South Sefton Clinical Commissioning Group

Board Meeting
Agenda

To be held on Thursday, 28 March 2013 at 1.00 pm to 4.00 pm
Boardroom, Third Floor, Merton House, Stanley Road, Bootle L20 3DL

Attendees

Dr Clive Shaw	Chair	(CS)
Lynda Elezi	Vice Chair, Lay Member	(LE)
Dr Craig Gillespie	Clinical Vice-Chair, Board Member	(CG)
Dr Steve Fraser	GP Board Member	(SF)
Dr Andrew Mimnagh	GP Board Member	(AM)
Dr Ricky Sinha	GP Board Member	(RS)
Dr Paul Thomas	GP Board Member	(PT)
Dr John Wray	GP Board Member	(JW)
Roger Driver	Lay Member	(RD)
Lin Bennett	Practice Manager – Interim Board Member	(LB)
Sharon McGibbon	Practice Manager - Interim Board Member	(AF)Dr
Dan McDowell	Secondary Care Doctor, Board Member	(DMcD)
Fiona Clark	Chief Officer, Southport & Formby CCG/South Sefton CCG	(FLC)
Martin McDowell	Chief Finance Officer, Southport & Formby CCG/South Sefton CCG	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
Margaret Carney	Chief Executive, Sefton MBC	(MC)
Libby Kitt	Sefton Links Patient Representative	(LK)

No	Item	Lead	Verbal/ Report	Action
13/30	Apologies for Absence	Chair	Verbal	To note
13/31	Minutes of Previous Meeting	Chair	Report	To approve
13/32	Action Points from Previous Meeting	Chair	Report	To discuss
13/33	Business Update	Chair	Verbal	To note
13/34	Chief Officer Report	FLC	Paper	To note
13/35	Portfolio Leads Update	All	Verbal	To note
Performance				
13/36	Performance Reports			
	(a) Finance Update	MMcD	Report	To note
	(b) Prescribing Update	BP	Report	To note
	(c) Performance and Quality Report	MC	Report	To note
Policy/Strategy/Health Improvement				
13/37	Strategic Plan	MMcD	Verbal	To ratify
13/38	Everyone Counts	TJ	Report	To approve

No	Item	Lead	Verbal/ Report	Action
13/39	2013/14 Financial Outlook Report	MMcD	Report	To approve
13/40	Plans for Healthwatch in Sefton	Sam Tunney	Report	To note
13/41	Low Utilisation of Summary Care Records	Paul Shillcock	Report	To note
13/42	Quality Premium	FLC	Report	To note
13/43	Francis II - Update	DF	Verbal	To note
13/44	Paediatric Update	Dr W Hewitt	Verbal	To note
Governance				
13/45	Prioritisation Framework	MC	Verbal	To note
13/46	Board Committees – Terms of Reference	TJ	Report	To approve
For Information				
13/47	Register of Interests	FLC	Report	To note
13/48	Hospitality Register	FLC	Report	To note
13/49	Minutes of Committees a) Audit Committee b) Quality Committee c) Finance & Resource Committee d) Merseyside CCG Network e) Health and Wellbeing Board f) Medicines Management Operational Group g) Strategic Integrated Commissioning Group h) Engagement and Patient Experience Group i) Locality Meetings - Crosby Locality Maghull Locality Bootle Locality Seaforth Locality j) Remuneration Committee	Various Not Available Yet Not Available Yet	Reports	To note
13/50	Any Other Business			
13/51	Date, Time and Venue of Next Board Meeting Thursday, 30 May 2013 at 1.00pm			

Motion to Exclude the Public:

Representatives of the Press and other members of the Public to be excluded from the remainder of this meeting, having regard to the confidential nature of the business of be transacted, publicity on which would be prejudicial to the public interest, (Section 1{2} Public Bodies (Admissions to Meetings), Act 1960).

South Sefton Clinical Commissioning Group

Board Meeting Minutes

Thursday, 31 January 2013 at 1.00 pm to 4.00 pm
Crosby Lakeside

Board Members		
Lynda Elezi	Vice Chair, Lay Member	(LE)
Dr Craig Gillespie	Deputy Clinical Chair, Board Member	(CG)
Roger Driver	Lay Member	(RD)
Dr Steve Fraser	GP Board Member	(SF)
Dr Andrew Mimnagh	GP Board Member	(AM)
Dr Ricky Sinha	GP Board Member	(RS)
Dr Paul Thomas	GP Board Member	(PT)
Dr Dan McDowell	Secondary Care Doctor, Board Member	(DMcD)
Libby Kitt	Sefton Links Patient Representative (co-opted)	(LK)
Lin Bennett	Practice Manager	(LB)
Sharon McGibbon	Practice Manager	(AF)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
In attendance		
Tracy Jeffes	Head of Planning and Delivery	(TJ)
Malcolm Cunningham	Head of Performance & Health Outcomes	(MC)
Dr Gina Halstead	GP Lead, Quality	(GH)
Steve Astles	Head of CCG Development	(SA)
Dr Pete Chamberlain	GP	(PC)
Apologies		
Dr Clive Shaw	Chair	(CS)
Dr John Wray	GP Board Member	(JW)
Peter Morgan	Deputy Chief Executive, Sefton Council (co-opted)	(PM)
Minutes		
Melanie Wright	Business Manager	

No	Item	Action
13/1	**Apologies for Absence** were noted. It was agreed that, in Dr Shaw's absence, Dr Gillespie would chair today's meeting.	
13/2	**Minutes of Previous Meeting** An amendment at minute 12/222 noted that the Governing Body approved the Safeguarding Children and Vulnerable Adults Policy at the last meeting. Subject to the minor amendment above, the Minutes were approved as an accurate record of the meeting.	
13/3	**Action Points from Previous Meeting** The Action Points were closed out save for the following notes. *12/174* *Any Qualified Provider* - Craig Gillespie reiterated his query in relation to hearing aid services at Aintree and the impact of AQP. MC confirmed that the national tariff will be applied.	

No	Item		Action
		Fiona Clark has asked for an update on AQP from Derek Rothwell, which will be brought back to the Board.	
	12/185	**End of Life Business Case**	
		The report was deferred at the previous meeting pending Chair's action. Clive Shaw, Steve Astles and Moira McGuinness to discuss further. *Carried forward.*	SA
	12/190	**QIPP Update**	
		A spreadsheet will be circulated which demonstrates the QIPP projects which are currently ongoing. *Carried forward.*	MMcD
	12/198	*Cardiology*: Dr Gillespie and SA have met with Cardiology peers at Aintree, which had been positive, although there were some financial concerns. Discussions around collaboration had taken place.	
	12/199	*Performance and quality*: MC advised that Aintree have commenced a review of all deaths within the Trust, which should be completed by mid-April. AQUA have also undertaken a review as part of this work. This should be reported to the CCG Quality Committee.	DF
	12/213	*End of Life Review:* the review is in process, which will interview a number of providers across Sefton. A report will be produced for further consideration by the Board.	
	12/222	*Community Services for Spirometry* - new service is being commissioned for which a business case has gone to Finance & Resource Committee. It is expected that the waiting list will reduce. Aintree are also undertaking some catch-up work.	
13/4	**Business Update** In the absence of the Chair, this will be considered at the next meeting.		
13/5	**Chief Officer Report** Fiona Clark welcomed Dr Dan McDowell to the Board. Fiona Clark also advised the Board as to the appointment of Fiona Doherty into the role of Transformational Change Manager. 86.66% of roles within the CCG have now been filled. The majority of remaining vacancies are within the Finance Team and these are out to recruitment. *CSU*: Debbie Fairclough is Head of Client Operations for the local CSU team for Sefton. Communications lead is Lyn Cooke. Lesley McKinnell will be the local contact for Contracting. Luke Garner and Maria Dorpman are supporting business intelligence. Other functions are awaiting leads, which will be resolved in the following week. *Planning*: Fiona Clark advised as to the draft status of the planning documentation and the Board development session in February will consider this further. The final submission is due in March. The timetable is such that a prospectus is due for the public in June. When the NCB Merseyside have commented on the planning document, it will be circulated to the Board. It is different to the planning process at the PCT, as lead managers already engage with lead clinicians in their portfolio areas and this shapes the development of the plans. The Business Plan is driven by the Commissioning Intentions and the Board have been engaged in the development thereof.		

No	Item	Action
	Specialised Commissioning - the NCB Cheshire, Warrington & Wirral are the team who will be leading on specialised commissioning and the Merseyside CCGs have a meeting scheduled with the Moira Dumer in this regard. The Board noted the SS CCG £240m budget, of which £5m is running costs. *Authorisation*: further information in relation to the detail around the authorisation conditions will be provided by the NCB Merseyside Area Team and a rectification plan will then be submitted for 8 February 2013. *GP Cover - Chair* - gone out to advert in relation to Dr Shaw's backfill and some interest has been expressed. However, another replacement will be required to cover the 12-month secondment of Dr Peter Chamberlain, who has been successful in his application to work with the IHT in the USA. <u>Noted</u>.	
13/6	Portfolio Leads Update Dr Gillespie updated as to work in relation to the Heart Failure respecification. Dr Gillespie has also attended Clinical Performance Group and the contract meeting at Liverpool Heart & Chest NHS Trust. There is an issue with identifying patients' GPs in Sefton, in terms of North or South. Accordingly, patients are being allocated to South, which is incorrect and should be rectified for the next meeting. Brendan Prescott is the CCG management lead in relation to this contract, supporting Dr Gillespie. Dr Mimnagh reported on the commencement of contract negotiations with Liverpool Community Health Services. In terms of clinical development, there is a walk-in centre review being undertaken by a national review team. Lin Bennett added that district nurses are getting their own clinical EMIS web system, which Lin advised did not offer a two-way process between practices and district nurses. However, Dr Fraser advised that was not the case; the systems should have inter-operability. Libby Kitt advised that LINks had met with Locality Managers and more work is planned to how best for the local network to include patient involvement. LINks are also participating in the Engagement and Patient Experience Group, along with representatives from Sefton Council to consider this further. At the second development session next week, there will be a focus on continuing and building on engagement so far. Dr Fraser referred to the Medicines Management meeting attended along with Brendan Prescott, with the CSU which reviewed service lines in the specification. Portfolio lead areas now need to be identified for each Board member, as soon as possible. Dr Sinha has agreed to be the lead for Mental Health (Dementia/Learning Disabilities).	
13/7	**Performance Reports** (a) **Finance Update** The financial position against the operational budget at the end of month 9 is £449k under spent. This is a favourable movement of £104k when comparing to the month 8 financial position, which is largely attributable to an under spent position within Prescribing budget.	

No	Item	Action
	South Sefton CCG has a reserve of £3.4m of which £2.3m has been committed leaving a balance of £1.1m as uncommitted. The forecast year end out turn position for South Sefton CCG prior to the application of contingency reserves is £449k under spent. This represents a -0.19% overspend of the CCG annual budget. However, this money will be required in the following year to fund the NHS Merseyside overspent position. Plans for 2013/14 will be considered at the Board Development session in February. Key risks include (page 12) £1.4 over performance at Aintree which has been beneficial as the contract this year is fixed, however, this will require consideration as part of next year's contracting process, together with an understanding of the detail. Fiona Clark asked that MMcD investigate this further with Finance and SA to investigate from a contracting perspective. Continuing Healthcare/Restitution - the outcome of claims is unlikely to be known by the end of March, so an estimate will be included in the region of £1m - £2m. DF advised that feedback has been made to the DoH that the timescales are challenging. Noted.	SA/MMcD
	(b) Prescribing Update The South Sefton CCG position for month 7 (October 2012) was a forecast under spend of £2,639,704 or -9.2 %. This is a slight improvement on the September forecast of £2,577,070. This has been a unique year in relation to relatively high cost and high volume drugs coming off patent. One practice is forecasting an overspend, but this is due to a coding irregularity and will be rectified. Lin Bennett queried patients who attended the Walk-in Centre/Darzi to obtain antibiotics when these were felt inappropriate by their own GP. Brendan Prescott advised that the difficulties in forecasting around the Walk-in Centre and that this practice skewed the figures for Litherland and was removed in consideration of the locality as a whole. Dr Mimnagh and Steve Astles are undertaking a piece of work to resolve these issues. Noted.	
	(c) **Performance and Quality Report** CDiff remains a problem with Aintree on amber and Liverpool Heart and Chest on red. It is not clear where the problem arises in terms of community or hospital acquired. Catherine Beardshaw is pulling together a task and finish group to address this. Dr Gillespie referred to the discussion at the Liverpool Heart and Chest Quality Committee which had discussed this in terms of where the infection was acquired. There was a discussion as to whether hospitals notified GPs when patients were identified as having acquired the infection in the community. Dr Halstead felt it was important that the health community behaved in the same manner, but felt the pathways could be improved and communication was poor. It was felt that this issue was capable of being addressed.	

No	Item	Action
	Dr Mimnagh suggested a primary care quality indicator would be appropriate. Dr Halstead felt a root cause analysis was appropriate in primary care. Brendan Prescott advised that a root cause analysis has taken place at a number of practices throughout Sefton and that Sandra Craggs (Pharmacist) has undertaken this work and this remains on the agenda. *A&E at Aintree* is still meeting the target but there have been a number of issues. RTT and Cancer are also on target. The CQC report on Aintree is now available and signed off most concerns, except one around record keeping and added one regarding medicines management. Steve Astles is meeting Aintree next week with a view to understanding what further support commissioners can offer regarding A&E/Urgent Care. Board members are welcome to attend. Sefton Council are involved and it was felt that the presence of social services was already making an impact. *62-day cancer waits*: there was a discussion around the proposal by the Cancer Network in terms of referrals from initial to final trust taking place at day 42 instead of day 61. This discussion is ongoing. The quality dashboard was discussed at Quality Committee last week and suggestions were made as to future content. Noted.	
13/8	**Financial Plan 2013/14** High level plans for CCGs have been drafted and will be shared later this week. Over the next month, a fuller version will be presented to the Board for discussion at the February Board Development session, for formal sign-off in March. Noted.	
13/9	**Quality Update**  Board quality presentation V2 30 1 There was a discussion around dementia screening at Aintree and CQUIN. It was felt that the pathway needed to be more robust. Dr Halstead also noted the difficulties in dementia screening, which was a medical condition for which there was no cure and patients who may not consent to screening. Dr Chamberlain felt that early identification was important for patients to ensure a care plan could be put in place and proper support offered. Dr Halstead asked the Board what method of referral back to GPs or directly onwards was preferable to GPs. Dr Mimnagh discussed the demonstrated reliability of the Friends and Family test. Adult inpatient, acute and maternity will be implemented first. Dr Halstead referred to a recent meeting with LINks at which possible CQUINs 2013/14 were discussed. It was felt that the issues around cancelled appointments could be included in the quality contact.	

No	Item	Action
	Fiona Clark provided some historical context in relation to CQUINs. Dr Fraser asked whether Advancing Quality measure can be adapted for primary care. Martin McDowell advised that the CCG has made provision for its AQuA membership. Further work to understand the detail of the work with AQuA is required. Noted.	MMcD
13/10	**Health Inequalities Group for People with a Learning Disability** This paper was ratified.	
13/11	**PCT Transfer Schemes** This paper describes the work taking place and the CCG's responsibilities from 1 April. Fiona Clark confirmed that she is comfortable with the content of this report. Lin Bennett raised transfer around primary care and the six year legacy. Fiona Clark advised that she is meeting Tom Knight and Tony Leo to consider this and suggested a meeting involving the Practice Managers. All LES when due for renewal will need to come to the Board for approval as part of the strategic plan as an NHS standard contract. Fiona Clark advised that where practices have employed people on non-recurrent funding, this is the liability of the practice, not the CCG. Noted.	FLC
13/12	**Practice Learning Time** Tracy Jeffes reiterated the recommendations contained within the report. Dr Mimnagh felt that venued forums must deal with the strategic plan, performance data as key organisational development opportunities. The Board wished to continue with protected learning time and the venued events. Dr Gillespie felt that three GPs were probably not required. This was discussed at the Southport & Formby CCG role and Dr Niall Leonard was keen to lead on this, with support of the two Practice Nurse Facilitators. Dr Gillespie agreed with this approach and the Board approved this recommendation. Lin Bennett was keen that non-medical training needed to be factored into the plans. Another practice manager to be invited to the planning session. Noted.	TJ
13/13	**Virtual Ward Update** Dr Chamberlain referred to the difficulties encountered over the last few months on this project and provided an update in relation to workstream developments. Quality improvement PDSAs have been implemented on a monthly basis to deal with any issues that arise. Dr Chamberlain also talked through some of the other developments contained within the report. Dr Chamberlain also acknowledged the difficulties that had arisen in implementing the model, particularly around the district nursing service. There are proposals contained within the report to project manage the Virtual Ward. Dr Mimnagh raised the question of whether the community version of EMIS will be capable of sharing data with EMIS in practices. Dr Chamberlain confirmed that it will and a tab can be activated or not to view data.	

No	Item	Action
	Dr Chamberlain also alluded to the difficulties encountered in getting practices to sign up. Dr Gillespie asked the Board whether they were assured that the process was robust and, if not, what the Board required by way of additional assurance. Fiona Clark asked Dr Thomas if he would be interested in taking up an executive role in relation to this project. Dr Thomas had been concerned previously, but felt that some improvements had been made. Dr Thomas agreed to be the Board support to Dr Chamberlain in this piece of work. Martin McDowell referred to the financial plans 2013/14. The cost of this are included in the 2% non-recurrent monies. This money will need to become recurrent at some point, but providers have to make a 4% efficiency saving and this will need to be considered, in the context of quality and safety. Martin McDowell reiterated that a real commitment to achieving these savings is required. The Board agreed they were assured in relation to this project and approved the recommendations contained within this report. Fiona Clark referred to Dr Hughes' request that the Board halt this project and whether the Board felt this was necessary. The Board agreed that it did not see the necessity to halt this project, as it was assured of progress. It was also agreed that a regular report would be brought to Board on a quarterly basis to tie in with future wider constituent meetings.	SA
13/14	**Ophthalmic Service Plans** The formation of this commissioning strategy was originally generated within a locality. Libby Kitt welcomed the proposals contained within the report, on behalf of patients. Dr Thomas referred to a historical service which had been provided by opticians, but which was withdrawn due to governance issues and felt it was important to ensure opticians were sufficiently engaged. FLC explained that the LOC, along with the LMC, LPC and LDC regularly meet with the Chair/Chief Officer. Dr Mimnagh reminded the Board that there is 'world leading' fauvial surgery available in Liverpool and this should be maximised. Dr Fraser felt clinical decision making needed to be reviewed at locality level. Dr Duper requested support from a GP with an interest in ophthalmology to undertake a task and finish scoping exercise. The Board approved the recommendations contained within the report.	
13/15	**Approval of CCG Network NOAC Position** NICE recommended Dabigatran or Rivaroxaban as a treatment option in AF for the prevention of stroke and systemic embolism. The CCG Network statement was approved at Board in July 2012. However, some clarification on the statement was requested from the AF task group of the Cheshire & Merseyside Cardiac Network. This was discussed at Network in November 2012. The statement was presented to the Pan Mersey (APC) in January 2013 who recommended a consistent adoption and approval of the statement across Merseyside. This statement is now presented to the Board.	

No	Item	Action
	Dr Fraser agreed to distribute the response received in relation to the question of legal liability. The guidance was to follow NICE Guidelines and agreed guidance locally. In the event of an appeal, an IFR would be necessary. This response was not felt to be helpful. Dr Gillespie questioned the basis for the Network decision and noted that these drugs are effective NICE-recommended drugs. However, they do not present a significant advantage by comparison to existing drugs, except by way of convenience. Dr Gillespie felt that this placed considerable responsibility upon clinicians. Dr Gillespie also raised the fact that prescribing is underspent and whether this should mean that a drug that is NICE approved should not be prescribed. Martin McDowell mentioned the finite resources available. Dr Gillespie felt that individual clinicians should be able to discuss with patients and come to a view that Warfarin was the best option. Dr Thomas raised the fact that surely advancement means that the best medicine possible should be prescribed to the patient. Brendan Prescott advised that the purpose of the statement was to ensure the right process was followed, considering the best care for the patient. Dr Fraser expressed his support for the statement and said he would be happy to discuss with a patient. There was some confusion about whether the statement supported NICE guidance; the Board agreed that the report did not say the drugs cannot be prescribed, but to agree to be discerning regarding the contraindications to tolerance referred to therein. The Board still felt there was confusion around prescribing to patients who preferred the NOAC to warfarin. Dr Fraser advised that the Network said NOACs should not be prescribed in these circumstances. For the recommendations contained within the report, as per page 61 of the papers: That the board accept the Medicines Management recommendations, notes the additional emphasis placed on a subset of the NICE guidance in appendix 1, having confirmed nothing presented limits implementation of the NICE guidance where clinically appropriate. the following Board members approved : Dr Sinha, Dr McDowell, Dr Fraser, Dr Mimnagh, Dr Gillespie, and Dr Thomas. The Board therefore approved the statement.	SF
13/16	**NHS Merseyside - A New Approach to Estates Management** Adrian Wallace of Fulcrim/Renova attended on behalf of LHSP and outlined the contents of the report. Driving forward and efficiency programmes and investments form part of the work planned by the new organisation, together with the mechanics of how this might work. In terms of context, from 1 April CCGs will not have responsibility for estates. Properties owned by the PCT will transfer to Propco. Graham Pink is now CEO of both Renova and LHSP. This approach has been considered on a local level, the result of which is contained in the proposals contained within this report.	

No	Item	Action
	Martin McDowell referred to the report and made reference to the saving of £17m over three years. The budget across Merseyside is £35m per annum. The Board approved the recommendation contained within the report.	
13/17	**Memorandum of Understanding – Dispute Resolution** Approved.	
13/18	**Appointment of Registered Nurses to the Governing Body** Approved.	
13/19	**Register of Interests** John Wray, GP Partner in practice, new request to be submitted. Paul Thomas, Ricky Sinha, Dan McDowell, Lynda Elezi, Lin Bennett, Sharon McGibbon and John Wray to be sent a new form. Fiona Clark and Debbie Fagan to be included. Noted.	
13/20	**Hospitality Register** was noted.	
13/21	**Minutes of Committees** a) Audit Committee – no minutes were available. b) Quality Committee – no minutes were available. c) Finance & Resource Committee – no minutes were available. d) Merseyside CCG Network were noted. e) Health and Wellbeing Board were noted. f) Medicines Management Operational Group were noted. g) Strategic Integrated Commissioning Group were noted. h) Engagement and Patient Experience Group – no minutes were available. i) Locality Meetings were noted.	
13/22	**Any Other Business** There was no other business.	
13/23	**Date, Time and Venue of Next Board Meeting** Thursday, 28 March 2013 at 1.00pm	

Motion to Exclude the Public:

Representatives of the Press and other members of the Public to be excluded from the remainder of this meeting, having regard to the confidential nature of the business of be transacted, publicity on which would be prejudicial to the public interest, (Section 1{2} Public Bodies (Admissions to Meetings), Act 1960).

Board Meeting
Action Points

Thursday, 31 January 2013 at 1.00 pm to 4.00 pm
Crosby Lakeside

No	Item	Action
13/3	**Action Points from Previous Meeting** 12/185 **End of Life Business Case** The report was deferred at the previous meeting pending Chair's action. Clive Shaw, Steve Astles and Moira McGuinness to discuss further. *Carried forward.* 12/190 **QIPP Update** A spreadsheet will be circulated which demonstrates the QIPP projects which are currently ongoing. *Carried forward.* 12/199 *Performance and quality*: MC advised that Aintree have commenced a review of all deaths within the Trust, which should be completed by mid-April. AQUA have also undertaken a review as part of this work. This should be reported to the CCG Quality Committee.	SA MMcD DF
13/1	**Performance Reports** (a) **Finance Update** Fiona Clark asked that MMcD investigate over performance at Aintree with Finance and SA to investigate from a contracting perspective.	SA/MMcD
13/9	**Quality Update** Martin McDowell advised that the CCG has made provision for its AQuA membership. Further work to understand the detail of the work with AQuA is required.	MMcD
13/11	**PCT Transfer Schemes** Lin Bennett raised transfer around primary care and the six year legacy. Fiona Clark advised that she is meeting Tom Knight and Tony Leo to consider this and suggested a meeting involving the Practice Manager.	FLC
13/12	**Practice Learning Time** Lin Bennett was keen that non-medical training needed to be factored into the plans. Another practice manager to be invited to the planning session.	TJ
13/13	**Virtual Ward Update** It was also agreed that a regular report would be brought to Board on a quarterly basis to tie in with future wider constituent meetings.	SA
13/15	**Approval of CCG Network NOAC Position** Dr Fraser agreed to distribute the response received in relation to the question of legal liability.	SF

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/34	**Author of the Paper:** Fiona Clark Chief Officer Fiona.clark@sefton.nhs.uk

Title:

Chief Officer's Report

Summary of the Paper/Key Issues:

This paper presents the Governing Body with the Chief Officer's monthly update.

Action/Decision Required:

1 The Governing Body is asked to note the contents of this report.

2 The Governing Body is asked to give delegated authority for the sign off of the Transfer schemes to the Chair, Chief Officer and Chief Finance Officer- Senior Leadership Team.

Date of Report:

20 March 2013

13/34

Report to Board

March 2013

1. Authorisation - Rectification Plan

The final Rectification Plan including evidence was uploaded to KMS on 28 February 2013 and a copy is attached hereto.

A copy of the evidence referred to therein is available upon request.

A final response is expected by the end of March as to whether any conditions are to be imposed on the CCG from the 1 April 2013.

2. Local Enhanced Schemes (LES) Update

Angela Parkinson, Locality Lead who has responsibility for Primary Care across Sefton, has been working since October 2012 to map and understand both the PCT and the CCG LESs. This work has taken much longer than anticipated, but we are now in a clearer position where we can give due consideration to all the LESs and the payments made to practices.

There is still work to be done in transferring these to the NHS standard contracts with accompanying clear service level agreements and I have agreed an approach with Tony Leo- Director of Commissioning at NCB Merseyside. This has been communicated to all practices.

In line with the changes to the NHS the LESs will stay with the CCG, with payments being made via the NCB Merseyside because of the shift of contractual responsibilities to the NHSNCB.

Future consideration will need to be given by the CCG in relation to investment in primary care, in conjunction with NCB Merseyside and involving the Local Medical Committee. To this end the work that Dr Bal Duper is leading to develop with the membership of the CCG a Primary Care strategy, will help to inform and drive future development in this area. There will need to be a separate group convened comprising of the Chief Officer, Chief Finance Officer, Lay members and Secondary Care Doctor in order to clearly and transparently manage the potential conflict of interests this area exposes.

3. 111 Update

The CCG have now signed off the Directory of Services (DOS). The DOS testing is complete. There is on-going work to refine the DOS but it is ready for the ‘go live’ date. The joint Sefton Local Clinical Advisory Group (LCAG) has met chaired by Dr Andy Mimnagh (111 lead for South Sefton CCG and the necessary additional Clinical Governance evidence was submitted, it is assumed currently that this is satisfactory, as no comments have been received by the overall Merseyside Clinical lead Dr Fiona Lemmens (GP in Liverpool CCG).

The LCAGs do not have delegated decision making authority from the CCG Governing Body. The LCAGs are accountable to the CCG Governing Body, to this end minutes from the LCAG will be received and any recommendations from this group considered and appropriately actioned.

The service readiness testing at NHSD has been completed both locally and in Milton Keynes and has been passed by DOH. There is further work on-going, but it appears that we are in a healthy position.

4. Procurement

Following the public consultation carried out in August 2012, the Government has now laid regulations in relation to procurement. These being known as The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013. They cover:

- general issues,
- requirements to procurement, patient choice and competition
- Investigations, declarations, directions and undertakings.

These regulations will guide the CCG in this area.

5. Authorisation of Transfer Schemes

The Transfer Scheme process continues to progress at pace and although we were expecting the Schemes to be ready for receiving at the Governing Body today, due to delays with the Department of Health drafting of the legal provisions, that has not been possible . Whilst the DH had previously issued guidance that CCGs are not expected to carry out formal sign off of the schemes before the 31st March 2013, further guidance was issued on Friday 15th March setting out the DH expectations in terms of "receiver assurance".

This guidance requires Boards of receiving organisations are now asked to provide assurance to the Secretary of State that:

The organisation has to the best of its ability:

- Carried out due diligence on sender transfer scheme instructions;

- Understands and agrees the property, assets, and liabilities transferring according to function, to the organisation as the most appropriate permitted receiver in the new system architecture.

As this due diligence process has not yet concluded the Governing Body is asked to delegate authority to the Chief Officer, Fiona Clark and Chair (Clive Shaw) to sign off the assurance process. This sign off must take place before the 25th March and the Chief Officer will ensure there is an independent assessment of the process prior to sign off.

6. Bulletin for proposed CCGs

These are produced monthly by the NHS National Commissioning Board (NHS NCB). They provide all members of the CCG with useful information and updates and I attach an electronic link to the March 2013 Bulletin. (http://www.commissioningboard.nhs.uk/blog/2013/03/07/ccg-bulletin-issue-30/). If anyone would like a copy via any other method please speak to Mel Wright-Business Manager.

7. Progress to Transition

As from the 1st April 2013 we will be officially an NHS statutory body. There are still a few vacancies which we are actively recruiting, with Becky Williams joining us in the role of CCG Analyst and we have the welcomed return from maternity leave of Jan Leonard Joint Head of CCG Development.

I just wanted to reflect on the last 12 months. Firstly, to thank all the Governing Body members and the wider CCG members for the support. I would also like to acknowledge the CCG support team for which I am privileged to lead. There have been some extremely tight time scales, rapid pace and at times incredible demands; all of which have taken place against a backdrop of personal uncertainty and immense change. They have behaved in a professional manner and I am confident that we have a team that can support the CCG members, to deliver the ambitious plans to improve patient care and reduce health inequalities in the CCG.

8. Recommendation

1. The Governing Body is asked to note the contents of this report.

2. The Governing Body is asked to give delegated authority for the sign off of the Transfer Schemes to the Chair, Chief Officer and Chief Finance Officer- Senior Leadership Team.

Appendices

Appendix 1 - Rectification Plan

Fiona Clark
Chief Officer
20 March 2013

Rectification Plan

Version 4: 28 February 2013

South Sefton Clinical Commissioning Group

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
4.1A	A	Provide evidence that constitution complies with the requirements of Part 1 of Schedule 1A of the Health and Social Care Act.	• More context around Local Authority Boundaries re CCG geographical areas • More detail within section 3 – Functions of the Clinical Commissioning Group eg detail of any work in partnership with Local Authorities, securing public involvement in planning. In particular to set out at a high level how and by whom these functions may be discharged on behalf of the CCG.	I	A revised constitution is attached, with 4 minor amendments, which do not materially affect the constitution but add the required clarity. Page 2 – map showing the CCG boundary that is wholly within the Sefton Local Authority boundary and which complements the information already provided on page four which details configuration of the CCG. Section 4.1 (b) included at page 11 to reference this map. Page 13, Section 5.15 includes a reference to exclusion of the public at meetings when appropriate. Page 30 an additional sentence is included regarding variation (section 25.3). A letter is submitted from BMA Law and a statement from the Chair of the CCG re the development of the constitution and choice of BMA Law version. Alongside this are the minutes of the CCG decision making in relation to the development of the CCG Constitution from July to November 2012.	1a 1b 1c 1di 1dii 1e	March 2013

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
					An additional review has been undertaken by MIAA and a further thorough governance review, which addresses the requirements of Schedule 1a of the Health and Social Care Act (2012) and response to the MIAA review. This details where the evidence is located in the NHS South Sefton CCG Constitution for both chapter 5 and the decision making processes of the CCG. Alongside this the Governance Framework is resubmitted to show the decision making process in the CCG.	1f 1g 1h	
			• To provide in the main body of the document, more detail around the decision making process of the CCG.		See comments under 4.1A.		March 2013
4.1B	A	Provide evidence that constitution is 'otherwise appropriate' i.e. it complies with regulations and takes account of guidance and model constitution.	• More detail around the composition, role and duties of the wider constituent meeting and how it links to the Governing Body. • To provide detail as to how the CCG will ensure that arrangements are in place to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved in the planning, development and consideration of changes and decision making in relation to CCG Commissioning arrangements.	I	See comments under 4.1A. See comments under 4.1A.		March 2013 March 2013
4.2.1A	A, E	Provide evidence that governance arrangements are in place to identify and manage different types of risk, including key risks to delivery of QIPP.	• Can't see the line of sight from the different sources of evidence.	II	Oversight for planning and monitoring of QIPP performance has been assigned to the Finance & Resource Committee. The Finance & Resource Committee has established a separate sub-group in order to perform the task. Meeting dates have been confirmed for the 2013 Calendar year.	2 QIPP Subgroup	21 February 2013

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• Good clear Risk Strategy but does this really align to the QIPP delivery, implementation and financial risks • What are the risk sharing arrangements? • Is there not a clear description to show the governance arrangements? Is there a diagram, a plan? it is difficult to know what document is best to look at.		The Terms of Reference for the sub-group are attached and will be ratified at the F&R Committee meeting on 21 February 2013. Principles of risk strategy (e.g ANZAC scoring mechanisms will be adopted to measure QIPP delivery, implementation and financial risk facing the CCG. All risks facing the CCG will be reported using this process. Discussions in place with NHS S&O CCG regarding identifying adequate resources to cover financial risk in 13/14. Wider discussions in place with Merseyside CCG network regarding establishing a risk-pool to build upon the 12/13 risk pool (e.g. collective risk-pool approach to high-cost elective secondary care NHS treatments over £20k in value). This may be extended to cover high cost low volume placements for complex care. Risk-sharing to be discussed in the February Board development session. Formal proposals to be presented to the Board for discussion and adoption in March. The diagram attached describes the QIPP governance arrangements and links to the Governing Body and Strategic Plans	3 QIPP Terms of Reference 4 QIPP Governance	
			• Has the QIPP plan been approved at the governing body? If so can this be added as evidence?		The QIPP plans will form an integral part of the CCG's strategic plans which are being refreshed. The Strategic Planning group meets on an informal basis. It is expected that the CCG's strategic plans will be presented to the Wider Constituent Group Meeting in March.		

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			General comments – no clear line of sight, accountability and assurance re QIPP				
			• Suggest minutes & ToR of Finance & Resource committee be submitted as evidence. (Question: is QIPP a standing agenda item? And what is the frequency of this meeting and membership?)		• Have included ToR and minutes of F&R committee – Yes, standing item, meets at least 9 times per year	15 ToR F&R 16 F&R Mins 17-19 Appendices	21 March 2013
			• If QIPP subcommittee only meets quarterly how can the CCG keep a grip? Can the frequency not be increased in year 1 then reviewed?		• Agreed – Meetings now held on monthly basis apart from August & December – main meeting will be quarterly to inform group of performance ahead of any reporting requirements to AT / NHSNoE.	20 Updated schedule of QIPP meetings	
			• Is there any evidence of the key risks to QIPP delivery? If so submit as evidence.		• 12/13 Programme has been rated green throughout the year – no risks identified. The bulk of CCG related schemes focus on secondary care contracts (delivered through efficiency) and prescribing which has been on course to deliver throughout the year.		
			• Have any papers describing the approach taken by South Sefton CCG been presented at the governing body or the finance and resource committee? If so submit as evidence		• Not at this stage – paper planned for March F&R and GB as part of strategic financial plans.		
			• Please elaborate on comments in actions being taken to address the issue (your submission) "Discussions in place with NHS S&O CCG regarding identifying adequate resources to cover financial risk in 13/14" as you describe the risk pool in the subsequent bullet point?		• Yes – informal discussion took place this morning (11th Feb) between 2 chairs and CFO as to how we would create and manage a risk reserve across the 2 CCG's to deal with issues such as strategic investment / specific pressures that carry greater risk to one CCG than the other etc. This reserve would be controlled through agreement by the AO, CFO and 2 Chairs and would potentially be up to 1% of resource allocation although this is yet to be confirmed.		

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
					• It was agreed that the concept would be explored in greater detail in the February Board Development Sessions to ask the Board members how this reserve could be managed and what areas they thought it could cover. • It is planned to take a formal paper to the Board in March outlining options and a proposed recommendation.		
			• In the finance update and the QIPP update at the Board minutes neither items describe the governance or risks to delivery.		• F&R Committee minutes reflect progress and will receive the QIPP sub-group ToR in February (copy attached).	16 F&R Mins 21 QIPP Group ToR	21 February 2013
4.2.1F	E	Provide evidence that arrangements are in place to deal with and learn from serious untoward incidents and never events.	• Recognise that plans where in transition can you now demonstrate the implementation of policies and plans?	II	The Quality Committee formally approved adoption of the SUI Policy on 24 January (copy minutes herein). Specific reference is drawn to the following: 12/8 Quality Dashboard 13/5 Quality Report 13/7 Quality Contract 13/8 Risk Register 13/10 SUI Update 13/11 Policies (SUI Policy for Ratification). A SUI Review Group has been established and details of the membership, dates of meetings and feedback are included herein. The Chief Nurse will represent the CCG at the Mersey Quality Surveillance Group. A letter detailing the Chief Nurse's invitation is attached, together with Guidance Outline.	5 South Sefton Quality Committee Notes 6 Sui Terms of Reference 7 Letter Merseyside Quality Surveillance Group 8 Establish Quality Surv Group	Completed

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
					The pending publication of the Mid Staffs Inquiry Report (Francis 2) was discussed at the Quality Committee in January 2013 (minutes attached). It is an agenda item for the meeting in February where a report and action plan will be presented. This will then be presented to the Governing Body in March 2013. The CCG Chief Nurse and GP Clinical Quality Leads are going to a Kings Fund seminar on 27 February 2013. The Chief Nurse has met with the Relationship Manager from the CSU on 7 February 2013 to discuss the Francis Report and support that will be required from CSU and the potential impact on the service they provide. The Chief Nurse, in collaboration with other Mersey CCG Chief Nurses to develop CQUIN and quality indicators relating to Compassion in Practice (National Nursing and Care Strategy) and the Francis Recommendations. This has been supported by CSU and the CQUIN and Quality Workshop on 10 January 2013 and at the CQUIN event with providers on 30 January 2013. Francis was also discussed at the Audit Committee on 6 February 2013, copy minutes included herein, please refer to 13/6, which is also referenced in the attached Action Tracker. *Winterbourne* A database has been developed to identify adults with LD/Mental Health and Autism who are in independent treatment and assessment units out of area. This information has been sent to the NCB Area Team on 1 February 2013. A CCG GP Clinical Lead has been identified for LD/Mental Health.		

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• How the CCG receives the information and acts upon it there is plans to do but you now need to evidence that you have done.		By 28 February 2013, a joint CCG/Local Authority database will be completed of children who are in out of area treatment centres. A joint CCG and local authority action plan is in the process of being completed re Winterbourne recommendations. This has been discussed at the Quality Committee in January 2013 and a full report will be presented in February 2013 to the Quality Committee, together with the Strategic Integrated Commissioning Group meeting on 11 March 2013 and the Governing Body on 27 March 2013. Support regarding incident reporting is from the CSU. The names of the Chief Nurse and Business Manager have been provided by way of access to Datix/Steis. The CCG's Chief Nurse is attending the SUI Training Day organised by the Cluster/Area Team on 13 February 2013. The Chief Nurse has completed and returned the SUI Checklist along with the CCG SUI policy to Peter Groggins and Christine Griffiths-Evans at on Friday 1 and Monday, 4 February 2013 respectively. A copy of the Quality Early Warning and Reporting system is attached which includes governance arrangements.	9 Early warning reporting system	Completed
			• Can you mention anything re the network and co commissioning arrangements, any additional support i.e. MIAA, AQUA, regular meetings with CQC anything that will support your submission.		The Chief Nurse will represent the CCG at the Mersey Quality Surveillance Group. A letter detailing the Chief Nurse's invitation is attached, together with Guidance Outline. The Chief Nurse will also represent the CCG at the Mersey Cluster SUI meetings (date of next meeting 18 February 2013).	7 Letter Merseyside Quality Surveillance Group 8 Quality surveillance group	

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
					Audit committee meeting held 7th February, minutes as yet not produced. Discussed involvement of MIAA in the review of CCG's committees. Minutes can be forwarded for upload to KMS week commencing 11th February. The CCG has confirmed that they will continue their membership of AQuA. This membership contribution will also mean that the CCG receives support from the Academic Health Science Network. The Chief Nurse has also attended a Webex on 28 February 2013 with AQuA to identify the support required to the CCG generally. *CQC* Dates have been confirmed for the Chief Nurse to meet with the CQC Compliance Inspectors. The meeting is arranged for 6th March 2013 10am with Christine Penlington and Robert Taylor (CP covers Aintree, Liverpool CH and Merseycare, RP covers Sefton).		Completed
			• Do you have a Local management group, led by GP members with practice staff as well as CCG staff?		The Serious Untoward Incidents Management Group of which Terms of Reference are attached.	6 SUI Terms of reference	Completed
4.2.3D	E	Provide evidence that the CCG has established appropriate systems for safeguarding.	• Our only comment would be that as your policy was only endorsed by the quality committee and not fully approved, endorsed or signed off by your governing body you remain with this condition. • No clear governance or line of sight from subcommittee to governing body.	II	The Governing Body approved the adoption of the Safeguarding Policy on 28 November 2012, please see 12/222 in the attached minutes. The CCG Safeguarding Assurance Framework demonstrates lines of accountability and governance arrangements.	10 Board minutes 11 Ass F'work	Completed

Number of Threshold	14C(2) Ref	Proposed condition	Remaining evidence gap/Issue to be addressed post Moderation and Conditions Panels	Support level	Actions being taken to address the issue	Supporting documents	Timescale
			• In evidence submitted it says Governing body approved the adoption of the policy - although In the minutes under AOB - Fiona Clark advised that the Safeguarding Vulnerable Adults & Children policy was approved at the quality committee. When reading the quality committee minutes there is no policy and no reference to the policy and no evidence of approval or sign off. • In support of this are there any training plans, CRB checks, evidence that an escalation system is in place to keep the governing body aware of incidents and how do you feedback to your member practices and co commissioners?		Further reference is made to the slides presented at the Site Visit on 30 October 2012, included herein, the Safeguarding Accountability and Governance Framework. The Quality Committee minutes referred to are those of 23 November 2012 and sign off is evidenced at minute 12/10 therein. Reference is further made to the draft Minutes of the Governing Body for 31 January 2013, where minute 13/2 notes the approval of the Safeguarding Children and Vulnerable Adults Policy. The minutes of the Quality Committee of 24 January, specifically item 13/13.	12 Safeg Slides 13 QC Mins 23 Nov 14 Minutes 310113 5 South Sefton Quality Committee Notes	

South Sefton Clinical Commissioning Group

Board meeting
March 2013

Agenda Item: 13/36 (a)	**Author of the Paper:** Clare Shelley Head of Financial Management and Planning NHS South Sefton Clinical Commissioning Group Clare.Shelley@sefton.nhs.uk

Title:

Finance Update

Summary of the Paper/Key Issues:

This paper presents the Governing Body with an overview of the Financial Performance for NHS South Sefton Clinical Commissioning Group. It details the performance against budget to date and risks in relation to the end of year financial position.

Action/Decision Required:

The Governing Body is asked to note the contents of this report.

Date of Report:

11 March 2013

Report to Board

March 2013

1. Introduction and Background

This paper provides the Governing Body with an overview of the Financial Performance for South Sefton Clinical Commissioning Group as at the end of February 2013.

This report will provide the Governing Body with information regarding:

- The financial position at the end of month 11 including forecast outturn
- Financial Risks

2. Healthcare Financial Position

2.1 Month 11 Financial Position

The financial position against the operational budget at the end of month 11 is £681k under spent. This is a favourable movement of £59k when comparing to the month 10 financial position, which continues to be largely attributable to an under spent position within Prescribing budget.

The 2012/13 indicative budgets delegated to South Sefton CCG equate to £236.4 million.

The table below provides a summary of financial position as at the 28th February 2013 and forecast outturn prior to the application of contingency reserves.

Detail	Annual	Year to Date			Forecast Outturn
	Plan	Plan	Actual	Difference	
	£	£	£	£	£
Secondary Care Total	133,545,081	122,547,431	122,662,315	114,884	216,415
Block Contract Total	37,521,847	34,394,997	34,402,078	7,081	8,000
Prescribing Total	29,757,253	27,277,471	25,317,241	(1,960,230)	(1,870,638)
Other Healthcare Total	16,924,888	15,573,795	15,952,319	378,524	551,557
Risk Share Total	17,007,761	15,885,215	16,670,663	785,448	1,004,871
Miscellaneous Total	(1,065,188)	(1,201,367)	(1,207,626)	(6,259)	0
Sub Total	**233,691,642**	**214,477,542**	**213,796,990**	**(680,552)**	**(89,715)**
Reserves	2,667,234	(118,334)	(118,334)	0	(1,845,335)
Grand Total	**236,358,876**	**214,359,208**	**213,678,656**	**(680,552)**	**(1,935,130)**

Please note figures in brackets represent an under spend. Positive figures represent an over spend.

A further breakdown is available in Appendix A.

2.2 Forecast Outturn

The forecast year end out turn position for South Sefton CCG prior to the application of contingency reserves is £90k under spent. This represents a -0.04% under spend of the CCG annual budget. The projected financial position following the application of reserves is £1.9m under spent.

Additional costs have been built into the forecast for expenditure we are expecting later in the financial year for Pharmacy high cost drugs, over performance on PbR contracts within the Independent Sector Treatment Centres and also Non Contracted Activity.

2.3 Financial Risk

The following risks have been identified as part of this financial year.

Restitution Claims

A provision has been placed into the accounts for the sum of £1.879m across Southport and Formby CCG and South Sefton CCG in relation to outstanding restitution claims. This is in line with the Merseyside Cluster approach. There is a risk if the number of successful claims is higher than anticipated. This will be monitored between now and the end of the financial year.

Ambulance Services

The contract continues to overspend due to an increase in ambulance calls. The forecast to date shows £203k over the budget for 2012-13. There is sufficient contingency to offset this pressure at this level of over spend. The activity continues to be monitored each month and forecast amended accordingly.

Pharmacy

The pharmacy over spend is a result of increased volume and drug costs and has continued throughout the year. There are sufficient funds within CCG contingency reserves however costs continue to be monitored each month. There is further risk if the overspend continues to rise above recent trends.

Independent Sector Treatment Centres

Activity levels have risen sharply during month 10 for Renacres & Spire Healthcare and were higher than anticipated. There is a risk if the activity continues at this level through to the end of the financial year. This however is being monitored by the finance team.

Continuing Healthcare & Free Nursing Care

The Broadcare system is still in the process of being updated. The forecasted out turn position has been arrived by comparing historical spend across a number of years and has been reviewed with the CHC team.

Prescribing

The Prescribing Pricing Authority has now provided the year to date expenditure and year end forecasted figures based on month 9 actual data. This has been factored into the financial position and year end forecasts. There is an element of risk if the level of under spend

estimated reduces. This will be closely monitored each month as updated reports are submitted from the PPA.

There are sufficient contingency reserves to manage the risks as described above. The estimated risk reduces during the year as more actual information is received.

3. Recommendations

The Governing Body is asked to note the content of the paper notably:

- The year to date position and the forecasted year end position
- The financial risks identified within this paper.

Appendices

Appendix A Summary of the Financial Position as at month 11.

Clare Shelley
Head of Financial Management and Planning
NHS South Sefton Clinical Commissioning Group
March 2013

Summary Financial Position as at Month 11 (February) 2012/2013

Consortium: South

South Sefton Clinical Commissioning Group

Detail		Annual Plan	Year to Date Plan	Actual	Difference	Y/E
		£	£	£	£	£
Secondary Care	Non Contract Activity	1,388,328	1,272,566	1,353,042	80,476	95,596
	The Christie NHS Foundation Trust	91,220	83,612	145,383	61,771	67,000
	Wrightington, Wigan And Leigh NHS Foundation Trust	439,908	403,249	436,652	33,403	36,000
	University Hospital of South Manchester NHS Foundation Trust	57,660	52,855	73,330	20,475	22,000
	Warrington And Halton Hospitals NHS Foundation Trust	61,995	56,826	75,183	18,357	24,000
	Lancashire Teaching Hospitals NHS Foundation Trust	106,471	97,599	114,200	16,601	18,000
	Central Manchester University Hospitals NHS Foundation Trust	24,152	22,140	25,630	3,490	4,000
	Aintree University Hospitals NHS Foundation Trust	83,512,840	76,596,615	76,596,615	0	0
	Alder Hey Children's NHS Foundation Trust	10,127,792	9,283,804	9,283,804	0	0
	Liverpool H&C NHS FT South CCG	840,088	785,520	785,520	0	0
	Liverpool Women's NHS Foundation Trust	8,773,161	8,035,335	8,035,335	0	0
	Royal Liverpool and Broadgreen University Hospitals NHS Trust	11,848,878	10,861,463	10,861,463	0	0
	Southport and Ormskirk Hospital NHS Trust	7,209,510	6,668,198	6,668,198	0	0
	St Helens and Knowsley Hospitals NHS Trust	1,514,831	1,408,441	1,408,441	0	0
	Countess of Chester Hospitals NHS Foundation Trust	96,250	88,221	82,162	(6,059)	(7,000)
	Wirral University Teaching Hospital NHS Foundation Trust	270,468	247,927	230,817	(17,110)	(21,000)
	Clatterbridge Centre for Oncology NHS Foundation Trust	7,181,528	6,583,061	6,486,541	(96,520)	(22,181)
Secondary Care Total		**133,545,081**	**122,547,431**	**122,662,315**	**114,884**	**216,415**
Block Contract	Cheshire and Wirral NHS FT	22,085	20,240	27,321	7,081	8,000
	Lancashire Care NHS FT	123,921	113,587	113,587	0	0
	Liverpool Community Health NHS Trust	13,943,166	12,781,225	12,781,225	0	0
	Merseycare NHS Trust	15,539,141	14,244,210	14,244,210	0	0
	Southport & Ormskirk Community Services	7,893,534	7,235,735	7,235,735	0	0
Block Contract Total		**37,521,847**	**34,394,997**	**34,402,078**	**7,081**	**8,000**
Prescribing	Prescribing	29,757,253	27,277,471	25,317,241	(1,960,230)	(1,870,638)
Prescribing Total		**29,757,253**	**27,277,471**	**25,317,241**	**(1,960,230)**	**(1,870,638)**
Other Healthcare	Independent Sector Treatment Centres	2,844,454	2,624,865	3,041,962	417,097	479,330
	North West Ambulance NHS Trust	5,909,397	5,416,940	5,604,348	187,408	202,807
	Anticoagulation	64,770	59,370	65,184	5,814	7,000
	PbR Reserve	1,684,386	1,528,239	1,528,239	0	0
	The Walton Centre NHS FT	299,812	298,283	298,283	0	0
	Patient Transport Services North West Ambulance NHS Trust	11,803	10,793	10,210	(583)	(700)
	Children's Services	1,413,614	1,344,340	1,332,673	(11,667)	(8,788)
	Glucose Tolerance Tests	40,000	36,863	15,692	(21,171)	0
	Dermatology Assura	558,511	511,963	439,963	(72,000)	0
	Other Commissioned Healthcare	4,098,141	3,742,139	3,615,765	(126,374)	(128,092)
Other Healthcare Total		**16,924,888**	**15,573,795**	**15,952,319**	**378,524**	**551,557**
Risk Share	Pharmacy	963,384	883,092	1,751,431	868,339	874,240
	Oxygen	325,983	298,815	264,195	(34,620)	(34,620)
	Continuing Care	15,718,394	14,703,308	14,655,037	(48,271)	165,251
Risk Share Total		**17,007,761**	**15,885,215**	**16,670,663**	**785,448**	**1,004,871**
Miscellaneous	Melling Practice Recharge	(3,387,334)	(3,105,057)	(3,105,057)	0	0
	Primary Care	430,700	394,802	394,802	0	0
	PCT Allocations	2,667,234	(118,334)	(118,334)	(0)	(1,845,335)
	Clinical Commissioning Group	1,891,446	1,508,888	1,502,629	(6,259)	0
Miscellaneous Total		**1,602,046**	**(1,319,701)**	**(1,325,960)**	**(6,259)**	**(1,845,335)**
Grand Total		**236,358,876**	**214,359,208**	**213,678,656**	**(680,552)**	**(1,935,130)**

Prepared by Chloe Rachelle
Management Accounts Assistant
NHS South Sefton Clinical Commissioning Group
21/03/2013

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/36(b)	**Author of the Paper:** Brendan Prescott CCG Lead, Medicines Management Brendan.prescott@sefton.nhs.uk

Title:

Prescribing Update

Summary of the Paper/Key Issues:
This paper presents the Board with an update on the prescribing budget position based upon month 9 (December 2012) prescribing data

Action/Decision Required:

The Governing Body is asked to note the contents of this report.

Date of Report:

14 March 2013

Report to Board

March 2013

1. Executive Summary

The South Sefton CCG position for month 9 (December 2012) was a forecast under spend of £2,659,384 or -9.3 %. This is a slight decrease of £13,000 on the November 2012 forecast.

2. Introduction and Background

This is a regular monthly update on the management of the South Sefton prescribing budget. As we move into the final quarter of 2012-13, the forecast is likely to become more reliable.

3. Content

Work at practice level continues balancing practice requirements and the CCG commissioning intentions for medicines.

Review of care home patients continues and a report will be drawn up for May Board. .

The inaccurate forecast for one practice has been reducing month on month since the error was rectified.

Further work on the impact of one off patent expiry for 2012-13 has been carried out with an estimated saving of £322,370 in 2012-13.

4. Recommendations

The Governing Body is asked to note the prescribing update

Appendices

Appendix 1 : Performance table of budget versus spend (month 9, December data)

Brendan Prescott
CCG Lead, Medicines Management
14 March 2013

South Sefton Clinical Commissioning Group

Appendix 1

Prescriber Code	Prescriber Name	Total YTD Spend	Total Budget	Total FOT	Variance £	Variance (%)
N84001	42 KINGSWAY	£757,458	£1,076,004	£999,153	-£76,851	-7.1
N84002	AINTREE ROAD MEDICAL CENTRE	£372,944	£517,946	£491,946	-£26,000	-5.0
N84003	HIGH PASTURES SURGERY	£1,349,304	£1,908,763	£1,779,850	-£128,912	-6.8
N84004	GLOVERS LANE SURGERY	£943,618	£1,362,115	£1,244,714	-£117,401	-8.6
N84007	LIVERPOOL RD MEDICAL PRACTICE	£753,235	£1,069,478	£993,582	-£75,896	-7.1
N84009	AZALEA SURGERY	£346,222	£525,614	£456,697	-£68,917	-13.1
N84010	MAGHULL HEALTH CENTRE (DR SAPRE)	£282,722	£392,996	£372,935	-£20,061	-5.1
N84011	EASTVIEW SURGERY	£842,695	£1,242,705	£1,111,588	-£131,117	-10.6
N84015	BOOTLE VILLAGE SURGERY	£974,404	£1,406,987	£1,285,324	-£121,663	-8.6
N84016	MOORE STREET MEDICAL CENTRE	£960,988	£1,411,630	£1,267,626	-£144,004	-10.2
N84019	NORTH PARK HEALTH CENTRE	£984,335	£1,488,613	£1,298,424	-£190,189	-12.8
N84020	BLUNDELLSANDS SURGERY	£1,024,576	£1,472,105	£1,351,506	-£120,599	-8.2
N84023	BRIDGE ROAD MEDICAL CENTRE	£1,035,567	£1,437,289	£1,366,003	-£71,286	-5.0
N84025	WESTWAY MEDICAL CENTRE	£905,219	£1,283,494	£1,194,063	-£89,431	-7.0
N84026	CROSBY VILLAGE SURGERY	£311,280	£440,388	£410,606	-£29,782	-6.8
N84027	ORRELL PARK MEDICAL CENTRE	£355,810	£550,721	£469,345	-£81,377	-14.8
N84028	THE STRAND MEDICAL CENTRE	£1,025,464	£1,449,526	£1,352,677	-£96,849	-6.7
N84029	FORD MEDICAL PRACTICE	£754,571	£1,077,176	£995,345	-£81,831	-7.6
N84034	PARK STREET SURGERY	£758,129	£1,170,171	£1,000,038	-£170,133	-14.5
N84035	15 SEFTON ROAD	£627,945	£912,064	£828,315	-£83,749	-9.2
N84038	CONCEPT HOUSE SURGERY	£552,297	£614,377	£728,528	£114,151	18.6
N84041	KINGSWAY SURGERY	£539,500	£814,793	£711,647	-£103,146	-12.7
N84043	SEAFORTH VILLAGE PRACTICE	£185,482	£276,184	£244,667	-£31,517	-11.4
N84605	LITHERLAND TOWN HALL HTH CTR (TAYLOR)	£411,338	£590,255	£542,591	-£47,664	-8.1
N84615	RAWSON ROAD MEDICAL CENTRE	£316,032	£449,904	£416,874	-£33,030	-7.3
N84616	SEFTON ROAD SURGERY	£158,021	£414,326	£208,443	-£205,883	-49.7
N84621	THORNTON PCT PRACTICE	£344,151	£510,473	£453,965	-£56,508	-11.1
N84622	MAGHULL HEALTH CENTRE (DR THOMAS)	£288,300	£410,667	£380,293	-£30,375	-7.4
N84624	MAGHULL HEALTH CENTRE	£217,197	£447,885	£286,501	-£161,384	-36.0
N84626	HIGHTOWN VILLAGE SURGERY	£278,357	£420,594	£367,177	-£53,416	-12.7
N84627	CROSSWAYS PCT PRACTICE	£297,494	£460,661	£392,421	-£68,240	-14.8
N84630	NETHERTON PCT PRACTICE (DR CHOUDHARY)	£233,762	£340,686	£308,352	-£32,334	-9.5
Y00446	MAGHULL PCT PRACTICE	£482,952	£675,339	£637,056	-£38,283	-5.7
Y02514	LITHERLAND PRIMARY CARE WALK-IN SERVICE	£38,882	£37,000	£51,289	£14,289	38.6
Total		**£19,710,253**	**£28,658,926**	**£25,999,542**	**-£2,659,384**	**-9.3**

Brendan Prescott
14th March 2013

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/36 (c)	**Author of the Paper:** Malcolm Cunningham Head of Performance and Health Outcomes malcolm.cunnigham@sefton.nhs.uk

Title:

Performance and Quality Report

Summary of the Paper/Key Issues:

This paper presents the Governing Body with an update in relation to Performance and Quality.

Action/Decision Required:

The Governing Body is asked to note the contents of this report

Date of Report:

14 March 2013

Contents

Introduction and Background

This performance report provides a monthly performance update for South Sefton CCG. Information is available for CCGs on a PCT footprint, provider and cluster level to enable analysis and action for recovery for areas of underperformance.

This report includes the following:

- Underperforming KPI Trends
- Operating Framework Performance Measures 2012/13 for PCTs and Provider trusts
- Performance Recovery Action Plans
- General and Acute Activity Monitoring table comparing 2010/11 with 2011/12 activity
- A&E Attendances and Emergency Admissions in acute trusts (year to date 2012 to 2013)

Performance Reporting at CCG level

There has been good progress in developing a Mersey wide view on contracts at CCG level and there has also been significant work done on a range of other intelligence work streams that will add value to CCGs performance monitoring via the new Merseyside Intelligence Portal.

A range of intelligence products are in development and will be made available via the Mersey Portal including:

- Monthly Budget Statements at CCG and GP Practice level(subject to local information governance agreements) - These reports give an overall monthly position across a range of budget lines for all practices (Pbr, Non Pbr, block contracts and prescribing etc.) and can be made available at patient level where the data allows.
- Monthly Contract Reconciliation Reports - To enable GP Practices to validate Secondary Care data returns and raise challenges on specific hospital attendances and spells.
- Practice level Prescribing Indicator Reports and Budgets developed in partnership with the Mersey Medicine Management leads.
- High Impact User Report at CCG and Practice level showing patients who have had multiple contacts with Secondary Care in the past 12 months.

- First draft Clinical Dashboards - These are initially based on existing Clinical Indicator sets defined by the 'old' PCTs with local practices and combine local indicators from all of the localities. Once these indicators are capable of being delivered at a Mersey footprint level, a 'pick list of indicators' and local dashboards can then be created to enable individual CCGs to focus on the indicators that relate to their own areas of local interest.

- First draft practice level Risk Stratification report providing risk scores on the possibility of readmission to hospital within 12 months. First draft will be based on secondary care data only with GP data and other data sources added over the coming months. GP data is being piloted in a small selection of practices in Liverpool and will be rolled out once the outcomes are validated and assessed.

Work undertaken to enable the technical links that allow users to log on to the portal from their desktops has taken longer than expected, however, these issues are being resolved and full rollout for all CCGs / GPs is now commencing. There are a range of additional products in development. These include:

- CCG / Practice level reports on Merseycare and 5 Boroughs Mental Health activity and referrals
- First draft Community Activity data at CCG / Practice level from the initial flows of the Community Minimum data sets
- Further development and localisation of all of the phase 1 reports
- Contract Quality Indicator / CQUIN Dashboard covering all Mersey hosted contracts
- Mersey QIPP Programme Monitoring Dashboard
- Practice Level Referral reporting
- Practice Level Waiting List Reporting

It is important to note that all of the initial reports being presented are open to further development in response to user engagement and requirements. It has been requested that the Merseyside CCG Network support the setting up of a 'Mersey Intelligence Development working group'. CCG Boards are requested to put forward volunteers from each CCG area who have an interest in developing intelligence to engage in the specification of new data collections and reports for CCGs.

Executive Summary on Performance Trends

KPI	Underperforming Trusts	Underperforming PCTs
MRSA Bacteraemia	Aintree ⇔	
C-Difficile Infections	Aintree ⇩	NHS Sefton ⇧
Referral to Treatment (RTT)	**% Admitted Within 18 Weeks** Southport & Ormskirk ⇩ **RTT Incomplete Pathways 18 Weeks** Southport & Ormskirk ⇩	**Numbers Waiting on an Incomplete Pathway** NHS Sefton ⇩ **% Admitted Within 18 Weeks** NHS Sefton ⇩
Cancer Waits	**All Cancer 2 Month Urgent Referral to Treatment** Southport & Ormskirk ⇧ **62 Day Cancer Screening** Aintree ⇧ **62 Day Consultant Upgrade** Southport & Ormskirk ⇧ **All Cancer 2 Week Wait** Southport & Ormskirk ⇔	**All Cancer 2 Month Urgent Referral to Treatment** NHS Sefton ⇧ **62 Day Consultant Upgrade** NHS Sefton ⇧
Mental Health		**Early Intervention in Psychosis** NHS Sefton ⇧
Proportion of GP Referrals using Choose & Book		NHS Sefton ⇧
A&E 4 Hour Wait	Aintree ⇩ Southport & Ormskirk ⇧	
Ambulance Cat A response within 19 minutes	NWAS ⇩	

Key

⇧ **Performance Improving**
⇩ **Performance Worsening**
⇔ **Performance Remaining the Same**

NHS Merseyside Performance Overview - January 2013 Report

PCT	Overall	RTT admitted 90% Oct 2012	62 Day Cancer Q2 2012/13	C Diff Nov 2012 YTD	A&E 4 Hour Wait QTD 30/12/12	Mixed Sex Accommodation Nov 2012	Ambulance Cat A Nov 2012	Health Checks Q2 2012/13	Health Visitors October 2012
Merseyside									
NHS Halton & St Helens									
NHS Knowsley									
Liverpool PCT									
NHS Sefton									

PLEASE NOTE: This performance overview was presented last month. There have been no updates since.

The 'North SHA Performance Overview' provides a performance summary at PCT commissioner level of eight key indicators which help to give a reflection of performance overall. The indicators have been chosen either because of their priority as set out in the NHS Operating Framework for England 2012/13 or because there are particular challenges in the North of England. They should not be viewed as an exclusive set of indicators and the detailed performance table included in this report highlights performance against a much larger range of indicators. The key indicators used are subject to change from time to time to reflect areas of continued focus.

DATA THRESHOLDS AND TIME PERIODS

Indicator	Data Period	Upper Threshold (Green)	Lower Threshold (Amber)
RTT Admitted Patients Seen within 18 weeks	October 2012	90%	
62 Day Cancer Waiting Times	Quarter 2 2012/13	85%	
C- Difficile Infections	Year to Date November 2012	0 Z-Score	1 Z-Score
Mixed Sex Accommodation	November 2012	0 Breaches	Breach rate <1 per 1000 FCEs
A&E 4 Hour Wait	Q3 to date at 30th December 2012	0 Main Provider Trusts breaching the 95% threshold	
Ambulance Cat A (8 Mins)	November 2012	75%	71%
Health Checks - Eligible patients offered an NHS Health Check	Q2 2012/13	Meets plan	80% of plan level
Health Visitors - number of WTE on ESR	October 2012	Meets PCT Cluster target	Within 2% of PCT Cluster target

NHS Merseyside Performance Overview - January 2013 Report

Provider	Overall	RTT admitted 90% Nov 2012	62 Day Cancer Q2 2012/13	C Diff YTD Nov 2012	A&E 4 Hour Wait Q3 YTD 30/12/12	Mixed Sex Accommodation Nov 2012	VTE Assessments Nov - 12	6 Week Diagnostic Wait Nov 2012
Aintree Hospital Trust								
Alder Hey Childrens Trust								
Liverpool Heart & Chest								
Liverpool Womens Trust								
Royal Liverpool & Broadgreen								
Southport & Ormskirk Hospitals								
St Helens & Knowsley Hospitals								
The Walton Centre								
Warrington & Halton Hospitals								

PLEASE NOTE: This performance overview was presented last month. There have been no updates since.

The 'North SHA Performance Overview' provides a performance summary at Provider level of seven key indicators which help to give a reflection of performance overall. As with the commissioner overview the indicators have been chosen either because of their priority as set out in the NHS Operating Framework for England 2012/13 or because there are particular challenges in the North of England. They should not be viewed as an exclusive set of indicators and the detailed performance table included in this report highlights performance against a much larger range of indicators.

DATA THRESHOLDS AND TIME PERIODS

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RTT Admitted Patients seen within 18 weeks	October 2012	90%	
62 Day Cancer Waiting Times	Quarter 2 2012/13	85%	
C- Difficile Infections	Year to Date November 2012	0 Z-Score	1 Z-Score
Mixed Sex Accommodation	November 2012	0 Breaches	Breach rate <1 per 1000 FCEs
A&E 4 Hour Wait	Q3 to date at 30th December 2012	95%	
Proportion of Adult Admissions Risk Assessed for VTE	November 2012	90%	85%
Diagnostic 6 Week Waiting Times	November 2012	99%	97%

CLUSTER CORPORATE PERFORMANCE DASHBOARD – COMMISSIONER LEVEL

Performance Indicators		Halton & St Helens	Knowsley	Liverpool	Sefton	Mersey Cluster
Headline Measures						
Quality (Safety, Effectiveness & Patient Experience)						
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - January	12	3	11	5	31
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - January	76	34	130	105	345
Resources (Finance, Capacity & Activity)						
PHS16: Numbers Waiting on an Incomplete Referral to Treatment Pathway	12/13 - December	16,299	8,576	22,029	14,497	61,401
Supporting Measures						
Quality (Safety, Effectiveness & Patient Experience)						
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - December	88.38	86.76	88.84	84.21	87.19
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - December	89.53	88.55	90.16	85.71	88.61
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - December	96.39	96.77	96.49	95.18	96.14
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - December	89.66	96.55	91.73	86.30	90.44
PHQ06: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat') (Cumulative)	12/13 - December	99.33	99.19	97.82	97.83	98.39
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - December	99.42	100.00	99.69	97.67	99.07
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - December	98.89	100.00	99.33	98.91	99.20
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - December	95.97	94.61	96.03	98.07	96.35
PHQ10: Early Intervention in Psychosis (Cumulative)	12/13 Q3 Oct - Dec	46	27	90	32	195
PHQ11: Crisis Resolution Home Treatment (Cumulative)	12/13 Q3 Oct - Dec	341	269	1,389	675	2,674
PHQ16: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	12/13 - December	21.96	17.30	13.14	17.41	16.97
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - December	93.55	94.68	93.81	89.97	93.02
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - December	98.15	97.60	97.98	97.51	97.87
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - December	0.0	0.2	0.6	0.4	0.3
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - December	95.21	95.09	95.51	94.20	95.02
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - December	95.16	95.34	95.52	94.38	95.11

Performance Indicators		Halton & St Helens	Knowsley	Liverpool	Sefton	Mersey Cluster
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - December	94.88	97.07	95.63	95.93	95.68
PHQ31: % who have been offered an NHS Health check (Cumulative)	12/13 Q3 Oct - Dec	12.9	15.9	36.3	19.1	22.6
PHQ31: % who have received NHS Health check (Cumulative)	12/13 Q3 Oct - Dec	5.2	4.6	12.6	8.6	8.4
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 Q3 Oct - Dec	85.1	90.0	90.4	83.0	86.9
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 Q3 Oct - Dec	57.1	100.0	98.7	80.0	89.8
SQU12 - % women who have seen a midwife by 12 weeks & 6 days of pregnancy	12/13 Q3 Oct - Dec	94.8	105.4	86.7	92.2	92.3
SQU19_05 - % Prevalence of breastfeeding at 6-8 wks after birth	12/13 Q3 Oct - Dec	22.40	16.20	27.30	26.60	24.85
SQU19_06 - % Coverage of breastfeeding at 6-8 wks after birth	12/13 Q3 Oct - Dec	99.80	95.80	95.80	99.10	97.50
SQU22 - Results of cervical screening test within 2 weeks	12/13 - January	99.23	98.18	98.45	98.17	98.57
SQU23 - % Diabetic Retinal Screening	12/13 Q3 Oct - Dec	97.89	98.62	104.17	N/A	N/A
Reform (Commissioner, Provider & building capability and						
PHF07: Bookings to services where named consultant led team was available (even if not selected) (Cumulative)	12/13 - December	91.36	91.38	84.94	90.68	88.15
PHF08: Proportion of GP referrals to first outpatient appointments booked using Choose and Book (Cumulative)	12/13 - December	52.36	36.55	63.79	36.92	50.67

Achieving Plan
Variance from Plan
Significant variation from plan

PROVIDER CORPORATE PERFORMANCE DASHBOARD

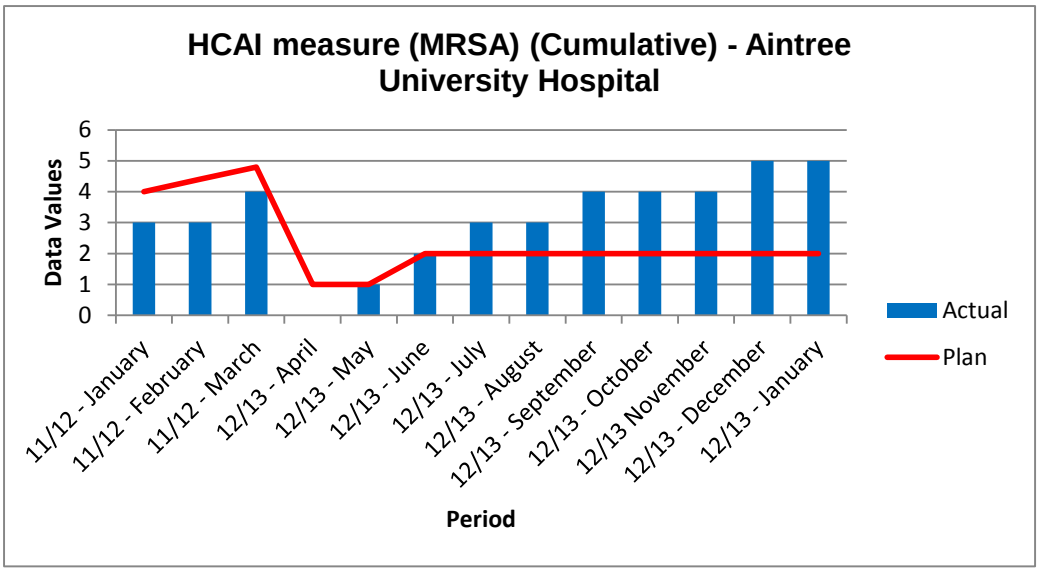
Performance Indicators		Aintree University Hospitals NHS Foundation Trust	Alder Hey Children's NHS Foundation Trust	Liverpool Heart & Chest NHS Foundation Trust	Liverpool Womens NHS Foundation Trust	Royal Liverpool & Broadgreen University Hospitals NHS Trust	Southport & Ormskirk Hospital NHS Trust	St Helens & Knowsley Teaching NHS Trust	The Walton Centre NHS Foundation Trust	Warrington & Halton Hospitals NHS Foundation Trust
Headline Measures										
Quality (Safety, Effectiveness & Patient Experience)										
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - Jan	5	0	0	0	2	0	8	0	1
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - Jan	64	0	8	0	48	16	30	7	15
Supporting Measures										
Quality (Safety, Effectiveness & Patient Experience)										
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - Dec	87.41		79.06	87.66	92.72	85.36	91.70		91.19
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - Dec	89.00		78.29	89.22	95.93	85.41	92.45		92.00
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - Dec	85.25			92.31	99.01	100.00	100.00		98.17
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - Dec	93.22		70.37	95.56	98.84	75.00	77.78		86.96
PHQ06: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat') (Cumulative)	12/13 - Dec	97.80	100.00	98.24	97.17	98.95	98.89	99.68	100.00	100.00
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - Dec	98.61	100.00	100.00	98.70	99.25	96.35	99.73	100.00	100.00
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - Dec	100.00	100.00			98.94	100.00	100.00	100.00	100.00
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - Dec	94.44				100.00	100.00	100.00		
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - Dec	90.92	80.94	87.00	95.83	94.38	85.56	96.47	94.12	93.75
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - Dec	97.54	96.22	97.60	95.51	98.52	96.69	98.34	98.20	98.50
PHQ21: RTT - % of incomplete pathways within 18 weeks	12/13 - Dec	96.62	93.88	93.93	92.78	95.22	91.92	97.58	98.12	91.71
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - Dec	0.54	0.00	0.00	0.52	0.00	0.39	0.00	0.00	0.00
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - Dec	96.42		99.56	97.48	94.57	92.96	94.66	100.00	95.74
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - Dec	96.32		99.56	97.48	94.79	93.39	94.92	100.00	95.32
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - Dec	95.52				95.86	96.49	96.39		93.67
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 Q3 Oct-Dec	80.9				92.93	85.86	87.41		80.70
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 Q3 Oct-Dec	100.0				98.46	75.86	91.67		21.05
Resources (Finance, Capacity & Activity)										
A&E % Patients waiting <4 Hours	Q4 YTD 10th Feb	93.7%	96.8%		99.9%	94.6%	93.2%	93.0%		94.7%
North West Ambulance Service										
	2012/13	April	May	June	July	August	Sept	October	November	December
Cat A response within 8 mins % R1	75%	77.1%	76.1%	75.7%	76.9%	75.2%	75.1%	73.6%	72.0%	70.8%
Cat A response within 8 mins % R2	75%			79.4%	79.8%	78.7%	76.6%	76.8%	76.1%	72.9%
Cat A response within 19 mins	95%	94.8%	94.2%	95.6%	95.9%	95.8%	94.6%	94.6%	95.1%	94.2%

Achieving Plan
Not Applicable
Variance from Plan
Not Available
Significant variation from plan

Performance Recovery Action Plans

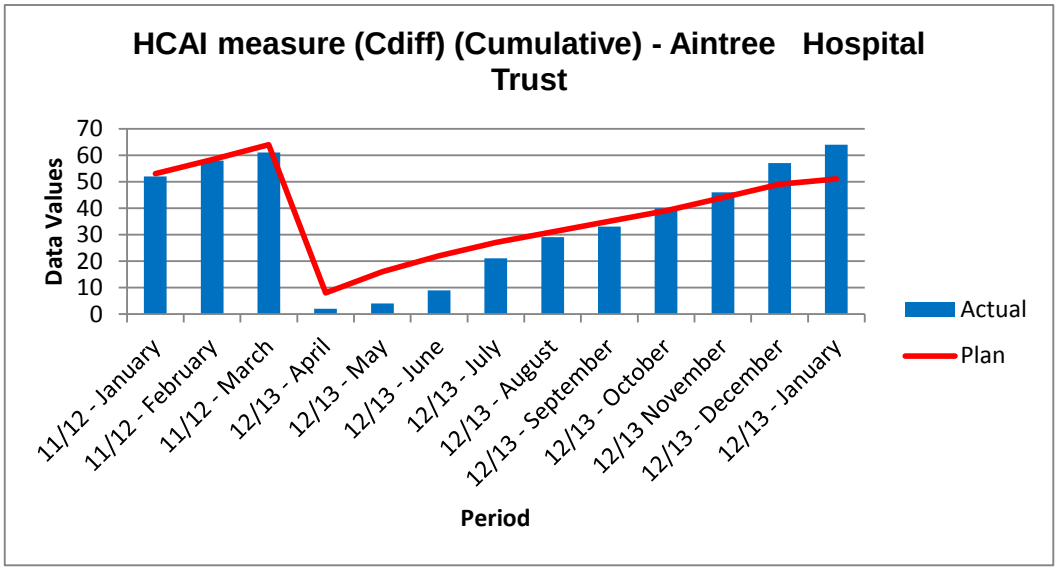
1. MRSA

In Aintree Hospital Trust, there were five cases of MRSA cumulatively at January 2013 against the tolerance of two cases. Each case has been thoroughly investigated. The issues have been discussed at contract meetings and quality meetings. A Health Care Acquired Infection Group (HCAI) has been set up and is chaired by the Trust Chief Executive with CCG quality leads as members. Action plans are continually reviewed and updated to minimise the risk of more cases.



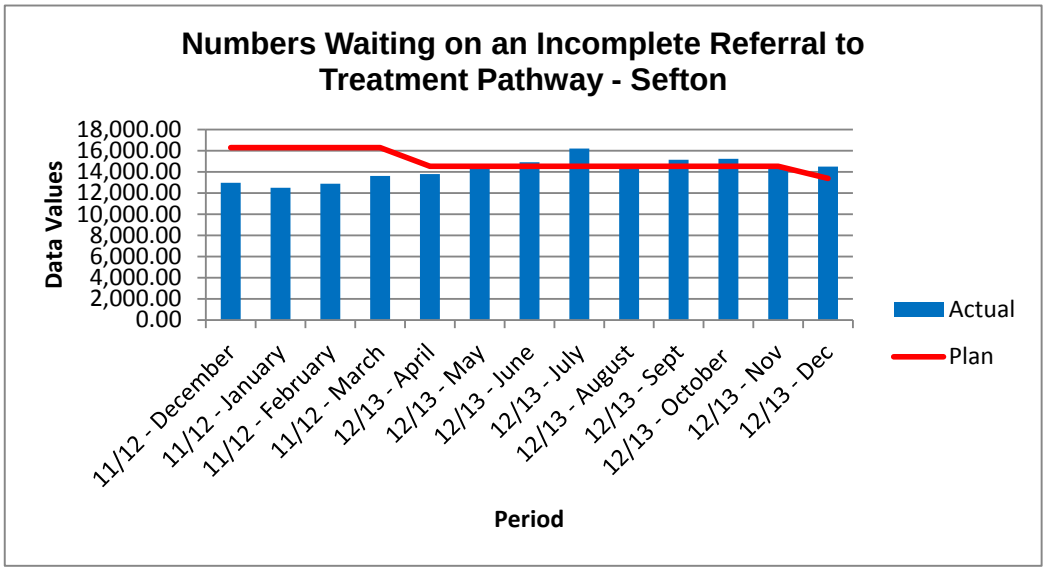
2. Cdifficile Infections

In Aintree Hospital Trust, there were 64 cases of Cdifficile cumulatively at January 2013 against the tolerance of 51 cases. Each case has been thoroughly investigated. The issues have been discussed at contract meetings and quality meetings. Action plans are continually reviewed and updated to minimise the risk of more cases.



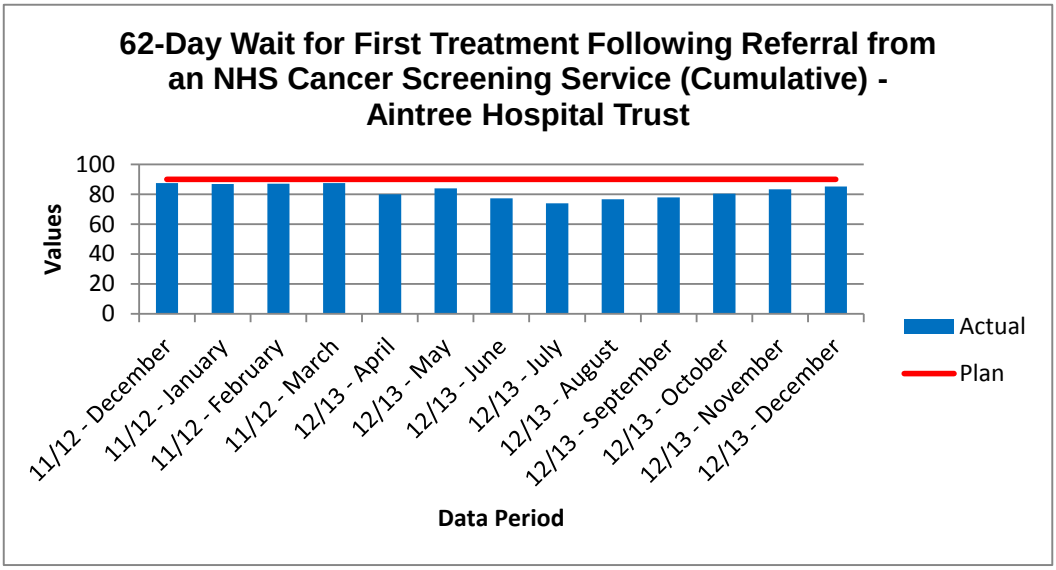
3. Number waiting on an incomplete RTT pathway

The numbers on the incomplete pathway should be used in conjunction with the delivery of the RTT for incomplete to assess if the system is working appropriately. Unfortunately whilst still delivering the incomplete target (92% with 18 weeks) a number of trusts are seeing a rise in the number of patients on an incomplete pathway – this in itself does not indicate a problem but contract and performance managers will need to work with providers to examine the numbers of long waiters and to ensure that trusts are not developing waiting list problems.

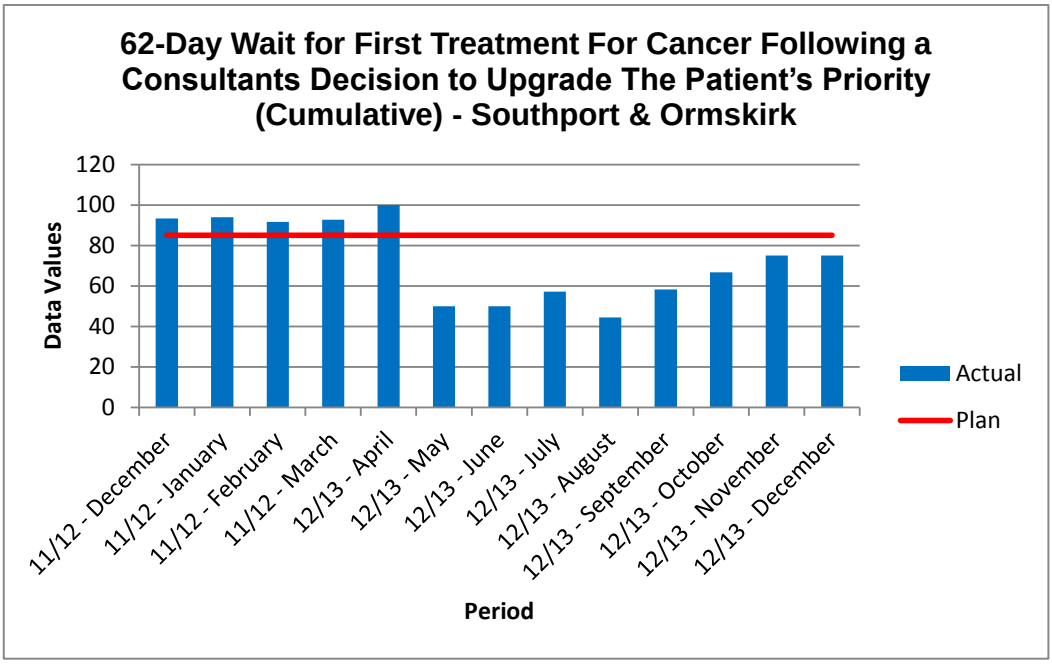


4. Cancer Waits

At Aintree Hospital Trust the 62 day wait for first treatment following referral from an NHS Cancer Screening Service at December 2013 was 85.25% against the 90% target. This continues to be a challenge due to the very small numbers treated each month with the majority of delays being due to patient choice and clinically complex pathways. The Trust cancer management team continue to work with Intensive Support Team in order to progress in all aspects of pathway management. The Trust is focusing on achieving the target for Q4.



For the 62 days wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority in December 2012, Southport and Ormskirk Hospitals Trust are reporting 75% year to date against the 85% target. This is an underperformance of 10%. This year to date underperformance is carried forward from previous months; there were no patient breaches for consultant upgrade during the month of December.



5. Referral to Treatment (RTT) - % of admitted pathways within 18 weeks

At December Southport and Ormskirk Hospitals Trust were showing 85.56% against the 90% target. The backlog of patients waiting over 18 weeks has not made it possible to carry out additional activity to clear the longer waiters and still meet RTT targets. Lower performance trajectories have been agreed with the SHA and commissioners between December and February. The Trust is on plan to have no patients waiting over 52 weeks by April 2013. With regards to the percentage of incomplete pathways within 18 weeks, the Trust achieved 91.92% against the target of 92%, just slightly below.

6. A&E <4 Hour Wait

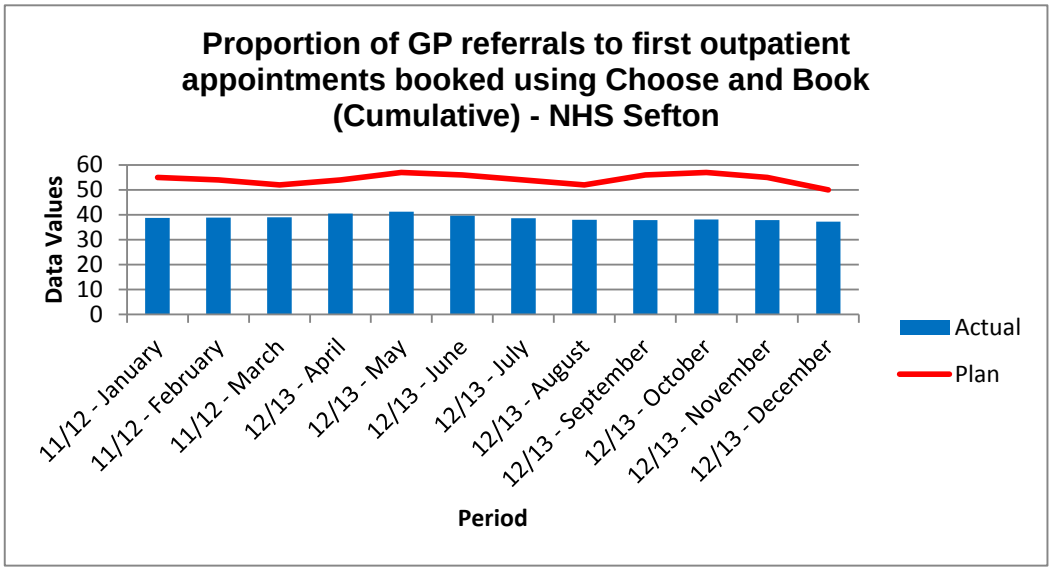
For A&E <4 hour wait at Aintree Hospital Trust, for the above reporting period stood at 93.7% against the 95% target. Aintree face many challenges as with other trusts. It is the high numbers of frail elderly and complex patients attending who require admission and require a longer stay which affects available beds for new patients. All escalation beds have been opened and where necessary some elective work has been cancelled to provider non elective beds. The Division of Medicine is working with local CCGs to review opportunities for improving non elective pathways. The Trust is focusing on achieving the target for Q4.

For the above indicator, Southport and Ormskirk Hospitals Trust achieved 93% against the 95% target. The significant increase in both the non-elective admissions and ambulance attendances alongside the acuity increase seen across the region has led to reduced performance. An A&E Performance

Action Plan is in place to tackle issues and implement alternative pathways. Internal daily stretch targets have been established to set out expectations for delivery in February and March to provide assurance for Q4 compliance.

7. Choose and Book

After a December position of 36.92%, Choose and Book performance at Sefton increased considerably and averaged 40% in January 2013 but performance has slightly dipped to an average of 39% throughout February 2013 to date. The national NHS average is currently 53%. Work is on-going to increase the use of Integrated Choose & Book.



8. Ambulance Response

The number of incidents in December was more than modelled, adversely impacting upon the in-month and cumulative positions. High levels of red call demand have continued, with an overall cumulative increase over plan of 10.2% in December. Of particular interest is the variable increase in demand seen across the region, with Merseyside however showing the lowest increases and hence the adverse impact upon performance.

During December the average daily 'tipping point' in call volume of 980 was exceeded every day by a significant average increase of 198 incidents each day, illustrating the high call volumes experienced. Hospital turnaround delays remain a significant cause for concern and have a significant adverse impact upon daily emergency capacity availability. Locally Southport & Ormskirk Hospitals Trust showed some of the longest turnaround times in excess of an average overall arrival to clear time for all attendances of 39 minutes. In addition their compliance in using the HAS screen system to 'stop the clock' remains very poor.

Efforts continue across Merseyside to reduce the reliance upon the emergency ambulance service and where possible provide patients with an alternative to hospital attendance. However the growth in red calls for those with the most immediate life threatening or serious needs inevitably means that the impact of these and other initiatives is reduced.

CCGs continue to be provided with access to the new comprehensive turnaround performance reports and are encouraged to use this more 'granular' information to then seek to intervene locally with Trusts where performance gives rise to concern. A Merseyside workshop with providers and NWAS was held on the 1st February to further develop understanding and stimulate local action to resolve difficulties and practical bottlenecks and improve turnaround performance. Unfortunately not all Trusts were in attendance and local follow up action on a 1:1 basis is planned.

NWAS overall trajectories are in place to deliver the red (Cat A) 8 and 19 minute targets by year end, despite the slight reductions in performance during December. Delivery of the red 1 80% target for 2012/13 only remains a significant challenge, with the majority of ambulance services nationally experiencing significant difficulties. The NWAS cumulative position for red 1 calls at the end of December has fallen slightly to 74.8%.

December	**North West (%)**	**Merseyside (%)**
Red (Cat A) 8 mins 75% target	72.72%	77% (Mersey)
Red 1 (Cat A) 8 mins 80% target, end March 2013 (revised to 75% for 2013/14)	70.84%	72.42% (Cheshire & Mersey)
Red 2 (Cat A) 8 mins 75% target	72.91%	73.91% (Cheshire & Mersey)
Red (Cat A) 19 mins 95% target	94.1%	94.9% (Cheshire & Mersey)

NHS Merseyside - Actual activity compared to planned activity - Cumulative to January 2012 & January 2013 for General & Acute Specialties

PHS07	GP G&A Referrals for First Outpatient Appointment									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	61091	53643	-7448	-12%	54511	57337	2826	**5.2%**	3694	7%
Knowsley	38726	38605	-121	0%	39837	40920	1083	**2.7%**	2315	6%
Liverpool	98173	97835	-338	0%	100535	97871	-2664	**-2.6%**	36	0%
Sefton	55255	56979	1724	3%	56460	57699	1239	**2.2%**	720	1%

PHS08	Other Referrals for First G&A Outpatient Appointment									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	24491	30577	6086	25%	30514	32823	2309	**7.6%**	2246	7%
Knowsley	21204	20864	-340	-2%	20394	21378	984	**4.8%**	514	2%
Liverpool	83434	83631	197	0%	85485	77825	-7660	**-9.0%**	-5806	-7%
Sefton	34386	34718	332	1%	35056	35013	-43	**-0.1%**	295	1%

	All referrals for first G&A outpatient appointment									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	85582	84220	-1362	-2%	85025	90160	5135	**6.0%**	5940	7%
Knowsley	59930	59469	-461	-1%	60231	62298	2067	**3.4%**	2829	5%
Liverpool	181607	181466	-141	0%	186020	175696	-10324	**-5.5%**	-5770	-3%
Sefton	89641	91697	2056	2%	91516	92712	1196	**1.3%**	1015	1%

PHS10	All first G&A outpatient attendances									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	77626	78611	985	1%	78177	81167	2990	**3.8%**	2556	3%
Knowsley	55135	51263	-3872	-7%	51409	53747	2338	**4.5%**	2484	5%
Liverpool	169257	168154	-1103	-1%	170499	165054	-5445	**-3.2%**	-3100	-2%
Sefton	82254	79984	-2270	-3%	80146	82402	2256	**2.8%**	2418	3%

	Elective Ordinary G&A Admissions									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	7446	8534	1088	15%	8338	8723	385	**4.6%**	189	2%
Knowsley	4649	4333	-316	-7%	4252	4196	-56	**-1.3%**	-137	-3%
Liverpool	10952	11576	624	6%	11768	11153	-615	**-5.2%**	-423	-4%
Sefton	7452	7445	-7	0%	7361	7313	-48	**-0.7%**	-132	-2%

	Elective Daycase G&A Admissions									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	26132	28676	2544	10%	27755	31689	3934	**14.2%**	3013	11%
Knowsley	15918	15907	-11	0%	15551	17163	1612	**10.4%**	1256	8%
Liverpool	40609	43435	2826	7%	43232	46058	2826	**6.5%**	2623	6%
Sefton	29480	30883	1403	5%	30099	31944	1845	**6.1%**	1061	3%

	All Elective G&A Admissions									
	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	33578	37210	3632	11%	36093	40412	4319	**12.0%**	3202	9%
Knowsley	20567	20240	-327	-2%	19803	21359	1556	**7.9%**	1119	6%
Liverpool	51561	55011	3450	7%	55000	57211	2211	**4.0%**	2200	4%
Sefton	36932	38328	1396	4%	37460	39257	1797	**4.8%**	929	2%

	Non-Elective G&A Admissions									
PHS06	2011/12				2012/13				Growth 11/12 to 12/13	
PCT	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
Halton & St Helens	34042	34880	838	2%	34,537	36,103	1566	**4.5%**	1223	4%
Knowsley	19595	18229	-1366	-7%	18,463	18,937	474	**2.6%**	708	4%
Liverpool	48307	47900	-407	-1%	47,221	46,945	-276	**-0.6%**	-955	-2%
Sefton	28332	27955	-377	-1%	28,076	29,446	1370	**4.9%**	1491	5%

Data Sources

Plans - Vital Signs/IPM Submissions

Actuals - Monthly Activity Return

General & Acute - All specialties excluding well babies, obstetrics & psychiatry

General and Acute Activity Monitoring

These figures refer to the period April to January 2012

The period April to January contains no more working days in 2012/13 than it did in 2011/12.

GP G&A Written Referrals for a first outpatient appointment.

Overall, Merseyside saw a noticeable increase in referrals between September and November. This trend has continued into January, and has resulted in an increase in GP referrals between 2011/12 and 2012/13 of 2.7% (6,765 GP referrals); while in previous months there had been fewer than last year. This increase has also seen an over-performance against plan for 2012/13. Referrals for 2012/13 have increased in the past two months at 1% above plan (2,484 referrals), compared to around 2% below plan in previous months. This may warrant further investigation if it continues.

Sefton has seen an increase in year-to-date referrals in November, the organisation was below the 2012/13 plan in October. NHS Sefton are 2.2% (1,239 referrals) over plan, which shows an increase in over performance compared to November.

Other referrals for a first outpatient appointment

Other referrals are down on last year (1.6%, 2,751 referrals) across Merseyside. This figure has dropped steadily over the summer from the 0.79% increase shown at June, and a significant improvement from the May position which was 9% over the previous year's figures. The under-performance has shown a particular growth between October and November.

The Month 10 figures also show Merseyside is 2.6% under planned levels for 'Other' Referrals in the year to January.

It is worth noting that the increase seen in GP Referrals has not been reflected in Other Referrals which remain below plan.

When viewed in the context of total referrals ('GP' and 'Other' Referrals together) this equates to an overall increase of 1% (4,014 referrals) since last year, while referrals are below plan for 2012/13 by 0.5% (1,926 referrals). It is worth noting that this is the second month at which total referrals have fallen below last year's levels, and appears to be the result of falling referral levels during the year.

Sefton have previously shown a year-on-year increase in 'Other Referrals' (peaking at 13% in May), but have now fallen to 0.1% below plan after reducing consistently in previous months.

All first G&A outpatient attendances (G&A) Cumulative

In January, Merseyside shows a 1.2% (4,358) increase in attendances compared with same period in the previous year. There is also a 0.6% (2,139) over performance compared to plan.

The key drivers behind the over performance in these areas are:

- The additional COPD activity recorded for Liverpool Heart & Chest Hospital
- Additional activity associated with National Screening programmes
- Additional activity to support the achievement of 18 weeks in all Specialties

Elective Ordinary G&A Admissions

Elective ordinary G&A admissions for Merseyside are 1.1% (334 spells) under plan for the year and 1.6% down on the previous year. These are not a cause for concern, although have moved closer to plan since last month.

Elective Day Case Admissions

Elective Day Case Admissions for Merseyside are however, significantly over planned levels for 2012/13 by 8.8% (10,217 Day Cases) and 6.7% (7,953 Day Cases) on the same period of the previous year. Both comparisons are up noticeably on the reported positions from last month, although this represents a return to the trend seen in previous months, and the comparison with 11/12 continues its downward trajectory from April.

When combining day case and ordinary elective admissions, all PCTs show an over-performance against plan and all have shown an increase of between 1-2% since last month. Again, this is a return to the levels of performance seen in the August report.

In all cases there is evidence of an increase in the day case rate greater than that which was planned for.

The key drivers behind the over performance are:

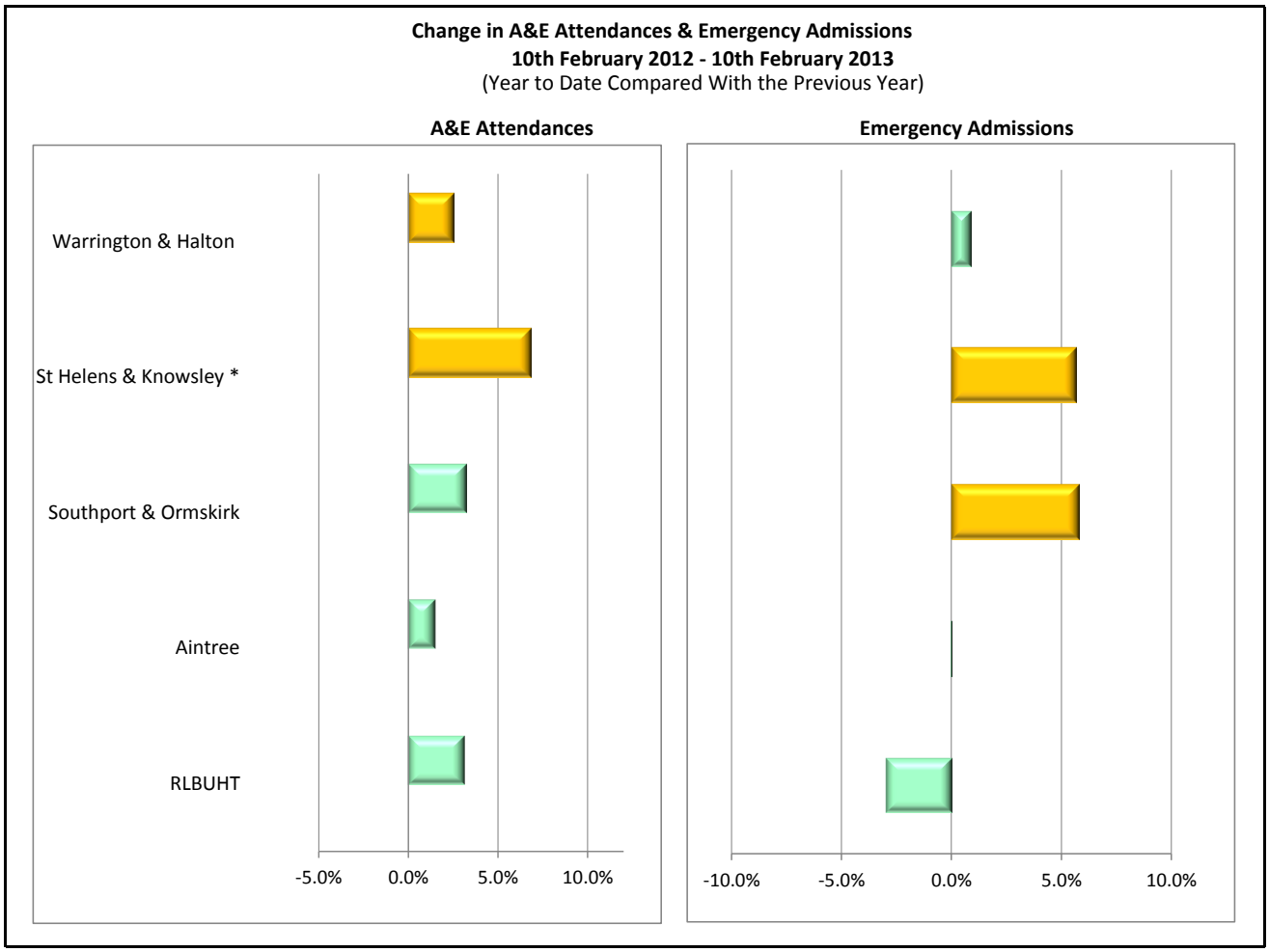
- Additional activity associated with National Screening programmes
- Additional activity to support the achievement of 18 weeks in all Specialties
- Appropriate shifts from Elective Admissions to Day Case procedures for specific surgical procedures. This is reflected in increasing Day Case rates for the BADs Basket of Procedures which is a positive improvement in service delivery.

Activity is levelling out as expected as the year progresses.

Non-Elective G&A Admissions

Merseyside is currently 1.7% over plan for the year to January and 1.3% over the activity levels for Non-Electives in the same period last year. Both comparisons show an increase compared to last month, and reflect a consistent trend this year.

This is being driven primarily by an increase in Non-Elective activity in the Sefton and Halton & St Helens localities. In Sefton, this relates primarily to activity at Southport & Ormskirk Hospital Trust where there is a 5.8% increase in spells, there was a particularly high number of spells in May. Work is on-going with the Trust to understand the Non-Elective/Urgent Care pressures currently being experienced, and the scale of the over-performance is diminishing.



	A&E Attendances						Emergency admissions (A&E and other)					
	Latest week	1 year previously	% change	YTD 2012/13	YTD 2011/12	% change	Latest week	1 year previously	% change	YTD 2012/13	YTD 2011/12	% change
RLBUHT	2092	1894	10.5%	89953	87269	3.1%	766	753	1.7%	32765	33779	-3.0%
Aintree	1686	1597	5.6%	73620	72552	1.5%	559	618	-9.5%	27409	27420	0.0%
Southport & Ormskirk	1859	1860	-0.1%	84699	82080	3.2%	586	549	6.7%	24615	23268	5.8%
St Helens & Knowsley *	1866	1721	8.4%	82768	77487	6.8%	865	838	3.2%	38725	36656	5.6%
Warrington & Halton	2021	1834	10.2%	87863	85702	2.5%	686	685	-0.1%	30904	30643	0.9%

Source: NHS Northwest
* Includes 'type' 3 attendances and is not directly comparable with the previous year

A&E Attendances & Emergency Admissions

This activity covers the period 1st April to 10th February:

All providers have had more A&E attendances in 2012/13 than they had in 2011/12 (to date).

Aintree, Royal Liverpool and Warrington have each seen a slight increase on 2011/12 (between 1.5% and 3.1%).

Southport & Ormskirk are 3.2% over last year; which represents a decrease compared to last month. Emergency admissions have grown over the same period.

St Helens & Knowsley however have had 5,281 (6.8%) more A&E attendances this year, this increase has fed a similar increase in emergency admissions (5.6%). The situations with both A&E attendances and emergency admissions have worsened in the past three months.

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/38	**Author of the Paper:** Tracy Jeffes Head of Delivery tracy.jeffes@sefton.nhs.uk

Title:

Everyone Counts

Summary of the Paper/Key Issues:

This paper presents the Governing Body with an update in relation to the planning document 'Everybody Counts', the content of which the Governing Body have developed during previous development sessions.

Action/Decision Required:

The Governing Body is asked to note the approve of this report.

Date of Report:

14 March 2013

13/38

NHS

South Sefton Clinical Commissioning Group

Everyone Counts

Planning for Patients in South Sefton 2013-2014

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1.0 Introduction

NHS South Sefton Clinical Commissioning Group (SSCCG) brings together 34 doctor's surgeries. It has four distinct geographical localities - Crosby up to Hightown in the north, Bootle in the south, Seaforth and Litherland in the centre and Maghull to the east. From April 2013, it is fully responsible for planning and buying or 'commissioning' the majority of local health services for its 155,500 patients. Its Governing Body is made up of local doctors, nurses, practice staff and lay people, who are well placed to know the health needs and views of people living in the area, and who will lead and be accountable for the work SSCCG carries out.

This plan sets out an ambitious programme to ensure that health and health services in south Sefton continue to improve in the future, amidst an increasingly complex and challenging social and economic environment. SSCCG has a budget of £240m in 2013-2014 and will need to work innovatively and even closer with its partners if it is to make improvements. So, this plan also reflects the progress SSCCG has made in developing working relationships with its partners since coming into being - with organisations and groups including Sefton Council, hospitals, local people and voluntary, community and faith organisations.

Over the past 18 months, SSCCG has played an active role in local commissioning and operated in shadow form from April 2012 to being awarded statutory body status effective from April 2013, as part of the changes to the NHS. Its work during this period has informed the priorities detailed in this operational plan for 2013-2014.

SSCCG's plans for the year ahead build on what we already know about health and wellbeing in south Sefton – identified through mapping, analysis, research and evidence, Sefton's joint strategic needs assessment, called the Sefton Strategic Needs Assessment (SSNA), and involving and informing the people who live in the area – and which also responds to the goals set out in the following:

- Everyone counts – planning for patients 2013-2014
- NHS Outcomes Framework
- NHS Constitution
- Strong financial management and good progress against our local plans as part of the national Quality, Innovation, Productivity and Prevention (QIPP) programme

1.1 Our vision and values

Our vision and values clearly set out what we want to achieve for everyone who lives in south Sefton. They embody our commitment to our local and statutory duties, and most importantly, our local people.

Our vision

We want to work with the local community and other partners, to improve the health and healthcare of everyone living in south Sefton, spending money wisely, and supporting clinicians to do the best job they can.

Our values

- Stay local and work in partnership
- Be transparent, open and honest
- Be approachable and accessible
- Show integrity – say what we mean and do what we say
- Be focused on what we want to achieve – prioritise what we do

Our aims

To work collaboratively to:

- Reduce health inequalities
- Improve quality of care
- Be patient - centred and put communities at heart of what we do – support them and their wider needs
- Deliver value for money – ensure efficiency
- Ensure sound governance
- Make a difference, do things differently - do good

1.2 How we developed our plan

We shaped our plans around the effectiveness of current services, the views and experiences of the people living locally and the national standards that we aim to achieve. This section describes these considerations in more detail. Appendix 1 sets out how we have involved and informed our partners about our strategy for delivery in 2013-2014.

Health in south Sefton

Significant inequalities in health remain between different parts of south Sefton. Life expectancy for men is 76 years and for women it is nearly 82 years – this is almost 2.5 years less than the national average for men and almost 1 year less for women. Overall, the difference in life expectancy between the most and least deprived wards of south Sefton is over 10 years. This 'gap' in life expectancy and high levels of ill health amongst some south Sefton residents is strongly linked to lifestyle choices such as smoking, alcohol, obesity and mental wellbeing.

There is a strong history of commissioning against the priorities set out in Sefton's first two joint strategic needs assessments (JSNAs). The latest refresh of the JSNA in 2012 was carried out by SSCCG and Sefton Council and the results have formed the basis of the Health and Wellbeing Strategy (HWBS) – which is in turn shaping priorities for both organisations.

The strategic objectives of the HWBS are:

- Ensure all children have a positive start in life
- Support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- Support older people and those with long term conditions and disabilities to remain independent in their own homes
- Promote positive mental wellbeing
- Seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- Build capacity and resilience to empower and strengthen communities

Listening to local people

In all our discussions with south Sefton residents over the past few years, some clear and consistent themes have emerged about what they want for their health and from their health services. Our plans for 2013-2014 reflect these themes and priorities:

- More care closer to home rather than in hospital
- Better integrated care – so, the many different health services to work better together, to make people's care and treatment easier
- More choice and involvement for people in their care and treatment
- Continued focus on programmes and services that prevent ill health, and that promote independent living
- Improve access to drug and mental health services
- Support for the most vulnerable and excluded people in our communities
- For people's views to be listened to, particularly those who find it difficult to voice their opinions

Priorities across the NHS

There is a clear mandate for NHS commissioners to achieve more. Our plans take account of this mandate and focus our work on the standards set out in the NHS Constitution and the NHS Outcomes Framework:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

In working towards achieving the goals set out in this plan, we will:

- Guarantee that no community is left behind or disadvantaged
- Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients
- Treat patients as respectfully and put their interests first
- Transform NHS services to enable patients to take more control and make informed choices if they want to

2.0 Improving Outcomes, Reducing Inequalities

2.1 Overview of our plans for 2013-2014 – Plan on a Page

Our 'Plan on a page' summarises our key areas of delivery in 2013 – 2014 in the context of our vision, our corporate aims, the joint health and wellbeing strategic objectives and linked to the achievement of progress against the NHS Outcomes framework and delivery of the rights enshrined within the NHS Constitution.

South Sefton CCG – Plan on a page

South Sefton CCG Our vision: We want to work with the local community & other partners, to improve the health and healthcare of everyone living in south Sefton, spending money wisely, & supporting clinicians to do the best job they can

Context	Strategic	System	Enabling Themes	Programmes	Transformational Change	Improving Outcomes	NHS Outcome Framework
Growing elderly population Inequalities of health care Improving quality of Life	**Corporate Objectives** Consolidate robust CCG strategic plan within financial envelope Maintain systems to ensure quality and safety of patient care Deliver through establishment of PMO approach to CCG programmes Ensure C&M CSU deliver successful support to the CCG Sustain engagement of CCG members, partners and stakeholders Drive clinical leadership development through Governing body, locality and wider constituency	Optimising use of Secondary Care Driving Improvement in Health & Wellbeing	Patient & Public Engagement	Unplanned Virtual Ward	• Pro active case management • Reviewing patient pathways with Aintree for emergency patients • Support of the Community Geriatrician • Supporting Nursing and Care homes • Evaluation of Out of Hours service and 111 • Risk stratification / Pro active case management • Investment in Community services • Health care acquired infections • Roll out of Virtual Ward	• Reduce emergency admissions to secondary care • Reduce Follow Up Appointments • Reduce Readmissions • Redesigned community services to reduce hospital attendances and manage care more effectively in a community setting • Increased independence of the frail & old • Reduction in avoidable admissions • Increased integration • Reduce non elective admissions over 65's – 5% '13/14, 20% by '16/17	**QUALITY PREMIUMS** Reducing potential years of life lost through amenable mortality Reducing avoidable emergency admissions Improving patients experience of hospital services – Ensuring roll out of Friends & Family test Preventing healthcare associated infections
			The Francis Report	Long Term Conditions	• Primary Care LES primary care to improve diagnosis management of Atrial Fibrillation • Vascular Health Checks • Further investment in community respiratory services • Primary care risk stratification	• Reduced admissions with LTC as primary diagnosis • Person centred, integrated primary care provision • Reduction under 75 mortality rates • Earlier diagnosis of respiratory illness	
			Any Qualified Provider	Diabetes	• Performance management of IGR diabetes prevention pathway with Public Health • Benchmark practices against treatment targets and offer additional support to those not achieving. • Review training of staff in primary care in relation to diabetes • Ensure patients receive foot care/screening • Review multi-professional input into care homes	• Decreased numbers of unnecessary emergency admissions • Increase numbers of nine processes being recorded • Increased numbers of people being referred to Healthy Lifestyle services	
			Programme Management Office CQUINs	Mental Health	• Achievement of Care Programme Approach (CPA) follow up target. • Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%. • Increase Dementia detection. including care home staff liaison (51% to 75% by 2015/16) • Refresh Sefton Dementia strategy • Locality approach via psycho-geriatrician service • Adoption of quality of life principles, safe models of care	• Improved integration across services • Appropriate, timely support received by patients • Improved early intervention, including increased access to Memory Assessment Services • Ensuring patients are safe and receive safe, effective care • Improved support services for carers • Improved diagnosis rates • Increased home based assessments	
Care closer to home Safe Care Financial Challenge Winter Pressures	**Health and Wellbeing Board Objectives** Promote positive mental health & wellbeing Build capacity & resilience to empower & strengthen communities Support Older People & those with long term conditions & disabilities to remain independent in own homes Support people early to prevent and treat avoidable illnesses and reduce health inequalities Seek to address social & economic issues which contribute to poor H&WB Ensure all children have positive start in life	Improving Quality of Primary Care and Delivery of Community Services Ensuring Cost Effective ness in High Quality Tertiary Care	Information Management Technology Innovation	Children's	• Review ADHD services • Review of Children's Equipment Services • Review pilot of Community Children's nursing team • Collaborative working with NCB/LA re: Health visitor and school health national implementation plans • Review the Health economy recommendations which result from the Youth offending service inspection	• Improved integration of services, including transition to Adult services • Reducing emergency admissions and EG Asthma • Reduced length of stay • Early identification of families in need of support to promote the safeguarding of Children & Young People	**LOCAL PRIORITIES** Reduce COPD admissions through A&E at Aintree Hospital Reduction in prescribing for three high risk antibiotics 1.Quinolones 2.Co-amoxiclav 3. Cephalosproins Reduce the number of GP referred patients (during normal working hours) who receive an AED assessment before being admitted into Aintree Hospital care
			Value for Money through Finance and Contracting	Planned	• Implement Community Ophthalmology Schemes • Better Care Better Value benchmark indicators to support improved performance • Any Qualified Provider procurements podiatry, audiology and MSK • Promote use of dyspepsia pathway • Commission Gynaecology community service pilot	• Patients receive care in the most appropriate setting and to improve the quality and experience of care for patients. • Reduced referrals to Secondary care	
			Quality of Care	Prevention	• Develop CQUIN increase breastfeeding rates • Develop an obesity strategy and clarify obesity treatment pathway. • Commission Alcohol Liaison Service at Aintree University Hospital • Build capacity to facilitate the provision of Identification and Brief Advice(IBA) across ranges settings	• Better Maternal Health / Early years health • Reduce rate of alcohol related hospital admissions • Reduce length of stay linked to alcohol related hospital admissions • Increased skills/knowledge of Primary Care & key stakeholders to identify those at risk of alcohol or drug dependency • Reduced Obesity levels	
			Sustainable Change Promotion of Self Care	Cancer	• Compliance with cancer waits 31 and 62 day targets • Peer review compliance • Cancer CQUIN incentivise 14 day key diagnostics pathway • Optimise performance- Cancer referral 14 days • Support to GPs via Cancer Network NAEDI project • Review CAB service for patients • Undertake needs assessment for psychological support services /physical activity programmes	• Ensure appropriate, timely Cancer treatment for our patients • Improved survival rates through early detection • Cancer Survivorship – improved support for people and families affected by cancer	
	CCG/ LA Joint Priorities Children & Young People Adults Public Health		Sefton Needs Assessment	End of Life	• Develop End of life strategy • Hospice at Home • End of Life facilitator	• To increase the number of people at end of life dying in their normal place of residence. + 1%	
			Clinical, Community, 3rd Sector collaboration	Primary Care Quality	• Develop Primary Care strategy • Support improvements using the Quality Premium	• Improved quality, capability and productivity, and capacity of Primary care services	
				Medicine Management	• Role out Optimisation plan across GP • Patient education to reduce waste	• Improved assurance that medicines are safe, appropriate, clinically effective and value for money	
Everyone Counts	**Fundamentals of Care**	**Patients' Rights: The NHS Constitution**			**Patient Centred, Customer Focused**	**Transformation of Health and Social Care at CCG Level**	**Financial Planning**

2.2 Priority Programmes - Programme Management Approach

Our Plan on a Page also highlights key programmes of work. To achieve our longer term strategy, we have identified actions that will enable us to secure the required progress we need to make in 2013-14. We have developed an internal Programme Management capability, supported by a Programme Management Office function, which we commission from Cheshire and Merseyside Commissioning Support Unit (CMCSU) to drive this work forward.

We have identified a lead clinician / Board member and a lead manager for each of our key programmes of work who are developing detailed implementation plans. A list of leads can be found in Appendix 2. These leads have worked in conjunction with key stakeholders, across the NHS, Sefton Council, and the voluntary sector and with local people, as appropriate to develop their plans. This includes an increasing emphasis on clinician to clinician discussion around the key priority areas, both across primary and secondary care, but also with the four SSCCG localities, where discussions are led by Locality GP Chairs. Each programme has a clear link to the transformation change required across the wider health system and to achieving the outcomes required for our population.

The following pages provide more detailed on each of the key programme areas:

- Unplanned Care
- Virtual Ward
- Long Term Conditions including, Chronic Obstructive Pulmonary Disease (COPD), Cardiovascular Disease (CVD)
- Diabetes
- Mental Health, Dementia and Learning Disabilities (LD)
- Children
- Planned Care
- Prevention – Obesity, Alcohol and Maternal Health
- Cancer
- End of Life
- Primary Care Development
- Medicines Management

Priority Area : Unplanned Care Clinical Lead: Dr Andy Mimnagh

OBJECTIVE
To redesign community services to reduce hospital attendances and manage care more effectively in a community setting. (Domain 1,3,4,5)

WHY CHANGE IS NEEDED?
There is an increase in pressure on emergency services due to the increasing elderly population. The CCG need to develop measures to support patients in their homes and the community to manage their condition. The current community and primary care services do not have adequate capacity to support the needs of these patients

DESCRIPTION
The Virtual Ward development. (see Priority area) Reviewing patient pathways with Aintree for emergency patients Support of the Community Geriatrician Supporting Nursing and Care homes Pro active case management Risk stratification Investment in Community services

KEY MILESTONES	Q1	Q2	Q3	Q4
Liaising with Aintree to review emergency pathway				
Geriatrician to support nursing homes				
Virtual ward implementation				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Non Elective admissions for Ambulatory Care Sensitive conditions				
Non elective admissions				
A&E attendances converted to non elective admission rates				

RISKS	MITIGATING ACTIONS
Primary care not engaging in virtual ward	Support and education during launch
Delay in implementing new pathways (financial risk as no reduction in admissions)	Recognise pace of change during 13/14 contract round and plan accordingly
Resistance to new ways of working	Project management, support to staff, regular briefings

WORKFORCE IMPLICATIONS
Training for staff in community settings to support new ways of working Closer working with other agencies (Local Authority and third sector) to deliver effective care

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Virtual Ward Clinical Lead: Dr Peter Chamberlain

OBJECTIVE

The goal of the Virtual Wards is to maintain happy independence for frail and old people. This will be achieved through a strategic and operational vision via the development of a community based comprehensive admission avoidance system. (Domains 1,2,3,4,5)

WHY CHANGE IS NEEDED?

The Challenge:
Our health care system is facing the challenge of an increasingly frail, elderly and complex population. We work within a fragmented health and social care system and spend the vast majority of health care on high acute care costs. The current financial environment means that any solution must be innovative, efficient and effective.

DESCRIPTION

There are key aspects which will need to be in place to enable this vision:

- Integration - Holistic integrated health and social care system at the community level.
- Long Term Conditions - Improve secondary disease prevention
- Information Technology - Empowering clinicians, facilitating communication & rapid patient flow.
- Self-Care Approach - Empowering patients, families and carers.

A patient can be referred by the General Practitioner (GP), intermediate care and acute trust via a Single Point of Access. Patients may also be referred following identification after risk stratification and acute trust in-reach.

KEY MILESTONES	Q1	Q2	Q3	Q4
Evaluation of primary implementation site - March 2013				
Roll out of reablement & urgent care team across patch June 2013				
Roll out of full-integrated IT system January 2014				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduce trust non-elective admissions for over 65s (*On Full roll out 2016/17)	20%	5%	10%	15%
Reduce trust medical outpatients for over 65s (*On Full roll out 2016/17)	3%	0%	1%	2%
Reduce A&E attendances for over 65s (*On Full roll out 2016/17)	15%	2%	5%	10%
Patient satisfaction EQ5D (e.g. ability to self-care, activities of daily living)				

RISKS	MITIGATING ACTIONS
Engagement of multiple stakeholders – including external bodies.	Virtual Ward Steering group and programme management
Lack of numbers of patients to make project financially viable	GP engagement, Information sharing, risk stratification.

WORKFORCE IMPLICATIONS

A shift from 'silo' working to bringing the primary health care team back in a form relevant to the 21st century we are establishing once again that 'team' is the best way to provide care. Working collaboratively as a unit, the professionals will be joined by a common referral pathway, weekly multi-disciplinary team meeting or 'virtual ward round' and a common case record.

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		21% of investment
2014/15		21% of investment
2015/16		21% of investment
Total		£2.7 million (64% of investment)

Priority Area : Long Term Conditions Lead Clinician:Dr Steve Fraser / Dr Craig Gillespie

OBJECTIVE
South Sefton's population is growing increasingly older, this creates pressures on Health and Social care. The CCG's objective is to manage long term conditions in as cost effective way as possible using integrated care methodologies to include self care and care closer to home to reduce the reliance on secondary care (Domain 1,2 & 4)

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduce under 75 mortality rates for CVD and respiratory disease	1%	0%	0.5	1%
CHD actual v predicted data	2%	0.5%	1%	2%
Reduce alcohol related admissions	2%	0.5%	1%	2%

WHY CHANGE IS NEEDED?
Increasing numbers of frail elderly patients with one or more co-morbidities will place increasing pressures on health and social services. This needs to be planned for now by reviewing services to ensure that patients have access to services that ensure early support to prevent acute episodes related to their chronic condition and they are educated to manage their condition.

RISKS	MITIGATING ACTIONS
Poor take up of vascular health checks	Monitor uptake, focus within locality groups, feedback on schemes for future developments
Poor provider performance in reducing admissions for respiratory conditions	Contract monitoring and clinical performance discussions

DESCRIPTION
Local enhanced service in primary care to diagnose and manage Atrial Fibrillation Vascular Health Checks Alcohol Nurse in A&E Increased investment in community respiratory services Development of the virtual ward and case management Primary care risk stratification

WORKFORCE IMPLICATIONS
Impact on primary care with multiple LES schemes Peer support may identify changes with workforce implications

KEY MILESTONES	Q1	Q2	Q3	Q4
Virtual Ward implementation				
Alcohol nurse in A&E				
Community Respiratory service				

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total	N/a	N/a

NHS
South Sefton Clinical Commissioning Group

Priority Area : Diabetes **Lead Clinician: Dr Nigel Taylor**

OBJECTIVE

Prevent or delay the onset of diabetes.
Improves the recording of the nine care processes for people with diabetes
Increase the number of people who access education for Type 1&2 diabetes (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?

There is now an increasingly aging population in Sefton. Compared to ten years ago (1998), Sefton's population now has fewer under 45s and more people aged 45+ (particularly 45-64). This is important in relation to diabetes prevalence as Type 2 Diabetes tends to present in middle-aged and older age groups (although it is becoming more common in younger overweight people). Sefton's population is estimated to plateau to around 272,500 in the next 20 years with the number and percentage of over 65s continuing to increase. Older people account for the majority of both hospital admissions and long term conditions.
The number of people in Sefton likely to have Diabetes is about is 13,783, or 4.94% of the total population. Sefton's prevalence of diabetes has risen over the last 4 years by around 500-600 patients each year. The number of people with diabetes in Sefton is predicted to rise by 42% to nearly 20,000 in the next twenty years. This equates to around 300 new patients per year. In Sefton, 42,102 people are estimated to have IGR (borderline diabetes). 70% of diabetes is thought to be preventable and obesity is thee key modifiable risk factor.
Between April 2008 to March 2009, there were 23 day case or elective Hospital admissions with Diabetes as a Primary Diagnosis across the four hospital trusts. Between April 2008 to March 2009, there were 125 emergency admissions with a primary diagnosis of Diabetes .
The average length of hospital stay (days) for day case, elective and non-elective admissions with a primary diagnosis of Diabetes = 493.
HbA1c is a marker of long-term control of diabetes. Better control leads to fewer complications in both insulin-dependent and non-insulin dependent patients with diabetes

DESCRIPTION

- Performance management of IGR diabetes prevention pathway (activity to include annual review, patient education and weight management) – work with public health
- Explore the benefits of commissioning education for patients with established diabetes
- Improve recording of all nine care processes using the diabetes dashboard
- Benchmark practices against treatment targets (HbA1c, blood pressure, cholesterol) and offer additional support to those not achieving.
- Review training needs of staff in primary care in relation to diabetes
- Ensure patients receive foot care/screening as agreed within Nice Guidance the foot care pathway as agreed by North Mersey Network Group
- Review multi-professional input into care homes for residents with diabetes
- Explore the potential working with intermediate care to increase care closer to home.
- Work with secondary care to understand diabetic patients flow through improved coding of data
- Ensure that patients are discharged as appropriate from secondary care to be managed in a primary/community setting
- Encourage healthy lifestyles in particular to reducing obesity levels

KEY MILESTONES	Q1	Q2	Q3	Q4
Increase recording of the nine processes				
Review training needs				
Launch Merseyside IGR pathway, managing overweight / obese patients with high blood sugar				
Develop an integrated pathway and monitor impact on emergency attendances/admission				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Decreased numbers of unnecessary emergency admissions				
Increase numbers of nine processes being recorded				
Increased numbers of people being referred to Healthy Lifestyle services				

RISKS	MITIGATING ACTIONS
Funding	
Lack of capacity within GP practices	
Educational issues	

WORKFORCE IMPLICATIONS

None at this time

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Mental Health Lead Clinician: Dr Ricky Sinha

OBJECTIVE
Achievement of Care Programme Approach (CPA) follow up target. Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%. Increase the proportion of people with depression/anxiety entering treatment . (Domain 4)

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Mental Health Measure - CPA	95%	95%		
Mental Health Measure - IAPT	9%	9%		

WHY CHANGE IS NEEDED?
High incidence of mental health across the borough . The challenge of matching the mental health needs of an ageing population with reducing resources.

RISKS	MITIGATING ACTIONS

DESCRIPTION
Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period. IAPT: The plan is to employ IAPT Wave 5 trainees, that are currently employed on temporary contracts as permanent staff post qualification, and to participate in Wave 6 of the roll out to achieve DH objectives of meeting 15% prevalence with recovery rates of 50% by 2014/15.

WORKFORCE IMPLICATIONS

KEY MILESTONES	Q1	Q2	Q3	Q4
Increase in number of people who receive psychological therapies	532	541	557	560

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	235,364	
2014/15		
2015/16		
Total		

Priority Area : Dementia Lead Clinician: Dr Ricky Sinha

OBJECTIVE
Refresh of the Sefton Dementia Strategy in line with recent policy changes including the targets in the Prime Ministers Dementia Challenge. Enhancing quality of life for people with dementia. (Domain 2)

WHY CHANGE IS NEEDED?
Increase in the numbers of people with dementia. Increase in Sefton's ageing population. Need to increase appropriate early referral to Memory Assessment Services. Need to improve access to support services for people with dementia and their carers / family.

DESCRIPTION
Case finding / diagnosis rates to increase from 51% to 75% by 2015/16 in line with GMS Contractual Changes 2013/14 – Enhanced service for Dementia Case Finding (6th December 2012) Facilitate further locality based approach of the psycho-geriatrician service. Improving public and professional awareness / understanding of dementia and impact on peoples lives. Facilitate appropriate support for patients, families and carers through co-ordination of VCF Sector.

KEY MILESTONES	Q1	Q2	Q3	Q4
Develop GP dementia screening tool				
Increased referrals to memory assessment service				
Increase in memory assessments in persons home				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Increase in diagnosis rates	75%	64%	69%	75%
Increase in prescribing of Cholinesterase Inhibitors				
Decrease in anti-psychotic prescriptions				

RISKS	MITIGATING ACTIONS
Lack of GP uptake in enhanced service for dementia case finding	Proactive clinical leadership and support
Capacity of psycho-geriatrician's may have resource implications	

WORKFORCE IMPLICATIONS
Enhance skill set of primary care workers in relation to dementia through appropriate training support.

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Learning Disabilities Lead Clinician: Dr Ricky Sinha

OBJECTIVE
Ensure effective and safe models of care for people with learning disabilities (Domain 5, 2 ,4) Commission annual health checks Quality of Life principles should be adopted in all health and social care contracts to drive up standards. (Domain 1)

WHY CHANGE IS NEEDED?
Response to the Transforming Care: local response to Winterbourne View Hospital and Francis Report that ensures people with learning disabilities , autism, a mental health condition or challenging behaviour are safe and well looked after for NHS funded care.

DESCRIPTION
Joint working with Sefton Council to ensure any placements outside Sefton will be monitored to ensure good pathways for discharge. Contracts will be used to hold providers to account for the quality and safety of the services they provide. The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities .

KEY MILESTONES	Q1	Q2	Q3	Q4
Local register of people with challenging behaviour for NHS funded care.				
Contract monitoring and reviews to drive up standards of care.				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Learning Disability Health Self Assessment Framework	Yearly			
Winterbourne View local response	1st April 2013	Action plan		
Annual Health Checks	Yearly			

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	£60,000 for Annual Health Checks	
2014/15	Possibly NCB investment	
2015/16		
Total		

Priority Area : Children's **Lead Clinician: Dr Wendy Hewitt**

OBJECTIVE
Children's Community Nursing Team Admission avoidance and facilitating early discharge for children and young people within South Sefton. Improve care pathways through joint working between primary and secondary care providers. Improve access to acute care which can be provided closer to home (Domain 1,2,3,4,5)

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Reduced emergency readmissions	N/a	No actual targets set for pilot, aim to see a reduction against expected activity levels CCNT activity aims to reduce PBR activity/income to meet service costs, therefore cost neutral		
Reduced A&E attendances at point of primary care	N/a			
Reduced length of stay	N/a			

WHY CHANGE IS NEEDED?
Children's community nursing teams support the range of needs from complex needs, chronic ill health, long term conditions and also acute illness. This includes supporting discharge from hospital and early assessment and treatment of children to support families to stay at home where possible. Whilst South Sefton has a complex needs nursing team who support known children on a planned care basis, there is limited capacity within the Alder Hey service to support the acutely ill child within the community.

RISKS	MITIGATING ACTIONS
CCG do not implement /fund service at end of pilot in 2013/14	Exit strategy agreed with providers.

DESCRIPTION
Developing Children's Community Nursing Team for South Sefton with Alder Hey Paediatric Service. 18 month pilot to assess the benefits in increasing acute care available outside of hospital settings. Also working in conjunction with Clare House on the End of Life project. Alder Hey pilot commenced April 2012 with extended funding from QIPP for 6 months 2013/14

WORKFORCE IMPLICATIONS
Nursing team funded via QIPP monies during pilot – 3.5 WTE to cover the Alder Hey patient flow footprint. South Sefton constitutes approx. 20% of this activity. The pilot is part of the Alder Hey Transformation Programme with an expectation from commissioners of reconfiguration of staff resources from inpatient to community team using QIPP principles.

KEY MILESTONES	Q1	Q2	Q3	Q4
Service review 12mth report to CCG				
Full service evaluation including evaluation of pathway redesign				
Service reviews to ensure readiness for winter pressures				
Full service evaluation of Clare House EOL project working in conjunction with local CCNTs				

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	PYE 85k – QIPP funding	
2014/15		
2015/16		
Total		

NHS
South Sefton Clinical Commissioning Group

Priority Area : Children's **Lead Clinician: Dr Wendy Hewitt**

OBJECTIVE
Improve outcomes for children through integrated commissioning and service delivery (Domain 1,2,3,4,5)

WHY CHANGE IS NEEDED?
1. Alder Hey are not providing the same support in South Sefton as exists in North Sefton from LCH 2. Service restructured to improve access and outcomes on previous poor performance 3. ADHD has no agreed multi-disciplinary pathway – works on historic practice 4. Demand for children's equipment has significantly increased

DESCRIPTION
Review community nursing support for children with complex needs in South Sefton Implementation of new T3 CAMHS specification Review of ADHD services Review children's equipment arrangements

KEY MILESTONES	Q1	Q2	Q3	Q4
Implementation of new T3 CAMHS specification				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
1. tbc				
2. KPIs in service spec				
3. Implementation of agreed pathway and KPIs				

RISKS	MITIGATING ACTIONS
LA could withdraw CAMHS funding	New steering group in place with performance framework that currently has robust clinical involvement and LA support

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Planned Care **Lead Clinician: Dr Peter Chamberlain**

OBJECTIVE
To ensure that patients receive care in the most appropriate setting and to improve the quality and experience of care for patients. (Domains 1,3,4,5)

WHY CHANGE IS NEEDED?
We know there are opportunities to change the way care is delivered for a number of clinical services, some of which will see care delivered in a community setting. This will improve the patients experience through offering more timely access and convenient locations.

DESCRIPTION
Implement Community Ophthalmology Schemes Ensure that key Better Care Better Value benchmark indicators are implemented where performance has declined Any Qualified Provider procurements podiatry, audiology and MSK Promote use of dyspepsia pathway Ensure the pilot Gynaecology community service is commissioned to reduce demand on secondary care

KEY MILESTONES	Q1	Q2	Q3	Q4
Community Ophthalmology Scheme launch				
Dyspepsia Pathway Promotion				
Make the community Gynaecology service recurrent				

WORKFORCE IMPLICATIONS
Training requirements for Community Optometrists wishing to participate in scheme. If significant shifts between providers for AQP / MSK may have workforce implications for current main provider.

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Ophthalmology first outpatient referrals (all providers inc Independent) and follow up rates				
Number of gastroscopies performed at UHA				
BCBV indicators, new to follow up, referrals				
Number of referrals to the Women's hospital				

RISKS	MITIGATING ACTIONS
Community Ophthalmology Scheme not fully utilised (financial risk) / Dyspepsia pathway not adhered to	Ownership of any changes by local GPs New model must demonstrate improved quality and experience for patients
Practices do not refer to the community services	Communication and monitoring referrals
Failure to deliver BCBV indicators (referral rates, follow ups and consultant to consultant) (Financial risk)	Performance management of rates, early discussion if performance slips with plan to bring performance back to trajectory

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Alcohol Lead Clinician: Dr Sunil Sapre

OBJECTIVE
To slow down the current rate of south Sefton resident alcohol related hospital admissions To increase the capacity and skills of AUHFT staff to provide screening and brief intervention support to increasing and higher risk drinkers (Domain 1,2,3,4)

WHY CHANGE IS NEEDED?
Alcohol related admissions is in the upper quintile in this CCG. In Sefton, approximately 1 in 4 men and over 1 in 7 women drink at increasing or higher risk levels. This is similar to regional average. Higher risk drinking is more common amongst males.

DESCRIPTION
In partnership with Liverpool CCG and Knowsley CCG jointly commission and performance manage the Hospital Alcohol Liaison Service at Aintree University Hospital Build capacity and skills to facilitate the provision of Identification and Brief Advice(IBA) across all staff at AUHFT Sefton council is currently commissioning an integrated substance misuse service. We will work with them to ensure the service is responsive to the needs of South Sefton residents and is integrated (via appropriate pathways) with CCG commissioned services.

KEY MILESTONES	Q1	Q2	Q3	Q4
To be agreed				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Achieve reductions in the projected rate of increasing AF1 alcohol specific admissions at AUH through increased nurse discharges	5%	5%	5%	5%
Achieve increases in bed days saved as a result of AF1 admissions, reducing length of stay	- 5% LOS	-5%	-5%	-5%

RISKS	MITIGATING ACTIONS
The funding of this service is reliant on 3 separate CCGs	Negotiate with Knowsley & Liverpool CCGs re continued investment in the service
Sefton MBC is tendering for a new integrated substance misuse provider - possible implications for current pathways	Ensure through performance meetings ongoing clarity re pathways and service functions

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	36,000	263,000
2014/15	38,000	276,000
2015/16	40,000	290,000
Total	114,000	829,000

Priority Area: Obesity **Lead Clinician: Dr Steve Fraser**

OBJECTIVE
Develop an obesity strategy and clarify obesity treatment pathway. (Domain 1,2,4,5)

WHY CHANGE IS NEEDED?
Nearly half of the adult population are overweight, obese or very obese (108,000 adults). A quarter of 5 year olds and more than a third of our 11 year olds are now overweight or obese.

DESCRIPTION
Develop an obesity strategy that links the current weight management programme with BMI screening, public health interventions and opportunities provided by Sefton Council and other voluntary sector organisations Work with public health to ensure that prevention based interventions/programmes are part of clinical interventions for patients (adults and children) who are overweight or obese Clarify the referral criteria and treatment pathway for bariatric surgery

KEY MILESTONES	Q1	Q2	Q3	Q4
Sefton wide obesity strategy agreed				
Every contact counts implemented				
Review bariatric surgery pathway				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16

RISKS	MITIGATING ACTIONS
Funding only ring fenced for 2 years	Value for money evidenced

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Maternal Health Lead Clinician: Dr Steve Fraser

OBJECTIVE
Increase initiation and continuation rates for breastfeeding (Domain 1,2,3,4)

WHY CHANGE IS NEEDED?
Sefton rates, although the highest in North Mersey are below the regional and national average. Breastfeeding . Breastfeeding is the best form of nutrition for infants. Exclusive breastfeeding is recommended for the first 6 months of life. Available evidence suggests breastfeeding may have long term benefits such as reducing the risk of obesity and type 2 diabetes

DESCRIPTION
The CCG will work with partners to develop an environment that encourages and enables women to breastfeed. We will work to ensure that services provide individualised care and support, specifically we will Use commissioning levers to ensure maternity providers used by Sefton women are on target to achieve the UNICEF Baby Friendly Initiative Develop a CQUIN that rewards maternity and community providers who achieve improvements in initiation and continuation rates Work with public health to explore the possibility of a similar reward scheme for the community peer support scheme. Contribute to the Maternity Services Liaison Committee action plan objective of increasing breastfeeding, especially amongst younger women and those from the most socially and economically deprived areas. Support the Liverpool City Region Child Poverty and Life Chances Commission to implement their plan to increase Breastfeeding across Merseyside.

KEY MILESTONES	Q1	Q2	Q3	Q4
Liverpool Community Health to complete stage 3 BFI assessment				
Agree collaborative approach to commissioning with NCB and LA				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
To be agreed				

RISKS	MITIGATING ACTIONS
Fragmented commissioning of key services which influence decisions to breastfeed and provision of breastfeeding support	CCG, NCB and LA to agree joint targets and performance monitoring, and service improvement systems.

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Cancer **Clinical Lead : Dr Debbie Harvey**

OBJECTIVE
Early detection (1) Improve cancer survival (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Late detection is believed to be the key reason why cancer survival in the UK lags behind Europe. As a Cancer Network Merseyside and Cheshire needs to save 4000 lives a year to fall in line with European average survival rates. This equates to 1 life per GP practice. The ageing demographic will also result in higher rates of cancer diagnosis, so we cannot afford to stand still.2 Evidence shows that cancers detected via emergency presentations are likely to be later stage with correspondingly poorer prognosis than those detected via a managed ideally 2 week wait route

DESCRIPTION
• Ensure GPs receive timely information relating to their practice's cancer performance, eg 2 week wait referral rates, diagnostic yield from 2 week wait referrals. presentation routes, staging data • Provide support (Cancer Network NAEDI project) to encourage reflective practice in relation to the management of potential cancer symptoms by general practitioners • Provide support (Cancer Network NAEDI project) to develop cancer early detection action plans at a practice level eg improving breast screening uptake or follow up of patients who decline bowel cancer screening

KEY MILESTONES	Q1	Q2	Q3	Q4
All practices have access to their cancer practice profiles				
Include cancer intelligence within Mersey intelligence portal				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
NAEDI primary care project managers make contact with % of practices	75%	75%	75%	75%

RISKS	MITIGATING ACTIONS
Lack of engagement by practices	
Delays in data provision	
Sustainability of project manager roles	

WORKFORCE IMPLICATIONS
The Cancer Network's National Awareness and Early Detection Initiative (NAEDI) project team are instrumental in providing support to individual practices. The team are employed by CRUK and exclusivity to Cheshire and Merseyside cannot be guaranteed

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Cancer Clinical Lead: Dr Debbie Harvey

OBJECTIVE
Early Detection (2) Improving cancer survival (Domains 1,4,5)

WHY CHANGE IS NEEDED?
Late detection is believed to be the key reason why cancer survival in the UK lags behind Europe. As a Cancer Network, Merseyside and Cheshire needs to save 4000 lives a year to fall in line with European average survival rates. This equates to 1 life per GP practice. The ageing demographic will also result in higher rates of cancer diagnosis, so we cannot afford to stand still. Evidence shows that cancers detected via emergency presentations are likely to be later stage with correspondingly poorer prognosis than those detected via a managed ideally 2 week wait route

• DESCRIPTION
• Incentivise 14 day pathways to key diagnostics (rather than outpatient clinic) through CQUIN • Ensure optimum performance against 14 day referral to first seen target for suspected cancer patients

KEY MILESTONES	Q1	Q2	Q3	Q4
Produce a leaflet to encourage attendance at 2 week wait clinics				
Introduce cancer waits CQUIN				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Cancer waits 2 week wait Aintree Hospital	93%	93%	93%	93%
Performance against cancer waits CQUIN requirements	Tbc			

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

Priority Area : Cancer Clinical Lead: Dr Debbie Harvey

OBJECTIVE
Improving the quality of Cancer Survivorship – supporting people and families living with and beyond cancer (Domains 2,3,4)

WHY CHANGE IS NEEDED?
There are now about 1.8 million people living in England who have had a cancer diagnosis. By 2030 it is anticipated that there will be 3 million people in England living with and beyond cancer. People living with and beyond cancer often have specific support needs which, if left unmet, can damage their long-term prognosis and ability to lead an active and healthy life. These needs can include information about treatment and care options, psychological support, access to advice on financial assistance and support in self-managing their condition Cancer patient experience surveys undertaken by Aintree Hospital indicate that there are unmet information support needs especially in regard to financial and benefits advice.

DESCRIPTION
Review the service provided by CAB for cancer patients in Sefton Undertake needs assessment for psychological support services for cancer patients in Sefton Review access to cancer information and support services outside the hospital setting in south Sefton Undertake needs assessment for physical activity programmes for cancer survivors

KEY MILESTONES	Q1	Q2	Q3	Q4
Psychological support needs assessment				
Physical activity needs assessment				
Review community information provision				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	Physical activity – 25k	
2014/15		
2015/16		
Total		

NHS
South Sefton Clinical Commissioning Group

Priority Area : Cancer Clinical Lead: Dr Debbie Harvey

OBJECTIVE
Ensuring prompt access to high quality cancer treatments (Domain 1,4,5)

WHY CHANGE IS NEEDED?
Ensuring that all cancer patients receive the appropriate treatment, promptly and delivered to a high standard, is critical to improving cancer outcomes. Cancer Peer review has identified some areas of concern in the quality of service provision locally. Performance for the 62 days referral to treatment standard has slipped during 2012/13, average performance 84.2% year to date (Commissioner based –December 2012) against a standard of 85%

DESCRIPTION
Identify the need for service improvements using the annual cancer peer review cycle holding providers to account through remedial action plans. Ensure compliance with cancer waits 31 and 62 day targets

KEY MILESTONES	Q1	Q2	Q3	Q4
Peer review reporting				
Introduction of cancer waits CQUIN				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Peer review compliance with measures	100%	100%	100%	100%
Performance against requirements of cancer waits CQUIN	tbc			
Cancer waits 31 days target	95%	95%	95%	95%
Cancer Waits 62 day target (aggregate measure)	86%	86%	86%	86%

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		
2014/15		
2015/16		
Total		

NHS
South Sefton Clinical Commissioning Group

Priority Area : End of Life Lead Clinician: Dr Debbie Harvey

OBJECTIVE

- To decrease the number of people at end of life dying in a hospital setting
- To Increase the number of people at end of life dying in their normal place of residence.

(Domain 3,4,5)

WHY CHANGE IS NEEDED?

Population forecasts published in 2012 suggest Sefton's resident population is set to grow by around 5% by 2035. The largest percentage increase across the population will be amongst older residents, aged 65 and over, with this age group expected to rise by more than 40% from 59,000 in 2012 to 83,000 by 2035. With 21% of residents in area aged over 65, Sefton already has one of the highest proportions of older residents nationally.
A survey commissioned by the National Audit Office and based on data from Sheffield in 2008 found that 40% of 200 patients who died in hospital were found to have had no medical need which required them to be in hospital at the point of admission, and could have been cared for and died elsewhere.

DESCRIPTION

- Hospice at Home

Consultant End of Life Care at Home Partnership, is an outreach service provided by a recognised Specialist Palliative Care Consultant led unit. It is able to provide a full range of hospice/specialist palliative care services and so give the patient and family the appropriate service at the appropriate time to meet their specialist needs. The aim of this service is to fill the gaps in the usual planned and currently funded community and sitting services, to ensure people can stay in their own homes. This is also in line with government policy to provide care to enable more patients to die at home.

- End of Life Care Home Facilitator

This End of Life Care Home Facilitator's role involves working within the framework of the North West End of Life Care Model, in ensuring best practice end of life care for all conditions.
The role plays a key part in enabling and empowering health and social care professionals to deliver best practice end of life care in their organisations.

WORKFORCE IMPLICATIONS

No End of Life Care Home Facilitator

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Increase of people dying in their normal place of residence				
Decrease in unnecessary hospital admissions/attendances				
GP Practices identifying and recording their 1% of patients at end of life				

RISKS	MITIGATING ACTIONS
Care homes not participating in education programmes	
Funding for EOL Care Home Facilitator not available after October 2013	
Patients not being identified as being at end of life	

KEY MILESTONES	Q1	Q2	Q3	Q4
Ensure staff capacity to deliver H@H service				
Increased number of care homes participating in education programme				
Encourage GP Practices to find their 1% of patients at end of life				

RESOURCE IMPLICATIONS

YEAR	INVESTMENT £	SAVINGS £
2013/14	H@H = £240,000 Care Home Facilitator = £18,750 (approx)	Not known at this time
2014/15	H@H = £240,000 Care Home Facilitator = £45,000	Not known at this time
2015/16	H@H = £240,000 Care Home Facilitator = £45,000	Not known at this time
Total	£828,750	Not known at this time

NHS
South Sefton Clinical Commissioning Group

Priority Area : Primary Care Quality Clinical Lead: Dr Bal Duper

OBJECTIVE
To devise a primary care medical strategy focusing on local priorities to support continuous primary care quality and development. The aim is to improve quality, capability and productivity further and to create capacity within primary care. (Domains 1,2,3,4)

WHY CHANGE IS NEEDED?
From April 2013 a statutory duty of the CCG will be to assist and support the NCB in discharging its duty in relation to securing continuous improvement in the quality of primary medical services. NHS restructures / changing policies especially in regard to NCB Primary care capacity and development to reflect NHS and population

DESCRIPTION
The process of developing the strategy will include key stakeholders and engagement of people directly involved in delivering primary care services. The strategy will consider • practice demographics • Workforce development • Clinical services particularly primary care through locality model • Premises / estate management • IT • Health outcomes of primary care activity

KEY MILESTONES	Q1	Q2	Q3	Q4
Draft Primary Care (Medical) Strategy				
Board Approval				
Implementation strategy				
Investment of areas in primary care strategy				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
Quality premium – primary care areas				
Primary care strategy in place				
Investment of primary care development				

RISKS	MITIGATING ACTIONS
Variable engagement from stakeholders	Involvement with partners eg: LMC, Locality clinicians
Involvement in primary care development reflecting patient needs	Strategy will reflect recommendations of recent Francis report
Resources within CCG for substantial piece of work	Consider investment

WORKFORCE IMPLICATIONS
To be determined via primary care strategy

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14	To be determined	
2014/15	To be determined	
2015/16	To be determined	
Total		

Priority Area : Medicines Management Lead Clinician: Dr Steve Fraser / Jill Thomas

OBJECTIVE
To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money. (Domain 1,2,3)

WHY CHANGE IS NEEDED?
Primary care prescribing accounts for one in every nine pounds spent in South Sefton CCG. The pressure on prescription item growth will continue at 6-7 % pa. There is a constant requirement to work towards the statutory duty of the CCG to remain in financial balance. There is a duty to ensure health outcomes for patients are improved by prescription of medicines rather than management of cost alone. This will require support in evidence based decision making, focussing on vulnerable patient groups and continued engagement with primary care prescribers

DESCRIPTION
A clear and realistic medicines optimisation plan based upon a realistic prescribing budget will keep primary care prescribers engaged in safe and effective prescribing. Strong medicines management team support will facilitate the delivery of the plan in addressing both therapeutic and disease areas in practice as well as supporting different ways of working along the prescribing process. Medicines management support provided to the 4 proposed virtual wards. Focus medicines reviews with care home patients as a vulnerable cohort of patients

KEY MILESTONES	Q1	Q2	Q3	Q4
Optimisation plan ratified				
Work stream plan developed				
Planned visits to practices with performance / engagement issues				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
All care home patients reviewed	800	800		
Virtual ward support initiated				
Evidence based decision making programme delivered				

RISKS	MITIGATING ACTIONS
Financial balance is not achieved	Prescribing quality scheme to engage practice
Lack of capacity of medicines management team to deliver support at practice	Support of team members and investment in key area to ensure support is consistent

WORKFORCE IMPLICATIONS
Practice coverage plan in place. Locality leads for medicines management now in place. Review of functions in practice to maximise benefits of support to prescribers.

RESOURCE IMPLICATIONS		
YEAR	INVESTMENT £	SAVINGS £
2013/14		1,100,000
2014/15		
2015/16		
Total		

2.3 Additional information relating to the NHS Outcomes Framework domains

Enhancing the quality of life for people with long term conditions

We will work with direct commissioners through the Health and Wellbeing Board to ensure we:

- Provide person centred integrated care for people with long-term conditions through improvements in primary care
- Put patients in charge and having ownership of their care through personalised care plans and budgets and ensure coordination and continuity of their care

South Sefton's population is growing increasingly older. The over 65 age group is set to increase by 32% from 56,400 in 2010 to 82,900 in 2035, meaning that this age group in Sefton will rise from accounting for 20% of the population to almost 30% of the population. The challenge for us to ensure that healthcare matches the needs of the elderly population and reduces the pressure and high cost delivery in acute trusts.

Sefton generally displays slightly higher levels than average of diagnosed long term conditions. Data were first collected in 2004-05 and disease register numbers have changed slightly since then. Note that these figures do not take into account the different age structures of areas.

	Sefton 2009/10	Sefton 2010/11	NW 2010/11	England 2010/11
Asthma	6.0%	6.1%	6.3%	5.9%
Cancer	1.8%	2.1%	1.6%	1.6%
CHD	4.5%	4.5%	4.0%	3.4%
COPD	2.3%	2.4%	2.1%	1.6%
Diabetes	5.6%	5.7%	5.8%	5.5%
Epilepsy	0.9%	0.9%	0.9%	0.8%
Hypertension	15.7%	15.9%	14.0%	13.5%
Hypothyroidism	3.4%	3.5%	3.0%	3.0%
Mental Health	1.0%	1.0%	0.9%	0.8%
Stroke	2.2%	2.2%	1.9%	1.7%
LD	0.5%	0.4%	0.5%	0.4%
Obesity	11.0%	10.2%	11.5%	10.5%
Heart Failure	1.1%	1.1%	0.8%	0.7%
Atrial Fibrillation	1.9%	1.9%	1.5%	1.4%
CKD	5.1%	5.0%	4.6%	4.3%

Source: www.ic.nhs.uk

When benchmarked against local and comparable primary care trust (PCT) areas, Sefton has:

- Similar levels of Coronary Heart Disease (CHD) and COPD to local PCTs but higher than comparable PCTs
- Higher levels of hypertension than local and comparable PCTs
- Lower levels of diabetes than local PCTs
- Lower levels of dementia than both local and comparable PCTs and the national and regional averages

EQ5D scores (0.67) for south Sefton show that SSCCG is in the bottom quintile. Unfortunately as the data is presented as a composite score for EQ5D it is difficult to determine the specificity of the data e.g. which specific part of ill health are they reporting (mobility, usual activities, anxiety, self-care, or pain and discomfort) however 52% feel supported to manage their own condition. The plans set out below aim to improve people's overall quality of life.

Plans for long term Conditions

- Support and refine use of risk stratification for people with long term conditions
- Develop use of personalised care plans for diabetes / COPD/ heart failure / Chronic Kidney Disease (CKD) across primary care, specialist community teams and secondary care
- Increase screening of dementia, COPD, Diabetes and CKD through:
- Virtual ward dementia screening protocol
- Increasing access to Spirometry
- Promotion of healthy living checks
- Increase patient understanding of their condition through:
- Roll out of our 12 week pro-active care education and behavioural change programme
- Tailored education programmes
- Increasing patient access to records
- Linking patients to online education

Intermediate care (Bedded units - Ward 35 / CCAU)

- Continue to review utilisation following improved urgent care GP cover and advocate a step-up approach from the community.
- Improve utilisation of the service towards a robust primary care supportive mode

Respiratory

Admissions with COPD are still above average despite a 30% reduction in COPD admissions in the last 5 years.

- Commissioning of an acute COPD community service and integration of current respiratory services. We expect a minimum 10% reduction in admissions for respiratory conditions.
- Increase the capacity and local access to the Community Spirometry service
- Ensure all patients with COPD and a Medical Research Council Dyspnoea >3 are referred to a pulmonary rehabilitation programme

Diabetes

- Ensure patients receive foot care / screening as specified
- Undertake review of the community service with a view to enhancing service offered

Community intravenous (IV) therapy

- Improved access to the community IV team following review of the forms, pathway and single point of access.
- Development opportunities for other IV treatments in the community including fluids, blood transfusion and picc line maintenance.
- Alignment of cellulitis pathway between community and acute trusts
- Increase access to microbiology consultant review through ward 35 attendance

Gynaecology

- Review impact of community service on acute trust demand

Palliative care / end of Life

- Continue to support the 'Hospice at Home' service delivered by Woodlands Hospice
- Increased number of patients being cared for and dying at home (if this is their choice)
- Support nursing homes to complete education programmes including the six steps to success and gold standard framework
- Increase the use of and monitoring of End of Life (EOL) Care Tools in the community, care / nursing homes and acute settings. These will include:
    - Gold Standard Framework
    - Liverpool Care Pathway
    - Advance Care Planning for patients in the last year of life
    - Preferred Place of Care
    - Increased usage of the End of Life Care Register

Virtual Ward

This programme supports the following two NHS Outcomes Framework domains:

Helping people to recover from episodes of ill health or following injury

We have developed a 'Virtual Ward' strategy (the pilot in Maghull is currently operational) in liaison with Aintree University Hospital (AUH), Liverpool Community Trust (LCH) , Sefton Council, neighbouring CCGs and other key stakeholders. This strategy will:

- Reduce avoidable admissions to hospitals
- Keep people out of hospitals if better care can be delivered in a different setting
- Ensure effective joined-up working between primary and secondary care
- Deliver high quality and efficient hospital care and coordinate care and support post discharge
- Work with providers to invest savings in better reablement and post discharge support

We have employed a part time GP lead supported by a lead manager to develop and implement this strategy across the whole of south Sefton.

We will seek to improve and invest in the generalist aspect of community care through the South Sefton Virtual Ward model. Principles to this include integration, pro-active care of long term conditions, IT and self-care. This includes development and changes to:

- Domiciliary Urgent Care
- Pro-active nursing
- Reablement
- Information management and technology and single point of access
- Linking of community specialist teams

Admission rates for over 74 year olds from nursing and residential homes in are the upper quintile.

As part of the Virtual Ward system we will seek to institute advanced care planning for nursing home, palliative and dementia patients in their last year of life.

Relevant supporting data

PROMS for Hip replacement 0.35 Bottom Quintile

Knee replacement 0.27 Bottom Quintile

Groin Hernia 0.04 Bottom Quintile

Emergency Admissions 388 mid quintile

The CCG will work with Aintree and other providers to improve the outcome of patients. Aintree participate in the North West's Advancing Quality Programme, which looks at specific measures to improve the clinical outcomes for patients. We will improve pathways to reduce the number of emergency admissions for children with lower respiratory tract infections.

Unplanned admissions for ACS:

- South Sefton: 1052 (second worse quintile)

Unplanned admissions for diabetes, asthma and epilepsy in U19s:

- South Sefton: 345 (second worse quintile)

Emergency admissions that shouldn't usually require an admission:

- South Sefton: 1145 (second worse quintile)

Emergency re-admissions within 30 days:

- South Sefton: 12.4% (second worse quintile)

To reduce avoidable admissions to hospital we will:

- Implement the 'Virtual Ward' model
- Institute advanced care plans for all nursing home, dementia and palliative patients in their last year of life
- Identify patients who are high users through risk stratification and pro-actively improving long term condition management
- Increase both specialist and generalist community urgent care cover
- Work with the acute trust in streamlining the urgent care pathways through the emergency area and facilitate coordination between the acute and community urgent care services.
- Support < 24h of stay for patients with specified ambulatory emergency conditions
- Support development of cross sector pathways and to increase awareness of alternatives to admission for A&E staff
- Facilitating a service level agreement between A&E and urgent care aspects of the community
- Increase appropriate use of NHS services through the pro-active care behavioural change
- Institute a 7 day urgent care team to investigate, monitor and support patients at risk of deterioration via our 'Virtual Ward' model.
- Review total health gain for patients following elective surgery and collaborate with our acute Trust to evaluate proactive choice of surgery with patients

Ensuring people have a positive experience of care

Currently 89% of patients have a good experience of primary care and 79% have a good experience of Out of Hours (OOH.)

We will work with practice to improve the quality of primary care - this is one of our strategic objectives. The OOH service is currently out to tender and we will work with the winner of the tender to improve patient satisfaction for OOH services

South Sefton patients 'Experience of Hospital Care' rating is above the national average.

We will work with each provider to understand the patient's experience, and together will implement the Friends and Family Test and ensure that the results are clearly published on the Trust and SSCCG websites.

Providers (ordered by number of admissions) for this CCG	Number of Admissions / spells (Acute 2010/11)	4b Inpatient Overall Experience	4.1 Outpatient Overall Experience	4.2 Inpatient Responsiveness to needs	4.3 A&E Overall Experience
Southport & Ormskirk Hospital NHS Trust	24,674	76	79	64	79
Aintree Hospitals NHS FT	2,054	77	79	69	83
Ramsay Healthcare UK Operations Ltd	1,260	NA	NA	NA	NA
Alder Hey Children's NHS FT	1,013	NA	NA	NA	NA
Royal Liverpool & Broadgreen Hospitals NHS Trust	984	77	81	70	82
CCG weighted average		76	79	64	79
England average		Tbc	Tbc	Tbc	Tbc

Treating and caring for people in a safe environment and protecting them from avoidable harm

Current Health Care Associated Infection (HCAI) rates:

- MRSA (rate per 1000) = 3.91 Bottom Quintile (worse)
- C Diff (rate per 1000) = 37.9 Bottom Quintile (worse)

During 2013-2014, we plan to:

- Significantly reduce C Difficile in all providers in the local health economy
- Use the National Quality Dashboard to identify potential safety failures in providers
- Deliver zero tolerance to MRSA infection and conduct Post Infection Review

We have support from CMCSU to ensure that the indicators relating to HCAI (MRSA and C Diff) are in the provider contracts for 2013-14. Our Chief Nurse supports the CCG Clinical Quality Leads in this area. HCAIs will continue to be a focus of discussion at the appropriate contract / quality meetings with remedial action planning being put in place as appropriate. We are working in partnership with Liverpool CCG and providers to set up a Strategic HCAI forum to address these issues that will be led and driven at a strategic level – CCG representation includes the GP Clinical Lead for Quality, Chief Nurse and the Head of Medicine's Management. Current status regarding HCAI will be a standard agenda item at the Quality Committee with reporting also to the Governing Body Board Meeting. We also plan to link to the Quality Premium, part of which covers HCAI.

3.0 The 3 local priorities – Quality Premium

Ownership of the local priorities

The following local priority areas have been agreed by:

- The CCG Governing Body during informal and formal Board meetings in February and March 2013
- The CCG Wider Constituent membership – through the Wider Group meeting in March 2013
- The Health and Wellbeing Board – formally presented at March meeting and supported
- The CCG Experience and Patient Engagement Group (membership including Sefton LINKs, Sefton CVS, Sefton MBC and CCG Board Lay and Practice Manager members.) March session
- The priorities have also been mapped to the Health and Wellbeing Strategic Objectives, the CCG Commissioning Intentions, and feedback from recent public consultation events to ensure that they fit strategically and respond to issues raised by local people. These are shown in Appendix 3

Our 3 local priorities are:

1) To bring about a reduction in Chronic Obstructive Disease (COPD) admissions through A&E at Aintree Hospital

Rationale - there is a high mortality rate from respiratory diseases in south Sefton and there are a high number of admissions to hospital related to COPD. The CCG will build on a scheme piloted in south Sefton within the last year which is part of our overall Virtual Ward strategy, to bring about the changes across the whole CCG area.

Measures - to achieve a 5% reduction in the number of admissions to A&E between the current baseline available compared to 12 months' time.

Although it is recognised that a general reduction in avoidable emergency admissions is included with the composite measure for the nationally stipulated quality premiums, the CCG has chosen a more ambitious figure in this particular area of COPD because it would bring about a real quality improvement for patients and would demonstrate sufficient "stretch" compared to the 0% of the national target.

2) To bring about a reduction in prescribing for three high risk antibiotics

Rationale - SSCCG has recognised as a priority the need to reduce the number of healthcare acquired infections (HCAI.) One of the factors, based on root cause analysis of HCAIs, has been the prescribing of high risk antibiotics both in primary and secondary care, without an appropriate indication according to local or national guidance.

We plan to work with constituent practices on the reduction of prescribing of three high risk antibiotics:

a. Quinolones b. Co-amoxiclav c. Cephalosproins

Work will include peer review sessions on prescribing activity for the three antibiotics at locality level during Quarters 1 and 2. There will be a CCG wide learning event to highlight appropriate prescribing by the end of Quarter 3. There will an offer to audit prescribing activity of the three antimicrobials and linking to appropriate / inappropriate indications.

Measures - 5% reduction in the overall number of items of quinolones, co-amoxiclav and cephalosporins. A baseline measurement of Quarter 3 2012-13 will be taken and the reduction will be measured on Quarter 3 2013-14 activity

3) **To reduce the number of GP referred patients (during normal working hours) who receive an AED assessment before being admitted into Aintree Hospital**

Rationale - at present approximately 89 % of non-elective GP referrals to Aintree University Hospitals are seen in the AED department before being admitted. In many cases the CCG believes that this is not essential and can be detrimental to patient care and to the patient's experience. This additional step in the patient pathway also results in an inefficient use of resources.

Measures - To reduce by 5 %, Non Elective Admissions to Aintree where source of referral is GP and where the patient has attended A&E on the same day. The current baseline figure will be compared with the figure in 12 months time.

Delivering and monitoring progress through localities

Our four localities will play a key role in the planning and implementation of these local quality premium priorities and monitoring progress towards the national measures. Locality Managerial leads will work with clinical leaders within the localities to drive this process, supported by the GP lead for Quality and the Head of CCG Development.

The proposed process is:

Quarter 1: Consider benchmarks and agree plan of action within each locality

Quarter 2: On-going implementation of plan and data review

Quarter 3: Review progress against quality measures

Quarter 4: Final data capture to demonstrate improvements

Progress against the measures will also be included in the CCG Board performance dashboard

4.0 The Basics of Care

SSCCG will drive quality improvement in the delivery of care from all providers and seek on-going assurance that provider cost improvement programmes, services are safe for patients with no reduction in quality and do not contravene NICE guidance.

We have plans in place to utilise suggested tools, Quality Dashboards, the Safety Thermometer together with intelligence from staff and patient surveys. A Quality Dashboard, that includes staff survey information, is presented to both the Quality Committee and our Board.

Our main providers voluntarily participate in the North West Transparency in Care Audit, which reports on a monthly basis in the public domain information on staff views regarding the organisation as a place to be cared for when a 'harm' (e.g. pressure ulcer or fall) has occurred on a particular ward or department. We have agreed the local quality indicators and CQUINs relating to patient safety and patient experience that they wish to be negotiated into the contracts for 2013-14 alongside the national mandated indicators and CQUINs – we will be supported in this by CMCSU in this. Our GP Quality Leads, supported by our Senior Management Team and CMCSU, lead Quality Contract meetings with providers, at which provider performance in relation to quality is monitored. Finance representation at the Quality Committee is provided by our Chief Finance Officer and the Quality representation at the Finance and Resource Committee is provided by our Chief Nurse as part of the CCG risk management processes.

'How to Guides', such as the Quality Impact Assessment of Provider CIPs and Rapid Response Review, will be utilised as appropriate under the Governance arrangements set out within the CCG constitution.

In addition we are commissioning a governance review by Merseyside Internal Audit Authority (MIAA) to test committee functions in order to add extra assurance.

5.0 Patients' Rights: The NHS Constitution

We are developing a framework to performance manage the requirements set out in the NHS constitution. The CCG Experience and Patient Engagement Group (EPEG) will have the responsibility within the governance structure to review this framework in order to reassure our governing body and our wider members that the rights and pledges from the NHS are adhered to across the system.

5.1 Eliminating Long Waiting Times

We have plans to ensure:

Referral to Treatment waiting times for non-urgent consultant-led treatment:

- 90% of admitted patients to start treatment within a max of 18 weeks from referral
- 95% of non-admitted patients to start treatment within a max of 18 weeks from referral
- 92% of patients on an incomplete non-emergency pathway (yet to start treatment) should have been waiting no more than 18 weeks from referral

We will ensure that patients have access to high quality treatment in a timely manner. This means patients will be seen and treated within the 18 week pathway. We will work with Aintree University Hospital to maintain performance of the PLT and ensure that we have early warning of any potential problem and offer alternate patient pathways.

We will work with the Trust, using contractual levers where appropriate, to ensure that no patient waits over 52 weeks and that the Trust moves to a maximum of 40 weeks.

Diagnostic test waiting times

We will ensure:

- 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral

In order to help the Trust deliver the 18 week pathway, we will work with it to enable patients to access diagnostic tests within 6 weeks.

5.2 More Responsive Care: Urgent & Emergency Care

A&E waits

We plan to ensure:

- 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- No patient to wait on a trolley for longer than 12 hours

We will work with the Aintree Hospital Trust to deliver the A&E standard. Our community based programme, 'Virtual Ward', which embraces technology with our providers to ensure patient get the best possible outcomes, aims to reduce emergency admissions by better managing people in the community.

Category A ambulance calls

We plan to ensure:

- 75% Category A calls resulting in an emergency response arrive within 8 minutes (met for red 1 and red 2 calls separately)
- 95% Category A calls resulting in an ambulance arriving at the scene within 19 minutes

Urgent and emergency care

- All handovers between an ambulance and an A&E department to take place within 15 minutes and crews ready to accept new calls within further 15 minutes
- Implement contractual fine for all delays over 30 minutes, with a further fine for delays of over an hour

Sefton has seen a surge in Category A calls in the later half of 2012. The CCG is looking at several data sources to understand this surge, however this target has been met by NWAS in the past and the CCG has confidence that NWAS will deliver the target. We will apply the contract levers and fine the Trust for breaches of the 30 minute handover time.

Cancer waits – 2 week wait

We aim to ensure:

- 93% max 2 week wait for first out patient appointments for patients referred urgently with suspected cancer by a GP
- 93% max 2 week wait for first out patient appointments for patients referred urgently with breast symptoms (where cancer was not initially suspected)

We will:

- Implement cancer waits CQUIN which incentivises delivery of first key diagnostic test (rather than outpatient appointment) by day 14 and reducing cancellations and DNAs of 2 week target appointments
- Modelling has shown that delivery of the first key diagnostic within 14 days has a strong positive impact on reducing 62 day breaches
- DNAs and cancellations of 2 week wait target appointments have a significant impact on efficiency and performance, as well as delaying treatment. The CCGs will produce a refreshed patient leaflet to be given by GP at the time of referral to help patients understand why they have been referred urgently and encourage attendance

Cancer waits – 31 days

We plan to:

Maintain good Trust and CCG level performance against this standard and the targets below. Surgical capacity is the most common issue accounting for breaches:

- 96% max one month (31-day) wait from diagnosis to FDT for all cancers
- 94% max 31 day wait for subsequent treatment where that treatment is surgery
- 98% 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen
- 94% max 31 day wait for subsequent treatment where that treatment is a course of radiotherapy

Cancer waits – 62 days

We aim to ensure:

- 85% max 2 month (62-day)wait from urgent GP referral for FDT for cancer
- 95% max 62 day wait from referral from an NHS Screening service for FDT for all cancers
- Maximum 62 day wait for FDT following a consultant's decision to upgrade the priority of the patient (all cancers) - no operational standard

We plan to:

- Implement cancer waits CQUIN which incentivises referral to treating trust by day 42 of the pathway
- Continue to monitor performance closely. A number of improvement areas have been identified E.g. Use of timed diagnostic pathways for specified tumours especially those using specialist surgical centres where multiple trusts are likely to be involved
- Aintree Hospitals have used the services of the Intensive Support Team and continue to implement recommendations. Southport and Ormskirk also plan to use the Intensive Support Team

5.3 Keeping Our Promises: Eliminating mixed-sex accommodation

We will work in partnership with our commissioned providers to ensure there are minimal mixed sex accommodation breaches. This will be monitored through the appropriate contract and quality meetings, supported by CMCSU, and appropriate action taken should breaches occur – such as remedial action plans or invoking of financial penalties. Performance and Quality Reports, which include mixed sex accommodation breaches, is a standing agenda item at our Quality Committee and Governing Body Meetings.

5.4 Keeping Our Promises: Reducing cancellations

Cancelled Operations

We plan to ensure:

- All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice
- No patient to tolerate an urgent operation being cancelled for the second time

We will work with Trusts to ensure that cancelled operations are kept to a minimum and where an operation is cancelled patients are offered an alternative date within the 18 week pathway where possible.

5.5 Mental health

We plan to ensure:

- 95% of the proportion of people under adult mental health specialities of Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric in-patient care during the period. (Currently 97.25% is achieved)
- The full roll-out of the access to psychological therapies programme by 2014-15 and reach a 50% recovery rate

5.6 Keeping Our Promises: Choice and the information to exercise it

We are committed to ensuring the delivery of the 18 week Referral to Treatment (RTT) standard for our population and will continue to rigorously performance manage providers to ensure contract compliance with this national standard.

As set out in the NHS Constitution, we will ensure that in the unlikely event of a patient breaching this target when they have not chosen to wait longer, or when it is not clinically appropriate they do so, there is an effective working process in place to offer a range of alternative providers using the 'Right to Redress' process adopted by our local providers.

We will work with all our providers to ensure outpatient letters provide patients with information on their 'right to treatment' within maximum wait times and have a process in place for patients who are concerned or will likely to wait longer to formally redress the situation.

During 2013-2014, we will explore the health market for service providers who have the capacity and capability to deliver high quality, timely and cost effective services that our population require and are able, within the competitive market, to demonstrate a willingness and ability to meet all national and local standards.

We will promote the use of Choose and Book with our GP colleagues, and we will continue to work with our Local Hosted Trusts to reduce slot issues to the gold standard '0.04 slot issues per successful Choose and Book Booking'. This will be performance managed to ensure capacity is proactively managed and appointments made available to Choose and Book.

5.7 Keeping Our Promises: Dementia, IAPT and Military Veteran health

Dementia

Aim to increase timely detection rates across Sefton to 75% by 2015-16:

Primary Care: Dementia: (NHS Outcome Framework Domain 1, Domain 2, Domain 4 and Domain5)

Current rate of detection for dementia is: NHS South Sefton CCG – 52%

Virtual Ward and via CQUIN's with Liverpool Community Health Trust and Merseycare NHS Trust

Improved access to GP & health screening for Sefton residents over age 65

In the GMS – Contractual Changes 2013/14 (for consultation) the NHS Commissioning Board to develop a Dementia Case Finding Scheme with GP's.

Extra support for GPs on dementia, the Department of Health is working on a dementia toolkit for surgeries. This is to better equip them to spot and diagnose dementia, and to help people with dementia and their carers to manage the condition.

GP support from Alzheimer's' Society (Sefton) for training and awareness raising

Increase in 'appropriate' patient flow from GP practices to Memory Assessment Units in Waterloo and Southport

Increase in locality based assessment of the psycho-geriatrician service e.g. in persons home, as appropriate

Increase in appropriate prescribing of anti-dementia drugs which can help to delay progression of disease

Secondary Care:

A National CQUIN has been developed that will have 3 main aims:

Identify people with dementia – members of staff in hospitals will ask members of the family or friends of a person admitted to hospital if the patient has suffered any problems with their memory in the last 12 months

Assess people with dementia – if there is evidence to suggest a problem with their memory, that person will be given a dementia risk assessment

Refer on for advice – a referral would be made for further support either to a liaison team, a memory clinic or a GP

Aim to enhance the quality of life for people with dementia:

Improve access to post diagnostic support through access to a full range of services including Alzheimer's Society Dementia Community Support Service, Peer Support Groups / Dementia Cafes following diagnosis

Working collaboratively with Sefton Council and other partners ensure each person has a personalised care plan post diagnosis

Ensure people with dementia have access to advocacy assistance if required through Sefton Pensioners Advocacy Centre, Sefton Carers Centre

Ensure people diagnosed with dementia and their carers have full benefits check post diagnosis

Increased carers assessments and individualised support for carers of people with a diagnosis of dementia

Improve access to appropriate community and social networks to maintain independence via voluntary community and faith sector support and sign up to Dementia Action Alliance

Aim: Achievement of the Care Programme Approach (CPA) follow up target: (NHS Outcome Framework Domain 2, Domain 3, Domain 4)

Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%

Increase the proportion of people with depression/anxiety entering treatment

NHS outcomes framework 2013-14 Domain 4 - Ensuring that people have a positive experience of care. Patient experience of community mental health services (4.7)

Care Programme Approach (CPA): 95% of the proportion of people under adult mental health specialities of CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.

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Improving Access to Psychological Therapies (IAPT)

Aim: Improving Access to Psychological Therapies (IAPT): (NHS Outcome Framework Domain 2, Domain 3, Domain 4)

The plan is to employ IAPT Wave 5 trainees that are currently employed on temporary contracts as permanent staff post qualification.

Funding for wave 5 investment been agreed by Financial Sub Committee of NHS Southport and Formby CCG and NHS South Sefton CCG to ensure success in achieving the 11% prevalence target for 2013/14

To participate in Wave 6 of the roll out to achieve DH objectives of meeting 15% prevalence with recovery rates of 50% by 2014/15.

Three IAPT CQUIN's have been developed to achieve the overall outcome on improving access to psychological therapies

CQUIN 1:

Inclusion Matters (IM) will increase the delivery of psychological therapies through on-line, telephone, text and remote video interactions.

1. IM to develop an e-clinic model to improve online access to psychological therapies.
2. Train 10 staff in each area to deliver online therapy in year one
3. By Q4 trained staff to deliver 15% of therapy online
4. IM to produce Quarterly progress report

CQUIN 2:

Inclusion Matters will establish on-line relapse prevention facilities.

1. IM to develop an on-line relapse prevention facility.
2. Train 5 staff in each area to act as online facilitator in year one
3. To develop online relapse prevention facilities in relation to at least three different conditions
4. By Q4 online relapse prevention will be offered to all clients who have finished a course of therapy in relation to the specific conditions
5. IM to produce Quarterly progress report

CQUIN 3:

In conjunction with Inclusion Matters Merseyside, Mayden Health, and Health Care Gateway, Inclusion Matters will develop a system for sending GP letters electronically.

1. IM in conjunction with partners to develop an electronic GP letter system

2. By Q4 all IM staff trained to in using electronic GP letters
3. IM to produce Quarterly progress report

Military Veteran health

- Under the new commissioning arrangements commissioning of services for Armed Forces Veterans, Reservists and Armed Forces Families (serving, reservist or veteran) are the responsibility of CCGs in the North West
- CCGs across Merseyside were asked to consider funding the MVIAPT service for a further 12 months. The request is that each CCG allocates £30k for the service for 13-14. We have signed up to this for 2013-2014
- Further work will need to be undertaken to understand patient flows and service uptake as current data suggest fluctuation in referral levels. Once this work has been completed, we will be better placed to understand future commitments

- We will undertake a mapping exercise of local services offering support to military veterans and their families to support and encourage partnership working
- MVIAPT will be encouraged to meet with CCG colleagues and seek to promote an increase in referrals
- We will ensure through workforce development strategies that Military Veterans and the issues they face are part of any continuing professional development programme

What is a Veteran?

The Ministry of Defence (MOD) defines a veteran as “anyone who has served in HM Armed Forces, at any time, irrespective of length of service (including National Servicemen and Reservists)”.

In 2011 a number of legislative initiatives were proposed that ensured continued support for current and ex-service personnel. They included:

Armed Forces Act 2011: Annual duty to report on progress against the Military Covenant to Parliament including Health & Social Care Bill 2011: Includes duty of the NHS Commissioning Board to commission services on behalf of the Armed Forces.

NHS Mental Health Strategy 2011: Includes a specific provision for veterans.

Under the new commissioning arrangements commissioning of services for Armed Forces Veterans, Reservists and Armed Forces Families (serving, reservist or veteran) are the responsibility of CCGs in the North West. CCGs will also be responsible for the commissioning of emergency care services for veterans and family member in their area.

Sefton Community Voluntary Services have led on the establishment and servicing or a Sefton Armed Forces Community Covenant Partnership to co-ordinate multi – agency activity. Sefton has now developed, and signed off, a Local Community Covenant which sets out commitments to supporting the Sefton armed forces community.

CCGs across Merseyside were asked to consider funding the Military Veteran IAPT service for a further 12 months. The request is that each CCG allocates £32k (circa) for the service for 13/14. South Sefton CCGS have signed up to this for 2013-2014. The funding will be used for providing access to veterans to:

An IAPT based Psychological Service adapted for ex and current Service Personnel and their families. This project is hosted by Pennine NHS Foundation Trust

The Live at Ease Project – To support ex-service men/women adapt to civilian life. Support including help with housing, accommodation, employment, training, debt advice and drug and alcohol dependency issues. The project will also support family members.

Liverpool Public Health Observatory is carrying out a health needs assessment for ex armed forces personnel and their families, on behalf of Merseyside and Cheshire Directors of Public Health. What do we already know about the needs of families? Initial findings have already identified the following:

Poor access to health and wellbeing advice

Depression, reliance on alcohol and anxiety as being common within service families

Worrying about a husband/wife/partner away on active service

Struggling to cope alone and with children

Living far away from their immediate family, lack of immediate support

Limited social network, moving around prevents friendships and support networks forming

Financial insecurity, unable to work due to house moves and caring commitments

Domestic abuse as both victims and perpetrators

Most recent available data from Wirral NHS 2007, estimates that the following number of veterans resident in the north and south Sefton population.

PCT/ Age	16-24	25-34	35-44	45-54	55-64	<65's
Sefton	516	797	1996	2282	2400	7992

Currently all service personnel and families do not have an NHS number making it difficult to establish the level of spend on these groups. A project is on-going to map across Defence medical Service (DMS) number to the NHS number.

Further work will need to be undertaken to understand exact numbers, patient flows, and service uptake as current data suggest fluctuation in referral levels. Once this work has been completed CCGs will be better placed to understand future commitments, Consideration will need to be made for the recent military veterans redundancy scheme that will increase veterans returning to Sefton.

The Northwest armed forces Network held a commissioning handover event in March 2013, including handover arrangement for Clinical Commissioning Groups (CCGs). Each CCG identified a lead person to support and develop their local Military Health agenda

South Sefton CCG will continue to work with Sefton CVS to undertake a mapping exercise of local services offering support to military veterans and their families to support and encourage partnership working.

CCGs should ensure through workforce development strategies Military Veterans and the issues they face are part of any continuing professional development programme.

6.0 Patient Centred, Customer Focussed

6.1 NHS services, 7 days a week

We plan to respond to the Medical Director's report to ensure primary and community services deliver high quality, responsive services out of hours and ensure better access to routine services 7 days a week in urgent and emergency care and diagnostic services.

We have dedicated project management support to the area of unplanned care. The demographics of south Sefton show an increasing trend in our frail elderly. It is the intention in 2013-14 to review and transfer this element of care through work with all our partners, and to this end we aim to establish a collaborative network. It is intended that the network involves the following membership:

- Mental Health Services
- Social Services
- Hospital Services
- Ambulance Services
- Community Services
- Other CCG

Our strategic planning refresh and business plan for 2013-14 will focus on the four CCG key strategic elements - namely driving improvement in the public health and wellbeing of Sefton residents, improving quality of primary care and delivery of community services, reducing the demand on secondary care and ensuring cost effectiveness of high quality tertiary care. All these are intrinsically linked to the true use of NHS services 7 days a week.

As commissioners we will work through the newly established network to specifically shape primary, community and secondary care services and focus on integration with social care, the Ambulance Trust and the third sector. This work will help to drive our service transformation.

Work needs to be undertaken with our main secondary care provider to scope and understand the diagnostic requirements of our population and the capacity needs. This will not only support unplanned care delivery, but also our planned care delivery. This work should support the findings of the review launched on the 18th January 2013 by Sir Bruce Keogh – NCB Medical Director.

We work closely with Southport and Formby CCG, Liverpool CCG and Knowsley CCG around the University of Aintree NHS Foundation Trust footprint. However, work across all six Merseyside CCGs with the NCB's Local Area Team to firm up future arrangements to 'share and spread' learning is currently underway. There is a specific focus on the impact of the major strategic service changes, such as the reconfiguration of trauma, vascular, cancer and rehabilitation services at this more regional as well as local level for each individual CCG commissioner.

The work plan of the Merseyside CCG network will be prioritised during 2013-14 to focus on and be cognisant of the Keogh review.

6.2 More transparency, more choice

In the summer of 2013, the Healthcare Quality Improvement Partnership (HQIP) will develop methodologies for case-mix comparison and publish activity, quality measures and national survival rates for every consultant in:

- Adult cardiac surgery
- Interventional cardiology
- Vascular surgery
- Upper gastro-intestinal surgery
- Colorectal surgery

- Orthopaedic surgery
- Bariatric surgery
- Urological surgery
- Head and neck surgery
- Thyroid and endocrine surgery

We will expect our providers to publish on their websites their own information about the services they deliver in these specialities in the HQIP format in preparation for inclusion in the standard contract 2014-15.

We are currently developing a plan to detail how we intend to increase Choice in 2013-14 at all points of the pathway and how, where and in what services / pathways Choice and competition will make the most difference.

6.3 Listening to Patients and Increasing Their Participation

We work with providers and partners to gather public insight into local health services, and our Quality Lead GP is working with Sefton LINk and Aintree Hospital to develop a CQUIN on patient experience. We have systems to ensure patient experience and insight is reported to our Quality Committee for scrutiny and action, as this section describes:

Acting on feedback

We are exploring a number of options presently and working with providers in the development of a patient feedback framework (via the CQUIN) which places the patient at the centre of the service. However, taking into account the national policy direction, we are considering utilising the Patient Access to Health Records programme as a key mechanism by which patients can leave feedback in real time. We will be working with CMCSU to fully realise the potential of developing technology and utilisation of social media tools and other programmes via an

expanding digital eco system. We recognise the opportunity for developing ICT-based solutions and models that support the development of a participative society where patients, their families and carers respond and interact collaboratively for their own benefit and for the benefit of the wider community as a collective movement (Social Return on Investment).

We recognise that the Friends and Family Test is still in developmental form and understand that each provider will have chosen to develop its own systems and processes (as independent businesses) to capture and report patient feedback. With the potential for diverse fragmentation of systems across providers and possible manipulation of data, we are focussed on the development of technological based systems, supported by a communication strategy and enhanced patient and public participation programme, which encourages the local people of south Sefton to become active citizens in their own health. Implementation of this programme fully supports the DH publications 'The Power of Information' (May 2012), articulating the NCB's commitment to improved customer service, through systematic patient and public involvement, intelligence based insight and positive patient outcomes.

We are of the opinion that the introduction of capturing real time feedback via Patient Access to Records (PATR) would generate significant savings (and supports the QIPP agenda) for providers who currently employ capacity and invest in systems and processes to support their own patient experience agenda and the newly introduced Friends and Family Test (FFT). In collaboration with our provider partners, we will seek to fully understand the potential for cost savings through development and implementation of comprehensive technological systems, whose main focus is on the patient experience, not based upon the commissioner / provider relationship. There is potential to capture all patient feedback in real-time via one source (PATR), linked to the NHS Information Centre for Health and Social Care (such a system could also be utilised by Social Care partners) providing a comprehensive data-set for patient consumption. The implementation of this process fits with the ideology and vision of the NCB National Director for Patients and Information, Tim Kelsey and supports the further role out of FFT into primary care by 2014-15.

We would welcome the opportunity to be a pathfinder in demonstrating how we will utilise the Patient Access to Health Records as a functional mechanism in reporting the consequences of feedback from the FFT.

Informing patients

We will continue to:

- Work with the local Health and Wellbeing Board to assess population need
- Work with Health Watch to ensure public involvement plans match local expectations for engagement at individual and collective level
- Develop metrics to evaluate socio economic return on investment and other impacts of patient and public involvement activities

We have played an integral role in the development of Sefton Health and Wellbeing Board (HWBB). Our Chair has been a member of the shadow HWBB since its inception and has more recently been joined by our Accountable Officer. The HWBB, building on previous close working relationships in Sefton, has led an approach to assessing the population needs through a refresh of the JSNA, the Sefton Strategic Needs Assessment (SSNS). The results of SSNA have formed the basis of the Joint Health Strategy, which is currently out for consultation and has been the subject of a very extensive consultation process and (along with CCG commissioning intentions for 2013-14) the focus of five large public events across Sefton in December 2012 and January 2013 (see Appendix 1).

A joint working group for both CCGs in Sefton, called the Engagement and Patient Experience Group (EPEG), has been established, which feeds directly into the Quality Committee of each CCG. This group has a broad membership and is chaired by both CCG Lay Board members and comprises Governing Body practice managers, CCG senior managers, Sefton Council engagement leads, Sefton CVS and Sefton LINk. In future it is hoped members and officers of Health Watch will join the group. EPEG acts by co-ordinating engagement activities and considers patient information from all parts of the system, including practice level Patient Reference Groups, LINk Community Champions, who work in local community settings and feed into CCG localities, LINk local service provider experience reports, and CCG wide systems, such as trends from complaints.

Once in place, we will work with Health Watch to ensure that public involvement plans match local expectations for engagement at all levels.
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We are seeking to work with CMCSU in developing our metrics to evaluate the socio economic return on investments (SEROI) and other impacts of our patient and public involvement activities. We are alerted to the work of the NHS Institute of Innovation and Improvement in

collaboration with David Gilbert of In Health Associates and Sally Williams of Frontline. We are seeking to use the learning from the number of case studies referenced in 'The economic case for patient and public involvement in commissioning', co-authored by David Gilbert and Sally Williams. In addition, we will underpin the development of metrics to evaluate the SEROI by utilising learning from implementing our programme supporting shared decision making and fully utilising the recently published 'Smart Guides to Engagement'. We also await the soon to be published 'individual' and 'collective' involvement guidance from the NCB.

6.4 Better data, informed commissioning, driving improved outcomes

Key areas include:

- The universal adoption of the NHS number as the primary identifier by all providers in 2013-14
- We will use our contracts with Trusts to ensure the NHS number is used as the primary identifier, whilst GP practices will have to use the NHS number as part of the implementation of 111
- By the end of December 2013, over 95% of GP practices in Sefton CCG's will be on the EMIS Web clinical system. EMIS Web will provide the opportunity to utilise its searches and reports module to collect clinical data. A Risk Stratification facility is already in place and currently being utilised to present analysed data back to GP practices for clinical care
- A dedicated team of Information Facilitators within Informatics Merseyside will support GP practices and Sefton CCG's to extract and report on clinical data as required
- We will use NHS Standard Contract sanctions in 2013-14 if we are not satisfied with completeness and quality of provider data on SUS
- We will ensure that secondary care providers' account for patient outcomes and that they ensure the adoption of safe, modern standards of electronic record keeping by 2014-15
- Based on our agreed Informatics Strategy of developing a local Electronic Patient Record (EPR) we are working with all partner Trusts to enable economy wide joined up patient care through systems integration, interoperability and information sharing, encouraging and developing integrated and electronic clinical pathways and communications across health care sectors

- We will ensure secondary care providers comply with data collections based on Information Standards Board and NCB advice by 30 September 2013
- We aim to move to a paperless referral system by 2015 to enable easy access to appointments in primary and secondary care
- We will work with GP practices to pro-actively increase uptake and utilisation of Choose and Book and support practices with training on the Advice and Guidance module to ensure paperless referral systems are utilised wherever possible
- Work is currently on going to utilise EMIS Web's internal referral system to enable electronic referrals across primary and community care. This will be rolled out to all EMIS users as the functionality becomes available
- Direct Commissioners will be responsible for the development of the primary care medical care record by spring 2015
- An Informatics Strategy has been developed in conjunction with Informatics Merseyside. One of the key components of the strategy is patient empowerment. A key element of this component is the Patient Access to Medical Records project which is currently in progression with two pilot sites. The pilot will establish correct processes and protocols around Patient Access. The results of the pilot will be discussed by our Governing Body and Local Medical Committee and from this point, future activity will be planned accordingly in response to the findings of the pilot
- The NCB is accountable for ensuring delivery of IT services is devolved to CCGs to manage GP IT services
- We have an SLA in place with CMCSU (and its strategic partnership with Informatics Merseyside) to commission appropriate GP information services to provide clinical assurance and safety

6.5 Higher standards, safer care

Together with the HWBB, we will work with providers to ensure the recommendations in Transforming Care: A National response to Winterbourne View Hospital and Francis report are implemented and ensure a dramatic reduction in hospital placements for people with learning disabilities or autism in NHS funded care, which have a mental health condition or challenging behaviour.

Our Joint Commissioning Manager for adult services is leading across health and social care on the local response and planning to Winterbourne. We are receiving commissioning support from CMCSU regarding individual packages of care and complex cases but we have, along with Sefton Council, retained a specific joint post that has a portfolio around Learning Disability and the commissioning of individual packages of care. Once the Francis Report is published, plans are in place to present the recommendations to the HWBB, Quality Committee and Governing Body. Chief Nurses across Merseyside are working collaboratively to ensure that Nursing Quality Indicators and necessary CQUINs are negotiated into the contracts for 2013-14 as appropriate

We aim to ensure the Compassion in Practice standards and application of the 6 C's are implemented across all the services provided for our population. We are involved in regional work to inform the implementation of the strategy. In particular, we will work in partnership with the NCB Local Area Team in this particular as part of its quality improvement role.

We have an identified lead for Primary Care Quality, and this subject is a standard agenda item at the Quality Committee.

Comply or Explain Procurement Rule:

We will encourage Trusts to (comply) purchase though framework agreements unless they can (explain) articulate a clear reason to take a different approach. To be discussed with trusts during contract negotiations and specified in the NHS Standard Contract.

The NHS will have to "Comply" with NICE guidance on new drugs and treatments or "Explain" why there is a delay. We will ensure that the latest NICE approved treatments are available in their area and if not then they will be responsible for explaining to patients why not.
Through NHS Constitution, patients have a right to NICE drugs and NHS organisations have a statutory duty to fund them. This will be discussed with trusts during contract negotiations and specified in the NHS Standard Contract

Innovation

The CCG is committed to innovation and driving up standards across the system. All positive NICE Technology Appraisals (TAs) are considered for formal adoption via the Pan Mersey Area Prescribing Committee (APC). Recommendations on adoption of TAs at this forum are passed to the respective governing bodies across Merseyside. We have representation at the APC. Both Formulary and Guidelines and New Medicines Subgroups are sub committees of the APC and we are represented at the sub committees. Sub committees provide the agenda to the APC on adoption of TAs. APC recommendations are accepted at CCG Medicines Operational Groups and formally ratified at board. Local formularies will cover all Merseyside CCGs. The local formulary will be published via the CCG website linking to the Pan Mersey formulary. This will obviously incorporate NICE TA adoption and will be tracked by medicines management support from CMCSU.

We are a member of the North West Cost Academic Health Science Network. By agreement with the Merseyside CCG Network, Dr Andy Davies Chair of Warrington CCG is the CCG representative on the group. We will use a number of methodologies to ensure the adoption of innovation including improving methodologies and spread.

Our 'Virtual Ward' will embrace technology with our providers to ensure patients get the best possible outcomes, for example community nurses using tablets to access patients records in the patients home, thus delivering real time record keeping and reducing duplicate inputting. We will also look at the use of telemedicine in the Virtual Ward in order that patients can make better informed decisions about accessing health services, an example might be when a COPD patient exacerbates they have a better understanding of the type and severity of the exacerbation.

7.0 Transforming health and social care at CCG level

7.1 Joined up Local Planning

Organisations across the local health economy have worked together to identify the parents of children with special educational needs or disabilities who could benefit from a personal budget based on a single assessment across health, social care and education.

Our plans:

Following the Draft legislation on 'Reform of Provision for children and Young people with Special Educational Needs (SEN) published in September 2012 it is expected that this will be followed up in 2014 with the new SEN Code of Practice.

Sefton Council is already working towards its implementation of the National Funding Proposals (Schools funding reform: Next steps towards a fairer system) and its joint funding arrangements with health. It is subsequently expected that the outcomes from this will be followed up in 2014 to comply with legislation around personal budgets in the new SEN Code of Practice.

Workforce Plans

We will work closely with providers to ensure they have robust workforce plans and there will be no compromising on quality improvements or any reduction in safety as a result of these plans.

7.2 Quality, Innovation, Productivity and Prevention (QIPP) 2013-14

CCGs' outline QIPP plans for 2013-14 should include the key milestones and outcomes to be delivered and detail on:

- Learning from 2012-13
- How they will ensure the delivery of wider service and financial sustainability
- Outline plans to ensure triangulation of activity, quality and cost data to drive QIPP planning and assurance
- Confirm that clinically led quality impact assessment of all cost improvement programmes (CIP) and detail how CIP will have medical director and nursing director sign off
- Activity plans and forecasts for the next 2 years
- Confirm that local metrics (such as staff and patient views and the Safety Thermometer) have been used to reflect needs of health economy in the planning

We remain on course to deliver our QIPP schemes in 2012-13, mainly drawn from three key areas - prescribing, efficiency delivered by local providers and transformational schemes - working in conjunction with local commissioning and public sector bodies to develop new ways of working through productivity and innovation.

We have reviewed plans from 2012-13 and provisionally identified areas where existing schemes will make a contribution to the delivery of QIPP in 2013-14. These plans will be worked up over the next few weeks and details will be included within our final submission. We are looking to work with the NCB Local Area Team to ensure that existing PCT QIPP targets are allocated to successor bodies and would be grateful for advice on how this will be achieved.

We have sought assurance from provider executive teams that known CIPs have been rigorously assessed in terms of from a service quality and patient safety perspective, and we awaiting response.

We have assumed steady state activity plans over the next 2 years based on a view that increased demand for services will be offset by productivity gains elsewhere in the system – we have made provision for 1% contingency reserve within our financial plans to deal with the costs of any unexpected growth in activity. We will work with public health colleagues to review these assumptions over the next few weeks and more details of specific assumptions will be provided in the final plans.

We continually review local metrics and are using key tools, such as 'Right Care', to help shape and influence our plans in respect of the needs of the local health economy.

QIPP PLANS 2013/14	Description	£'000	Total £'000
Transformational Schemes			**3,492**
Prescribing	ARB	27	
	Statins	54	
	ED	58	
	Other	1,009	
			1,148
Provider Contracts	Tariff efficiency - 4%		**7,052**
Total			**11,692**

8.0 Financial Planning

8.1 Financial Control

Surplus policy

We have planned to make a surplus of 1% of our revenue resource.

Managing risk

We have set aside 2% of our recurrent resource allocation for investment on a non-recurrent basis in 2013-14. We will focus this investment in local schemes aimed at transforming pathways to deliver savings in later years and to redesign services to meet changing needs of our local population. There are some residual schemes left over from the PCT legacy, which we have made provision for within our plans. We will work with other commissioners, including the NCB Local Area Team to agree these schemes between now and final plan submission. We have established risk share arrangements with Southport and Formby CCG, which will include review of the 2% non-recurrent investment and adjustments to baselines where additional analysis proves incorrect. We are also exploring wider risk share agreements with other CCGs in Merseyside, particularly in respect of high cost Mental Health package of care. We have included contingency of 0.5% specifically to deal with growth areas in 2013-14 in our plans.

Planning assumptions

We have assessed growth in demand and have included a contingency within our financial plans in 2013-14.

Tariff

Our plans have been constructed in line with tariff assumptions.

Integrated care plans

We will be working with local partners, notably Sefton Council providers and the voluntary sector to identify how the recurrent reablement funding (c. £1.8m across the Sefton area) can be best invested to deliver maximum benefit in terms of health outcomes and improving effectiveness of the local healthcare system. It is envisaged that this will be managed through a sub-group of the Strategic Integrated Commissioning Group established with the Council.

8.2 Contracting for Quality

CQUIN

CQUIN applies to 2.5% of the value of all services commissioned through the NHS Standard Contract. One fifth is to be linked to national CQUIN goals and CCGs and direct commissioners should outline to plans to apply this to ensure delivery of improvements in:

- Friends and Family test
- Improvement against the NHS safety Thermometer (excluding VTE)
- Improving dementia care (FAIR)
- Venous Thromboembolism – 95% patients being risk assessed and achieve locally agreed goal for no. of VTE admissions that are reviewed through RCA

CQUINs will only be paid where providers meet the minimum requirements of high impact innovations.

We are working collaboratively across Merseyside with the support of CMCSU to deliver a co-ordinated approach to CQUIN across the health economy. CCGs have identified CQUIN schemes for negotiation into 2013-14 contracts and where possible have come to an agreement regarding common CQUINs – the Chief Nurses are leading on the development of specific portfolio related areas. The CQUINs have been

identified in commissioner workshops that have taken place in November 2012 and January 2013. Providers were also asked, via CMCSU, to put some suggested CQUINs forward for commissioners to consider. A further meeting has been arranged whereby commissioners and providers will meet in order to start the negotiation process.

CMCSU is liaising with Specialist Commissioning regarding any local CQUINs that have been developed that may be applicable for tertiary units in the area.

Local and regional CQUIN plans

We will work with our neighbouring CCGs and CMCSU to monitor the national CQUINs with our providers. We will also work collaboratively to develop and monitor the implementation of the Alternative Quality contract, which is being developed with local clinicians and in collaboration with West Lancashire CCG.

Our plans include CQUIN within applicable provider contracts at 2.5%. Alongside national measures, it is anticipated that a number of local measures will be applied consistently across Merseyside and will be agreed and reported within the final draft of commissioning plans.

Key performance indicators (KPIs)

We have a clinical lead for quality that, with our Lead Nurse, will develop our KPIs will providers and engage in performance management. In collaboration with the contract management team this will also provide a direct link to our Governing Body. We will include appropriate penalty clauses in standard contracts and will apply them accordingly.

Continuity of care

We will designate A&E as a commissioner required service, and in addition (as part of the designation) we will require the following services to support A&E):

- Anaesthetics
- ICU / HDU
- Diagnostics
- Path labs

Appendix 1 - How we involved people in our plans

We have worked with and consulted a wide range of partners to develop our plans for 2013-2014. Below are some of the ways we have done this:

Big Chat

We held our first public event in summer 2012, inviting local residents to give their views about how health and health services should develop in the future. Sefton Council and Sefton LINk (the forerunner to Sefton Health Watch, the patient's champion) joined forces with us at the event to gain feedback on the priorities identified in our joint strategic needs assessment, the Sefton Strategic Needs Assessment (SSNA).

SSNA involvement events

Together with Sefton Council, we held nearly 50 public and partner events during 2012 to gain wide ranging feedback on the priorities set out in the SSNA. These were organised to ensure as many people as possible could comment on the findings of the SSNA, from hard to reach communities to partners in different parts of the health and social care system.

Talking Health and Wellbeing in Sefton

All the feedback gained from the Big Chat and SSNA involvement events have been used to inform the overarching draft Health and Wellbeing Strategy for Sefton (HWBS). Our plans for 2013-2014 outlined in this document also reflect these locally developed priorities and goals. In December 2012 and January 2013 we again worked with Sefton Council to hold five public Talking Health and Wellbeing sessions across Sefton to test out our specific SSCCG plans and the themes contained in the HWBS. There were also over 40 other events where people were invited to comment on the objectives and priorities in the draft HWBS.

Appendix 2 – Clinical and managerial leads for each programme

Area	South Sefton CCG Lead	CCG Team Lead
Alcohol	Dr Sunil Sapre	Tina Ewart
Cancer	Dr Debbie Harvey	Sarah Reynolds
Children	Dr Wendy Hewitt	Jane Uglow
Contracting	Dr John Wray	Stephen Astles / Jan Leonard
COPD	Dr Steve Fraser	Sandra Boner / Jenny Kristiansen
CVD	Dr Craig Gillespie	Stephen Astles / Sandra Boner
Communication / Patient Engagement	Roger Driver / Lin Benett	Lyn Cooke / Tina Ewart
Dementia / Mental Health	Ricky Sinha	Geraldine O'Carroll / Kevin Thorne
Dermatology		Billie Dodd
Diabetes	Dr Nigel Taylor	Moira McGuiness
End of Life	Dr Debbie Harvey	Moira McGuiness
Integrated Care	Dr Peter Chamberlain	Stephen Astles / Billie Dodd
IT	Dr Steve Fraser	Alison Johnson
Medicines Management/Prescribing	Dr Steve Fraser / Jill Thomas	Brendan Prescott
Quality	Dr Gina Halstead	Debbie Fagan, Steve Astles, Billie Dodd
Patient and Public Involvement	Libby Kitt / Lin Bennett	Jackie Robinson / Tracy Jeffes
Prevention and Public Health	Dr Steve Fraser	Cathy Warlow / Helen Chelleswamy / Margaret Jones
Primary Care Quality	Bal Duper	Angela Parkinson / Debbie Fagan
Unplanned Care / 111 Care	Dr Andy Mimnagh	Billie Dodd / Stephen Astles / Malcolm Cunningham
Governance	Lynda Elezi	Tracy Jeffes

*Italics – not a Board member

Appendix 3 – South Sefton Local Priorities Mapping

South Sefton Local Priorities Mapping			
Reduction in hospital admission for people with COPD			
Health and Wellbeing Strategy Priorities 2013 – 2018	South Sefton CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support Older people and those with long term conditions and disabilities to remain independent in their own homes.** **Consultation and engagement identified that the following was important :-** **" Maintaining independence by supporting people to remain well, with care closer to home, improvement of primary care through virtual wards, good access to public transport and early intervention, prevention and diagnosis for those with limiting long term illness and / or disabilities**	**Improving Primary Care** Health Checks – continuing to promote the scheme to detect those at risk of heart disease and diabetes **Improving Community care** Virtual ward , further develop the programme which brings together a range of health professionals to better manage patient conditions so they do not need hospitalisation and to support them in the understanding of their condition and what they can do to stay well- including patients with dementia, long term conditions and those at end of life. **Long term conditions** Alongside the virtual ward , we want to increase screening and provide specific initiatives to improve the care of dementia, lung disease and heart disease patients **Improving the use of hospital care** Reducing emergency admissions to hospital – along with the virtual ward we want to develop a 7 day urgent care team to investigate monitor and support patients at risk o deterioration whilst in hospital, promoting the appropriate us of emergency services to South Sefton residents. Ensuring hospital and community services work better together – working to ensure patients journey between hospital, community and primary care services is as smooth as possible, including better discharge planning , services for diabetes and cancer through our virtual wards	"Access to timely services" "Proper and effective advice and support for people with long-term conditions." "Self-help support. Need to distinguish when self-care is appropriate and when it is appropriate to seek professional" "As soon as the patient is diagnosed with LTC/WHATEVER, get the Proper Discharge Planning in place – NOT SELECTIVELY Everyone to get same service level to eliminate gaps in Discharge planning" "Thinking of the virtual ward, can the patient still get a second opinion?" "The challenge of multi complex health needs, i.e. Lung disease, COPD, Cancer etc." "Tele health technology" "Virtual wards – keep people at home and deliver services" "Long-term conditions, working age of people, diabetes – need to focus on these through early intervention and support to prevent people developing more complex needs." "Try to get appropriate use of secondary care"	" More access to services at a local level , rather than going in to hospital –using voluntary and community organisations locally" (Bootle) "Better respite for long term illness sufferers and better promotion of these services" (Bootle) "Give confidence in self-management" (Bootle) "Hospital at Home service will positively support older people with long term conditions" (Maghull) "Virtual Ward and Long term conditions objectives – a good idea" (Maghull) "more social care in hospital to support discharge" (Maghull)

South Sefton Local Priorities Mapping

Reductions in antibiotics prescribed

Health and Wellbeing Strategy Priorities 2013 – 2018	South Sefton CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support people early to prevent and treat avoidable illness and reduce inequalities in Health** **Consultation and engagement identified** **Find different ways to support people early to avoid them needing expensive acute services and surgical procedures**	**System Wide Improvements** We will work with public health to support prevention initiatives , provide training to health and social care staff to support their patients and clients and support those with long term illnesses to manage their conditions	"Self care needs to improve, not all bad backs need physiotherapy, people need to take some pain relief and see if it gets better on its own, the same for coughs and colds etc. We need to change people's mind about running to the hospital and GP with every niggle." "Look at prescriptions – issue of wasted repeats" "Understanding when to access services ie campaigns for coughs"	" Take control of own lives , manage sickness" (Bootle) " Stop pharmacy repeat prescriptions service" (Crosby) "Cost of medication not being used"

Improved diagnosis of cancer, shift diagnose to primary care rather than in acute settings

Health and Wellbeing Strategy Priorities 2013 – 2018	South Sefton CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Strategic Objective **Support people early to prevent and treat avoidable illness and reduce inequalities in Health** **Consultation and engagement identifies Primary care services need to be local and accessible, reducing waiting times for GP appointments ,accessible walk in centre, focus on early diagnosis to prevent cancer, heart disease, stroke and improve falls prevention service.** **Find different ways to support people to avoid them needing expensive acute services and surgical procedures**	**System Wide Improvements** Improving cancer services. We will recruit a McMillan GP to influence how cancer services are provided for patients from detection through to end of life , working closer with the Mersey Cheshire Cancer Network Early Detection Project manager to support GP practices around cancer rates amongst their patients- all with the aim of increasing survival rates	"The challenge of multi complex health needs, i.e. Lung disease, COPD, Cancer etc." "Early, prompt and effective diagnosis and treatment." "Issue of cost effectiveness of blanket screening" "FR Has to go to Clatterbridge for meds not available locally." "Focus on prevention would reduce need for acute services" "People who don't see the benefit long term ie smokers with cancer they don't see that smoking will give them cancer 10 years down the line so they don't care about it now just when it is too late" "Health checks/Health screening offered/targeted at specific ages"	"Clusters of people with cancer and Asthma not being investigated properly"(Crosby) "Sefton residents have to go to Clatterbridge. In 2017 the new Royal Hospital will have a unit. Cancer unit at Aintree, consultant doesn't hold a clinic in Aintree so has to go to Clatterbridge. But must be realistic about what can be achieved in the next few years. This is also an issue in terms of costs of travel. (Crosby) "Early diagnosis and intervention by screening will save money in the long run, prevent unnecessary treatment and hospital stays but need pump priming for screening)" (Crosby)

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/39	**Author of the Paper:** Martin McDowell Chief Finance Officer Martin.mcDowell@sefton.nhs.uk

Title:

2013/14 Financial Outlook Report

Summary of the Paper/Key Issues:

This paper presents the Governing Body with the CCG's opening financial position for 2013/14 to the Governing Body, and advises upon risks still inherent in the baseline exercise and contract agreement process.

Action/Decision Required:

The Governing Body is asked to note/approve:

- Approve the opening revenue budget for the financial year 2013/14.
- Note that the opening budgets deliver the key metrics required by the NHS Commissioning Board in terms of 1% surplus.
- Note that the CCG has provided a 1% Contingency reserve which is in excess of the NHS Commissioning Board recommendation of 0.5%.
- Note that the CCG planned expenditure is within its running cost target.
- Note that the CCG has identified transformational schemes using 2% of non-recurrent expenditure.
- Approve the proposal to introduce a Sefton-wide "risk-share" agreement which allows up to 2% of baseline expenditure across the CCG's.

Date of Report:

19 March 2013

South Sefton Clinical Commissioning Group

Report to Board

March 2013

1. Background

1.1 This paper provides details of the CCG's opening budgets for adoption in 2013/14, although this is subject to clarification of key issues.

1.2 The changes made to the structure of the NHS, which come into operation from 2013/14 are wide-ranging with a number of new bodies taking over the former responsibilities of Primary Care Trusts. This has led to increased complexity in terms of setting budgets for the new bodies. Some responsibilities have transferred across the new bodies since the exercise to identify baseline spending was undertaken in September 2012 and it remains unclear whether the funding sits in the right place at present. A specific risk within the Sefton Health Economy was the creation of two separate CCG's and the requirement to split baseline expenditure across the new organisations using estimates in key areas (e.g. mental health, community contracts etc.). Alongside this issue, there are a number of issues that remain unresolved and this paper will outline these risks.

1.3 A summary of the Financial Strategy using intelligence collected from a range of sources in relation to projected uplifts and reductions to expenditure plans is presented below,

Table 1: Financial Strategy Summary	**2013/14 £m**		
	Rec	**Non-R**	**Total**
Base Allocation	227.1	0.0	227.1
DH Growth Allocation	5.2	0.0	5.2
Running Cost Allowance	3.7	0.0	3.7
Lodgement B/F	0.0	1.2	1.2
Surplus B/F	0.0	1.2	1.2
Available Resources	**236.0**	**2.4**	**238.4**
Commissioning Budgets			
NHS Contracts	168.8	1.2	170.0
NCA's	1.6	0.0	1.6
Independent Sector	3.4	0.0	3.4
Other Secondary Care	1.9	0.0	1.9
CHC/FNC/Complex Care	18.0	0.0	18.0
Primary Care	1.1	0.4	1.5
Prescribing	28.7	0.0	28.7
Sub-Total	**223.5**	**1.6**	**225.1**
Reserves & Pressures			
Pay & Prices Cost Pressures	12.8	0.0	12.8
Other Cost Pressures	2.5	0.0	2.5
Corporate Running Costs	3.6	0.0	3.6

Table 1: Financial Strategy Summary	2013/14 £m Rec	Non-R	Total
Other Corporate costs	0.9	0.0	0.9
2% Non-Recurrent Reserve	0.0	4.6	4.6
Contingency Reserve	2.5	0.0	2.5
Other Reserves	3.5	0.0	3.5
Investment Plans	1.8	(0.6)	1.2
Lodgement C/Fwd	0.0	1.2	1.2
Anticipated Baseline Adjustments	(13.9)	0.5	(13.4)
Less Efficiency Target	(8.5)	0.0	(8.5)
Sub-Total	**5.2**	**5.7**	**10.9**
Anticipated Spend	**228.7**	**7.3**	**236.0**
Forecast Surplus / (Deficit)	**7.3**	**(4.9)**	**2.4**
Expressed as %	**3.1%**		**1.0%**

1.4. Detailed budgets showing expenditure information at cost centre level will be reported to the Governing Body in its May meeting.

2. National Context

2.1 The Department of Health (DH) issued its planning guidance for CCG's under the cover of *Everybody Counts : Planning for Patients 2013/14.* This publication sets out the DH's expectations for health service priorities for the forthcoming year. In the document, the DH outlines five specific offers to the public, notably,

- NHS Services – 7 Days a Week
- More Transparency, More Choice
- Listening to Patients and increasing their participation
- Better data, informed commissioning, driving health outcomes
- Higher Standards, safer care

2.2 In addition to these offers, the DH also set out five domains aimed at improving services through the NHS Outcomes Framework,

- Preventing people from dying prematurely
- Enhancing the quality of life for people with Long-term conditions
- Helping people to recover from episodes of ill-health or injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

2.3 In setting out the Outcomes Framework and offers, the DH have been less prescriptive than previous years when key programme areas were identified and commissioners were advised to provide for a fixed level of investment within their financial plans. The CCG

commissioning plan will incorporate all these areas although some of the financial consequences have yet to be determined (e.g. HFMA have been commissioned by Sir Bruce Keogh to undertake a costing exercise to quantify the costs associated with providing NHS Services for 7 days a week). This report is expected to be published towards the end of this calendar year and will inform 2014/15 financial plans. At this stage, the impact of national planning has not been explicitly included within financial plans apart from notable exceptions (e.g. IAPT). The CCG plans to apply the "Right Care" methodology across its key commissioning budgets to deliver the required improvements within its financial envelope.

2.4 The CCG's baseline commissioning allocation has been established at £227.1m through the exercise to split commissioning responsibilities across PCT successor bodies. In addition to this, all CCG's in England received uniform levels of growth of 2.3%, which equated to an uplift of £5.2m for the CCG. The CCG running cost allowance was set at £3.680m based on the Attribution Data Set (ADS) registered population adjusted to new ONS projections which estimated South Sefton's population at 147,366 (and equates to £24.97 per head). The 2012 ADS registered population for the CCG is 153,503 (which would equate to £23.97 per head).

2.5 In previous years, the DH published target allocations for PCT's to describe how actual allocations compared to "fair shares" targets and traditionally NHS Sefton faired well in terms of its actual allocation being above its expected fair shares allocation. The approach taken in 2013/14 by the DH is aimed at keeping the health system as stable as possible so it has attempted to use planned expenditure levels from 2012/13 as the starting points for 2013/14 allocations. A working group is still reviewing future allocation levels and it is possible that a move towards "fair shares" may be implemented in 2014/15 along with changes to key demographic weightings (e.g. Age, deprivation etc.).

2.6 The DH's Quality, Innovation, Productivity and Prevention (QIPP) programme will enter its fourth year of a five year programme in 2013/14, with its aim to deliver £20 billion worth of savings and efficiencies in this period. Section 8 of this report will describe the impact of this on the CCG.

2.7 The DH set an annual level of planned efficiency within its publication of tariffs for providers. The target has been set at 4% for 2013/14 and is expected to continue at around this level in future years. The responsibility for setting the tariff in 2014/15 will transfer to Monitor and speculation suggests that the national average approach taken by the DH may not be the basis of tariff setting in future. Monitor may potentially favour the use of an average tariff taken from selected providers who can provide that they deliver high quality, cost-efficient services. This may lead to differential impacts on providers in terms of ability to deliver savings in the future. The DH also takes expected levels of inflation into account when setting the tariff as described in the table below. The CCG financial plans have been constructed on the basis of applying a 1.1% contract reduction to its NHS expenditure baseline.

Table 2: 2013/14 net price adjustment (mandatory PbR tariff)	% adj.
Pay and price inflation	2.7
Total national efficiency requirement	-4.0
Net price adjustment	-1.3
Additional mandatory tariff increase for underlying cost pressures	0.2
Net uplift (prices in scope of mandatory tariff)	-1.1

Data Source : Table 1 : Payments by Results Guidance for 2013/14

2.8 In demonstrating sound financial planning, all CCG's are expected to ensure that 2% of recurrent funding is only committed to non-recurrent expenditure. The CCG's will have to submit business cases to the National Commissioning Board (NCB) Area Team for Merseyside for approval. The proposed schemes for the CCG are identified in section 5.

2.9 The DH has maintained the amount available for Trusts to earn via Commissioning for Quality and Innovation schemes (CQUIN) at 2.5%. This scheme is available for all services commissioned under standard NHS Contracts and the guidance describes the funding as non-recurrent. The CCG plans account for this funding on a recurrent basis given that it is likely that the scheme will continue into the long-term future with the nature of the schemes changing on an annual basis. A proportion of the CQUIN funding 0.5% is retained to fund national schemes where appropriate to providers whilst the balance 2.0% is available to fund agreed local priorities.

2.10 The DH has also indicated its commitment to introduce PbR for Mental Health services in future years. In 2012/13 use of consistent currencies (clusters) for all patients in mainstream adult and older people's secondary mental health services was introduced. For this year contracts have been rebased using the clusters and mandating the use of some quality and outcome measures. The guidance also emphasises the need to improve the quality and completeness of clinical data that flows to the Mental Health Minimum Dataset. Commissioners will need to ensure that they are able to understand and interrogate the MHMDS to derive the information that they need to support effective service commissioning. It is not clear how this will impact on CCG budgets but introduction of PbR for Mental Health services should be considered as a medium-term risk.

3 PCT surplus and Lodgements brought forward from 2012/13

3.1 NHS Sefton's expected surplus for 2012/13 is £2.624m and it also agreed a lodgement sum of £2.619m with the SHA at the start of the year. The CCG will inherit its proportion of these sums based upon its share of the PCT baseline. This equates to c.45.3% for the CCG.

3.2 Surpluses are returned to CCG's in the following year whereas "draw down" of lodgement figures are reviewed on an annual basis depending upon national policy. Final lodgement figures will be agreed with the NCB local area team and at this stage the CCG is not planning upon drawing down any lodgement in 2013/14 and is expected to carry the full value (£1.186m) forward into 2014/15 financial plans.

4 2013/14 Opening Expenditure Budgets

4.1 The opening budgets for the CCG have been constructed using projected out-turn figures from 2012/13 financial year and will be subject to verification once the final outcome of 2012/13 has been assessed.

4.2 A general assumption of net 1.1% savings on NHS Contracts has been included in the opening budgets assessment. Work is continuing to understand the impact on individual providers, which may differ from the average national assessment.

4.3 The CCG Community prescribing budget has been uplifted by 5% before the application of a 4% efficiency saving leaving an overall increase of 1% to the 2012/13 projected out-turn figures.

4.4 The opening budgets include the CCG's share of reablement funding (which is provided recurrently) and the CCG will need to agree plans for use across the health and social care system with Sefton MBC £1.007m is included within the expenditure plans for this purpose.

4.5 The opening budgets exclude DH support for social care funding that had been previously provided by PCT's. The Local Area Team of the NCB now hold the responsibility for providing this allocation to Local Authorities although the CCG will work closely with Sefton MBC in agreeing priorities for this expenditure through the Health and Wellbeing Board. South Sefton's estimated share of this funding is £3.220m

4.6 Further work and analysis is still being undertaken by the CCG finance team to determine accuracy of budgets and the outcome of this review will be shared with the Governing Body in its May meeting.

5 Use of 2% Non-Recurrent Reserve

5.1 As mentioned in section 2.8, CCG's are required to spend at least 2% of their recurrent commissioning baselines on non-recurrent schemes. This equates to £4.647m for the CCG and the schemes described overleaf are proposed as priorities for the CCG in terms of deploying this funding.

Use of 2% Non-Recurrent Reserve	**2013/14 £m**	**2014/15 £m**
Virtual Ward Project	1.5	1.5
Mersey Rehab Project	1.1	1.1
CVS Support	0.7	0.7
Primary Care Development	0.5	0.5
Winter Pressures	0.4	0.4
Early Stroke Discharge	0.2	0.0
Community Spirometry	0.1	0.1
Other (IAPT / Tailored Care)	0.1	0.1
EMIS Licencing for Community use	0.0	0.2
Total	**4.6**	**4.6**

5.2 As can be seen from the proposal above, the CCG has outlined its commitments over the next two years. There are other schemes also being worked up and it is likely that the CCG will support other non-recurrent schemes over and above this value using recurrent funding. It should be noted that 2014/15 plans are provided for information at this stage and will be subject to confirmation in Q4 of the 2013/14 financial year. It should also be noted that should the schemes listed above be confirmed as recurrently funded, then the CCG's recurrent surplus will reduce.

5.3 Key schemes include the introduction of the Virtual Ward scheme as previously agreed by the Governing Body and proposed support for the Mersey-wide rehab programme which is being supported for an initial 2 years pending review of evidence to support its longer-term introduction.

5.4 The CCG has also proposed holding a reserve to help support local winter pressure arrangements outside of any nationally agreed support.

6 Investment Plans

6.1 The CCG is also holding reserves to support additional resources required for the emergency care commitments alongside funding retained to support initiatives previously identified as national priorities.

6.2 The negative figure reported non-recurrently indicates that some non-recurrent support is available to offset costs in the first year whilst the CCG reflects the full recurrent position within its budgets. This enables the CCG to plan for required recurrent savings with a longer lead-time.

7 Running Cost Allowance

7.1 As previously reported, the CCG's running cost allowance has been set at £3.680m. There remains a small unused level of contingency held against this reserve, but there are likely to be further pressures once key issues such as IT and Estates are resolved.

7.2 In addition to running costs, the CCG is likely to incur other costs supporting its commissioning programme (e.g. data facilitators etc.). These costs are excluded from the CCG's running cost calculations and will be reported separately. The CCG is expecting to receive an allocation from NCB with regard to support for primary care IT infrastructure. These figures have yet to be finalised and will be reported to the Governing Body once confirmed.

8 QIPP Plans

8.1 The CCG has inherited a share of NHS Sefton's QIPP target again based upon share of baseline expenditure. This figure has provisionally been established as £8.452m. Against this, the CCG has identified two clear QIPP schemes listed below,

Table 4: QIPP Schemes	2013/14 £m
Provider efficiencies through tariff	7.1
Prescribing schemes	1.1
To be confirmed	0.3
Total	**8.5**

8.2 The CCG currently has unidentified QIPP savings target of £0.300m. It is anticipated that the balance of the QIPP schemes to be identified will be delivered through service redesign as the CCG begins to implement schemes using the Right Care methodology. The CCG has already earmarked Ophthalmology services as an area to progress as a priority.

8.3 CCG's are expected to take a keen interest in savings delivered by providers through their efficiency plans. As part of agreeing contracts, clinical leaders in CCG's are asked to make their own assessment of cost improvements to satisfy themselves that services are safe for patients with no reduction in quality.

8.4 Progress against and required adjustments to the QIPP plans will be monitored separately via the CCG's QIPP sub-group. The sub-group will be asked to advise on plans to take corrective action to deliver the QIPP target if the shortfall remains unresolved.

9 Key Financial Risks and Pressures

9.1 As mentioned in the introduction to this paper, the changes to financial arrangements to support the introduction of the new commissioning infrastructure within the NHS are complex and key issues still remain unresolved.

9.2 The key risk relates to agreement of contract splits between CCG's and NHS Commissioning Board in relation to Specialised Services and how this will be managed during the year. An agreement has been reached to manage through a co-commissioning arrangement which is likely to involve significant changes to opening budgeted position in terms of both income and expenditure and could also have an impact on overall financial position.

9.3 At the time of writing this paper, the CCG had not reached agreement with any providers in respect of agreeing 2013/14 contracts so commissioning budgets remain indicative at this stage and subject to changes arising from final agreements with providers.

9.4 The CCG plans have been prepared using 2012/13 Financial Year out-turn position so any growth in demand will need to be funded using CCG contingency reserves. It remains imperative that members of the Group continue to manage referrals into secondary care using appropriate thresholds, whilst also supporting improvements in the urgent care system.

9.5 The CCG's are inheriting a favourable position with regard to community prescribing after significant savings were delivered in 2012/13 through a range of schemes, including introduction of generic products replacing previously patented products. In setting budgets for 2013/14, the CCG's have assumed a net 1% uplift in overall terms. It should be noted

that aspects of prescribing remain volatile and this area could present risks to budgets in 2013/14 and will require continued support from community pharmacist teams and practices to deliver a balanced position.

9.6 The plans assume that the CCG will recoup 1.1% from all NHS Contracts under the planned tariff adjustment. There are a number of separate factors within the construct of the tariff that may mean that this sum is unable to be recouped in full. These include best practice tariffs, changes to maternity pathways and reporting of x-rays within tariff. These all add to the potential risks facing the CCG and more work is required before final agreements can be reached.

9.7 The PCT proposes to provide adequate cover for the impact of Continuing Healthcare (CHC) restitution payments for claims identified by September 2012 within its 2012/13 reported accounts. There is a further deadline for claims due at end of March 2013 and may lead to residual risk for the CCG as it takes over responsibility for commissioning these services. The Governing Body will be regularly updated on progress in this area during the 2013/14 financial year.

10 Contingency Reserves

10.1 As a consequence of the heightened levels of financial risk described in section 9, it is recommended that the CCG plan for a 1% reserve as part of its contingency planning and this has been included within Table 1. This level of reserve exceeds the DH guidance which recommends a 0.5% contingency reserve within CCG plans.

10.2 As described in the February Board development session, the CCG is gathering better supporting information to review costs that had previously apportioned using estimated bases. The finance team supporting the two CCG's in the Sefton Health Economy are re-evaluating this information and it is likely to result in a number of baseline adjustments which should not impact on either CCG bottom-line position. These adjustments will be reported to both CCG Finance & Resource Committees when confirmed.

11 Proposed Baseline Transfer – "Sefton-wide" Risk Sharing Agreement

11.1 It is highly likely that a number of legacy issues will emerge during 2013/14 following confirmation of 2012/13 forecast out-turn figures for PCT's and review of the baseline exercise. Some of these issues may impact on the CCG's "bottom-line" position and will require a process to ensure that no unintended consequences arise and lead to potential de-stabilisation of services across the Sefton health economy.

11.2 To mitigate against this risk, both CCG's are asked to delegate the power to make a non-recurrent transfer of up to 2% of RRL to a sub-group comprising the Chairs and audit chair of both organisations, the Accountable Officer, and Chief Finance Officer. The outcome of these discussions will be reported through both CCG Finance & Resource Committees.

12. Conclusions & Recommendations

12.1 The CCG's Revenue Resource Limit (inclusive of running cost allowance) has been forecast at £238.4m for the financial year and anticipated expenditure is forecast at £236.0m which means that the CCG is projecting a surplus of £2.4m for the financial year, which equates to 1% of its forecast RRL. The CCG Governing Body is asked to approve the opening budgets for 2013/14 on this basis.

12.2 The CCG's underlying recurrent position has been assessed at 3% surplus which is additional to a 1% contingency reserve. The NHS Commissioning Board target contingency is 0.5% and the CCG plans exceed this at this stage.

12.3 The CCG remains on target to operate within its running costs target and further details will be provided to the May Governing Body.

12.4 The CCG has identified a range of transformational schemes for use of the 2% non-recurrent reserve.

12.5 The CCG has identified the bulk of its QIPP plan target with an outstanding balance of £0.300m remaining. It is anticipated that work undertaken in respect of service redesign during the year will deliver this target.

12.6 The CCG Governing Body is asked to approve the adoption of a Sefton-wide risk sharing scheme which delegates the power to transfer up to 2% of baseline allocation to a sub group to ensure that services across Sefton are not de-stabilised during 2013/14.

20 March 2013

Martin McDowell
Chief Finance Officer
NHS Southport & Formby CCG

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/40	**Author of the Paper:** Samantha Tunney Head of Business Intelligence & Performance, Sefton Council Samantha.tunney@sefton.gov.uk
Title: Plans for HealthWatch in Sefton	
Summary of the Paper/Key Issues: This paper presents the Governing Body with information on progress made in establishing HealthWatch Sefton.	
Action/Decision Required: The Governing Body is asked to note the contents of this report.	
Date of Report: 14 March 2013	

Report to Board

March 2013

1. Background

Further to previous reports significant progress has been made in establishing Healthwatch Sefton.

2. About Healthwatch

2.1. Healthwatch is the new consumer champion for the public, patients, health and care service users, and their carers and families. It has two forms: Healthwatch England, which was established on 1 October 2012; and local Healthwatch organisations which will start from 1 April 2013 based in upper-tier and unitary local authority areas in England2.

2.2. Healthwatch England will provide leadership, support and advice to the local Healthwatch network. It will use evidence based on experiences to highlight national issues and trends in order to influence national policy. Through the network and by receiving views directly, Healthwatch England will ensure that voices of people who use health and social care services are heard by the Secretary of State for Health, the Care Quality Commission, the NHS Commissioning Board, Monitor and local authorities in England.

2.3. A key role of local Healthwatch organisations will be to promote the local consumer voice to ensure that the views of patients, service users and the public are fed into improving local health and care services. The primary task of local Healthwatch organisations will be to gather evidence from the views and experiences of patients, service users and the public about their local health and care services and to provide feedback based on that evidence.

2.4. They will take this information and report the evidence to those in charge of arranging and funding services and making decisions – and those providing services – about the quality of care, including through statutory representation on the local health and wellbeing board. This should help to ensure that those who make decisions about health and care services can be aware of and act and respond quickly to concerns. Local Healthwatch organisations will also feed this evidence into Healthwatch England.

2.5. The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) sets out the requirements for arrangements for patient and public involvement activities through local Healthwatch organisations. Regulations laid in December 2012 make further provision about the criteria that bodies will need to meet in order to be contracted as local Healthwatch organisations, the duties on commissioners and providers, and the contractual arrangements between the local authority and local Healthwatch; and local Healthwatch and its contractors.

3. The Role of Healthwatch

3.1. The legislation seeks to ensure that local Healthwatch organisations:

- act independently of political parties, think tanks and campaigns;
- keep any campaigning as secondary to their core purpose, and limited to and focused on improvement to local health and care services, based on evidence gathered and views heard from the local community, and;
- pursue their primary purpose as a consumer champion.

3.2. The legislation seeks to prevent a local Healthwatch from:

- aligning itself to a particular party or political body;
- being set up or run with a main purpose of achieving particular policy changes or changes to the law, and;
- making political activities its main activity.

3.3. The legislation does not stop a local Healthwatch from:

- using robust evidence and feedback from the community as basis for raising the concerns of local people with local councillors, council officers and health service managers who have responsibilities for commissioning, providing or managing particular local health and care services;
- speaking out based on evidence, at a local level about service improvements that affect the quality of care;
- advocating a change in the law or policy, provided it is based on evidence, is genuinely in connection with its community benefit activities; and that such campaigning or activities do not become the organisation's main focus or activity; and
- passing findings, concerns or views from the local community to Healthwatch England, which will have a role to speak out at the national level about service improvements and to provide evidence which will inform government policy.

4. Who can get involved with Healthwatch?

4.1. The legislation does not stop people with professional experience in health and social care settings being involved in local Healthwatch organisations and their activities, as lay persons and volunteers. "Lay person" and "volunteer" are defined as those people who wish to give their time to something they feel passionately about in order to influence change and service improvements. In this context, the definition of "volunteer" could include someone with a health and social care background giving their time freely,

whereas the definition of a "lay person" is aimed at those without a professional health or social care background contributing their time. If volunteers come with a professional health or social care background this does not necessarily create a conflict of interest – it can be complementary to the work of the local Healthwatch organisation. It is important that a local Healthwatch organisation is diverse and inclusive of its local people and community – be it through paid staff, lay people or unpaid volunteers. Local Healthwatch should ensure that a range of ways are available for people to get involved so that lay persons and volunteers can give their time in ways that suit their own needs and preferences.

4.2. With regard to elected members the legislation covering Local Healthwatch does not specifically disbar councillors from being involved in Local Healthwatch Organisations although the legislation does prevent local authorities from running Local Healthwatch Organisations.

5. Progress in establishing Healthwatch Sefton

5.1. On 13th December 2012 the Cabinet of the Council accepted the proposal from the "Commissioning Options for Healthwatch report" for Sefton Council for Voluntary Services (CVS) to set up an arm's length Company to Operate Healthwatch Sefton form 1st April 2013. This report had previously been considered by the Health and Wellbeing Board, at its meeting of, and the two Clinical Commissioning Groups for Sefton.

5.2. Implementation of Healthwatch Sefton has progressed since this decision was made, and the following actions have been taken:

- Sefton CVS Board have agreed to form the subsidiary company named Healthwatch Sefton and work is underway to resister the company with Companies House prior to the 1st April 2013. In order to avoid potential conflicts of interest the Memorandum of Understanding excludes elected members from the Local Healthwatch Organisations governance.

- The recruitment process for the appointment of the Chair of Healthwatch has now been concluded, subject to reference. Shortlisted candidates attended an interview comprising of the following panel: The Chair of the Health and Well-Being Board; Chair of South Sefton Clinical Commissioning Group, Chief Officer of both Clinical Commissioning Groups; Director of Adult Social Care and the Deputy Chief Executive of Sefton CVS.

- As previously reported Healthwatch will have a statutory seat on the Health and Well-Being Board. It is anticipated that the Chair will represent Healthwatch on the Health and Wellbeing Board.

- A workshop on patient and public voice was held in February to review the work of the landscape of patient and public involvement across Sefton and to identify the positive legacy that LinKs provides for Healthwatch Sefton moving forward. A further report on developing an approach to Public and Patient Engagement will be presented to the Health and Wellbeing Board in April, Healthwatch Sefton being an important constituent part.

5.3. A further report will be brought back to the Board once Healthwatch Sefton is up and running has established it's the priorities for Healthwatch Sefton during 2013/14.

6. Independent Complaints Advocacy Service

6.1. Section 185 of the Health & Social Care Act transfers a duty to commission independent complaints advocacy services from the Secretary Of State to individual Local Authorities. This transfer will take place on 1st April 2013. Whilst the funding to be made available is not ring-fenced and Local Authorities have a duty to ensure that local complaints advocacy operates effectively providing value for money, lack of a sufficient level of funding could jeopardise the quality of the delivery of this service.

6.2. The Government's Localism agenda supports the shifting of the commissioning of NHS complaints independent advocacy services from central government to Local Authorities as it feels that Local Authorities are better placed to determine what services are appropriate to be arranged for their local area and giving them responsibility for arranging them.

6.3. Independent advocacy services are services assisting persons making or intending to make complaints in relation to the provision of NHS services or the exercise of certain NHS bodies. They cover complaints made under:

- Procedures operated by certain NHS bodies or providers of services
- Section 113 and of the Health and Social (Community Health and Standards Act 2003)

6.4. NHS Complaints to the Health Service Commissioner in England or the Public Service Ombudsman in Wales are also covered.

14 March 2013

Samantha Tunney
Head of Business Intelligence & Performance
Sefton Council

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/41	**Author of the Paper:** Paul Shillcock Primary Care Informatics Manager Paul.Shillcock@imerseyside.nhs.uk

Title:

Low Utilisation of Summary Care Records

Summary of the Paper/Key Issues:

This paper presents the Governing Body with a report on the low uptake of the Summary Care Records project across NHS South Sefton CCG. Thus far within the project, only one GP practice in the CCG area has uploaded records, with a further two agreeing to upload.

A stated Government target is for every patient to have the opportunity to have their records uploaded by March 2013 and it is likely that CCGs will be performance managed on this target.

Action/Decision Required:

The Governing Body is asked to approve the recommendations contained within this report to increase utilisation of Summary Care Record uptake.

Date of Report:

14 March 2013

Report to Board

March 2013

1. Executive Summary

It is a key requirement for all GP Practices to make the Summary Care Record (SCR) available to all of its patients and it is a target that CCG's are likely to be measured against. The current target across the NHS is that all patients who want an SCR should have one created by March 2013. This target is set out in the SCR National Business Case and is also be referenced in the 2012/13 NHS Operating Framework.

At present, utilisation of SCR in South Sefton is very low. The current breakdown is as follows:

Practices in Scope	30	Practices on EMIS Web, EMIS LV or INPS
Practice Live	1	
Practices Agreed to go Live	2	Awaiting Training
Practices Declined or no response	27	
Practices Out of Scope	*5*	*3 Practices on EMIS PCS, 3 migrating from ISOFT*

This equates to 6,937 patients in Sefton having their records uploaded, out of an approximate population of 277,826, representing 2.49% of the whole Sefton population.

Whilst National information is difficult to obtain, South Sefton is a low utiliser within the local North West Region, and has a 'Red' RAG status on NHS North West's most recent quarterly report (see Appendix B).

It is recommended that a process of re-engagement occurs across the CCG and that a communique is issued from the board underlining the strategic importance of complying with the SCR achievement targets and ensuring all Sefton patients have the opportunity to have an SCR created.

2. Introduction and Background

The Summary Care Record was formerly part of the National Programme for IT (NPfIT) but, following a ministerial review in 2010, was maintained as a target for all NHS Organisations. The review found that it was "….reasonable for citizens to expect that when they arrive in an Accident and Emergency department or require treatment out of hours, clinicians have access to the essential medical information they need to support safe treatment and reduce the risk of inadvertent harm…."

Initial objections to the Summary Care Record were that it contained an 'opt out' consent model which both the local LMC and National GPC objected to. In 2010 however, the governance model was amended Nationally so that only an 'emergency care record' of Medications, Allergies and Adverse Reactions would be shared, with any detailed information over and above this requiring the explicit consent of the patient. There are currently no plans in Sefton to extend the SCR beyond the 'emergency care record' scope.

As this report focusses on the low utilisation of Summary Care Record in South Sefton, it does not go into detail on the benefits and detailed background of the project although a summary is provided below.

3. Engagement

The SCR project has been actively project managed by Informatics Merseyside since November 2012, when Sefton LMC gave its approval to proceed and clinical systems became in scope.

Since commencing the project actively in South Sefton, all GP practices in scope have been written to, asking if they would like to participate in the project. These initial communications have been followed up and the following is a summary of project engagement thus far:

- Patient Information Programme (PIP) run across Sefton, informing all patients of the SCR and their right to opt out, commenced in 2010.
- Initial email invites to participate sent to all GP Practices in scope in June 2012.
- Letter written to all GP Practices (See Appendix A) in December 2012.
- On-going promotion and information via Co-ordinator practice visits.
- Inclusion of SCR information in 'CommunicateIT" newsletter.

4. Content

At present in South Sefton, the majority of GP practices are either unwilling to participate in SCR, or still have concerns with its use. The vast majority of practices in the CCG now have compliant systems as EMIS Web, EMIS LV and INPS Vision both have SCR capability. EMIS PCS is not compatible, and although CSC Synergy is compatible, all practices on that system are migrating to EMIS Web within the next few months so are not being approached to participate at this time.

During communications with the practices that are in scope, the following issues have arisen:

4.1. The following anecdotal reasons for not participating have been given by GP practices across the CCG:

- "We do not see SCR as a priority"
- "We thought it was already happening"
- "We thought this project had 'gone away.'"
- "We have concerns over security and privacy."
- "We do not want other people to be able to add to the record."
- "The patients do not want it.".

The initial three areas above are around the perception of the project whilst the concerns over security and privacy have been addressed within the governance framework agreed Nationally. No-one is able to add into the record.

4.2. Locally, there has also been a view that participation in the National Programme is less of a priority as Sefton has taken a pro-active approach to local data sharing, which shares more clinically rich data with local Trusts and this may have an impact on the importance

practices attach to the National project. Whilst this may be true, local data sharing is obviously geographically restricted whereas SCR is a National project and has the capability of improving patient safety and clinical outcomes on a National basis.

4.3. Discussion with some GP practices indicates that awareness amongst practice managers is good, it may however be the reluctance or the concerns of GP's to participate that is preventing greater utilisation.

4.4. Some misconceptions still exist within the views expressed around SCR. The governance model however is Nationally approved by the GPC and BMA and locally, by Sefton LMC.

Informatics Merseyside will continue to engage with all practices across the CCG in discussing these concerns and resolving queries and can provide regular reports on the outcome of these discussions but the intervention of the Board and localities will undoubtedly assist in the aim of increasing uptake of SCR across South Sefton and in helping to deal with any concerns.

5. Recommendations

A clear issue with utilisation of Summary Care Record is that practices either do not see it as a priority, or are not clear on various aspects of the project. It is recommended that the Governing Body approve the following steps:

- A communique from the CCG Board to be sent to Lead GP's underlining the strategic importance of the project.
- The SCR Project Manager from Informatics Merseyside to re-engage with sites via presentations at locality and practice manager meetings. Connecting for Health (CfH) has also offered to participate in any such events as we require. From this, practice objections to SCR to be escalated to localities and Board via reporting.
- Locality Managers to assist in the promotion and uptake of the project by forwarding any concerns to Informatics Manager or CCG Lead.
- Consideration should be given to including SCR uptake in any schemes or local enhanced services to GP practices from CCG.

6. Focus for Board

SCR is a key target for all NHS organisations and the project in its current format has full approval from the GPC, BMA and Sefton LMC. South Sefton currently has only 2.49% of its patient population uploaded into the Summary Care Record.

The current target within the NHS is that all patients who want an SCR should have one created by March 2013. This target is set out in the SCR National Business Case and is also referenced in the 2012/13 NHS Operating Framework. It is highly likely that CCG's will be performance managed against this National target so active consideration of how to increase utilisation across the CCG is highly recommended.

South Sefton Clinical Commissioning Group

Appendices

Appendix A - Letter Sent to all GP Practices in 2012:
Appendix B - North West Summary Care Record Summary as at December 2012.

March 2012

Paul Shillcock
Primary Care Informatics Manager
Merseyside & Cheshire CSU

Appendix A - Letter Sent to all GP Practices in 2012:

Dear Colleague

NHS National Summary Care Record (SCR) in NHS Sefton

We are pleased to advise you that local implementation of the Summary Care Record (SCR) for Sefton patients is now under way. This project offers a real chance to improve patient safety and clinical care while providing important safeguards about consent and confidentiality.

The SCR will contain essential health information about any medicines, allergies and adverse reactions derived from the patient GP record. Where a patient and their doctor wish to add additional information to the patient's Summary Care Record, this can only be added with the explicit consent of the patient. Once SCRs are created for all patients in Sefton, authorised NHS healthcare staff in urgent and emergency care settings that need access to the information will begin to view these records when delivering clinical care.

Following the 2010 review into the Summary Care Record, in which a number of patient and clinician bodies were involved, the BMA agreed to work with the programme. Also, Sefton LMC has approved of the rollout of the Summary Care Record locally. Some practices will choose not to upload SCRs at the time of roll-out and there is no obligation on practices to take part. These practices will be re-engaged on a regular basis to ensure they are given the opportunity to upload. At present, there is no national requirement or guidance for a practice currently not uploading and hence, there is no requirement for these practices to write to patients to inform them that their record has not been uploaded.

The first phase of the project, the Public Information Programme (PIP), was distributed in 2010. The purpose of the PIP was to inform patients of the benefits of the SCR and their choices. All patients in the Sefton area aged 16 and over were sent a SCR information pack. Following on from this, practices were asked to ensure that all new patients received a SCR information pack.

The PIP lasted a minimum of 12 weeks, allowing patients sufficient time to make their choice. The SCR upload is the second phase of the project and over the coming months the SCR project manager will work with each practice to schedule their SCR upload.

What should a practice do now?

The next step for practices that wish to upload SCR's, is to nominate an SCR lead, this person will be responsible for cascading the guidance material within the practice, and ensuring relevant practice staff understand their responsibilities. The SCR project manager will use this lead as the main point of contact and will arrange SCR Concept training with them to ensure practice staff have the required information to deal with enquiries.

The SCR Project Manager will contact your practice within the next week to discuss any queries you may have and to request the name of the SCR lead within your practice.

Thank you in anticipation of your support, should you have any initial queries please email Michelle.Harvey@imerseyside.nhs.uk

Yours sincerely
Michelle Harvey
IM&T Projects & Benefits Manager, Informatics Merseyside

NHS

South Sefton Clinical Commissioning Group

Appendix B - North West Summary Care Record Summary **as at** December 2012

PCT Cluster	% Patients with records created	PCT Name	Map Reference	GP Practices	Registered Population	Awareness & Engagement				Planning							Adoption		
						Project Manager In Post	Business Case Developed	Project Board Established	SCR Clinical Lead In Place	Potential GP Practices	Potential GP Practices (% of Total)	GP Practices that have Sent Patient PIP Letters	Total PIP Letters Sent (To Patients > 16 years)	Patient Opt-Outs	Patients Surveyed for Opt-Out	Patient Opt-Outs (% of Patients Surveyed)	GP Practices Uploaded	Patient Records Created	Potential GP Practices Planning to Upload Records
Cheshire	20%	Central & Eastern Cheshire	A	51	473,018	!	!	!	!	40	78%	50	386,646	6,347	473,014	1.3%	2	7,344	4
		Warrington	B	27	209,197	✓	✓	✓	✓	25	93%	27	167,770	1,945	209,197	0.9%	21	172,206	3
		Western Cheshire	C	39	263,114	✓	✓	✓	✓	36	92%	39	219,834	3,438	263,114	1.3%	11	62,221	0
		Wirral	D	60	331,144	✗	✓	✗	✗	40	67%	60	273,310	4,572	254,851	1.8%	12	62,883	0
Cumbria	0%	Cumbria	E	80	513,124	!	✓	!	!	45	56%	80	435,829	0	0		0	0	0
Lancashire	1%	Blackburn With Darwen	F	29	169,472	✓	!	✗	!	8	28%	28	130,750	724	168,507	0.4%	0	0	7
		Blackpool	G	21	153,593	✗	✗	✗	✗	12	57%	0	0	0	0		0	0	0
		Central Lancashire	H	85	473,261	✗	✗	✗	✗	47	55%	85	384,900	2,700	308,051	0.9%	0	0	0
		East Lancashire	I	64	388,747	✓	!	!	!	16	25%	64	314,295	1,980	388,747	0.5%	0	0	15
		North Lancashire	J	37	340,099	✗	✗	✗	✗	18	49%	37	286,258	1,904	139,798	1.4%	1	22,582	0
Manchester	33%	Ashton, Leigh & Wigan	K	65	320,960	✓	✓	✓	✓	56	86%	65	226,563	2,242	229,442	1.0%	44	211,149	5
		Bolton	L	51	297,621	✓	✓	✓	✓	49	96%	31	239,280	3,781	294,148	1.3%	29	188,187	1
		Bury	M	33	196,064	✓	✓	✓	✓	33	100%	33	158,868	1,977	179,359	1.1%	33	195,571	0
		Heywood, Middleton & Rochdale	N	39	224,377	✓	✓	✓	✓	26	67%	38	179,427	1,357	91,220	1.5%	21	95,029	3
		Manchester	O	99	574,481	✓	✓	✓	✓	32	32%	99	440,390	2,635	468,800	0.6%	10	68,106	22
		Oldham	P	47	240,943	✓	✓	✓	✓	19	40%	47	192,600	1,153	89,456	1.3%	19	96,157	2
		Salford	Q	50	250,261	✓	✓	✓	✓	48	96%	50	202,969	0	0		27	150,474	1
		Stockport	R	50	300,033	✓	✓	✓	✓	16	32%	50	246,203	289	26,031	1.1%	11	77,296	7
		Tameside & Glossop	S	42	241,328	✓	✓	✓	✓	16	38%	42	196,406	1,560	174,932	0.9%	8	48,673	13
		Trafford	T	37	235,731	✓	✓	✓	✓	24	65%	37	187,533	2,887	171,122	1.7%	10	52,228	0
Merseyside	10%	Halton & St Helens	U	54	322,072	✓	✓	✓	✓	23	43%	54	261,066	2,459	271,602	0.9%	1	2,355	0
		Knowsley	V	33	161,095	✓	✓	✓	✓	29	88%	26	128,771	1,448	94,676	1.5%	28	151,043	0
		Liverpool	W	95	496,318	✓	✓	✓	✓	38	40%	95	402,511	4,173	494,495	0.8%	3	17,806	0
		Sefton	X	54	277,826	✓	✓	✓	✓	12	22%	54	234,002	0	0		1	6,937	0
		North West Total		1242	7,453,879					708	57%	1191	5,896,181	49,571	4,790,562	1.0%	292	1,688,247	83

*We are still awaiting more up to date figures on SCR achievement but this is being hampered by the current organisational change within the NHS. Future reports will be categorised by CCG area.

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/42	**Author of the Paper:** Fiona Clark Chief Officer fiona.clark@sefton.nhs.uk

Title:

Quality Premium

Summary of the Paper/Key Issues:

This paper is to update the Governing Body in relation to the payment of the Quality Premium for CCGs.

Action/Decision Required:

The Governing Body is asked to approve the recommendations contained within this report.

Date of Report:

March 2013

Report to Board

March 2013

1. Background

1.1. In December 2012, the National Commissioning Board published its draft guidance on Quality Premium 2013/14 payments for CCGs.

Link: http://www.commissioningboard.nhs.uk/wp-content/uploads/2013/02/qual-premium.pdf

1.2. The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

1.3. The quality premium paid to CCGs in 2014/15 – to reflect the quality of the health services commissioned by them in 2013/14 – will be based on four national measures and three local measures.

1.4. The national measures, all of which are based on measures in the NHS Outcomes Framework, will be:

- reducing potential years of lives lost through amenable mortality (12.5% of quality premium): the overarching objective for Domain 1 of the NHS Outcomes Framework;
- reducing avoidable emergency admissions (25% of quality premium): a composite measure drawn from four measures in Domains 2 and 3 of the NHS Outcomes Framework;
- ensuring roll-out of the Friends and Family Test and improving patient experience of hospital services (12.5% of quality premium), based on one of the overarching objectives for Domain 4 of the NHS Outcomes Framework;
- preventing healthcare associated infections (12.5% of quality premium), based on one of the objectives for Domain 5 of the NHS Outcomes Framework.

1.5. The three local measures, which should be based on local priorities identified in joint health and wellbeing strategies, will be agreed between individual CCGs and the area teams of the NHS Commissioning Board (NHS CB).

1.6. The NHS CB will reserve the right not to make any payment where there is a serious quality failure during 2013/14.

1.7. Subject to regulations due to be made and laid in Parliament early in the New Year:

- it will be a pre-qualifying criterion for any payment that a CCG manages within its total resources envelope for 2013/14 and does not exceed the agreed level of surplus drawdown

- the total payment for a CCG (based on its performance against the four national measures and three national measures) will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments, (c) maximum 62-day waits from urgent GP referral to first definitive treatment for cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

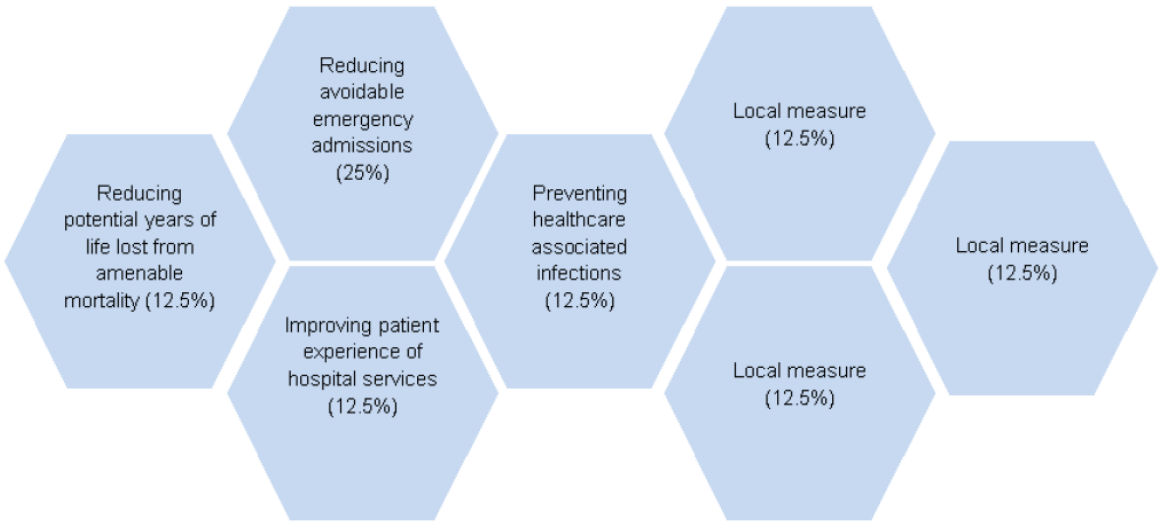
1.8. The total financial envelope for the quality premium will be announced in the New Year. This will be on top of a CCG's main financial allocation for 2014/15 and on top of its £25 per head running costs allowance.

1.9. The regulations will set out the purposes for which CCGs will be able to spend their payments.

1.10. This document has the status of draft guidance until it is revised to reflect the content of the regulations and published as final.

1.11. The likely payment is £5 per head, although this remains unconfirmed. For a population of 147,366, this would give a potential of £736,830 for South Sefton CCG, if all areas were achieved, which could equate to £21,671 per practice. A full breakdown of potential income can be found at Appendix 1.

1.12. The Quality Premium will be comprised of the following elements.



1.13. In addition, the CCG has to meet the four NHS Constitution measures and manage within its total resources for 2013/14.

1.14. Where a CCG does not deliver the identified patient rights and pledges on waiting times, a reduction of 25% for each relevant NHS Constitution measure will be made to the quality premium payment.

1.15. The quality premium payment will be made in the 2014/15 financial year.

2. Local Context

South Sefton CCG's Governing Body considered the options for the local priorities using data available in the South Sefton CCG Outcomes Pack provided and also the work that has been undertaken on Better Care, Better Value/Right Care over the past twelve months.

These deliberations and recommendations were then shared at the Wider Constituent Forum on 12 March 2013, led by Dr Bal Duper, Clinical Development Lead for Primary Care.

The outcome from this discussion provided a refinement of one of the local priorities, affirmation of the second priority and a complete refresh of the third priority.

3. The Three Local Priorities

3.1. To bring about a reduction in Chronic Obstructive Disease (COPD) admissions through A&E at Aintree Hospital

3.2. To bring about a reduction in prescribing for three high risk antibiotics:

a. Quinolones b. Co-amoxiclav c. Cephalosporins.

3.3. To reduce the number of GP referred patients (during normal working hours) who receive an AED assessment before being admitted into Aintree Hospital

Work has been undertaken on the activity schedules to ensure that these local priorities are stretching and reductions of health inequalities drive change for health improvement.

The Health and Wellbeing Board received these on 13 March 2013 and endorsed these local priorities as complimentary and aligned to the components of the newly emergent Health & Wellbeing Strategy.

4. Recommendations

The Governing Body is asked to:

4.1. approve the three local priorities; and

4.2. note the potential payment regime.

Appendices

Appendix 1 NHS South Sefton CCG Draft Quality Premium

19 March 2013

Fiona Clark
Chief Officer
NHS South Sefton CCG

Appendix 1 NHS South Sefton CCG Draft Quality Premium

CCG Population: 147,366 **Value of Quality Premium = £5 (estimated)**

CCG manages within its total resources for 13/14 – the QP will not be paid if financial balance not achieved

Measure	% of QP	Value for CCG	Achieved 12/13	Eligible QP Funding	Achieved 13/14	Eligible QP Funding
Domain 1 – preventing people from dying prematurely	12.5%	£92,103.75				
Domain 2&3 – enhancing quality of life for people with LTC and helping people to recover from episodes of ill health or following injury	25%	£184,207.50				
Domain 4 – ensuring that people have a positive experience of care	12.5%	£92,103.75				
Domain 5 – treating and caring for people in a safe environment and protecting them from avoidable harm	12.5%	£92,103.75				
LP1 – reduction in admissions for patients with COPD	12.5%	£92,103.75				
LP2 – reduction in prescribing for three key antibiotics	12.5%	£92,103.75				
LP3 – increase in the proportion of patients who need to be admitted to Aintree, to be admitted directly to the appropriate speciality rather than via A&E	12.5%	£92,103.75				
Total	100%	£736,830				

NHS Constitution Rights & Pledges	Achieved 12/13	Adjustment to Funding (25%)	Quality Premium Funding	Achieved 13/14	Adjustment to Funding (25%)	Quality Premium Funding
Referral to Treatment Time (18 weeks)	If the CCG fails to meet any element of the NHS Constitution Rights and Pledges, a 25% deduction will be made to each area of non-achievement.					
A&E Waits						
Cancer Waits – 62 days						
Category A Ambulance Calls						

If all elements of both Measures and NHS Constitution Rights & Pledges are achieved, this could amount could be received by each member practice	**£21,671**

South Sefton Clinical Commissioning Group

BOARD MEETING
March 2013

Agenda Item: 13/46	**Author of the Paper:** Tracy Jeffes Head of Corporate Delivery Tracy.Jeffes@sefton.nhs.uk

Title:

Board Committees – Terms of Reference

Summary of the Paper/Key Issues:

This paper presents the Governing Body with the revised Terms of Reference for the Audit Committee and Finance & Resource Committee.

A summary of the changes is given below:

Audit Committee

- Add the monitoring review of the BAF to the Committee's Work Schedule for discussion at every meeting
- Amend to : "To review and make recommendations to the Governing Body with regard to the approval of annual accounts."
- Amend to: The Duties of the Audit Committee should be changed from "To review and approve the annual report on behalf of the Governing Body".
- Amend to "To review and make recommendations to the Governing Body with regard to the approval of the annual report."
- Amend to: "To undertake annual review and assessment of the CCG's performance in respect of compliance with the requirements of the Information Governance Toolkit".
- Add: "To review any reports from external providers in relation to assurance regarding the function and operation of systems used to support the CCG's business".
- Quorum change "The Audit Committee Chair and one other Member" to "At least two members".

Finance and Resource Committee

- Debbie Fagan Chief Nurse and Brendan Prescott have been added to the membership
- Duties of the Committee – bullet point 16 - "to receive recommendations from the local

individual patient review (IFR) panel and approve as appropriate" has been removed.

- Quorum – Attendee list of Board for each meeting and individual questionnaire for the purpose of the CCG's business

- Establishment of sub groups of the Committee ii) separate panel to meet on behalf of CCG – to receive recommendations from the local IFR panel, and approve as appropriate. Given that these requests may require urgent action, the Chair has the power to take action after consulting with whoever he/she deems appropriate

- A number of typographical errors were corrected.

Action/Decision Required:

The Governing Body is asked to approve the amendments detailed above.

Date of Report:

14 March 2013

South Sefton Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

Audit Committee

Terms of Reference

1. Authority

The Audit Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

The principal functions of the Committee are as follows:

i) To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the Group's activities to support the delivery of the Group's objectives.

ii) To review and approve the arrangements for discharging the Group's statutory financial duties.

2. Membership

The following will be members of the Committee:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Board Member

Other officers required to be in attendance at the Committee are as follows;

- Internal Audit Representative
- External Audit Representative
- Counter Fraud Representative
- Chief Finance Officer
- Chief Nurse

The Chair of the CCG will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

Other senior members of the Group may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Officer. Representatives from NHS Protect may be invited to attend meetings.

At least once a year the Committee should meet privately with the external and internal Auditors. Regardless of attendance, external audit, internal audit, local counter fraud and security management (NHS Protect) providers will have full and unrestricted rights of access to the Audit Committee.

Members are expected to personally attend a minimum of 75% of meetings held.

Relevant Officers from the CCG may be invited to attend dependent upon agenda items. Officers from other organisations including Mersey Commissioning Support Service (MCSS) and from the Local Authority Public Health team may also be invited to attend dependent upon agenda items.

3. Responsibilities of the Committee

The Audit Committee is responsible for;

- Reviewing the underlying assurance processes that indicate the degree of achievement of the Group's objectives and its effectiveness in terms of the management of its principal risks.
- Ensuring that there is an effective internal audit function which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Officer and the Group.
- Reviewing the work and findings of the external auditors and consideration of the implications of management responses to their work.
- Reviewing policies and procedures for all work relating to fraud and corruption as set out by the Secretary of State Directions and as required by the NHS Protect.
- Reviewing findings of other assurance functions (where appropriate) and consider the implications for governance arrangements of the Group (e.g. NHS litigation authority, Care Quality Commission etc.).
- Monitoring the integrity of the financial statements of the Group and to consider the implications of any formal announcements relating to the Group's financial performance.
- Responding on behalf of the Governing Body, to any formal requirements of the Group in relation to the audit process (e.g. the report from those charged with governance).
- Monitoring and review of the CCG Board Assurance Framework (BAF) to support the CCG's integrated governance agenda.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone):

- To review and recommend approval of the detailed financial policies that are underpinned by the Prime Financial Policies within the Group's Constitution to the Group's Governing Body.
- To review and approve the operation of a comprehensive system of internal control, including budgetary control, which underpin the effective, efficient and economic operation of the group.
- To review and recommend to the Governing body the approval of the annual accounts.
- To review and approve the Group's annual report on behalf of the Governing Body
- To review and approve the arrangements for the appointment of both internal and external audit and their annual audit plans.
- To review and approve the arrangements for discharging the group's statutory financial duties.
- To review and approve the Group's Counter Fraud and Security Management arrangements.
- To review the circumstances relating to any suspensions to the Group's constitution (as set out in the Scheme of Delegation and Reservation) and to report to the Governing Body and Wider Membership Council on the appropriateness of such actions
- To undertake annual review of its effectiveness and provide an annual report to the Governing Body to describe how it discharged its functions during the year.

5. Administration

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

6. Quorum

The Audit Committee Chair and one other member will be necessary for quorum purposes.

7. Frequency and notice of meetings.

The Audit Committee shall meet on at least four occasions during the financial year. Internal Audit and External Audit may request an additional meeting if they consider that one is necessary.

8. Reporting

The ratified minutes of Audit Committee will be submitted to the Governing Body. Exception reports will also be submitted at the request of the Governing Body. The ratified minutes will also be sent to the Quality Committee to support its role in monitoring the Group's integrated governance arrangements.

9. Conduct

All members are required to maintain accurate statements of their register of interest with the governing body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

10. Date and Review

These Terms of Reference were approved by the NHS South Sefton CCG Governing Body on [date to be inserted]

Version No. [1]
Review dates [ ]

South Sefton Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

Finance & Resources Committee

Terms of Reference

1. Authority

The Finance & Resources Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

The principal functions of the Committee are as follows:

i) The Committee shall be authorised by the CCG Governing Body to undertake any activity within these terms of reference and act within the powers delegated to it in line with the Scheme of Reservation and Delegation.

ii) To provide assurance to the Governing Body that there are appropriate systems in place which operate in order to enable the Committee to fulfil its monitoring requirements.

iii) To provide regular reports to the Governing Body on a timely basis and to provide an annual report on the work carried out by the Committee including a self-assessment of how it has discharged its functions and responsibilities.

2. Membership

The following will be members of the Committee:

- Clinical Board Member (Chair)
- Clinical Board Member
- Lay Member (Governance) (Vice-Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Board Member
- Locality Clinical Representatives (x4)
- Chief Officer
- Chief Financial Officer
- Head of Performance & Health Outcomes
- Head of Corporate Delivery
- Head of CCG Development

The Chair of the CCG will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

Members are expected to personally attend a minimum of 60% of meetings held and can send a deputy to attend in their absence as required.

Relevant Officers from the CCG will be invited to attend in line with agenda items. Officers from other organisations including Mersey Commissioning Support Unit (MCSU) and from the Local Authority Public Health team will also be invited to attend in line with agenda items.

3. Responsibilities of the Committee

The Finance and Resources Committee is responsible for;

- Advising the Governing Body on all financial matters and to provide assurance in relation to the discharge of statutory functions in line with the Standing Financial Instructions (SFI's).
- Reviewing the overall financial position of the CCG to ensure that the organisation meets its statutory financial duties.
- Overall financial management of the organisation including the delivery of investment plans, monitoring of reserves, and delivery of financial recovery plans and cost improvement plans.
- Ensuring that the performance of commissioned services is monitored in line with CCG expectations.
- Monitoring key performance indicators (e.g. any outlined in the NHS Operating Framework).
- Advising the Governing Body on the approval of annual financial plans.
- Monitoring and advising appropriate courses of action with regard to other key areas of CCG business (notably procurement, contracting and monitoring progress of Foundation Trust (FT) applications of local providers.
- Supporting the work of the Audit Committee through review of financial arrangements as required.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone):

- Oversee the development of the short and medium-term strategies for the CCG including assessment of the assumptions underpinning the financial models.
- To ensure the delivery of financial balance and that the organisation meets its statutory financial targets.
- Ensure that the Finance and Performance Plans are consistent with and complementary to the CCGs Annual Budget, Commissioning Plan ("One Plan") and Strategic Plan.

- To monitor implementation of the annual financial plan to ensure that the total resource available to CCG is invested in high quality services that support the achievement and delivery of specified priorities.
- Approving any variations to planned investment within the limits set out in the detailed financial policies of the CCG, ensuring that any amended plans remain within the overall CCG budget and do not adversely affect the strategic performance of the CCG.
- Monitoring Financial and Operational Performance across all commissioned services on an exception basis, assessing potential shortfalls and risk and recommending actions to address them.
- Monitoring Key Performance Indicators (KPIs) relating to CCG performance, for example as outlined in the NHS Operating Framework and One Plan.
- Monitoring delivery of the QIPP programme and agreeing corrective action if required.
- Monitor key risks facing the CCG, understand the financial consequences and make recommendations for inclusion on the CCG risk register accordingly.
- Oversee the development and delivery of capital investment plans including any schemes progressed through the LIFT or 3PD initiatives.
- Oversee the development and implementation of the Estates strategy.
- Oversee the development and implementation of Human Resource strategies, plans and corporate policies.
- Maintain an overview of recruitment, retention, turnover and sickness trends.
- To ensure that services provided by other organisations, notably Merseyside CSU, are being delivered as per the CCG's expectations and to advise on remedial action where necessary.
- To review, monitor and agree corrective action for all agreed financial performance indicators (KPIs to be determined based on CCG finance regime when published).
- To review the CCG procurement strategy and advise on an appropriate course of action regarding commissioning of new services / re-tendering arrangements for existing services
- To review and monitor progress regarding contracting arrangements with healthcare providers
- To monitor progress of local provider plans, particularly aspirant FT's, to advise the governing body in terms of key issues and any recommend decisions as appropriate.
- The Committee will review monthly reports detailing performance of commissioned services against core standards, national & local targets and the CCGs Strategic Plans, review may be on an exception basis.

5. Establishment of sub-groups of the Committee

The Committee will undertake regular review of its workload and will from time to time establish sub-groups to ensure that it conducts its business in an effective and appropriate manner. The Committee will establish 2 initial sub-groups as follows,

i). QIPP Sub-Group to undertake detailed review of all QIPP schemes, monitor progress and advise on corrective action as required.

ii). Individual Funding Request Sub-Group to receive recommendations from the local IFR panel, and approve as appropriate. Given that these requests may require urgent action, the Chair has the power to take action after consulting with whoever he/she deems appropriate.

6. Administration

The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

7. Quorum

Meetings with at least 50% of the committee membership, at least one Clinical Board Member, at least one Lay Person and either the Chief Officer or Chief Financial Officer in attendance shall be quorate for the purposes of the CCG's business.

8. Frequency and notice of meetings

The Committee shall meet at least 8 times a year. Members shall be notified at least 10 days in advance that a meeting is due to take place.

9. Reporting

The ratified minutes of the Finance and Resources Committee will be submitted to the Governing Body private meeting. Exception reports will also be submitted at the request of the Governing Body. The minutes and key issues arising from this meeting will be submitted to the Audit Committee.

10. Conduct

All members are required to maintain accurate statements of their register of interest with the governing body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

11. Date and Review

These Terms of Reference were approved by the NHS South Sefton CCG Governing Body on [date to be inserted]

Version No. [1]
Review dates [ ]

South Sefton CCG
Register of Interests
March 2013

Board Member	Own Interest	Partner's Interest
Dr Clive Shaw	GP Partner, 30 Kingsway GPSI Aintree Hospital (1 session per week)	Non declared
Dr Craig Gillespie	GP Partner, The Blundellsands Surgery CVD Lead, NHS Sefton	Non declared
Dr Steve Fraser	Employed as Principal, Seaforth PCTMS GP Practice	GMS GP Partner in South Manchester
Dr John Wray	Non declared	Non declared
Dr Andy Mimnagh	GP Partner, Eastview Surgery Chairman Sefton Local Medical Committee Editor, "Target Pad" Organisation.	Non declared
Dr Paul Thomas	Partner, High Pastures Surgery, Maghull	Non declared
Dr Ritesh Sinha	Non declared	Non declared
Libby Kitt	Non declared	Non declared
Martin McDowell	Joint Post with Southport & Formby CCG	Assistant Director of Finance Liverpool Community Healthcare Trust
Roger Driver	Area Dean, Bootle Deanery Team Rector, Bootle Team Ministry Trustee, St Leonards Youth Community Centre Chair, Sefton Health & Social Care forum	Liverpool Diocese Education Department (Church schools in South Sefton)
Dan McDowell	Non declared	Non declared
Lynda Elezi	Non declared	Non declared
Lin Bennett	Ford Medical Practice – Practice/Business Manager	Non declared
Fiona Clark	Joint Post with Southport & Formby CCG	Non declared
Dr John Wray	Skymed LTD (Aviation Medicine Services)	Non declared

Hospitality Register
March 2013

South Sefton Clinical Commissioning Group

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:

None declared

South Sefton Clinical Commissioning Group

Audit Committee
Minutes

Thursday, 29 November 2012, 3.30pm to 5.00pm
Location Crosby Lakeside Centre

Attendees
Linda Elezi (Chair), Lay Member
Roger Driver , Lay Member
Lin Bennett, Practice Manager

In Attendance
Martin McDowell, Chief Finance Officer (Designate)
Stuart Baron, Audit Manager, PriceWaterhouseCoopers
Angharad Ellis, Audit Manager (Mersey Internal Audit Agency)
Debbie Fagan, Chief Nurse (Designate)

Minutes
Deborah Mooney, Minute Taker

No	Item	Action
1.	**Welcome & Introductions** **Apologies** Stuart Davison, Local Fraud Specialist (MIAA) Peter Chambers, Audit Partner, PriceWaterhouseCoopers Adrian Poll, Audit Manager (Mersey Internal Audit Agency)	
2	**Declaration/Register of Interests**	
3	**Constitution/Terms of Reference** The Constitution for SS was accepted by the wider constitution meeting prior to authorisation including the terms of reference, presented to the Committee today for discussion. The Committee discussed the terms of reference and recommended the following changes to the Board Paragraph 2, page 2 insert “specialist” after fraud. take out (NHS Protect) Paragraph 1, page 2 add in “or Cheshire Merseyside Commissioning Support Service” after NHS Protect. Paragraph 4, page 2 insert “Cheshire Merseyside” instead of “Mersey”. Section 3 – Add the monitoring review of the BAF to the Committee’s Work Schedule for discussion at every meeting.	

No	Item	Action
	The Committee agreed that one of its key functions would be to assure itself that the process underpinning the BAF was robust and thorough. Section 4. Duties of the Committee Following a discussion in terms of reviewing and approving the annual accounts, it was agreed that the Governing Body should review and approve the annual accounts and report. (Note: This requires a change in the Scheme of Delegation and reservation in sections 4.1 and 4.2 in that this matter should now be reserved to the Governing Body as opposed to being delegated to the Audit Committee). The Duties of the Audit Committee should be changed from "To review and approve the annual accounts on behalf of the Governing Body". To "To review and make recommendations to the Governing Body with regard to the approval of annual accounts." The Duties of the Audit Committee should be changed from "To review and approve the annual report on behalf of the Governing Body". To "To review and make recommendations to the Governing Body with regard to the approval of the annual report." "To undertake annual review and assessment of the CCG's performance in respect of compliance with the requirements of the Information Governance Toolkit". Add in "To review any reports from external providers in relation to assurance regarding the function and operation of systems used to support the CCG's business". A copy of the PCT's 20/11/12 Annual Governance Statement (AGS) to be provided to at the next meeting to help inform the Committee in terms of area covered. MMcD was asked to confirm arrangements regarding the provision of Security Management Services. Post meeting Note – This service will be provided by CMSCU as part of its core offer. Section 6 – Quorum change "The Audit Committee Chair and one other Member" to "At least two members". Section 2 Reporting – The ratified minutes will be sent to the Quality Committee to support its role in monitoring the Group's integrated governance arrangements. Constitution for SS was accepted by the wider constitution meeting prior to authorisation including the terms of reference. Presented	

No	Item	Action
	to the Committee today for discussion.	
4	**Internal Audit Update** Discussions are on-going in relation to the internal audit plan with the CCG at present, which will include core assurance coverage in the plan. The plan will remain flexible, MMcD to agree plan with MIAA(AP) and report back to next Committee. The CCG has 50 days allocated to it for 12/13 financial year. MMcD confirmed that MIAA had been confirmed as the CCG's Internal Audit provider. MMcD highlighted some risks around the Integrated Financial Single Environment (IFSE) project, notably the requirement that the CCG will be operating on a different ledger system to the PCT. MMcD updated on the working balance arrangements in relation to the closedown of the CCG. Where debtors/creditors are more than one year old, CCG's will inherit the outstanding transaction. Where debtors/creditors are less than one year old, NHS CB will inherit the outstanding transactions.	
5	**Local Counter Fraud Services Update** Plan to be pulled together following up data from Locality Lead meetings.	
6	**External Audit Update** The practice arm of Audit Commission has been abolished. First Audit plan for the CCG will be received by Committee for Q4 2013/14 financial year. Roles & Responsibilities of Internal Audit, External Audit & LCFS to be discussed at next meeting. MMcD updated the Committee in respect of the appointment of external Auditors for the CCG. The NHSCB are required to instruct the Audit Committee to formally appoint auditors. This is expected to take place in December.	MIAA (AP) PWC (SB) MIAA(SD)
7	**Information Governance Toolkit** MMcD outlined the requirements of the Information Governance toolkit and noted that they are based on Audit principles – Action plan to be brought to the next Audit Committee in February 2013.	MMcD
8	**Work Schedule** The Committee agreed that the point to receive minutes of other committees and review business inter-relationships Finance & Resource Committee and Quality Committee should be brought forward to Mtg 1 on work schedule. To be updated.	MMcD
9	**Meetings Schedule** 5th June 2013 this is a provisional meeting scheduled and may not be required at this stage.	
10	**Any Other Business** MMcD noted that he held a joint position with SSCCG in response to	

No	Item	Action
	request from RP regarding receiving hard copies of papers, members were asked to notify the PA in advance.	
11	**Date and Time of Next Meeting** – Thursday, 7th February 2013, 1.30pm to 3.00pm, venue – 3C, Merton House.	

South Sefton Clinical Commissioning Group

South Sefton Quality Committee

Thursday 24 January 13
15:30 – 17:00
Merton House

Attendees:
Dr Gina Halstead, Fiona Clark, Martin McDowell, Anne Dunne, Dr Craig Gillespie, Debbie Fagan, Tracy Jeffes, Steve Astles, Lin Bennett, Dr Andrew Mimnagh, Angie Parkinson, Dan McDowell, Jamie Hester, Roger Driver, Dr Debbie Harvey, Billie Dodd, Bal Duper

Minutes
Tracey Cubbin, Administrator Sefton CCG Team

No	Item	Action
13/1	**Welcome and Introductions** CG welcomed the group for the second SS Quality Committee Meeting. The group also welcomed Dr Dan McDowell, Secondary Care Consultant on the Governing Body, who will be attending future meetings.	
13/2	**Apologies** Dr Kong Chung	
13/3	**Minutes of the last meeting – 22 November 2012** Minutes of the last meeting were agreed as an accurate record with updates noted below: - **12/8 Quality Dashboard** Malcolm Cunningham and Debbie Fagan will be liaising with the CSU to further develop the Performance and Quality Dashboards to reflect the requirements of the CCG going forward. Meetings between the CCG lead officers, the GP Clinical Quality Leads and CSU have been scheduled. The Committee supported the developments to the dashboard and acknowledged that this was work in progress as we are transitioning to the new arrangements, including commissioning support. The Quality Committee also noted that the Quality Dashboard was one part of the Early Warning System in place within the CCG. **Action:** **DF to feedback at the next meeting re: Quality Dashboard development**	**DF**
13/4	**Declarations of Interest** FLC, DF, TJ and MMcD all confirmed they have joint posts with Southport & Formby CCG.	

13/49(b)

13/5	**Quality Report** The Committee were asked to note the Quality Dashboard. DF reported that due to reporting timelines there was no significant change from the last meeting. DF reported that she has asked the CSU to ensure that the Patient Safety Alerts reported information was updated to reflect the current position as some of the alerts had a date from several years previous. DF and GH provided an update on HCAI. A Strategic Group has been set up across the Sefton and Liverpool Health economy to address this challenging issue and to improve quality and performance in this area. This meeting is being co-ordinated by Aintree Hospitals but will be Chaired by the NCB Mersey Area Team Director of Nursing & Quality. The CCG are awaiting a date which is likely to be in February 2013. **Action:** **DF / GH to feedback at the next meeting** DF / SA informed the Committee that review work is on-going with Aintree Hospital re: SHMI. Updates will be given to both the Quality Committee and the Governing Body. **Action:** **On-going updates for consideration to the Committee and the Governing Body**	DF / GH
13/6	**Virtual Ward (VW) Quality Improvement Process – update** JH updated the Committee on progress to date with regard to Virtual Ward and described the Quality Improvement workstreams that were being undertaken. JH described the relationship between performance / outcome measures and the use of PDSA cycles to support quality improvement. A list of performance / outcome measures being captured to be sent to Steve Astles for review. **Action:** **JH to send SA the list of performance / outcome measures**	JH
13/7	**Quality Contract** - **2012/13** GH and AM gave an overview of provider performance with regard to the Quality Contracts/ CQUINs to date. GH reported that it was unlikely that Aintree would meet the CQUIN re: Advanced Care Planning. DF informed the Committee of a recent letter sent to Merseyside by the Performance Team outlying the likely financial penalty for not achieving elements of CQUIN in 2012/13 AM informed the Committee that there was room for further visibility of the Health Visiting Service within General Practice and that there was room for improving the relationship between the Health Visiting Service and the Primary Healthcare Team. DF highlighted the national programme to support the growth in establishment of the Health Visiting workforce and the new service model (4 Tier Model) **Action:** **DF to liaise with Helen Lockett (Director of Nursing LCH) to resolve this issue** - **Preparation for 2013/14** DF/GH / AM/SA informed the Committee of the preparation to date	DF

	for the Quality elements of the contracts for 2013/14 which is being supported by CSU. Feedback was given on the commissioning workshop on 10 January 2013 and the planned event with Providers on 30 January 2013. DF informed the Committee of the collaborative work the Mersey Chief Nurses are undertaking regarding Quality Nursing Indicators which will encompass 'Compassion in Practice' (national nursing and care strategy) and reflect the recommendations from the Francis (2) Inquiry once published on 6 February 2012. GH also informed the Committee of the meetings she has had with links to look at nutrition at Aintree Hospitals and to see if this could be captured in a CQUIN or as part of the Quality Indictors based upon feedback they had from a patient experience perspective. The Committee agreed that this should be pursued and acknowledged the place that patient experience and the feedback from LINKS has as part of the CCG early warning system. - **Alternative Quality Contract** GH / DF / FLC gave a brief overview of the Alternative Quality Contract that was being progressed in Southport & Formby CCG in collaboration with West Lancs CCG for Southport & Ormskirk Hospitals NHS Trust. This agenda item was for information purposes only and the information had been sent to relevant Quality Leads in Sefton and Liverpool.	
13/8	**Risk Register** **Integrated Governance / Auditors** TJ presented the corporate risk register to the Committee which will be a regular agenda item going forward. FLC explained the purpose and relevance to the Committee going forward.	
13/9	**NHS Merseyside Quality Transition Status Report December 2012** Update from quality legacy handover meeting with NHS Mersey 10 January 2013 AM updated the committee after attending the above meeting which is part of the on-going transition of the quality agenda from the NHS Mersey Cluster to the CCG. AM reported that the CCG appears to be in a good position regarding this and there is a commitment to continue attending these meetings until the end of March 2013.	
13/10	**SUI update** - **Feedback from handover meeting 18 Jan 13** The above meeting was cancelled; DF is now due to meet with Christine Griffith-Evans on 24 January 2013, to continue the SUI handover process. DF informed the Committee that there was a training event planned for February 2013 with the Mersey Cluster / NCB Area Team that she would be attending on behalf of the CCG as part of the SUI handover. DF reported that the CSU are identifying the staff who will be supporting the CCG going forward as part of the Core Offer. FLC asked that we ensure that we are linking closely with the CSU regarding process of SUI's in this transition period, DF happy to liaise and update at a future meeting as required. - **SUI handover checklist** DF informed the Committee that the CCG have to complete a SUI	

	checklist and send back to the Mersey Cluster / NCB Area Team (needs to include the SUI policy). - **Feedback from NHS Mersey SUI group 21 January 2013** DF gave verbal feedback from the meeting that took place this week. The Committee were informed that the next meeting scheduled for 18 February would be led by the CCGs with support from the CSU as part of the handover transition.	
13/11	**Policies** - **SUI policy for ratification** DF presented the CCG SUI policy for adoption by CCGs which is required as part of authorisation. Any comments or amendments to be sent to DF by 1 February 2013 at the latest at which time the Committee agreed to endorse the policy in line with the Scheme of Reservation and Delegation by Chair's action. The policy will be reviewed on the publication of the Francis Inquiry recommendations and be brought back to the Committee as appropriate. **Action:** **Any amendments to the SUI Policy to be sent to DF no later than 1 February 2013. For Chair's action re: adoption by the Committee as of 1 February 2013**	All Chair
13/12	**C-Diff Strategic Meeting – CCG / Aintree Hospitals** Refer to 13/5.	
13/13	**Safeguarding** - **Jimmy Saville (DH Letter) – Responses** DF informed the Committee that the DOH have issued a letter after a review was commissioned by the Government. The CCG have forwarded this letter to all their main providers. Providers have responded stating that they have actioned the points contained within the letter. - **LSCB Section 11 Audit** DF and AD informed the Committee of the Section 11 audit sent by the LSCB that requires completion. This shows evidence as to how we discharge duties regarding Safeguarding Children. This is difficult to complete as a purely commissioning organisation as some elements are provider focused. The audit will be completed and will be sent to the LSCB at the end of January 2013. It will be presented to the Committee at the next meeting. **Action:** **DF / AD to present Section 11 audit to the Committee at the next meeting** - **MOU update Safeguarding Hosted Service** DF reported that the MoU re: the hosted service has been circulated by Halton CCG. Some amendments have been made and these have been sent back to the Chief Nurse in Halton. Awaiting final MoU for sign-off. - **Serious Case Review / Management Review updates** AD stated that there case that was described at the last meeting was still on-going. - **Winterbourne** DF informed the Committee that Geraldine O'Carroll will present a joint CCG / LA response paper at the next Quality Committee giving	DF / AD

	an update of the local action being taken in response to Winterbourne – it will give information regarding the collation of assurances for the relevant Committees and Governing Body to be certain that services are safe for patients.	
13/14	**Safeguarding Children and Vulnerable Adults Policy and Flow Chart** - **Safeguarding Flowchart** LB expressed concerns that the latest flowchart that was sent to practices from Liverpool Community Health was different to the one they had previously. LB raised concerns that the Social Care telephone number connects to Sefton Council Switchboard / Call Centre. LB felt that this was inappropriate given the nature of the calls and the information that would need to be provided; also personal information relating to the patient was asked for up front before even speaking to the Safeguarding team directly. Some concerns were also expressed that the Switchboard / Call Centre is manned by local people who may know the practice staff and the patient. LB also raised the issue that practices were also completing their documents for CQC registration of which safeguarding is a component part. DF advised that after the original flow charts were sent out to Practices, LCH did change some of the information but this should be in-line with the local policy. The Committee agreed as a whole that these issues need to be raised with the Local Authority. FLC suggested that this needs to be looked at a strategic level. DF advised that the Named Doctor for Sefton is Dr Goddard who has taken over from Dr Briggs in November 2012. There was a query re: how many sessions Dr Goddard will be doing for Sefton going forward. **Action:** **DF to liaise with LCH re: number of sessions being undertaken by Dr Goddard.** **AD / DF to liaise with LB to see what support they can be given re: CQC and Safeguarding.** **FLC / DF to liaise with Social Care re: Call Centre issues**	DF AD / DF FLC / DF
13/15	**Primary Care Quality** Angela Parkinson and DR Bal Duper attended the Committee to inform them of the work to date on rge Primary Care Strategy and the Quality Premium. AP reported that she and Debbie Fagan met with Debbie Swantz to look at QP / Quality work across the CCGs. DF and AP have also discussed the links with the Practice Nurses Facilitators, Practice Nursing and Primary Care Quality. AP and BD briefed the group on on-going pieces of work relating to Primary Care Quality and advised that a draft Quality Strategy will be available by May 2013. AP stated that a Sefton wide primary care quality (PCQ) steering group was originally established in March 2012 comprising of CCG Chairs, GP Quality Leads, Practice Managers North and South, Medical Director of Mersey Cluster, members of PCT/CCG management team. With the appointment of the Chief Nurse and the introduction of the Quality Committee the PCQ steering group has now been superseded with the Quality Committee having oversight. AP described elements being used to identify / develop Sefton PCQ	

	markers: - National Outcomes Framework 5 domains / Clinical Commissioning Group Outcomes Indicator Set (CCG OIS)(Appendix 1) - AQUA - ATLAS - QOF /Calculating quality reporting suite (CQRS) - Merseyside Shared Intelligence Portal - Locality model for peer review, comparative referral data for QP indicators - Locality model Community Champion - Progress of Care Quality Commission (CQC) registrations - Locality knowledge - Quality improvement in primary care will be supported by: - Maintaining relationship with NCB/LAT - Attending CCG Quality Network Meetings to enable peer review, learning environment - Supporting Dr Bal Duper to lead on PCQ across Sefton CCGs - Working closely with Practice Nurse Lead Educators - Discussion at locality meetings - Identifying a task and finish group - Supporting the Boards to fulfil its responsibilities for the proposed Quality Premium - Supported by primary care development plan **Action:** **The committee agreed that Primary Care Quality will now be a standing item on all future agendas.**	AP/BD
13/16	**Continuing Health Care Update** DF and MMcD updated the Committee on progress to date from both a nursing and finance perspective. Next update from CSU expected February 2013. CHC has been recorded on the corporate risk register. DF and FLC informed the Committee that the CHC Managers from the CSU were coming to SMT to update on progress in order to give assurances.	
13/17	**National Care / Nursing Strategy update** DF informed the committee of the launch of 'Compassion in Practice' (national nursing and care strategy) in December 2012. DF will update the Committee regarding the implications for commissioning in future meetings and it's relationship to Francis (2) once published in February 2013. **Action:** **DF to provide an update with implications for commissioning and the relationship to Francis (2)**	DF
13/18	**Resuscitation** - **Regional do not Resuscitate Adult Policy** DF presented the North of England Adult DNAR policy that had been sent to her by a Chief Nurse from another CCG. DF explained that it was for information purposes only at this stage as we didn't know the status of the document and weren't aware that it had formally been sent to the CCG. **Action:** **DF to contact Dr John Hussey, NCB Mersey Area Team Medical Director, to gain further information regarding the status of the policy** - **Local Care Homes** AM informed the Committee of a local Nursing Home requesting GPs to sign DNAR forms. Concern was expressed that a proper	DF

	process needed to be followed with this and that patients required individual assessment in the first instance. The point was raised that as well as quality of care issues there were also contractual issues that this raised. **Action:** **To be addressed outside of the meeting and report back to the Quality Committee as required** The committee were asked to note that this agenda item is separate to the North of England Adult DNAR policy.	AM/DF
13/19	**Work Plan** The draft work plan was tabled at the meeting for information purposes and DF asked all to have any comments back to her no later than 8 February 2013. DF will then liaise with FLC/CG to update the work plan accordingly and present as a final document for sign-off at the next meeting. **Action:** **All to send comments on workplan to DF by 8 February 2013.**	All
13/20	**Research** DF asked the committee to note that to date she had received 3 x Research Governance requests from the Mersey Research Governance Group. These had been in relation to: contacting GP practices regarding Paediatric Asthmas contacting GP practices regarding GP Assessment contacting a member of staff for follow-up research regarding Advancing Quality - **CCG Responsibilities** DF informed the Committee that Debbie Fairclough from the CSU would be coming to a future meeting to discuss what the CCG responsibilities are going forward in relation to research and how the CSU can support this. **Action:** **DF to arrange for CSU to update the Quality Committee at a future meeting**	DF
13/21	**Any other Business** - **Pete Chamberlain** FLC advised the group that Pete Chamberlain has been awarded a one year scholarship at the Harvard School of Public Health working on quality and improvement. An advert will be placed shortly to cover Pete's secondment, SA/JH to update at a future meeting regarding progress on this. Change of times for all future Quality Committee meetings The committee agreed that all future meetings will be held from 3:00 – 5:00 TC to update room bookings / agendas etc. and will send out an updated meeting schedule to the committee. - **Francis Report** DF informed the Committee that the Frances Report will be available on the National Commissioning Board (NCB) website on 6 February 2013. DF/AM / GH will be travelling to London on 27 February 2013 to attend the kings Fund Frances Enquiry and will update at the subsequent Quality Committee meeting in March	

	2013. The Committee will receive a report in February re: Francis recommendations and an accompanying CCG action plan. **Action:** **DF to bring a report and action plan to the next Quality Committee meeting for consideration**	DF
13/22	**Date and time of Next Meeting** Thursday 21 February 2013 3:00 – 5:00 Room 3C, Merton House	

South Sefton Clinical Commissioning Group

Finance & Resource Committee Minutes

Thursday 24th January 2013 1.30pm to 3.00pm
Meeting Room 3C, Merton House, Bootle

Attendees

Roger Driver (Chair)(RD)	Lay Member, SS CCG
Sharon McGibbon (SMG)	Practice Manager
Martin McDowell (MMD)	Chief Finance Officer, SS CCG
Steve Astles (SA)	Head of CCG Development, SS CCG
Malcolm Cunningham (MC)	Head of Performance & Outcomes, SS CCG
Tracy Jeffes (TJ)	Head of Delivery, SS CCG
Debbie Fagan (DF)	Chief Nurse
Dr Steve Fraser (SF)	GP Board Member

In attendance

Fiona Doherty (FD)	Project Manager
Dr Gustav Bernie (GB)	GP South Sefton

Minutes

Karen Lloyd	PA to Chief Finance Officer

No	Item	Action
13.1	**Welcome & Introductions** The Chair welcomed everyone to the meeting and the committee members introduced themselves. **Apologies** Apologies were received from: Linda Elizi, Fiona Clarke and Geraldine O'Connell.	
13.2	**Notice to meeting of any other business** Committee members were invited to give notice of any additional items to be tabled under any other business. There were no additional items to be tabled.	
13.3	**Declaration/Register of Interests** The following declarations of interest were declared: Fiona Clarke, Martin McDowell, Malcolm Cunningham, Tracy Jeffes, Debbie Fagan, Steve Astles and Fiona Doherty all have shared appointments covering both South Sefton CCG and Southport and Formby CCG.	

No	Item	Action
13.4	**Minutes of the meeting of Thursday 22nd November 2012** The minutes were approved as a true and accurate record.	
13.5	**Action points of the previous meeting not covered elsewhere on the agenda** There were no action points to consider that were not included on the agenda.	
13.6	**Terms of Reference** The Terms of Reference were reviewed in line with amendments required at the previous meeting. DF will be added to the membership. **Agreed: The Terms of reference will be submitted to the Board in March 2013 for ratification.**	
13.7	**Month 9 Financial Report** MMD presented the F & R Committee with an overview of the Financial Performance for South Sefton Clinical Commissioning Group. It detailed the performance against budget to date and gave explanations for key variances. The financial position against the operational budget at the end of month 9 is £449k under spent. This is a favourable movement of £104k when comparing to the month 8 financial position, which is largely attributable to an under spent position within Prescribing budget. The 2012/13 indicative budgets delegated to South Sefton CCG equate to £236 million. South Sefton CCG is over spent by £76k in relation to Secondary Care contracts as at month 9. As anticipated there is a balanced financial position in relation to the block contracts commissioned by South Sefton CCG as the contracts are on a fixed price basis with no exclusions. Prescribing is currently under spent by £1.5m. The contract with the North West Ambulance Trust is currently overspent by £144k, with a projected overspend of £192k at year end. Other areas of overspend within Other Healthcare includes the Independent Treatment Sector which is overspent by £357k as at month 9. MMD noted that, the approach to contracting during 12/13 has been to agree fixed price contracts with Merseyside hosted contracts. As a result PbR and Non PbR over performance will not incur additional costs. The exception to this agreement is high cost drugs within secondary care, as included within the risk share. The converse applies, in that the CCG will not be reimbursed for under performance. This will significantly reduce the level of financial risk during the 2012/13 financial year. The forecast year end out turn position for South Sefton CCG prior to the application of contingency reserves is £449k under spent. This represents a -0.19% overspend of the CCG annual budget. **MMD drew attention to the following risks:** • Restitution Claims • PbR Contract with Wrightington, Wigan and Leigh NHS FT • Ambulance Services • Pharmacy • Independent Sector Treatment Centres	

No	Item	Action
	• Continuing Healthcare & Free Nursing Care • Prescribing • Melling Practice The 12/13 QIPP plans are RAG rated green as they are on track to be delivered in full this financial year. The budgets have now been set for financial year 2012-13 and are based on £2 per head of registered population. The running costs budget for 2012-13 is £372K and is based on April 2012 registered list sizes. A further £41k budget has been transferred from South Sefton CCG investments to cover further work in relation to the setup of the CCG primarily GP cover RD requested clarification of data validation regarding high cost non contract patient activity. MMD responded that this service was provided by the CSU**.** SF commented on a positive report regarding activity and usage of Care at the Chemist Scheme. MMD requested that SF circulate this report. GB noted the financial pressure of an ageing population and the additional pressures that this will create in the future. **Agreed: The Committee noted the contents of the Finance Report.**	**SF**
13.8	**Business Case reviews**	
13.8.i	**End of Life Care Home Facilitator** This business case was presented to the committee. Approval was sought to fund the post of the End of Life Care Home Facilitator, on a non-re-current basis for a three year period through to March 2016. RD suggested that further information should be provided to evidence the monitoring and benefits of the business case. MC noted that FD had been recruited to provide support in the production of business cases going forward. SA will discuss with MM (the author), the provision of an updated business case to bring before the committee. **Agreed: The Committee agreed to defer this business case pending further information.**	**SA/MM**
13.8.ii	**Hospice at Home Funding** The Finance & Resource Committee were presented with options to defer or otherwise the procurement process for the End of Life at Care at Home service currently being delivered by Woodlands Hospice. The options for consideration were: 1. Proceed with original arrangement to take the service through the procurement process in 2013 2. Extend contract for one year The committee noted that the End Of Life Review was currently underway and findings would be published at the end of February. It was further noted that the Committee would appreciate a more detailed analysis of benefits monitoring to support the proposal. SA will discuss this with MM. **Agreed: The Committee agreed to support option 2 – Extension of contract for one year.**	**SA/MM**
13.8.iii	**Inclusion Matters** The Finance and Resource Committee were presented with options for improving access to talking therapies in primary care for the patients of	

<table>
<tr><th>No</th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>South Sefton CCG.

a) Approve funding to retain at least two PWP trainees once they become qualified. This will allow the provider to maintain current service delivery, and continue to meet prevalence at 8.5%.
b) Approve funding to retain all 5 PWP trainees who would otherwise leave in April. This will allow the service to treat an additional 609 patients per annum and prevalence will peak at 10.8%.
c) Approve funding to retain the 5 PWP's from April and the 2 HITs, who are due to leave in Sept. This will allow the service to treat an additional 769 patients per annum and prevalence will peak at 11.2%.
d) Approve funding to retain all Wave 5 staff and in addition recruit 11 Wave 6 trainees (6 PWPs and 2 HITs) and two Band 2 administrators. This will mean the service is able to meet the DH target of 15% prevalence by March 2014, treating 6509 patients per annum.

Financial Implications

The financial implications for South Sefton CCG for each of the above proposals are as follows:

<table>
<tr><th>Option</th><th>2013/14 Cost</th><th>Full Year Cost</th></tr>
<tr><td>a</td><td>41,969</td><td>44,035</td></tr>
<tr><td>b</td><td>105,308</td><td>110,088</td></tr>
<tr><td>c</td><td>135,542</td><td>170,556</td></tr>
<tr><td>d</td><td>236,735</td><td>*501,001</td></tr>
</table>

* These are indicative costs as the current service contract is due to end on 31st March 2014 and therefore will be subject to retendering.

MC noted that when this service is tendered a wider remit will be included and it is anticipated that savings could be achieved. SF commented that the service is currently challenging to access and recovery rates of 50% are not being met. GB contributed that it is his experience that it is taking longer than anticipated for this service to achieve its potential benefits.
Action: Drs GB and SF will collaborate with MC during the drafting of tenders to ensure that they reflect local clinical input.
Action: GOC to meet with provider to ensure that CCG are receiving full value for money and to agree incremental improvement of prevalence targets.

Agreed: The Committee agreed Option C</td><td>MC/SF/ GB

GOC</td></tr>
<tr><td>13.8.iv</td><td>Evidence into Practice supporting decision makers
BP presented the Finance and Resource Committee with a proposal for a development programme which will increase understanding amongst clinical decision makers about how they make decisions, and how their processes of decision making and that of their clinical colleagues can be enhanced. The proposed programme would help support the CCG vision of promoting "high quality, cost effective health care in collaboration with patients and partners to improve health outcomes."

The cost of the proposal is £5700.</td><td></td></tr>
</table>

No	Item	Action
	BP suggested that Neal Maskrey who is the Professor of Evidence-Informed Decision Making at Keele University will attend a Wider Constituency event to give further details of the scheme. **Agreed: The Committee agreed to support this project with funding of £5700**	
13.8.v	**Rheumatology business case** BP presented this business case on behalf of the author Graham Reader Lead Adviser Interface Meds Management. The Pan-Mersey Area Prescribing Committee has recommended that Mersey CCGs commission biological agents (e.g. anti-TNFs) for a number of additional indications, and in rheumatoid arthritis in patients who fail a first line anti-TNF and fit NICE criteria for second-line biologics in all aspects except they are intolerant of methotrexate (and co-prescription of methotrexate is a technical requirement of the NICE guidance). These recommendations have come to light due to repeat applications to the IFR process, indicating they are not exceptional, and therefore a commissioning decision is desirable. It should be noted that IFR panels have approved many of these cases and such much of the funding required is already being spent, and that in many cases alternative treatments are as expensive, or more so. The Finance and Resource Committer were asked to decide whether to approve or not the commissioning of the additional uses of biologic agents as recommended by the Pan-Mersey Area Prescribing Committee, and to continue funding rituximab in ANCA vasculitis as previously commissioned pending introduction of funding for this by NHSCB. BP noted that this business case had previously been presented to the Area Prescribing Committee. SF noted that NICE guidelines had not been as prescriptive as clinical leads had anticipated. BP commented that if agreed, activity would be monitored. **Agreed: The Committee approved the commissioning as requested and the continuation of funding.**	
13.8.vi	**Proposal for the establishment of a Spirometry assessment and Review Service for South Sefton** SA presented this business case which proposed a Spirometry assessment and review service for South Sefton. It is anticipated that the service will provide quality assured spirometry for patients with respiratory symptoms that require accurate diagnosis and also annual review spirometry to inform patient management. The service will supply timely results to the patient, general practices and acute trusts to assist coordination of patient care. Planned spirometry will be offered within 4 weeks of annual testing date. Unplanned spirometry will be offered an appointment within 2 weeks of referral. SA commented that the current service is not fit for purpose. MMD noted that this request needs to be considered alongside all other Commissioning intentions. **Agreed: This business case to be resubmitted in February 2013 as part of Wider financial plan which includes other commissioning intentions.**	

No	Item	Action
13/9	**Contract Performance 12/13** MMD noted that the Contract Performance Update had been dealt with in the Finance Report	
13/10	**2013/2014 Contracting Update** **MMD presented** the Finance and Resource Committee with the timetable in respect of the 2013/14 Planning and Contracting round. **Agreed: The Committee noted the contents of this update.**	
13/11	**QIPP Update (Sub Group)** MMD presented this item. A QIPP subgroup is required meet quarterly to monitor QIPP plans for South Sefton CCG. Membership agreed: MC, FD, Head of CCG Development, MMD, SA and DR GB**.** **Action: Proposals for meeting dates will be circulated.**	**MMD**
13/12	**IFR (Individual Funding Requests) Update** MMD presented this report for information. IFR applications are for services not currently commissioned by the NHS. MMD drew attention to £0 entries in the report. **Action: MMD will advise IFR Team not to approve requests without funding estimates.** **Agreed: The Committee noted the contents of this report.**	
13/13	**Work Schedule:** The Committee reviewed the Annual Work Schedule and agreed that it is currently fit for purpose. **Agreed: The Annual Work Schedule will be reviewed in January 2014**	
13/14	**Meetings Schedule:** The Committee reviewed the Meetings Schedule and agreed that it remains acceptable. The date of the next meeting was noted.	
13/15	**Any other Business** There was no other business	
13/16	**Review of Meeting** GB requested that meeting times be brought forward by 30 minutes to enable his participation. This was agreed by the Committee and all members will be notified accordingly. MMD requested feedback regarding meeting style, papers, presentations etc. Currently all members are satisfied with meeting style and content. MMD offered an open invitation to all members to provide feedback at any time regarding any aspect of the meeting.	
13/17	**Date & time of next meeting Thursday, 21st February 2013, 1.00pm to 2.30pm, 3C, Merton House**	

Knowsley Clinical Commissioning Group

Clinical Commissioning Groups Network meeting

Notes of Meeting Held on 6th February 2013

Part 2

Present:	*Name*	*Initials*	*Organisation*
	Dr Andrew Pryce	AP	Chair, Knowsley CCG
	Tom Fairclough	TF	Head of Commissioning, Knowsley CCG
	Dr Clive Shaw	CS	Chair, South Sefton CCG
	Fiona Clark	FC	Accountable Officer, Sefton CCG & Southport & Formby CCG
	Martin McDowell	MMc	Chief Finance Officer, Sefton CCG & Southport & Formby CCG
	Tom Jackson	TJ	Chief Finance Officer, Liverpool CCG
	Dr Steve Cox	SC	Clinical Accountable Officer, St Helens CCG
	Ian Davies	ID	Head of Operations & Corporate Performance, Liverpool CCG
	Paul Brickwood	PB	Chief Finance Officer, Knowsley, Halton & St Helens CCG's
	Simon Banks	SB	Accountable Officer, Halton CCG
	Dr Cliff Richards	CR	Chair, Halton CCG
	Dr Niall Leonard	NL	Chair, Southport & Formby CCG
	Nick Armstrong	NA	Chief Operating Officer, Warrington CCG
	Dr John Caine	JC	Chair, West Lancashire CCG
	Johanna Reilly	JR	Director of CCG Assurance, NCB Area Team
	Gaynor Hales	GH	Director of Nursing & Quality, NCB Area Team
	Leigh Thompson-Greatrex	LTG	Head of Assurance & Delivery, NCB Area Team
	Clare Duggan	CD	Area Team Director, Merseyside
	Tim Andrews	TA	Managing Director, C&M CSU
	Debbie Bywater	DB	Director of Client Services & Transformation, C&M CSU

Notes:	Andrea Kelly	AK	Secretary, Knowsley CCG

1. Apologies for Absence — **Action**

Apologies were received from:

- Katherine Sheerin (Accountable Officer, Liverpool CCG)
- Ray Guy (Liverpool CCG)
- Dianne Johnson (Accountable Officer, Knowsley CCG)

2. NCB Area Team Update

Gaynor Hales updated the group on the recently released Francis Report. This report looked at Boards, PCT's CQC's and the role of Monitor and doesn't feel that the current system focuses enough on quality.

There are 290 recommendations included in this report and the Area Team are currently going through these recommendations and prioritising accordingly.

Fiona updated the Area Team members on the suggestion in Part 1 that the Francis Report be included on the CCG/Area Team Time Out Day.

The report raised some concerns regarding nursing home regulation and how to link in with local councils. The Area team are looking at the support it can offer CCG's in this area.

Clare explained that Quality Surveillance Groups are being set up for the end of February 2013. The focus of this first meeting will be aims, purpose and membership. The second meeting will then focus on the Francis report – providers are not to be invited at this stage.

Clare updated the group on the planning submissions and confirmed that meetings are being held with individual CCG's.

Clare explained that next week's CCG/Area Team meeting will have a focus on strategic challenges. The Area Team will host meetings with individual CCG's and the local council then bring the group together.

Clare updated on staff levels; 90 day's notice has been issued to 99 staff and the number this now affects is down to 67. Questions and answer sessions are being held with these staff; Clare asked if the CSU & CCG could send some representation to the next meeting on 2.5 week's time

3. CSU Update

Tim updated the Network on three areas:

a) Business Development Unit (BDU)

C&M CSU have recently had visit for Checkpoint 3 which focused on the BDU – feedback from these visits have been very positive.
Feedback has also been positive on the merger of the two organisations and it was felt that C&M CSU is well advanced in the CSU market.

Point 4 is due diligence focused, interviews and sessions on these areas will take place next week.

b) Service Update

There are currently 73 vacancies which are to go through the clearing process. The Senior Management Team is almost complete with the most recent appointment being John Hayes as the Head of Quality & Performance.

Tim explained that each function is well staffed with the focus to switch staff to the new way of working. There are a lot of changes going on in IT, with Tim looking for a single CSU domain.

c) Transformation & Innovation

Tim explained that the CSU is keen to ensure capacity in this area, and have some processes which will be shared with the CCG Network when they are ready.

The CSU will use CCG plans as a target for this work and will look at different areas each quarter. This quarter the CSU is looking at: patient experience, commercial contracting & funding models and the frail elderly. Tim advised that capacity for this area has been built into the structure as a system called a 'flexible resource pool'.

Tim confirmed that the full service offer will be available from April 2013.

4. Provider CIP's

Leigh gave a presentation showing a look back at the process for obtaining provider cost improvement plans (CIP's)during 2012/13.

Dr Cox noted there were five providers that did not engage with this process and it will be difficult to seek assurances moving forward towards signing the new contracts.

Leigh explained that letters have been sent to providers informing of a review after 6 months, but providers can only give the information required after the fourth quarter. CCG's will be taking this process on and require a handover from Phil Wadeson. It has been agreed that Phil will pick up with CGG's regarding non-recurrent spend. It was agreed that a session will be held between NCB and CCG's.

Action – Area Team to arrange a session on Finance with CCG's	**NCB**
The Network discussed and agreed that if providers are not giving the assurances required then contracts should not be signed. It was agreed to add this discussion to the CCG/Area Team Time Out agenda for further discussion.	
Action – Add Provider CIP's to agenda for CCG/Area Team Time Out	**FC**
Date and Time of Next Meeting **Wednesday 6th March 2013 1pm in Boardroom 2 & 3, Regatta Place**	

SEFTON SHADOW HEALTH AND WELLBEING BOARD
MEETING 7th JANUARY 2013
AT THE BOOTLE TOWN HALL

Present - Councillors Ian Moncur and John Kelly, Robina Critchley, Clive Shaw, Fiona Clark, Peter Morgan.

Also in attendance – Councillor Paul Cummins and Sam Tunney (Sefton Council)

Apologies – Janet Atherton, Margaret Carney and Niall Leonard.

ITEM	TITLE	ACTION
1.	APOLOGIES Apologies for absence were received from Janet Atherton, Margaret Carney and Niall Leonard.	Noted
2.	NOTES OF THE LAST BOARD MEETING The notes of the meeting held on 3rd December 2013 were circulated and noted as a correct record.	Noted
3.	MATTERS ARISING Pursuant to minute 3, a copy of the bid for funding to build Health Partnerships, was circulated with the agenda for information. Pursuant to minute 5, the Board was asked to note that arrangments were in hand for the Stakeholder event to be held on 26th February. Pursuant to minute 8,, the Board was advised that it was proving difficult to re-arrange the next two Board meetings and to get an agreed programme of meetings.	Noted
4.	GOVERNANCE REVIEW/PREPAREDNESS The Board received a report on the governance review of the Board. The Board was advised that the government guidance on HWBB was still not out in its final form, and the review had been based on the draft guidance and the Governments response to the consultation. The report presented the issues contained within the draft guidance and consultation response and the	

	Board was asked to take a view in relation to each. Flexible Geographic Scope – in relation to boundaries, whilst the CCG boundaries are co-terminous with the local authority, some of the CCG patients would be living outside of the area, but may be registered in another CCG area. Fiona advised that the CCG networks across Lancashire and Merseyside provided the opportunity for big strategic issues to be dealt with. Some of the bigger issues such as mental health, learning disabilities, were already being picked up as wider than Sefton issues, through various existing arrangements. Some of the issues which would need to be addressed across boundaries, included children being placed out of borough, safeguarding issues, including childrens homes that are in borough, but are not registered, and there is no record of children from out of the borough who are in the homes. Core Statutory Membership – the report set out details of the current membership and the statutory minimum membership. It was suggested that the Board needed a criteria to determine whether there is any added value in adding people to the Board. It was suggested that if anyone made representations to join the Board, that they ought to be able to describe what added value they would bring. It was important to maintain an open mind, but be seen not to set a precedent. Robina explained that looking across Merseyside, there was a mixed picture as to what other Boards had done in terms of membership. Fiona suggested that as the connected partnerships were thought through, there was a need to map them all so that the Board could describe how they relate to each. A note on viral change had been circulated with the Board agenda, and it was felt that the principles set out in that paper were ones which could help the Board think through how best to make connections, and maintain links to other parts of the wider health and wellbeing system. Councillor Moncur, suggested that as the regulations had not yet been made, that the Board should defer consideration of membership and other governance matters until the next meeting. For the next meeting, it was suggested that a review of who has been asked to join the board be undertaken, and that a criteria for membership be explored which would allow the Board	That Fiona to keep the Board appraised of Lancashire and Merseyside wide issues which are pertinent to the Board That further work be undertaken to identify children placed in borough, which are not known about in order to ensure their health and wellbeing needs are being addressed That arrangements be made for a viral change workshop to be held as Board development Agreed to defer consideration of Board membership until the regulations had

	to consider the merits or otherwise of expanding membership. The Board was also advised of the need to consider how it progresses work outside of meetings, and it was proposed that the Board consider the role of the Operational Group at a future meeting, but in principle it be supported. Fiona advised that she would speak to Claire Duggan about nominating someone from the NCB to sit on the Board to enable them to discharge their responsibilities. Sub-Committees/Delegation – the draft guidance referred to the creation of sub structures. Reference was made to the Integrated Commissioning Group. It was suggested that the Group ought to submit reports and its minutes to the Board, but that it should not become a formal sub-committee. Councillor Moncur suggested that a similar approach be taken in the new financial year, to holding alternate informal briefings with formal meetings of the Board. There is a need to prepare an annual forward plan of issues for the Board, and it was suggested that this be brought to the first meeting of the Board in the new financial year. Items would include the CCG Commissioning Plans, CCG Annual Report (September), NCB Assessment of CCGs in relation to quality premium. The relationship with the Overview and Scrutiny Function would be important to work through. It was suggested that the Overview and Scrutiny Management Board should consider how best it perform its role. One of the issues which would need to be explored further was the level of delegation that the local authority would want to give the HWBB. For example would it have the same level of delegation as Cabinet Members. For foreseeable future, it was suggested that there should be minimal changes as possible, whilst the Board transitioned into its formal role and that the situation be reviewed during the next financial year.	been made That Fiona to contact Claire to request her to nominate a representative to sit on the Board That the Integrated Commissioning Group minutes be included on the agenda in the new financial year and if any issues need to be escalated, that these be submitted as a report to the Board That contact be made with the Overview and Scructiny Management Board with a request once the Regulations are made to consider O and S worked in relation to the Board
5.	<u>MAPPING OF PARTNERSHIPS</u> A report was submitted which offered the Board the results of the two exercises it undertook at its workshop on 3rd December looking at the range of partners/ships which, and through whom, it should	

	work in achieving the outcomes of the strategic objectives of the draft health and wellbeing strategy and adopton of a list of national outcomes frameworks, that have a direct influence on the strategic objectives of the draft health and wellbeing strategy, which will lead to the development of a performance management framework.. The Board was asked to note the work undertaken, some of the potential gaps in the information as outlined in the report, consider information on outcomes in light of recently emerged guidance from the NHS Commissioning Board and agree to the suggested timetable/next steps. It was suggested that an emphasis needed to be placed on individual responsibility for health and wellbeing, and there was a need to test out the health impacts of for example, the housing policy. The proposed stakeholder event was in the process of being organised and it was critical to get the right people at the event. Peter suggested that he, Fiona and Sam meet to develop the programme. The Board considered the work undertaken to date, and highlighted potential gaps and it was suggested that if there were meetings of the Childrens Trust and Local Safeguarding Board they be asked to assist in identifying local and national outcomes for children. The Board was asked to request the Operations Board to assist in identifiying, local and national outcomes from non health based partnerships for adoption within the agreed outcomes for the emergent strategy. The Operations Board met on 22nd January and they would be asked to further develop the outcomes framework and partnerships maps.	That the work undertaken to date be noted, the gaps identified be filled at the stakeholder event, and the Operations Board be requested to assist and support this process. Peter, Fiona and Sam to meet to develop the programme for the stakeholder event
6.	<u>ALCOHOL STRATEGY</u> Ian Canning attended the meeting and presented a report highlighting the isuses being consulted on in relation to the alcohol strategy; presenting recommendation responses, asking the Board to agree with the content of the responses, and asking each organisation on the Board to send invidual responses to the consultation. Ian advised that the Consultation ended on 6th February and this was the only opportunity the Board would have to consider making a response. Expert	That the Board agree the response, but in so doing it is noted that it could push

	groups had met in December, and there were 5 themes: 1. minimum unit price – Clive requested evidence that this would be successful; 2. multi-buy promotion – this would work more effectively when aligned with the minimum unit price; 3. licensing – mandatory – suggest no change, but may want to consider supporting not serving in bottles. 4. community impact policy – public health to have an input into licensing applications. Would like to be able to, as only the police could currently. Ian suggested that the approach required, was to denormalise drinking. 5. freeing up responsible business – such as champagne being served at house viewings, alcohol at the opening of say a florist. Ian asked the Board to consider 1. making a response and to which parts 2. requesting the CCG's and Council to do the same Clive expressed the view that the proposals were up against a very large industry and he felt that the best approach was to effect change by empowering people. He was concerned denormalising alcohol, would result in it gaining a mystique which was not beneficial. Councillor Moncur indicated that the Board was considering a response to a consultation, when what was needed was for the Board to have a wider discussion in relation to alcohol and drugs, and the type of service needed.	drinking under ground, but it was recognised there was a need to do something. That evidence on minimum pricing be circulated to the Board That the Alcholol and Drugs be included in the Forward Plan as a key policy discussion
7.	<u>Agnenda Items</u> The Board was asked to agree that the following items be deferred to a future meeting, namely: 1. Board Development Report; 2. Tobacco Controls/Plain Packaging.	That the items be included in the Forward Plan
8.	<u>Forward Plan</u> The Plan was noted. A copy of the Rospa paper was circulated at the meeting and the Board was asked to note that SEfton was the only local authority in the North West to achieve a Gold Award for its Childrens Play Areas.	Plan be updated to include the deferred items

9.	<u>Date of Next Meeting</u> It was agreed that the next meeting be rescheduled from 11th February in order to encourage full attendance by the Board.	Noted

Sefton Strategic Integrated Commissioning Group (SSICG)

Minutes of the meeting held on 21st January 2013

Present :

Paul Acres	Chair of Sefton Strategic Integrated Commissioning Group	PA
Peter Morgan	Strategic Director People, Sefton Council	PSM
Fiona Clark	Interim Chief Officer – Sefton CCGs	FLC
Peter Moore	Head of Commissioning and Partnerships, Sefton Council	PM
Dr Clive Shaw	Chair of South Sefton CCG	CS
Martin McDowell	Chief Finance Officer	MMcD
Geraldine O'Carroll	Integration Commissioning Lead Sefton Partnership MCSS	GO'C
Dympna Edwards	Attending on behalf of Janet Atherton	DE
Carole White - (Minutes)	Senior Personal Assistant to Peter Morgan	CAW

In attendance for Item 3 only – Ian Canning, NHS Sefton

Apologies :

Tina Wilkins	Head of Vulnerable People, Sefton Council	TW
Robina Critchley	Director of Older People, Sefton Council	RC
Janet Atherton	Director of Public Health for NHS Sefton and Sefton Council	JA
Colin Pettigrew	Director of Young People & Families, Sefton Council	CP
Sam Tunney	Head of Business Intelligence & Performance, Sefton Council	ST
Dr Niall Leonard	Chair of Southport & Formby CCG	NL
Tracy Jeffes	Head of CCG Corporate Delivery – Sefton CCGs	TJ
Billie Dodd	Acting Head of CCG Development Southport & Formby CCG	BD
Steve Astles	Head of CCG Development South Sefton CCG	SA
Malcolm Cunningham	Head of Performance and Health Outcomes – Sefton CCGs	MC
Debbie Fagan	Chief Nurse for Sefton CCGs	DF

No.	Item	Minute	Action
1.	Minutes of the previous meeting	Agreed	
2.	Actions Arising / Update	Item 3 • Authorisation confirmation due on 22nd January 2013 Item 4 • Programme Management – On-going. Fiona Doherty recruited to post of Transformational Change Manager, reporting into MMcD. Programme Management to be	

No.	Item	Minute	Action
		an agenda item at the SSICG Meeting of 22nd April. <u>Item 5</u> • On-going <u>Item 10</u> • Sefton Carers Priorities – To be considered – agenda item for SSICG on 11th March. Phil Wadeson, Local Area Finance Director for the Merseyside Commissioning Board to become a Member of the H&WBB. phil.wadeson@liverpoolpct.nhs.uk ST to add to membership list.	ST
3.	Drug and Alcohol Needs Assessment Progress	• Ian Canning ran through with Members difference between the final and previous report and the outstanding challenges. • Deadline for completion - either w/c 28th January or w/c • 4th February. • Tender to be awarded after Easter. <u>Action</u> • Are we happy to share the care arrangements for Alcohol? • DE to feedback into FLC landmark dates, in order that FLC can raise at the relevant LMC Meetings. • FLC / CS / NL to come back to PM re a Member to join Procurement Process.	IC to circulate note to Members ALL DE / FLC FLC / CS / NL
4.	NHS Networks new content summary	• More monitoring being put in by NHS.	
5. / 6.	Funding Transfer from Health to support social services and reablement services 2013/14	<u>Background</u> In the 2011/12 Operating Framework for the NHS in England, the Department set out that PCTs would receive allocations totalling £648 million in 2011/12 and £622 million in 2012/13 to support adult social care. This funding was in addition to the funding for reablement services that was incorporated within recurrent PCT allocations of £150 million in 2011/12 rising to £300 million from 2012/13. From 2013/14, the funding transfer to local authorities will be carried out by the NHS Commissioning Board and the reablement funding will be carried out by the CCGs. In addition in January 2013 the DH allocated funding to support winter pressures and the PCT/CCGs will carry out this funding transfer. In each case the transfer will be made via a section 256.	

No.	Item	Minute	Action
	Winter Pressures Funding – Local Authority Allocation Reablement Funding	. • £468k Winter Pressures funding – PCT to via 256 agreement with the Council. PCT required to do a return in February to explain how funding has been spent. • 2013/14 allocation from NHSCB to support Social Care - £5,457,818 • Reablement – MMcD / TW / GO'C to meet shortly to agree investment of £1.8m to locally - via sec 256.	
7.	Any other Business	• GO'C now officially in her new joint role • Liz Johnson is soon to leave NHS / Sefton to take up a position at the CSU. • PM / GO'C to discuss way forward in light of Liz 'moving on'. • SSICG Draft Vision and Priorities – Action Plan – PM / DF as the leads to ensure document has been populated. This item to be an agenda item at the SSICG on 11th March. • PA asked if there was anything that Members wanted him to raise at the Merseyside Board Cluster Meeting – PA to reinforce the work that is being carried out by the SSICG.	PM / DF PA
		Date and time of the next meeting – 11th March 2013 at 3.30 p.m. – venue – Conference Room 3A, 3rd Floor, Merton House, Stanley Road, Bootle, Merseyside, L20 3JA	

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Engagement and Patient Experience Group
for South Sefton CCG and Southport and Formby CCG

07 November 2012, 15:00 – 17:00, Merton House

In attendance		
Kelly Jones	Engagement support CSU	(KJ)
Jackie Robinson	Head of Engagement CSU	(JR)
Lin Bennett	Practice Manager Board member SSCCG	(LB)
Sharon McGibbon	Practice Manager Board member SSCCG	(SM)
Wendy Anderson	Sefton LINk	(WA)
Roger Driver	Board Lay Member, South Sefton CCG (Chair)	(RD)
Helen Murphy	Sefton LINk	(HM)
Sarah Reynolds	Locality Lead, Southport & Formby CCG	(SR)
Diane Blair	Sefton LINk	(DB)
Libby Kitt	Sefton LINk member	(LK)
Lyn Cooke	Sefton Head of Communications, CSR	(LC)
Sam Tunney	Sefton MBC	(ST)
Jayne Vincent	Sefton MBC	(JV)
Ann Bisbrown-Lee	Sefton Link Chair	(ABL)
Roy Boardman	Practice Manager Board Member Southport & Formby CCG	(RB)
Jenny Kristiansen	Locality Lead, South Sefton CCG	(JK)
Tracy Jeffes	Head of CCG Corporate Delivery SSCCG, SFCCG	(TJ)
Rachel Bridge	Sefton CVS	(RB)
Apologies		
Roger Pontefract	Board Lay member, Southport & Formby CCG	(RP)
Billie Dodd	Head of CCG Development, Southport & Formby CCG	(BD)
Karen Leverett	Practice Manager, Southport & Formby CCG	(KL)
Steven Astles	Head of CCG Development, SSCCG	(SA)
Minutes		
Anne Lucy	Administrator, Southport & Formby CCG	

NO	ITEM	ACTION
12/30	**Apologies** were received and noted	
12/31	**Notes from the last meeting** The minutes were approved as an accurate record of the previous meeting	
12/32	**Matters arising not on the agenda** **12/23 Virtual Ward –** Steve Astles had met with LINk which now had sufficient detail of the Virtual Ward on which to develop a proposal to base/embed the patient voice. LK will bring the LINk proposal to the next meeting.	LK
12/33	**Authorisation update** TJ gave an update – The authorisation site visits for both Sefton CCGs went very well, with a large number of “reds turning to green.” Only a small number of criteria remained unmet; these would be systematically addressed in the coming weeks	

	and months. TJ thanked the group representatives for their valuable contribution towards the success of the two visits. The CCGs (particularly on the second visit) had been praised by the assessors for their strong patient engagement focus. The assessors had examined all levels of EPEG's work from practice level engagement through PRGs, through to the locality work/ liaison with the Community Champions and the EPEG's link into work at Board level. In response to a question from JV, TJ answered that any feedback from the visits in relation to patient and public engagement will come to EPEG and this is already part of the group's purpose. LK informed the group about an example of a piece work underway in conjunction with Terry Hill to support how patient choice influences commissioning. LK will feedback on this at future meetings.	LK
12/34	**Summary reports from the first Big Chat events** LC gave an update – a summary report has been produced to show interested parties an overview of the events and to outline what will happen as a result. The summary is now ready to be published. An interim website and e-bulletin will also be available from next month. Common themes identified in the summary are: • Care closer to home • Public involvement through two way dialogue **<u>Action</u> – LC to email group requesting any further comments by close of business on 15/11/2012** Once completed the final version, as well as other topical issues and events, will be publicised in local media (including the Crosby Herald, Midweek Visitor, Southport Visitor and Champion free papers). Additionally the CCG Chairs will be featured in radio / press articles in the North and South.	LC
12/35	**Proposal for Big Chat/JSNA and JHWBS Consultation Event (December)** TJ and ST had met to agree a joint approach to the next public events and presented a proposal for discussion by the group. ST noted that the proposal was recently approved by the Health and Wellbeing Board and the plan is to hold five events in the borough which will: • Feedback on SNA (JSNA) • Consult on the HWB strategy that is now in draft • Enable the documents to be shaped before sign off • Commence engagement before end November • Consult on commissioning intentions from CCGs • Make commissioning intentions clear and understandable for people In addition there the work will be taken to a range of other forums from the end of November. TJ noted that the first two events (due before Christmas) would be particularly important regarding consultation on commissioning intentions; the later events may be adapted based on feedback but would help people see the context of the strategy. The format would enable views to be fed in, but it was noted that both organisations would depend on networks for spreading the engagement future. RD noted that the two way flow was one benefit of the Big Chat events allowing groups to respond (whereas a forum was one way flow). The group discussed the format of the events, standardising communications and information to be recorded and disseminated, planning and resourcing for the future events. It was agreed that the small planning group reconvene as soon as possible to organise the events in detail. JR offered to co-ordinate the planning meeting. LA colleagues, Lay Board Members, CVS and LINk to be involved in this group.	JR
12/36	**Proposal from Carter Corson re EPEG development**	

	TJ gave an update - Carter Corson is the consultancy company that successfully bid to deliver our proposals for lots 2 and 4 in the national CCG development programme. A meeting in September began to shape the proposal further but it would be up to the EPEG to determine how best to shape, develop and increase the group's effectiveness based on the proposal. ST felt that it was important that a lasting legacy of self-development was built into the work once the consultancy came to an end. RB wished to ensure that the work did not go over old ground and the first session could be repetitive. JR noted that it had been discussed with Carter Corson that the programme should be building on earlier work to avoid repetition. TJ agreed to reinforce this message. JR felt that connectivity between this group and the Board would also need to be considered. RB suggested that the focus should be more on workshop two and three within the proposal – the connected committee and the influential committee. RD asked whether the group supported the premise behind the Relationship toolkit for GPs. The group discussed the toolkit and agreed that the proposal was not clear and discussion was needed to identify requirements. RB noted that the toolkit would need to be rolled out to GPs (protected learning time could be considered). LB felt that GPs might not use the toolkit as some areas were already covered by their own appraisal processes. GP/clinician involvement in public and patient engagement was however an area for further consideration and would be useful to focus on further. **<u>Action</u> – TJ asked for any further comments on the proposal to be emailed to her. She would liaise with Carter Corson to feedback views and agree the three half days for the new year.**	TJ
12/37	**Community Champions update** WA gave an update - Individuals are to be recruited to attend one pilot centre. Locality Leads are to be invited to the next Community Champions meetings (to tie in Locality Leads work and consult with focus groups). HM will be meeting Locality Leads in North Sefton, continuing the work she started in the South. She will be liaising with them to attend Locality meetings.	WA / HM and Locality leads.
12/38	**Patient Experience Report / Patient Choice Focus group** No reports were available for today's meeting but DB informed the group that discussions were taking place about the right the level of information to be shared with the group to form the basis of regular reports. TJ suggested that any available reports (regarding provider patient experience) could be shared with this group to see if it would be useful. This could also be provided to the quality committee and therefore directly influence commissioning when relevant. DB to send a report to the next meeting. TJ and JR offered support to the group to assist in streamlining the reports.	DB TJ/JR
12/39	**Reducing avoidable A&E attendances** SR provided an update regarding the work being done to identify / assess A&E attendances and asked the group if they could contribute ideas to reduce inappropriate attendances. Although previous work undertaken by other groups such as communications campaigns, QIPP projects, retrospective attendance follow up initiatives and other suggestions such as training, primary care access and triage were discussed further thought needed to be given to this area.. JR agreed to collaborate with SR re urgent care studies in other CCGs which have examined these issues. She noted that other CCGs shared the same problems with inappropriate A&E attendances.	SR/JR
12/40	**Patient Information Protocol** LC gave an overview and background to the protocol which dealt primarily with patient leaflets. She outlined the support that her department could offer the group.	

	The group discussed other media / publishing protocols and the setting up of a virtual reference group for patient information in order to test out messages. The group agreed that a standard template would be useful. **<u>Action</u> – Group to email comments to LC by close of business on 15/11/2012**	All
12/41	**PRG update** JR outlined that good progress had been reported in Sefton based on the work initiated by David Hammond, however some practices require further assistance and support – JR is providing this and will assist other practices on request. The next step is to set up quarterly meetings between PRGs in localities to help spare good practice, LB welcomed this and JR and LB/RB will liaise over involvement of the Practice Manager groups.	JR / LB/RB
12/42	**New CCG branding** Samples were shown to the group	
12/43	**AOB** None	
12/29	**Date and time of next meeting** 12 December 15:00 – 17:00, venue tbc Generally EPEG will meet every second Wednesday of each month from 10:00 – 12:00, however dates for the development sessions with Carter Corson in January, February and March would be required to be specifically agreed with Carter Corson and a longer session time made available (but could include business issues as well as development).	

PLEASE NOTE THAT SINCE THE MEETING IT HAS BEEN SUGGESTED THAT THE PROPOSED DATE OF 12TH DECEMBER BE CANCELLED DUE TO THE NUMBER OF PEOPLE UNAVAILABLE, THE PRXOIMITY TO THE LARGE PUBLIC EVENTS AND THE ADDITIONAL TIME REQUIRED FOR THE DEVELOPMENT SESSIONS IN JANUARY, FEBRUARY AND MARCH.

NEXT SESSION JANUARY 9TH 2013

South Sefton Clinical Commissioning Group

Maghull Locality Meeting Minutes

Friday 11 January 2013

Westway Medical Centre

Attendees

Dr Sapre	(SS)	Maghull Health Centre
Gillian Stuart	(GS)	Westway Medical Centre
Carole Howard	(CH)	Westway Medical Centre
Terry Hill	(TH)	South Sefton CCG Locality Lead
Dr Gill Thomas	(GT)	Broadwood Surgery
Judith Abbott	(JA)	Broadwood Surgery
Gill Kennedy	(GK)	High Pastures Surgery

Apologies

Jenny Johnson	(JJ)	South Sefton CCG

Minutes

Gary Killen Sefton CCG Administrator

No	Item	Action
13/01	**Apologies** Information	
13/02	**Minutes of last meeting – 7 December 2012** The minutes of the last meeting were reviewed and agreed as an accurate record.	
13/03	**Matters arising** **Wider Area Structures** GT – asked for clarification on the CCG wider area structures, TH stated that he would request that a member of the Senior CCG Management Team present to the group. **Action: TH to request a member of the Senior CCG team to attend the locality meeting to present the wider organisational structures** TH also stated that Tracy Jeffes is organising locality development workshops which the first is expected to be delivered in early February. **Medical reviews** Housebound patient medication review pilot was raised as an issue, Paul Cheston has been out to some practices to do desktop reviews but practices are not aware if patients have had reviews yet. TH to catch up with Paul for a progress update.	TH

No	Item	Action
13/05	**Prescribing Quality Scheme Update** TH provided an update on Care home reviews on behalf of Jenny Johnson. Care home reviews will be going on in each of the practices over the next 2 months. Maghull PCT practice has already been done. This is a project that was commissioned by South Sefton CCG at the beginning of the financial year. Extra money has been provided for it and the medicines management team have employed extra pharmacists to do the work. The review involves reviewing not only the patient's medication records but also visiting their homes. Recommendations will be passed to the GP's to action/advise. As there is only two months left of the project it would be appreciated if the GP's could get their agreement to any recommendations back as quick as possible, as all actions need recording on our data base.	
13/06	**QP Update** QP 6-11 – Data to be sent out to practices by the end of January. TH asked the practices if they wished to change the date of the February locality meeting considering the short timescales to audit, review and meet individually as practices before the audits are submitted. The Group agreed to change the date of the locality meeting to Friday 22nd February. QP14 – Bal Duper now is working with Angie Parkinson to work out reporting mechanism. GT queried whether walk-in centre data for QP14 will be removed. TH confirmed that the forthcoming data will exclude walk-in centre data. The data is due out in February for the localities to complete by mid-march	
13/07	**Any other business** GK explained the roles of the different persons in the CCG admin team and will circulate to the locality a structure framework of the admin team's roles. **Virtual Ward** TH handed out an email from Pete chamberlain with regards to Virtual ward Funding. TH provided the group with a draft District nursing specification for the practice to review. TH requested that if anybody had any queries to please contact Pete chamberlain directly. SS highlighted an issue concerning a patient who came into the surgery for a catheterisation procedure. After receiving an email from Dr Pete Chamberlain relating to catheterisation earlier in the day, SS subsequently had to refer a patient to A&E. If an action plan and the correct provisions were in place the patient could have been seen at home. GT commented it was unnecessary to send the patient to A&E. TH asked SS to forward the email from Peter Chamberlain to him he would look into this. **Action: SS to forward email to TH** **Risk Stratification** Paul Shillcock had sent out a sign up form for practices to sign up to streaming of Primary Care data. TH informed the group that approximately 80% of Liverpool CCG GP practices had already signed up to this. TH explained that after sign up, it takes approximately four weeks for the	SS

No	Item	Action
	primary and secondary data to be streamed for viewing. **Action: TH to request that Paul Shillcock contact SS with regards to risk stratification.** **HCA Appointment** The locality Practice nurse facilitators are currently working with Hugh Baird college in order to assess the need for building HCA capacity through apprenticeship schemes. TH has asked the practices to provide the number of HCA hours they provide per week. **TH to request HCA hours worked via email.** **Locality Pressures** TH asked the group if they were likely to use their full allocation of locality pressure funding. Westway, High Pastures and Dr Sapre all indicated that they would be looking to use all their allocation but would inform TH if they thought they could not. **Urgent Care system - Red** Due to pressures in the urgent care system, TH informed the group that he had been asked to call some practices in the locality to identify if there were also pressures **Cervical Screening** TH handed out a report showing results for Cervical Screening samples for women registered with Maghull practices from 01/11/11 to 31/10/12. The report illustrated that have been suggested to be high. The practices were asked if this is down to practices referring patients or whether it was patient choice. The group unanimously stated that it is down to patient choice and not referrals. The group requested clarification on the data provided as it wasn't clear what Maghull usage was like, compared to other localities and their local services. **Action: TH to request further clarification.** The group queried the reasoning behind why the capacity of the service had been reduced considering the importance of the targets and the difficulty in getting women to come in for cervical screening anyway. JA stated that women prepare themselves to for the screening, however if it is difficult to get into a service this will affect the uptake. It was stated that patients had been turned away when all appointments had been filled. **Action: TH to speak with Morag Reynolds and Steve Astles to find out why staffing has been reduced at Maghull and patients have been turned away.** TH asked if it would be helpful for ICIS to come out to a future meeting. P Briggs is interested in coming to the February meeting.	TH TH TH

No	Item	Action
	Action: TH to invite ICIS to a future meeting **Diabetic Foot Checks.** JA raised an issue regarding patient's who are referred to the Podiatrist/Chiropodist. The Podiatry/Chiropody team are not completing reports and sending to the practices to be input in to patient's records. In some cases this means patient are being sent for treatment twice. Steve Astles produced a form to be completed, but chiropody has not followed the correct process. **Action: TH to query with Ste Astles**.	TH
13/08	**Date and time of next meeting:** Friday 22 February 2012 1.00 – 2.30 Westway Medical Centre	

South Sefton Clinical Commissioning Group

Bootle Locality Meeting Minutes

Wednesday 23rd January 2013
1.00 pm – 2:30 pm
Park Street Surgery

Attendees
Dr Stephenson
Carol McCormick
Jenny Kristiansen
Helen Devling
Ronnie Holmes
Dr Chung
Pauline Sweeney
Dr Goldberg
Dr Sapre
Dr Morris

Guest Speakers
Peter Terry – Item 13/04
Paul Halsall – Item 13/05

Apologies
Pam Sinha
Ricky Sinha
Dawn Rigby

Minutes
Gary Killen – Sefton CCG Administrator

No	Item	Action
13/01	**Apologies** Noted	
13/02	**Minutes of last meeting** – 29 November 2012 Minutes were agreed as an accurate record. With the exception of Dr Sapre being removed from the attendees list to the apologies list.	JK to amend
13/03	**Matters arising** Erectile disfunctioning – Brendan Prescott gave some feedback through JK about this matter. He has taken it up with Southport & Ormskirk Hospital trust and trying to get it up and running before the end of this financial year.	

No	Item	Action
13/04	**Mersey Care NHS Trust – Peter Terry** Peter gave a quick overview of the services available from the Community Mental Health Team. He hopes to visit 35 GP practices every quarter to improve communication and to solve any operational issues that may arise. He said that he is happy to go out to see people individually if they need to discuss individual issues. It was agreed that Peter would attend the meetings on a 3 monthly basis unless anything arises in-between in which case he will attend as and when required. JK requested a copy of contacts for distribution to the practices. Inclusion matters were raised, Peter explained that a non CPA patient can still see a psychiatrist and inclusion matters. CMc raised the issue around calling the access team and getting mixed messages. PT said he would feed that back to the team and provide a response to the group.	**JK** to email information and contacts list to the group. GP Information Pack South Sefton Merton Back Page of GP Pack.docx **PT** – Provide feedback re: issue raised
13/05	**Medicines Management Update** PH gave a hand out regarding stoma patient numbers and the prescribing data for the last 12 months based on current prescriptions. Some of the practices felt that the numbers seemed quite low. JK asked if there was any other way to verify the data. CMc suggested all Bullins requests to be kept in a box, and data kept for ostomy products for home bound people. JK updated the group around developments regarding prescribing stoma products and her links with Aintree Hospital. JK said she will be meeting with the Specialist Stoma Nurse to work develop an SLA to support the prescribing for, and reviewing of, patients in South Sefton. PH gave a hand out for budgets for prescribing for each individual practice. PH informed the group that Sean Reck and Shaun Roach (Sefton medicine management pharmacists) have been carrying out care home medication reviews in the Bootle Locality. He asked if GPs/Practice Managers want them to come out to their practices to collect any updates regarding any action GPs have taken as a result of any appropriate recommendations made following the pharmacist's care home medication reviews. This is so that the outcomes can then be recorded. There email addresses are as follows: Sean.Reck@sefton.nhs.uk Shaun.Roche@sefton.nhs.uk shaunroche@nhs.net	
13/07	**Locality Pressures Update** JK informed the group that all sessions to finish at the end of February and all invoices to be submitted to JK by the middle of March at the latest. JK will then authorise for payment. A concern was raised around the value of asking the patient the audit questions at the actual appointment. The group agreed that it would	**JK** to feedback concerns regarding the audit process.

No	Item	Action
	be better to ask the patient those questions at the time of booking the appointment. JK asked the group to do what has been requested for now but will certainly feedback these concerns. To get feedback on the figures it was suggested that the use of the portal to analyse the results against last year's figures.	
13/08	**Business Case Update** JK explained to the group that whilst she has been working through the plan for implementing the agreed business cases there has been some pieces of work on a wider footprint running alongside that has had implications for the locality business cases. **HCA** The first business case that was scoped out was to increase HCAs to free up nurses to review housebound patients. Following the collection of how many HCAs there were across the locality it was deemed inappropriate to implement this business case as there was not enough capacity. This has also been the case across the other localities in South Sefton Work has been done around workforce planning in this area with Hugh Baird College who are very interested in supporting South Sefton with this. CMc asked if Moore Street would still be getting the revenue for the two HCAs they had trained up in their practice. JK said that she was unaware of the agreement to use the money in that way but would check if Moore Street can receive the cost they have incurred. HD agreed to email all practice mangers across the locality if they required a list of courses their HCA studied. **Audit of Stoma Products** The second business case to be scoped out was the stoma audit. Following receipt of further information it seemed futile to do an audit on what we already know, it was however decided to do a bigger piece of work across South Sefton to build a business case for change to the current system. Numbers of patients requiring stoma products was collected by medicines management. Whilst scoping out what was already in the system a Stoma Specialist Nurse was contacted at Aintree Hospital. Her role had been set up to work both pre and post operatively with patients. She was very keen to work with Sefton CCG and it was agreed to work on a plan via her manager. JK will be meeting with the Specialist Stoma Nurse to look at developing an SLA to support the prescribing for, and reviewing of, patients in South Sefton. It is hoped that this will be a collaborative piece of work that will require reshaping current provision to meet the needs of patients in South Sefton. **3rd party repeat prescriptions** – PH gave out a hand out regarding 3rd party prescriptions cost effectiveness. As this piece of work needs to be completed by the end of March the group agreed to run the process for a 5 week period instead of ten as proposed in the business case. JK agreed to email the practices with a revised version of the business case along with the script and forms required	**JK** to send out revised version

No	Item	Action
	which practice managers can go through with the identified administrators. Practices will need to double up 2 admin staff x 5 weeks (instead of 1 x 10 weeks) at the cost stated in the business case. The practice pharmacist will feed the information to a named person in medicines management to collate the figures and work out the savings. JK to tweak the business case and send out. PH to identify medicines management input.	of the 3rd party repeat prescriptions business case.  bus case 3rd p pres.doc **PH** – to identify medicines management input
13/09	**QP indicators 6,7,8,& 9,10,11** The templates have been discussed with CMc and HD for feedback and sent to Luke Garner to collect the data. . The data will be released by Luke to practice NHS net accounts around the 5/2/13. Practices will need to hold a review of the data and report back at the next Locality Meeting on the 28/2/13 where we will hold the peer review. HD has agreed to work with JK on pulling together an overall locality report following the peer review session on the 28th. **QP areas agreed** **QP 6-8** • **Gynaecology** – The aim is this service to be done in the community not hospitals. • **Dermatology** – To include the 2 week rule. • **24 hour blood pressure monitoring** – it was stated the costs for these to be done at practice level was too high i.e. Nurses time, calibrating the equipment. JK to do a business case to look into the costs for the practice against doing it at the hospital. JK to see if this is viable with coding at the hospital. If not another indicator will need to be identified. **QP 9-11** • **End of life –** All data for this needs to be provided by practices • **Heart Failure** • **COPD** **QP 14.** Regarding the reduction of patients going to A.E. Luke Garner to get data from October – December 2012 to the practices for comparison with the exercise completed last year. The locality will then need to decide if what they put in place in practices following last year's exercise has made any difference to A&E attendances. The data is due the end of February and will not include any people going through	**All**

No	Item	Action
	the walk-in centres.	
13/10	**Any other Business** **Spirometry** - At present waiting lists are 5 months. JK has completed 2 waiting list initiative's to clear the backlog and a business case for the development of a new spirometry service to hold community clinics across the locality hosted by Aintree NHS Trust. The business case will be submitted to the Finance and Resource Committee and if approved will commence in April 2013. . The proposed service will be set up to see new patients within 2 weeks from referral and follow-up patients to be seen within 4 weeks of referral. **Community Respiratory Service (CRS)** – JK informed the group around a piece of work she has been working on. She informed the group that the current CRS has been enhanced to provide a single point access for G.P's to refer to, the provider is by Liverpool Community Health. Existing cases currently on the caseload will be seen 8am – 8pm 7 days a week. New cases can be referred Monday to Friday 8am – 6pm. This service will be advertised via communications. Dr Ricky Sinha has asked for GP volunteers on the following sub committees. Finance & Resource or Quality. Unfortunately nobody was identified at the meeting The group requested a list of all LES Schemes that will be continuing next year. JK agreed to send out a list when it is agreed.	**JK** – send out list when available
13/11	**Date and Time of Next Meeting** Thursday 28th February 2013 1:00 pm – 2:30 pm Park Street Surgery	

Future Meeting dates – Next 6 months

Wed - 20/3/13
Thur – 11/4/13
Wed – 22/5/13
Thur – 20/6/13
Wed – 24/7/13
Thur - 22/8/13

South Sefton Clinical Commissioning Group

Seaforth and Litherland Locality Meeting

23rd January 2013
1.30pm – 3.00pm
Crosby Lakeside Adventure Centre

Attendees
Dr Duper (Chair)
Dr Nigel Taylor (Litherland Town Hall PCT Practice)
Dr Fred Cook (Orrell Park and Rawson Road)
Angela Dunne (Orrell Park and Rawson Road)
Dr Terry Thompson (15 Sefton Road)
Dr Colette McElory (15 Sefton Road)
Dr Andy Slade (Glovers Lane Surgery)
Dr Martin Vickers (Bridge Road Surgery)
Dr Naresh Choudhary (Netherton PCT Practice)
Lisa Roberts (Netherton PCT Practice)
Dr Noreen Williams (Ford Medical Pratice)
Lin Bennett (Ford Medical Practice)
Alison Harkin (15 Sefton Road)
Julie Price (Litherland Town Hall PCT Practice)
Caroline Nolan (Seaforth PCT Practice)
Dr Steve Fraser (Seaforth PCT Practice)
Minutes
Angela Parkinson

No	Item	Action
13/01	**Apologies** Colette Page	
13/02	**Minutes of Last Meeting** The minutes of the last meeting were agreed as an accurate record	
13/03	**Matters Arising** **QP14** Dr Duper had met with Neil Rotherham regarding the requirements for this indicator. Practices are required to implement their improvement plan agreed in QP13, and repeat the A+E audit using October – December data (2/1000 patients). The secondary care data will be available in February, Luke will organise for WIC data to be removed. Practices will be informed when the data is available to view on MSIP. Although practices were not asked to note percentages of appropriate / inappropriate A+E attendances on the first audit, the practice may get a feel for whether inappropriate attendance have increased or decreased. Practices will need to provide a report following the instructions in the QOF guidance by no later than 31 March 2013.	

No	Item	Action
13/04	**QOF Group Peer Review** • Dermatology • Urology • End of Life • COPD • Cellulitis Please see group peer review report (appendix 1). Practices are asked to highlight your own practice contribution on the report and forward to MIAA by 31st March 2013.	
13/05	**Succession Planning** Dr Duper asked the group to consider succession planning for GP Locality Lead. The role would include chairing the locality meeting, meeting with the locality manager and attendance at the Finance / Quality Committees. Anyone who would like to express an interest should contact angela.parkinson@sefton.nhs.uk	ALL
13/06	**Any Other Business** Caroline Nolan mentioned that the list of ABPI providers on the CCG website needed updating. Alison Harkin reported problems / confusion with fax numbers for 2 week cancer waits and confirmation of receipt of faxes – Sarah Reynolds will be contacted. Lin Bennett asked practices whether problems were being reported to Gary Francis at Aintree, as feedback from Aintree suggests that only 2 practices had contacted him using the email address agreed gp@aintree.nhs.uk Practices within the locality disputed these figures and reported contacting Aintree. Practices are urged to raise problems with the Trust. Practices who do not receive a response should contact Stephen.astles@sefton.nhs.uk GP representation at locality meetings was discussed. The view of the locality was that the identified GP clinical lead for each practice with knowledge of their population / practice issues should attend. The group discussed future meeting dates it was agreed that the first Wednesday of each month would be set for locality meetings. List of meeting dates will be put onto the CCG website	AP AP ALL AP
13/07	**Date and Venue of Next Meeting** **Wednesday March 6th 1 – 3pm at Crosby Lakeside Adventure Centre**	

South Sefton Clinical Commissioning Group

Remuneration Committee Minutes

13th March 9:00 a.m.
Merton House, Bootle

Attendees
L Elezi (Chair)
Dr C Shaw
Dr R Sinha
S McGibbon

Apologies
N/A

Minutes
Marie Rice

No	Item	Action
13/1	**Introduction and Background** South Sefton CCG must consider reasonable remuneration for the post of Chief Officer and Chief Finance Officer in line with the guidance received from NHS Commissioning Board, as detailed. The purpose of this meeting is to recommend to the Governing Body, remuneration to be paid to Chief Officer and Chief Finance Officer of South Sefton CCG & Southport & Formby CCG from April 2013, when the CCG's become established. The recommendation is in line with guidance received (as per below) from NHS Commissioning Board on remuneration for Chief Officers and Chief Finance Officers in CCGs.	
13/2	**Chief Officer Remuneration** **CCG Level** / **Population size** / **Pay range for Chief Officer** Level 3 / at or over 500k / £120k – £130k Level 2 / between 150k - 499k / £105k - £120k Level 1 / at 149k or below / £90k - £105k. The Committee discussed of Chief Officer. As previously detailed in the paper, the population of Southport & Formby CCG is 119,080 and the population of South Sefton CCG is 147,366. The pay level is based on the largest CCG, not the combined total. The committee agreed that based on the largest CCG, South Sefton, with a population of 147,366 the pay range level falls between level 1 (£90 - £105K). The Committee also identified that the population size at level 2 starts at 150K with a starting pay range of £105k and as the population for South Sefton CCG is only slightly below the level 2 bracket, the maximum	

No	Item	Action
	pay range for level 1 should be applied.	
13/3	**Chief Finance Officer Remuneration** **CCG Level** **Population size** **Pay range for Chief Officer** Level 3 at or over 500k £95k – £110k Level 2 between 150k - 499k £85k - £95k Level 1 at 149k or below £75k - £85k. The Committee discussed of Chief Finance Officer. The committee followed the same rationale to agree the pay range for the Chief Finance Officer and that the maximum of Level 1 pay range (£75k - £85k) should be applied.	
13/4	**Additional Payments Joint Management Arrangements** In line with guidance the Committee considered the guidance around Additional Premiums as detailed below: **JOINT MANAGEMENT ARRANGMENTS** - Where a CCG shares a Chief Officer/Chief Finance Officer with a neighbouring CCG, where each CCG has their own Governing Body, an additional premium of **up to 20%** of the appropriate pay range can be considered. This should be based on the population size of the largest CCG. The Committee discussed and agreed that as each CCG has their own governing body, this adds complexity to the role of Chief Officer/Chief Finance Officer. It was also identified that taking responsibility for two organisations should be recognised by awarding an additional 20% premium of salary as per guidance.	
13/5	**Development Pay** As per guidance, was not considered appropriate during this Committee meeting.	
13/6	**Recruitment and Retention** As per guidance, was not considered appropriate during this Committee meeting.	
13/7	**Additional Responsibility / Complex Factors** This was not considered appropriate during this Committee meeting.	
13/8	**Recommendations** The Committee recommends that the **Chief Officer** remuneration as from 1st April 2013 should be approved as follows: Pay range Level 1 £105K Additional Premium re Joint Management Arrangement plus 20% Total remuneration £126K The Committee recommends that the **Chief finance Officer** Remuneration as from the 1st April 2013 be approved as follows: Pay range Level 1 £85K Additional Payment re Joint Management Arrangement Plus 20% Total Remuneration £102K	