016/17**
Efficiencies	-2.00%
Net Inflator	1.80%
Prescribing	6.20%
CHC Uplift	12.00%
Pay / Incremental Drift	1.50%
Non Pay	1.00%
Other Uplifts	1.10%
Activity Growth	1.90%
Demographics	0.81%

The overall utilisation of the CCG's growth funds is set out below:

Bridge 2015/16 to 2016/17 Start Plan	**£,000**
Allocation Uplift	7,556
Underlying Surplus	815
2016/17 Opening Position	**8,371**
less	
1% NR Headroom	1,556
Reinstate 0.5% Contingency	778
Reinstate NICE Reserve	118
Activity Growth	3,258
Net Inflation (inc CNST 0.7%)	3,957
Investments / Other Financial Pressures	2,167
QIPP	-5,019
Net Cost Pressures	**6,815**
2016/17 Planned Surplus	**1,556**
Prior Year Deficit Payback	-7,114
Cumulative Position 2016/17	-5,558

This is how the allocations have been utilised in accordance with the planning guidance at an expenditure level.

Summary Schedule of Resource and Allocation 2015/16 to 2016/17							
	2015/16 Forecast	NR Adjustment	Virgin Adjustment	Recurrent Forecast	2016/17 Plan	Movement	
	£,000	£,000	£,000	£,000	£,000	£,000	%
Recurrent Resource (Excluding payback)	145,700			145,700	153,159	7,459	5.1%
Non Recurrent Allocations (Excluding payback)	1,514	1,514					
BCF S256 Funds	2,367			2,367	2,488	121	5.1%
Running Costs Allocation	2,990			2,990	2,966	-24	-0.8%
Total Resource	**152,571**	**1,514**	**0**	**151,057**	**158,613**	**7,556**	
Acute	90,329	-1,220	9,324	98,433	100,463	2,030	2.1%
Mental Health	12,127	-489		11,638	12,031	393	3.4%
Community	10,732	-74	-8,511	2,147	2,115	-32	-1.5%
Continuing Care	9,240			9,240	9,789	549	5.9%
Continuing Care - Risk Pool	818	-818			328	328	
Primary Care - Including Prescribing	23,902	-401	-770	22,731	23,400	669	2.9%
Other Programme	545	-77	-43	425	810	385	90.6%
Better Care Fund	2,367			2,367	2,406	39	1.6%
Better Care Fund (Above Allocation)	1,049	-752		297	297	0	0.0%
Running Costs	2,964			2,964	2,966	2	0.1%
Reserves - NICE					118	118	
Reserves - 1% NR					1,556	1,556	
Contingency - 0.5%					778	778	
Total Expenditure	**154,073**	**-3,831**	**0**	**150,242**	**157,057**	**6,815**	
Surplus/(deficit) including enhanced tariff	**-1,502**			**815**	**1,556**		
Prior year payback	-5,612				-7,114		
Cumulative Position	-7,114				-5,558		

The Plan show's an "in year surplus" of £1.6m, with payback for prior years (2015/16 being £7.1m), this gives an overall planned deficit for 2016/17 of £5.6m.

The CCG therefore "in year" meets the planning guidance to achieve a 1% surplus.

It should also be noted that the CCG has not taken account of any additional funding being allocated to Local Authority for the protection of social care above the levels that are funded within the allocation (including 5.1% growth).

The table below shows the Business rules and ESCCG achievement against each requirement.

Business Rules 2016/17	£,000	%
2016/17 Recurrent Resource (Including BCF)	155,647	
Recurrent Underlying Surplus	2,990	1.9%
2016/17 Surplus	1,556	1.0%
Contingency 0.5%	778	0.5%
Other Reserves - NICE	118	0.1%
1% NR Reserves - Not Committed	1,556	1.0%

The requirement for the CCG to hold a 1% non-recurrent reserve that is uncommitted has been included within the 2016/17 plans.

Risks / Key Issues:

- Contracts remain to be signed off and therefore movement in the position can still occur. This could generate additional pressures for the CCG to manage in year.
- Continuing Health Care spend in year in line with plan, recognising the Living wage allowance impact.
- Delivery of the QIPP programme for 2016/17
- Budget transfers to NHS England for CHIS/Children's Health Visiting that are not cost neutral.

Appendix 3: Staffordshire Sustainability and Transformation Plan Footprint

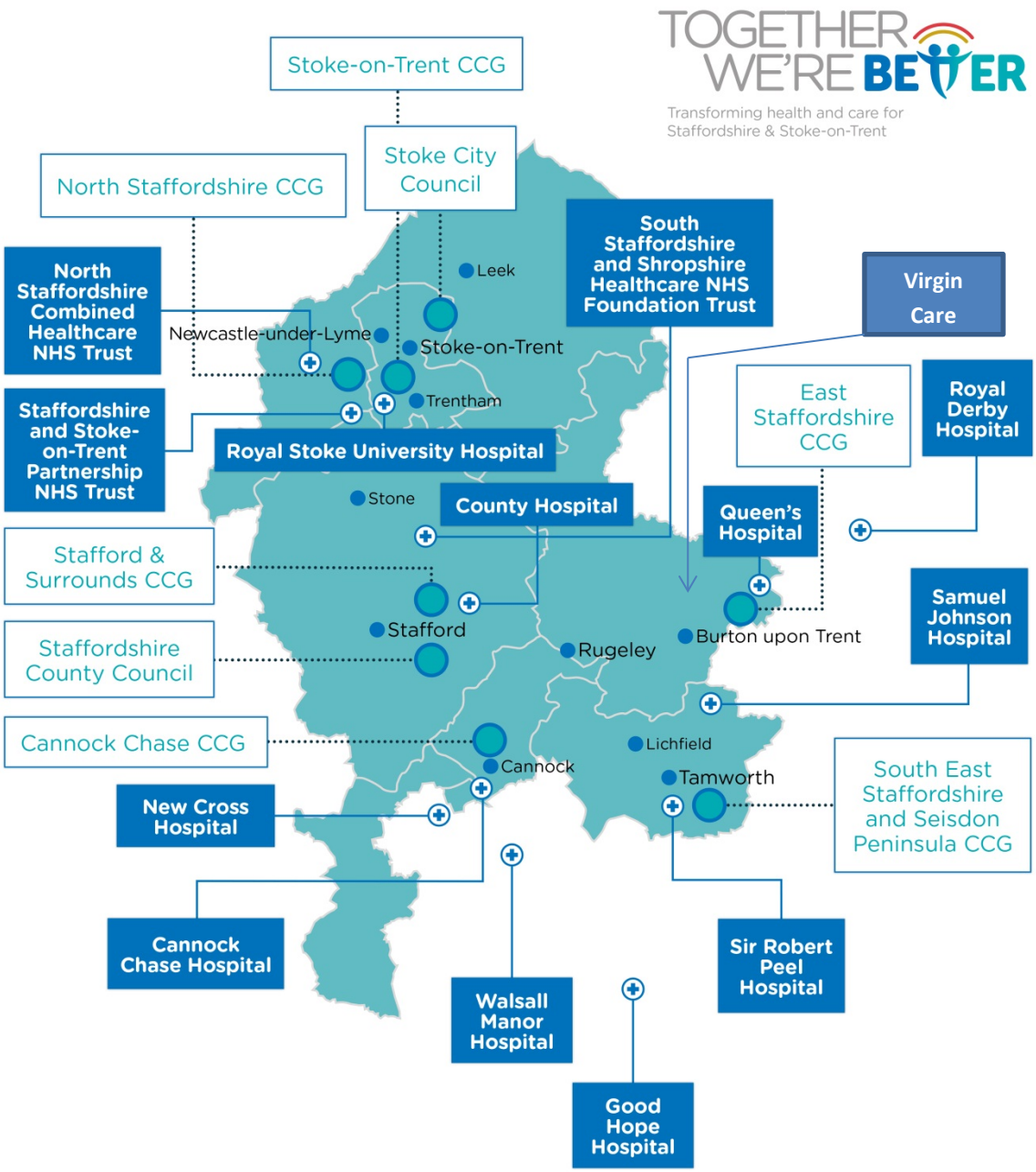
There is an agreement that has been ratified by Local Authorities, Clinical Commissioning Groups (CCG's) and Providers as to how we will work together to build a sustainable healthcare system for Staffordshire and Stoke on Trent. The '*Together we're Better*' programme is the vehicle that will drive this transformation with significant support from senior leaders from all parties described below.

The proposed footprint includes:

Table 1.

Clinical Commissioning Groups (CCG's) (6)	• North Staffordshire • Stoke on Trent • East Staffordshire • South East Staffordshire and Seisdon Peninsula • Cannock Chase • Stafford and Surrounds
Local Authorities (2)	• Staffordshire County Council • Stoke on Trent City Council
Hospital Trusts (3)	• University Hospitals of North Midlands NHS Trust (Royal Stoke University Hospital, County Hospital) • Burton Hospitals NHS Foundation Trust (Queens Hospital, Samuel Johnson Community Hospital, Sir Robert Peel Community Hospital) • Cannock Chase Hospital (part of Royal Wolverhampton Hospitals NHS Trust)
Community Health Trust (1)	• Staffordshire and Stoke on Trent Partnership NHS Trust
Mental Health Trust (2) Including delivery of services for learning disabilities	• North Staffordshire Combined Healthcare NHS Trust • South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Fig 1.


TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent
Stoke-on-Trent CCG
Stoke City Council
North Staffordshire CCG
North Staffordshire Combined Healthcare NHS Trust
Staffordshire and Stoke-on-Trent Partnership NHS Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Virgin Care
East Staffordshire CCG
Royal Derby Hospital
Queen's Hospital
Samuel Johnson Hospital
Stafford & Surrounds CCG
Staffordshire County Council
Cannock Chase CCG
New Cross Hospital
Cannock Chase Hospital
Walsall Manor Hospital
Good Hope Hospital
Sir Robert Peel Hospital
South East Staffordshire and Seisdon Peninsula CCG
Royal Stoke University Hospital
County Hospital
Leek
Newcastle-under-Lyme
Stoke-on-Trent
Trentham
Stone
Stafford
Rugeley
Burton upon Trent
Lichfield
Cannock
Tamworth

Appendix 4: UNIFY Trajectories for NHS Constitution Standards

E.B.3 – National Standard 92%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
RTT – % pathways within 18 weeks for incomplete pathways at the end of the period	Incompletes < 18 wks	6548	6740	6744	6475	6531	6442	6542	6309	6575	6503	6713	6843
	Total Incompletes	7025	7223	7220	6925	6977	6875	6981	6725	6994	6903	7111	7225
	%	**93.2%**	**93.3%**	**93.4%**	**93.5%**	**93.6%**	**93.7%**	**93.7%**	**93.8%**	**94.0%**	**94.2%**	**94.4%**	**94.7%**

E.B.4 – National Standard 1%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Diagnostics Test Waiting Times	Number waiting >6 wks	20	20	16	17	13	12	13	12	13	13	13	14
	Total Number waiting	2401	2406	2182	2343	2040	1859	2022	1937	2418	2420	2468	2729
	%	**0.8%**	**0.8%**	**0.7%**	**0.7%**	**0.6%**	**0.6%**	**0.6%**	**0.6%**	**0.5%**	**0.5%**	**0.5%**	**0.5%**

E.B.6 – National Standard 93%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer - all cancers two week wait	Number waiting < 2 wks	298	287	351	298	285	308	293	287	316	203	268	344
	Total number waiting	313	301	368	312	298	322	306	299	328	211	278	356
	%	**95.2%**	**95.3%**	**95.4%**	**95.5%**	**95.6%**	**95.7%**	**95.8%**	**96.0%**	**96.3%**	**96.2%**	**96.4%**	**96.6%**

E.B.7 – National Standard 93%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – two week wait for breast symptoms (where cancer not initially suspected)	Number waiting < 2 wks	57	43	55	50	50	66	53	57	63	45	55	60
	Total number waiting	60	45	57	52	52	69	55	59	66	47	57	63
	%	**95.0%**	**95.6%**	**96.5%**	**96.2%**	**96.2%**	**95.7%**	**96.4%**	**96.6%**	**95.5%**	**95.7%**	**96.5%**	**95.2%**

E.B.8 – National Standard 96%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – % patients receiving first definitive treatment within 31 days of cancer diagnosis	Number waiting < 31 days	95	124	85	126	106	132	104	79	108	98	93	110
	Total number waiting	98	129	88	131	110	137	108	82	112	102	96	114
	%	**96.9%**	**96.1%**	**96.6%**	**96.2%**	**96.4%**	**96.4%**	**96.3%**	**96.3%**	**96.4%**	**96.1%**	**96.9%**	**96.5%**

E.B.9 – National Standard 94%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – 31 Day standard for subsequent cancer treatments (surgery)	Number waiting < 31 days	9	7	15	10	14	8	13	10	12	11	8	9
	Total number waiting	9	7	15	10	14	8	13	10	12	11	8	9
	%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

UNIFY Trajectories for NHS Constitution Standards

E.B.10 – National Standard 98%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – 31 Day standard for subsequent cancer treatments (anti-cancer drug regimens)	Number waiting < 31 days	17	18	12	16	16	14	9	19	14	18	13	13
	Total number waiting	17	18	12	16	16	14	9	19	14	18	13	13
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

E.B.11 – National Standard 94%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – 31 Day standard for subsequent cancer treatments (radiotherapy)	Number waiting < 31 days	16	15	15	16	13	12	18	9	16	16	14	18
	Total number waiting	16	15	15	17	13	12	19	9	16	17	14	19
	%	100.0%	100.0%	100.0%	94.1%	100.0%	100.0%	94.7%	100.0%	100.0%	94.1%	100.0%	94.7%

E.B.12 – National Standard 85%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – all cancer 62 day urgent referral to first treatment wait	Number waiting < 62 days	17	28	23	27	20	26	19	17	29	18	17	27
	Total number waiting	19	32	26	31	23	30	22	20	33	21	20	31
	%	89.5%	87.5%	88.5%	87.1%	87.0%	86.7%	86.4%	85.0%	87.9%	85.7%	85.0%	87.1%

E.B.13 – National Standard 90%		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – 62 day wait for first treatment following referral from an NHS cancer screening service	Number waiting < 62 days	3	5	3	5	6	8	3	3	3	3	6	3
	Total number waiting	3	5	3	5	6	8	3	3	3	3	6	3
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

E.B.14 – National Standard None		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Cancer – 62 day wait for first treatment for cancer following a consultant's decision to upgrade the patients priority	Number waiting < 62 days	3	4	3	3	2	3	2	3	2	2	3	3
	Total number waiting	3	4	3	3	2	3	2	3	2	2	3	3
	%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%