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

NHS

Meeting in Common of the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups' Governing Bodies held in Public

Tuesday 17 March 2020, 4.30 pm
Minton Room, Smithfield One, Leonard Coates Way, ST1 4FA

Agenda

A=Approval R=Ratification S=Assurance D=Discussion I=Information

		Enc.	Lead	A/R/S/D/I	Time
1.	Welcome	Verbal	LC	I	4.30
2.	Apologies	Verbal	LC	I	
3.	Declaration of Interest and actions taken to manage conflicts	Enc. 01	LC	I	
4.	Quoracy	Verbal	SY	I	

Item for Discussion

Item for Information

Item for Approval

5.	Minutes of the Extraordinary Meeting in Common of the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups' Governing Bodies held in Public - The Future of Local Health Services in Northern Staffordshire - Decision Making Business Case	---	All voting members	A	4.35
6.	Close		LC		

Cannock Chase Clinical Commissioning Group
East Staffs Clinical Commissioning Group
North Staffs Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

NHS

STAFFORDSHIRE AND STOKE-ON-TRENT CLINICAL COMMISSIONING GROUPS
CONFLICTS OF INTEREST REGISTER 2019-2020
NORTH STAFFORDSHIRE CCG AND STOKE-ON-TRENT CCG GOVERNING BODIES
AS AT 12 MARCH 2020

Employing Organisation	Title	Forename	Surname	Role	GP Practice/Base/ Other	1. Financial Interest	2. Non-financial professional interests	3. Non-financial personal interests	4. Indirect interests	5. Actions taken *to mitigate identified conflicts of interest*
NS CCG	Dr	Waheed	Abbasi	Clinical Director / Board Member SOT CCG	The Village Surgery	1. GP Principal The Village Surgery **(October 2017 - ongoing)** 2. Director Abbasi Medical Services Ltd **(2011 - ongoing)** 3. Director Staffordshire Care Direct Ltd **(July 2017 - ongoing)** 4. Sessional GP Extended Access with NS GP Federation **(October 2018 - ongoing)** 5. Practice is member of Newcastle Central Primary Care Network **(October 2017 - ongoing)**	1. Membership of BMA, RCGP, GPwSI Mental Health and Drugs and Alcohol **(2009 - ongoing)**	None	1. Spouse is Director & Secretary of Abbasi Medical Services Ltd **(2011 - ongoing)** 2. GP Partner is a Clinical Associate in CCG **(October 2017 - ongoing)** 3. Other Directors in SCD Ltd are PCN members, one is GB member North Staffs CCG **(July 2017 - ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) interest recorded on the CCG Conflicts Register.
SOT CCG	Mr	Tim	Bevington	Lay Member Stoke CCG Board	Stoke-on-Trent	None	None	None	1. Child is employed as an Educational Psychologist with Stoke-on-Trent City Council **(ongoing)**	(h) interest recorded on the CCG Conflicts Register.
NS CCG	Dr	Alison	Bradley	Clinical Chair of North Staffs CCG	Werrington Village Surgery	1. GP Partner, Werrington Village Surgery (**2002 to date**). 2. Member Practice of North Staffordshire GP Federation **(current)** 3. Clinical Chair of North Staffordshire CCG **(August 2016 to date)** 4. Member practice of Moorlands Primary Care Network **(ongoing)**	None	None	None	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) Recorded on CCG Conflicts Register.
SOT CCG	Dr	Lorna	Clarson	Chair, Stoke-on-Trent CCG	Brook Medical Centre	1. Salaried GP at Brook Medical Centre, Bradeley **(November 2018 - ongoing)** 2. Senior Lecturer in General Practice Research, Keele University **(October 2018 - ongoing)** 3. Practice member of Whitfield Primary Care Network **(ongoing)**	None	None	1. Spouse is a GP Partner in Keele University Practice **(2017 to present)**	(a) to (g) plus (h) inclusive as required in any procurement decisions relating to third parties advice is offered to by company
Staffordshire CCGs	Mr	Neil	Cook*	Interim Deputy Director of Finance	Staffordshire Place 2	1. Director and Shareholder of Cuebrook Limited **(from November 2018 - ongoing).**	None	None	None	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) Recorded on CCG Conflicts Register.
NS CCG	Mr	Peter	Dartford	Lay Member for Patient and Public Involvement	Lay Member	None	1. Visiting Professor - University of Chester **(14.12.2016-31.08.2022)**	1. Non-Executive Director/Board Member North Staffordshire YMCA **(01.10.2016 - ongoing)** 2. Vice Chair of Governors Leek First School **(September 2015 - ongoing)**	None	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company (h) Recorded on CCG Conflicts Register.
NS & SOT CCGs	Dr	Steven	Fawcett	Clinical Director Stoke-on-Trent & North Staffs CCG Medical Director Stoke-on-Trent & North Staffs CCGs	Moorcroft Medical Centre	1. Salaried GP and GMS contract holder for Combined Healthcare Trust **(December 2018 - ongoing)** 2. Partner of Moorcroft Medical Centre LLP with Pharmacy2U **(January 2015 - ongoing)** 3. Member North Stoke 1 Primary Care Network **(ongoing)** 4. Member North Staffs GP Federation **(ongoing)**	1. Member of North Staffs LMC **(ongoing)**	None	1. Spouse is a nurse for Keele University Medical Centre **(ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
Staffordshire CCGs	Ms	Paula	Freeman*	Executive Assistant	Smithfield 1, Stoke-on-Trent	None	None	None	None	None required.
SOT CCG	Dr	John	Gilby	Clinical Director / Board Member SOT CCG	Brook Medical Centre	1. GP Partner **(ongoing)** 2. Member of GP Federation **(2015 - ongoing)** 3. Practice member of Whitfield Primary Care Network **(ongoing)**	None	None	1. Spouse is CEO at Countess of Chester **(ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
Staffordshire CCGs	Mrs	Cheryl	Hardisty*	Director of Strategic Commissioning & Operations	Staffordshire Place 2	None	None	None	None	None required.
SOT CCG	Mr	John	Howard	Lay Member for Governance	Smithfield 1, Stoke-on-Trent	None	None	None	None	None required.
NS & SOT CCGs	Dr	Latif	Hussain	Non-Executive Director North Staffs CCG, Stoke-on-Trent CCG (01.01.17)	Milehouse Medical Practice	1. GP Partner Milehouse Medical Practice **(June 1990 - ongoing)** 2. Director of Staffordshire Care Direct **(January 2018 - ongoing)** 3. Joint CD Newcastle Central Primary Care Network **(July 2019 - ongoing)** 4. Member of Norths Staffs GP Federation **(April 2016 - ongoing)**	1. Vice-Chair and active member North Staffs Basics Charity **(April 1996 - ongoing)** 2. Section 12 Approved Doctor MHA **(April 1999 - ongoing)** 3. Trustee of GRT UK Charity **(April 2018 - ongoing)**	None	1. Daughter-in-law is a Pharmacist **(ongoing)** 2. Son is a Paramedic for WMAS **(ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.

Staffordshire CCGs	Mrs	Heather	Johnstone*	Director of Nursing and Quality	Staffordshire Place 2	None	**1.** Visiting Fellow at Staffordshire University **(March 2019 - March 2022)**	None	**1.** Spouse is employed by UHB at Heartlands Hospital **(ongoing)** **2.** Step-sister employed by MPFT as a nurse **(ongoing)** **3.** Brother-in law works as an Occupational Health Nurse for Team Prevent at UHNM **(ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
NS & Stoke CCGs	Mr	Neil	McFadden	Lay Member	Smithfield 1, Stoke-on-Trent	None	None	None	None	None required.
Staffordshire CCGs	Mrs	Lynn	Millar*	Director of Primary Care & Medicines Optimisation	Staffordshire Place 2	None	None	None	None	None required.
Staffordshire CCGs	Mrs	Jane	Moore*	Director of Strategy, Planning and Performance	Staffordshire Place 2	**1.** Honouree Contract - Public Health Consultant **(ongoing)**	None	None	None	(h) recorded on CCG conflicts register.
SESSP CCG (CC, NS, SOT, SAS CCGs)	Mr	Douglas	Robertson	Secondary Care Consultant for: CC, NS, SESSP, SAS & SoT CCGs	Secondary Care Consultant	**1.** Receive referrals from Staffordshire GPs **(ongoing)**	**1.** Receive referrals from Staffordshire GPs **(ongoing)**	None	None	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
Staffordshire CCGs	Mr	Mark	Seaton*	Managing Director (North)	Smithfield 1, Stoke-on-Trent	None	**1.** Postholder is freeholder of a community building in Stoke **(ongoing)** **2.** Postholder is registered Pharmacist **(ongoing)**	None	**1.** Spouse if Head of Medicines Optimisation & Primary Care in neighbouring CCG **(ongoing)** **2.** Family member is an Optometrist at Spec Savers **(ongoing)** **3.** Family member is a school teacher potentially involved in CAMHS Trailblazer **(ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
SAS CCG	Mrs	Tracey	Shewan	Deputy Director Nursing and Quality	Staffordshire Place 2	None	None	None	**1.** Spouse NHS Lead for Shropshire Staffordshire Cheshire Blook Bikes **(ongoing)** **2.** Sibling is a Senor Nurse at MPFT **(ongoing)**	(a) to (g) inclusive as required in any procurement decisions relating to third parties advice is offered to by company. (h) recorded on CCG conflicts register.
Staffordshire CCGs	Mr	Marcus	Warnes*	Accountable Officer	Staffordshire Place 2	None	None	None	None	None required.
Staffordshire CCGs	Mr	Paul	Winter*	Deputy Director of Corporate Services & Governance	Staffordshire Place 2	None	None	None	None	None required.
SOT CCG	Mrs	Margy	Woodhead	Lay Member PPI, Stoke CCG	Lay Member	None	None	**1.** Committee member of Care & Fun Club Charity supporting Blythe Bridge Library **(2016 - ongoing)**	None	Declare interest if funding applied for and as required. (h) Interest is recorded on CCG Conflicts register.
Staffordshire CCGs	Ms	Sally	Young*	Director of Corporate Services, Governance and Communication	Staffordshire Place 2	None	None	None	None	None required.

* Individual/role works across PAN Staffordshire Clinical Commissioning Groups
1. Financial Interest *(This is where individuals may directly benefit financially from the consequences of a commissioning decision, e.g. being a partner in a practice that is commissioned to provide primary care services)*
2. Non-financial professional interests *(This is where an individual may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services*
3. Non-financial personal interests *(This is where an individual may benefit personally, but not professionally or financially, from a commissioning decision e.g. if they suffer from a particular condition that requires individually funded treatment)*
4. Indirect interests *(This is where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g. spouse, close relative (parent, grandparent, child*
5. Actions taken *to mitigate identified conflicts of interest*
(a) Change the CCG role with which the interest conflicts (e.g. membership of a CCG commissioning project, contract monitoring process or procurement would see either removal of voting rights and/or active participation in or direct influencing of any CCG
(b) Not to appoint to a CCG role, or be removed from it if the appointment has already been made, where an interest is significant enough to make the individual unable to operate effectively or to make a full and proper contribution to meetings etc
(c) For individuals engaging in Secondary Employment or where they have material interests in a Service Provider, that all further engagement or involvement ceases where the CCG believes the conflict cannot be effectively managed
(d) All staff with an involvement in CCG business to complete mandatory online Conflicts of Interest training (provided by NHS England), supplemented as required by face-to-face training sessions for those staff engaged in key CCG decision-making roles
(e) Manage conflicts arising at meetings through the agreed Terms of Reference, recording any conflicts at the start / throughout and how these were managed by the Chair within the minutes
(f) Conflicted members to not attend meetings, or part(s) of meetings: e.g. to either temporarily leave the meeting room, or to participate in proceedings but not influence the group's decision, or to participate in proceedings / decisions with the agreement of all other
(g) Conflicted members not to receive a meeting's agenda item papers or enclosures where any conflict arises
(h) Recording of the interest on the CCG Conflicts of Interest/Gifts & Hospitality Register and in the minutes of meetings attended by the individual (where an interest relates to such)
(i) Other (to be specified)

Extraordinary Meeting in Common of the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups' Governing Bodies held in Public

Tuesday 21 January 2020, 2 – 5 pm
Stoke on Trent Moat House, Etruria Hall, Festival Way, ST1 5BQ

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Members:			Quoracy	02/10/2018	06/11/2018	04/12/2018	08/01//2019	05/03/2019	25/06/2019	21/01/202
Present:										
North Staffordshire CCG Voting Members:										
Dr Alison Bradley	AB	North Staffordshire CCG Clinical Chair *(Meeting Chair)*		✓	✓	✓	✓	✓	✓	✓
Peter Dartford	PD	Lay Member – Patient and Public Involvement		✓	✓	✓	✓	✓	✓	✓
Neil McFadden	NMcF	Lay Member – Governance		✓	✓	✓	x	✓	✓	✓
Stoke-on-Trent CCG Voting Members:										
Dr John Gilby	JG	Clinical Director – Primary Care		✓	✓	✓	✓	✓	✓	✓
John Howard	JH	Lay Member – Governance		✓	✓	✓	✓	✓	✓	✓
Margy Woodhead	MWo	Lay Member – Patient and Public Involvement		✓	✓	✓	✓	✓	✓	✓
North Staffordshire and Stoke-on-Trent CCGs' Voting Members:										
Dr Waheed Abbasi	WA	Clinical Director – Mental Health and Specialist Groups		x	✓	x	✓	✓	✓	✓
Tim Bevington	TB	Lay Member		✓	✓	✓	x	✓	✓	✓
Dr Lorna Clarson	LC	Stoke-on-Trent CCG Clinical Chair / Clinical Director – Partnerships and Engagement		✓	✓	✓	✓	✓	✓	✓
Cheryl Hardisty	CH	Director of Commissioning and Operations		x	✓	✓	✓	x	✓	A
Dr Latif Hussain	LH	Non-Executive GP Board Member		✓	✓	✓	x	✓	✓	✓
Dr Steve Fawcett	SF	Medical Director		✓	✓	✓	✓	x	✓	A
Heather Johnstone	HJ	Director of Nursing and Quality		✓	x	✓	✓	✓	✓	✓
Jane Moore	JM	Director of Strategy, Planning and Performance		x	✓	✓	✓	✓	✓	✓
Neil Cook	NC	Interim Director of Finance							✓	✓
Dr Doug Robertson	DR	Secondary Care Board Member		✓	x	x	✓	✓	x	✓
Marcus Warnes	MW	Accountable Officer		✓	✓	✓	✓	✓	✓	✓
In attendance:										
North Staffordshire and Stoke-on-Trent CCGs:										
Tracey Shewan	TC	Director of Communications and Engagement		✓	✓	✓	✓	x	✓	✓
Paula Freeman	PF	Executive Assistant *(Minutes)*		x	✓	✓	✓	✓	✓	✓
Gemma Smith	GS	Associate Director of Strategic Commissioning							✓	✓
Becky Scullion *(representing CH)*	BS	Deputy Director of Commissioning and Operations								✓
Mel Stoddard	MS	Personal Assistant *(Minutes)*								✓
Paul Winter	PW	Deputy Director of Corporate Services, Governance and Communications		x	✓	✓	✓	✓	✓	A
Staffordshire Single Leadership Team:										
Lynn Millar	LM	Director of Primary Care		✓	✓	✓	✓	✓	✓	✓
Mark Seaton	MS	Managing Director – North Division		✓	x	✓	✓	x	x	✓
Sally Young	SY	Director of Corporate Governance, Communications and Engagement		✓	✓	✓	✓	✓	✓	✓
Public/Observers										

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Simmy Akhtar	SA	Healthwatch Stoke-on-Trent		x	x	✓	x	x	✓	✓
Dr Chandra Kanneganti	CK	North Staffordshire LMC Secretary								✓
54 members of public / press in attendance.										

2020/JAN/049	1. Welcome	Action
	AB welcomed members of the public to the Extraordinary Meeting in Common of the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups' Governing Bodies held in public. AB explained that the purpose of the meeting is to discuss, debate, and ultimately make a decision on the Decision Making Business Case (DMBC) for the Future of Health Services in Northern Staffordshire, following the conscientious consideration to the findings of the Pre Consultation Business Case (PCBC) held on 25 June 2019. Members of the public were reminded that the meeting is a meeting held in public of the two Governing Bodies, and not a public meeting. AB acknowledged that the Future of Health Services in Northern Staffordshire is an emotional subject and thanked everyone who has participated in the extensive consultation process which is reflected in the DMBC. AB explained that there would be an opportunity for one question per person at the end of the Governing Bodies discussion prior to a decision being made. AB asked that the public respect the process and observe the meeting first, so that the Governing Bodies may conduct their business, which they have committed to do in public. AB acknowledged that Governing Body members are aware of their duty and reiterated as follows: As decision makers you must be aware of your duty to have 'due regard;' • 'Due regard' must be fulfilled before and at the time a particular decision is made • The duty must be exercised in substance, with rigour and an open mind • The duty is non-delegable • The duty is a continuing one • Minutes of this meeting will be taken as an adequate record showing the duty has been considered.	
2020/JAN/050	**2. Apologies for absence**	
	Apologies were duly ***received*** and ***noted*** as above. SY pointed out that CH is represented by her deputy,BS, who has been instructed by CH to vote.	
2020/JAN/051	**3. Members' Declarations of Interest / Actions taken to Manage Conflicts**	**Action**
	No further declarations of interest made	
2020/JAN/052	**4. Confirmation of Quoracy**	
	The meeting was confirmed as quorate for North Staffordshire CCG and Stoke-on-Trent CCG.	
2020/JAN/053	**5. Decision Making Business Case regarding the future of Local Health Services in Northern Staffordshire**	
	GS presented an overview of the consultation process which took place from 10 December 2018 to 17 March 2019. The aim of the consultation was to gain feedback from the public and stakeholders with regard to the proposed model and option for locations for the delivery of	

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	Integrated Care Hubs, the location of the132 Discharge to Assess beds, and the removal of Tier 4 clinics from Leek Moorlands Hospital. GS presented the key themes resulting from the public consultation with regard to the hubs, beds, and Tier 4 services. GS explained that the Decision Making Business Case exists in order to assist the Governing Bodies in Common to make a final decision. The DMBC is a technical document to support decision making in public and conscientiously takes into account all of the consultation outcomes, identifies recommended options and proposed next steps regarding decision making. In line with the Public Sector Equality Duty, Governing Bodies in Common members were required to give due regard to the view of protected and minority groups who may be adversely affected by the proposals and mitigating actions within the Equality Impact Assessment. In line with the Health and Social Care Act 2012, it was asked that consideration must be given by the Governing Bodies in Common members with regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved, and be assured that these proposals will ensure that health services are provided in an integral way, will improve quality, reduce inequalities in access to services or reduce inequalities in the outcomes achieved. In line with NHS England assurance process, the CCGs were informed by NHS England that as there were no significant deviations in the proposals or finances, there would be no requirement for any formal assurance and were permitted to progress through the decision making process. In order to provide local assurance the CCGs have presented the high level outcomes of the DMBC to Board members of University Hospitals North Midlands (UHNM), Midlands Partnership Foundation Trust (MPFT), and North Staffordshire Combined Healthcare Trust (NSCHT). Both Staffordshire County Council and Stoke on Trent City Council have been formally briefed, and there has been a robust assurance process via the Overview and Scrutiny Committees (OSC) with the Joint Overview and Scrutiny Committee requesting to meet with the CCGs post the decision making process. In addition, the CCGs have been through the West Midlands Clinical Senate process in order to clinically test and validate the model and the Senate is fully supportive of the recommendations made within the DMBC. The recommendations to the Governing Bodies in Common were presented as follows: Integrated Care Hubs: • In South Stoke, option 1a (ETTF new build) • In Staffordshire Moorlands, option 2b (Leek rebuild) • In Newcastle under Lyme, Option 3a (Bradwell existing site) and • In North Stoke, Hayward existing site For community beds, implementation of option 6 (Hayward and Care Homes) Tier 4 clinics to be discontinued from the Leek Moorlands site. The North Staffordshire CCG and Stoke-on-Trent CCG Governing Bodies were given an opportunity to ask questions with regard to the presentation and discussion took place as detailed below. MWo stated that in June last year the outcome of the formal consultation was considered and there were concerns raised with regard to community beds and option 6. MWo expressed particular interest in the quality and safety of the care home market and sustainability, and how the DMBC has taken into these issues into account and reviewed the evidence.	

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	LC responded from a clinical perspective and explained that it is very important as clinicians to re-examine the evidence in order to be assured of the best intentions for patients. It was explained that therapy inputs are the same at both the Haywood and in care homes, and a re-run of the bed modelling has also been undertaken. An in-depth analysis has taken place regarding CQC ratings in care homes as well as the feedback that suitable beds are located nearer to patients' families. Education and training in best practice will be provided in order to maintain and raise the quality of care in care homes. Beds are commissioned by Continuing Health Care (CHC) for eligible patients and via the local authority for a number of patients where the care home is their normal place of residence. The D2A beds will be commissioned as part of the NHS standard contract which adds an additional level of scrutiny to ensure quality and safety is at an optimum level. HJ reiterated that the QIA process should not be down-played as a rigorous and lengthy process has been undertaken until QIA members were confident in the models proposed. A number of arrangements in place were extended or modified to ensure quality and safety. The Quality Information Sharing Meeting (QISM) includes representatives from the CCGs, local authorities and the CQC which reviews the current landscape of care home beds and any issues regarding quality and safety of care. The Nursing Home Quality Assurance Group (QUAG) covers the whole area and has been extended to assess where improvements may be needed to provide assurance. In addition, the CCGs employs a small team of quality nurses, which is a dedicated resource to undertake quality visits at care homes to ensure that patients are receiving high quality of care. The Provider Improvement Response team which is aligned to the Safeguarding team is now permanent and works with the local authorities to assure the quality and safety of care. PD stated that the QIA was reviewed in detail and approved with conditions to ensure quality is as it should be, and raised a question regarding schedule 4 & 6 of the standard quality contract, specifically who is responsible for ensuring compliance and monitoring. HJ responded that the CCGs oversee schedules 4 & 6 of the contract, which is why it is important to review in the same way as any other provider. PD raised concerns with regard to capacity in care homes. HJ responded that priority is that patients receive high quality of care, and that resource will be allocated accordingly. Any emerging risks will be managed by the Risk Review team. BS pointed out that capacity is part of contracting and there are regular meetings in place with the provider, with stringent processes in place which provides another mechanism for assurance. PD asked whether the contract is with the community provider or the care home. BS confirmed that the contract is over-arching with the community provider (MPFT). NMcF raised concerns with regard to the quality of the 67 privately owned care homes across North Staffordshire, and stated that 63% of the available beds are within homes which are CQC rated good or outstanding, one of which is outstanding. NMcF specified a lack of confidence due to inconsistencies in the care home private sector, and in particular the challenges in the Leek area where ratings are not as positive. GS explained that the reference to 67 homes is the total number of homes across the area, not the number of homes to be commissioned. As the feedback request was for beds closer to home, four care homes will be commissioned, which equates to 55 out of 1064 beds rated good or outstanding. Other commissioned beds are via Combined Healthcare with support from the local authorities. The analysis refers to a point in time and there is evidence of an upward trend. NMcF asked what 'not as positive' means and the implication for Leek patients. HJ responded that the CQC ratings range from inadequate to outstanding and the aim is to commission from the upper end. However, she pointed out that the ratings are not static and what could be rated as good today, could be requires improvement or inadequate tomorrow. The CCGs work closely with providers and the CQC and are therefore aware of concerns at an early stage and take appropriate action.	

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NMcF asked for clarity around the 8 requisite beds in Leek and Biddulph. GS confirmed that there are 57 beds rated good or outstanding and beds will be commissioned on the best available at the time of procurement.

PD asked how many of the 57 beds are currently empty to be able to commission. GS responded that a high level implementation plan would need to be in place, followed by market engagement. The procurement would take around 6 months, with an 18 month run-in period to ensure that capacity is phased in appropriately. GS reiterated that there is no immediate proposal.

MS raised a query with regard to future proofing, given the instability in the market and expressed concerns that the CCGs may be held to ransom with regard to bed costs, rather than being strategically managed. The consultation included concerns raised by the GP Federation regarding quality of care and MWo asked for clarification with regard to clinical support for the model of care at this point in time. WA responded that patients would not be placed in a care home if it was not up to standard. The CCGs will ensure that the 55 beds are fully supported utilising rigorous clinical supervision and monitoring. DR commented that the option of the Hayward plus one other will provide flexibility in the system to progress. The perception that the NHS is good and other providers are bad is not always the case. LH stated that the Primary Care Networks (PCNs) are also currently in the process of negotiation with care homes and looking at quality of care to include both residential and nursing homes.

TB stated that more data has been received since the consultation and questioned whether there is sufficient confidence in the 132 bed modelling. GS responded that the bed modelling has been re-run on numerous occasions and has resulted in a requirement of 128 – 138 beds, therefore 132 beds is sustainable and will take into account surges in planned and unplanned activity. The modelling is based on an average of 28 days and 95% occupancy. There are some challenges regarding length of stay (LOS) and all parties are working hard to address the issues to reduce to 28 days. LOS was tested by the Clinical Senate which indicated that 28 days was too long. The current LOS is 34 days and the system has 162 beds in place to include additional winter capacity. BS explained that Home First capacity has increased significantly. The Urgent Care team is managing activity alongside system partners on a daily basis. A trigger tool is used which proactively supports the process to ensure patients are appropriately discharged home. BS reiterated that other factors are taken into consideration and the response is around patient need.

PD commented that the system as a whole is disinvesting in prevention, and questioned how it is possible to reduce demand and reduce bed numbers to 132. GS referred to the challenges in LOS, and that patients are often in the wrong place at the wrong time. The key is to work with partners, including local authorities and the voluntary sector to develop services to avoid unnecessary admissions. LC commented that preventing patients from going to hospital is priority and it is imperative that work continues with our providers to develop new pathways of care. It is also recognised that there is a need to have rapid response services within the system, such as GPs, paramedics, and the Community Rapid Intervention Service (CRIS) which provides treatment for patients at home rather than hospital. In addition, there are other factors to consider including social care issues and infection.

JH stated that the proposed purpose of the care home option is for short stay rehabilitation and assessment, and asked whether the GB can be assured that staff will have the right skills to engage with patients. Recruitment and retention of staff is also difficult at the correct level and the system is in a state of flux, therefore can the GB be assured that there is sufficient sustainability of resource to engage with patients and their families in care homes. HJ responded that it is correct to highlight that the proposal is for short stay beds, which is completely different to the long stay care home beds commissioned via CHC and the local authorities. HJ acknowledged that staffing is a challenge and explained that the model will be procured and commissioned using the same robust specifications and quality metrics in the NHS contract for both community hospital beds and care home beds. MPFT will provide input with regard to therapy and rehabilitation support. With regard to the current nursing landscape

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shortfall, HJ felt encouraged by recent changes including reintroduction of the bursary scheme and modernisation in training, and expressed confidence that nursing will continue to positively evolve. LC addressed the point with regard to assigning a minimum number of beds per site and the impact on nursing staff, and explained that it would not be sustainable for the provider trust to employ small groups of nurses across a number of sites as this would pose a clinical risk. Consideration must also be given to training and mentorship as well as cover for sickness, holidays etc.

MWo raised a query with regard to elderly patients with mental health issues and asked how patients in an acute setting will be assessed in an appropriate environment, how this fits with the Discharge to Assess (D2A) model, and into rehabilitation and subsequently home. BS acknowledged that dementia patients do not always receive the best outcomes. NSCHT will continue to support the pathway to ensure that wraparound services are in place to support patients at home, and that the care provided is based on need.

PD commented that the workforce requirement for rehabilitation is much wider and includes physiotherapists and occupational therapists etc. and asked whether there are enough. GS acknowledged the need for some therapy input and indicated that regardless of where a bed is commissioned patients would need the same therapy input, therefore the challenges are equal. There are four care homes plus the Haywood already providing wraparound services. BS pointed out that wraparound services are also in place from a social care viewpoint and includes holistic therapies.

NMcF raised concerns with regard to the 132 bed modelling including the analysis being based on a short period of time from April to December 2019 which could have implications in the future, and suggested that more time was needed to consider the evidence. NMcF stated that the model is optimistic inreality and questioned how 162 beds could be reduced to 132 whilst taking into account winter pressures.

MW reminded GB members that in 2014/15 there were 361 commissioned beds and 631 12 hour breaches as opposed to last year with 182 beds and no 12 hour breaches. LOS for this area was the highest in the country with SOT patients having to wait for 24 days to go home, now it is 3 days. LOS has reduced by half and SOT has advanced from being the worst in the country to joint best. There were twice the number of beds and performance was worst. The bed modelling has been repeatedly tested, is robust and NHSE assurance received that the numbers are correct. It was concluded that the modelling is future proof.

TB questioned whether the Equality Impact Assessment (EIA) has taken into account the Bracking Principles. SY responded that the duty is upon the decision maker personally. Each GB member should have read the EIA and DMBC giving due regard to the Bracking Principles, Brown Principles, and Gunning Principles prior to making a decision. Risks must be assessed including the extent of any adverse impact, and how such risk may be eliminated. Not knowing is no defence.

JH stated following the useful public interaction at the end of the PCBC held in June 2019, the GB resolved to consider alternative options in addition to those presented at the time, and asked whether this has taken place. GS responded that the main challenge was around sustainability of minimum numbers of beds per site. A review of 40 per site was undertaken, to include benchmarking, working with partners with regard to safe staffing, and the Community Hospital Association evidence as well as consultation feedback. It was established that MPFT would struggle to recruit if sites were smaller than 40, in addition there needed to be a geographical spread to create a fair balance for all areas. Section 7 of the DMBC shows in detail the proposals regarding the geographical spread of care home beds, which covers the Hayward plus a geographical spread, mixed sex accommodation, and the feedback that the public wanted beds closer to home. GS clarified that there is evidence in place to support all options considered.

LC asked for assurance with regard to health inequalities. JM stated that the CCGs are

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	required to reduce health inequality and it is important that all key stages of the consultation have been evidenced. The case for change plus modelling of services is based on robust data sources including Public Health and local authorities. It is also important to note that once a decision is made, the implementation and detailed model of care will be developed with our providers to continue to meet local need. HJ noted that detailed travel analysis has been undertaken and requested a summary of key findings. GS explained that a lot of analysis has been undertaken which impacts on the QIA as a whole. It was established that the majority of people would be able to access a hub within a 30 minute timeframe. There are differences to consider around public and private transport as well as identifying areas of risk and what can be done differently. Travel time is difficult to model as carers and families do not necessarily live in the same area, therefore technical methodology has been applied. All of the tables have been evaluated by individual protected groups for the GB to consider. NMcF asked whether there is adequate finance in place to support the hubs and that there is dedicated protected funding for building costs. NC responded that the finance case is built around the model of care and that MPFT is responsible for estates costs. This is consistent with what is expected from an NHS business case and allocations around the Long Term Plan (LTP) to include allocations and inflation assumptions. The business case is subject to final sign off by MPFT and Procurement and the model is affordable as it currently stands. It is hoped that there may be some financial benefit although this is not built into the business case. NC clarified that 'optimum bias' is a weighting tool utilised to incorporate contingency within the business case. PD questioned how the new model of care will deliver better outcomes for patients. DR explained that as an experienced clinician within the acute sector, clinicians work closely with local GPs to ensure that patients receive the best possible care, which is not what has been done in the past. DR reiterated LC's point that the best way to address patient need is to avoid admission into hospital as once admitted it can be difficult to repatriate. Elderly patients can be susceptible to lose motivation, strength and become de-conditioned. This model of care will provide what is needed, as opposed to patients being discharged into a community bed for 6-8 weeks with a less likelihood of going home. This model of care which has been tested by the West Midlands Clinical Senate is a significant improvement, and is regarded as best practice in other areas, which will result in fewer patients in institutional care. In addition, there is a lot of merit in what is being proposed with regard to Tier 4 services as the old system does not work well and the new model will improve care. It will mean that patients will obtain advice sooner without the need to travel as virtual clinics will be offered. LH asked how risks will be managed during the transition period to ensure that patients are not left vulnerable. HJ stated that most importantly patient safety will not be jeopardised. BS explained that there will be a robust transition plan in place which will form part of the procurement process, to include patient and clinical safety.	
2020/JAN/054	**6. Any Other Business**	
	Questions and Comments from the Public Councillor Gary Bentley, Cheadle GB referred to the re-build at Leek Hospital and asked why the cost of building the hospital has not been considered when it has been confirmed that Cheadle hospital is fit for purpose, with the only downside being that there are 6 beds short, but it is only 5 miles away and asked how this has been addressed. GS advised that a scoring process has been undertaken and that the capital budget is separate and cannot be used for patient care. The budget is managed by MPFT. Although the rooms at Cheadle were considered as an option, the recommended option which scored	

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the highest was 2b. The GB has all options to consider and the recommendation is the option with the highest score.

Chris Taylor, Leek resident

CT asked how the CCGs can claim that all legal duties have been followed in relation to the Equality and the Social Care Act when there is no evidence in the papers to support moving Tier 4 services from Leek to the Royal Stoke. There has been no process to evaluate the effect of the proposal, no mitigating steps, and therefore no evidence. E.g. the journey time from Leek to Stoke on the bus is two hours. GS referred to the section in the EIA which refers to Tier 4 beds and explained that consideration has been given to positive and negative feedback, plus risk and mitigations as the CCGs are duty bound to do so. The EIA includes feedback from protected groups including the homeless and traveller communities.

Lesley Roberts, PPI member and MPFT Governor

LR stated that the results have been weighted towards money and not the opinion of the community and patient benefit. The consultation was clear that option 2 was the preferred option for community beds and the CCGs are refusing to use this and just going with option 6, so where is the democracy and patient benefit.

TS responded that the whole community has been considered, and whilst the biggest response to the consultation was from the Leek area, the CCGs have a duty to consider the whole population including Bradwell, South Stoke etc. The scores were re-run and option 6 was the highest.

GS reiterated that a legally sound process has been followed, and all feedback from the consultation has been taken into account and given due consideration. The clinical model is about what is clinically sustainable for patients and to ensure that patients' needs are met.

Andy Day, North Staffordshire Pensioners Convention

AD stated there have been a lot of promises and reassurance for the future including only commissioning beds in care home with a good or outstanding CQC rating. There are currently 86 beds in care homes, 41 of which are good and 45 require improvement, therefore the reality on the ground is different.

HJ interpreted the question to be how it is possible to commission from good or outstanding care homes and yet have patients in care homes which are currently rated inadequate. HJ explained that assessment of care homes is based on a point in time and CQC ratings are subject to change. There are currently patients placed in care homes and the CCGs' Nursing Support Team and Safeguarding Team work closely with those homes to ensure that patients remain safe.

Ian Syme

IS stated that the Bradwell Hall CQC score has been 'requires improvement' for the last four years, and the recent CQC inspection means that patients are put in a substandard care home. IS suggested that the public have been ignored and the need of the provider put before the need of the population. The driver for change is financial and whilst a lot of services have improved the CCGs have also saved £20m per year and yet the CCGs will pay £3m more for 55 care home beds.

MW acknowledged that finance is an issue as the CCGs are currently over spending by £2m per week, but reminded everyone that this is not the starting point for this debate. Better outcomes for patients are imperative as the current clinical model is doing patients harm, with too many being placed in beds by default. The clear advice received from Dr Ian Sturgess, NHS Improvement was that the system is out of date and in need of change. Community

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hospitals are expensive to run and it is more cost effective for patients to be in their own homes with the right support packages in place.

Evidence is clear that patients placed in a nursing home are more likely to go home than those in a community hospital. It is therefore more effective for patients to maintain a level of independence. MW reiterated that delivery of better outcomes for patients is first priority, not finance.

IS asked for clarity regarding the Integrated Care Model and how it would work.

MW stated that the Home First service is in place avoid admissions together with support in the community. Integrated services are provided via MPFT and NSCHT which provide services such as physiotherapy, social care provision, and all services are provided by a single team wrapped around the localities. There is an excellent interface between acute and the community.

Councillor Pamela Wood, Leek

PW commented that the difference between a community bed and a care home bed is to do with finance and quality. There are no trained nurses in care homes which is why they are cheaper, care home costs will shoot up and quality will not be up to standard. Both trusts claim to be investors in people and yet community beds are closing, with staff having to move locations on several occasions without being told why. There are concerns within the Moorlands community as well as concerns regarding staff morale.

BS stated that the most recent move was due to maintenance work taking place at the hospital and the patients and staff were decanted to Bradwell.

Pauline Elks, Leek resident

PE expressed shock and disappointment that the people's lives are being discussed and not a clinical economic model. Decisions over the past five years have been made on a flawed clinical model based on optimistic assumptions in that hope that they are true. Has it crossed anyone's mind that a different approach is needed?

TS explained that each GB member knows what due regard is and has a responsibility to take into account what is heard and read from the PCBC through to the DMBC.

Claire Gray, Nurse – A&E and Primary Care

CG commented that it is excellent that discharge rates have improved, and asked whether the 132 beds are in addition to the new beds at the Royal Stoke, whether funding is being provided for NHS nurses to improve the quality of care in private care home beds, and how the Primary Care Networks (PCNs) will be monitored to check the quality of delivery of care.

HJ responded that there is a small team of nurses who work with the care homes to ensure that quality and safety remains high, this is the Provider Improvement Response Team (PIRT).

CG asked why we have to do this. HJ explained that if a care home goes into failure there is a system-wide responsibility to re-home patients safely. It is therefore imperative that every bed stays open and patients receive high quality of care.

LM explained that the PCNs are currently out to national consultation and that the new GP contract includes enhanced care in care homes. A local Universal Offer is currently under negotiation with North Staffordshire Local Medical Committee (LMC). Locally there is already a Local Enhances Service (LES) in place covering both care and residential homes and there are good examples across Staffordshire where Primary Care supports practices to work differently and collaboratively.

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	Michele Paduano, BBC Midlands Health Correspondent MP asked for assurance with regard to the bed numbers given that the Royal Stoke has commissioned an additional 100 acute beds, 12 hour breaches are the second highest in the country, and flu rates are not exceptionally high this year. How can we be assured when there are huge numbers of patients waiting for beds? BS responded that plans were already in place to deal with the anticipated sharp rise in flu cases at the Royal Stoke so that patients could be treated quickly and correctly, and ensure that adequate infection control processes were in place, to alleviate the additional pressures. MP asked about resilience to support added pressures. BS stated that additional capacity was put in place to support Home First and in line with the winter plans the system was able to respond positively to support the Royal Stoke to manage the surge as part of the plan. DR reiterated the point already made by MW that historically the system has failed utilising high bed numbers, and this new model has sustainability built in and is about improving services. The system is under pressure and the CCGs cannot keep doing what has been done in the past. LC explained that community beds are rehabilitation beds which should not be confused with acute hospital beds. Councillor Julie Cooper, Newcastle Borough Council JC referred to option 3a the Integrated Care Hub at Bradwell and stated that 120 beds have been mothballed at Bradwell, and then as soon as there is a bad winter, beds are opened again to cope with winter months. Why are the beds at Bradwell closed when they are needed? GS responded that the need for decant and escalation has been built into the business case which will be a 20 bed ward at the Hayward. On-line question Which Tier 4 services will go from Leek? GS stated that all services would be delivered via the hubs to ensure equality with regard to access, except for services such as Rheumatology and MSK will be provided by MPFT. Jo Bentley JB asked what services would be included in the Integrated Care Hubs, specifically the Walk in Centre at Leek for minor injuries. GS explained that high level services will be delivered from the hubs such as district nursing, physios, and podiatrists etc. as well as more specialist services to support long term conditions, frailty, and social care. The model will be co-developed with partners and enhancements to services will be included in the implementation plan, and based on population need. Both the Haywood Walk in Centre and Leek minor injuries unit will form part of a wider consultation process with the Staffordshire Transformation Partnership (STP) during late summer. It is not anticipated that any changes to services will take place within the next 18 – 24 months.	
2020/JAN/055	**7. Governing Body decision**	
	SY outlined the voting process for the Governing Body meetings in Common. Each member has to vote on the recommendations set out. AB as Chair North Staffordshire CCG will take the vote for North Staffordshire CCG, and LC as Chair for Stoke-on-Trent CCG will take the vote for Stoke-on-Trent CCG. The vote will be by a show of hands by majority, and the Chairs for each CCG will have the casting vote. The Chairs decision is final.	

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AB explained that the Governing Bodies in Common are asked to:

To give conscientious consideration of the views gathered during the consultation as per Gunning Principles when considering the Decision Making Business Case.

In line with the Public Sector Equality Duty, to give due regard to the views of protected and minority groups who may be adversely affected by the proposals and the mitigating actions within the Equality Impact Assessment which is Appendix 4 of the Decision Making Business Case. These considerations must conform to the Bracking Principles.

In line with the Health and Social Care Act 2012, ensure that consideration is given in regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T); and assure themselves that these proposals will ensure that health services are provided in an integrated way, and will improve quality, reduce inequalities in access to services or reduce inequalities in the outcomes achieved (s.14Z1);

The two separate Governing Bodies are requested to give conscientious consideration to the outcomes of the Consultation and the incorporation of the findings into the DMBC. The two separate Governing Bodies are also requested to consider the recommended options outlined within the DMBC and the supporting narrative

To conclude, North Staffordshire CCG Governing Body ***voted*** as follows:

Community beds, implementation of option 6 (Hayward and Care Homes)

Votes for: DR, BS, JM, LH, WA, MW, LC, AB, HJ, NC.
Votes against: NMcF. Abstentions: PD, TB

NMcF was not satisfied with the care home solution in the long term, and has sufficient doubt with regard to quality of services, and suggested the GB in Common pause and think again.

PD stated that whilst he accepted the model of care, he was not assured that necessary measures are in place with regard to quality and safety in the care home sector.

TB was concerned about assurance with regard to the care home beds and sustainability of the care home sector in the future.

It was noted that two lay members abstained and one voted against.

Integrated Care Hubs:

- In South Stoke, option 1a (ETTF new build)
- In Staffordshire Moorlands, option 2b (Leek rebuild)
- In Newcastle under Lyme, Option 3a (Bradwell existing site) and
- In North Stoke, Hayward existing site

Votes for: DR, BS, JM, LH, WA, MW, LC, AB, HJ, NC, PD, TB
Abstentions: NMcF

NMcF stated he could not approve the Integrated Care Hubs without agreeing to the community beds option 6.

Tier 4 clinics to be discontinued from the Leek Moorlands site

Votes for: DR, BS, JM, LH, WA, MW, LC, AB, HJ, NC, PD, TB
Abstentions: NMcF

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	NMcF could not approve the Integrated Care Hubs without agreeing to the community beds option 6 To conclude, Stoke-on-Trent CCG Governing Body ***voted*** as follows: Community beds, implementation of option 6 (Hayward and Care Homes) Votes for: DR, BS, JG, JM, LH, NC, WA, JM, MW, LC Abstentions: TB, JH, MWo JH stated that as a non-Executive there is a legal requirement to ensure that any proposals will improve quality of services and was not convinced and assured that services will be improved or modified. MWo was not assured that all parts are in place to deliver community support, and has concerns with regard to quality and sustainability within the care home sector. MWo referred to clause 4 of the Bracking Principles and stated that more assurance and evidence was required. TB was concerned about assurance with regard to the care home beds and sustainability of the care home sector in the future. It was noted that all lay members abstained. Integrated Care Hubs: • In South Stoke, option 1a (ETTF new build) • In Staffordshire Moorlands, option 2b (Leek rebuild) • In Newcastle under Lyme, Option 3a (Bradwell existing site) and • In North Stoke, Hayward existing site Votes for: DR, BS, JG, JM, LH, NC, WA, JM, MW, LC TB, JH, MWo Abstentions: None Tier 4 clinics to be discontinued from the Leek Moorlands site Votes for: DR, BS, JG, JM, LH, NC, WA, JM, MW, LC TB, JH, Abstentions: MWo MWo referred to clause 4 of the Bracking Principles and stated that more assurance and information was required as to how services will be discontinued. To conclude, North Staffordshire CCG Governing Body ***agreed by majority*** to the three recommendations in the Decision Making Business Case and; Stoke-on-Trent CCG Governing Body ***agreed by majority*** to the three recommendations in the Decision Making Business Case.	
2020/JAN/056	**Close**	

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

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

Signed: .... Position: .... Date:............................

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