

## Board Meeting in Public Agenda

To be held on Thursday, 30 May 2013 at 1.00pm to 4.00 pm  
Boardroom, Third Floor, Merton House, Stanley Road, Bootle L20 3DL

**Please note: the formal Board meeting will commence following a brief period when members of the public will be able to highlight any particular areas of concern / interest and address questions to Board members.**

Attendees		
Dr Clive Shaw	Chair, GP Board Member	(CS)
Lynda Elezi	Vice Chair, Lay Member	(LE)
Dr Craig Gillespie	Clinical Vice-Chair, GP Board Member	(CG)
Dr Steve Fraser	GP Board Member	(SF)
Dr Andrew Mimmagh	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 - Board Member	(LB)
Sharon McGibbon	Practice Manager - Board Member	(AF)
Dr Dan McDowell	Secondary Care Doctor, Board Member	(DMcD)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
Margaret Carney	Chief Executive, Sefton MBC (Co-opted Member)	(MC)

The meeting will be preceded by a presentation by Dr Pete Chamberlain on the Virtual Ward Project

No	Item	Lead	Verbal/ Report	Action
13/58	Apologies for Absence	Chair	Verbal	To note
13/59	Minutes of Previous Meeting	Chair	Report	To approve
13/60	Action Points from Previous Meeting	Chair	Report	To discuss
13/61	Business Update	Chair	Verbal	To note
13/62	Chief Officer Report	FLC	Paper	To note
13/63	Portfolio Leads Update	All	Verbal	To note
<b>Performance</b>				
13/64	Performance Reports			
	(a) Finance Update	MMcD	Report	To note
	(b) Prescribing Update	BP	Report	To note
	(c) Update on Care Home Review Service	BP	Report	To note
	(d) South Sefton Sip Feed Project Report	BP	Report	To note



No	Item	Lead	Verbal/ Report	Action
	(e) Activity and Quality Report	MC	Report	To note
<b>Policy/Strategy/Health Improvement</b>				
13/65	Draft Strategic and Operational Commissioning Plan 2013-2016	MMcD	Report	To note
13/66	Draft CCG Prospectus	SA	Report	To approve
13/67	Virtual Ward Update	SA	Report	To note
13/68	Cancer Services	Sarah McGrath	Report	To note
<b>Governance</b>				
13/69	Conflicts of Interest Policy	Tracy Jeffes	Report	To approve
13/70	Board Assurance Framework	TJ	Report	To note
13/71	Update of Terms of Reference – Board Committees	TJ	Report	To note
<b>For Information</b>				
13/72	Register of Interests	FLC	Report	To note
13/73	Hospitality Register	FLC	Report	To note
13/74	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	Various          No minutes available  No minutes available	Reports	To note
13/75	Any Other Business			
13/76	Date, Time and Venue of Next Board Meeting Thursday, 25 July 2013 at 1.00pm at Merton House			

**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 Minutes

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

### Present

Dr Clive Shaw	Chair	(CS)
Dr Craig Gillespie	Clinical Vice-Chair, GP Board Member	(CG)
Dr Steve Fraser	GP Board Member	(SF)
Dr Andrew Mimmagh	GP Board Member	(AM)
Dr Ricky Sinha	GP Board Member	(RS)
Dr Paul Thomas	GP Board Member	(PT)
Roger Driver	Lay Member	(RD)
Lin Bennett	Practice Manager Board Member	(LB)
Sharon McGibbon	Practice Manager Board Member	(SMcG)
Dr Dan McDowell	Secondary Care Doctor, Board Member	(DMcD)
Martin McDowell	Chief Finance Officer	(MMcD)
Debbie Fagan	Chief Nurse	(DF)
Libby Kitt	Sefton Links Patient Representative	(LK)

### In attendance

Paul Shillcock*	Informatics Manager, Merseyside & Cheshire CSU	(PS)
Tracy Jeffes	Head of Delivery	(TJ)
Steve Astles**	Head of CCG Development	(SA)
Malcolm Cunningham	Head of Performance & Health Outcomes	(MC)
Dr Wendy Hewitt	CCG Lead for Paediatrics	(WH)
Dr Colette McIlroy	CCG Constituent Member GP, observing	(CMcI)

### Apologies

Lynda Elezi	Vice Chair, Lay Member	(LE)
Dr John Wray	GP Board Member	(JW)
Fiona Clark	Chief Officer	(FLC)
Margaret Carney	Chief Executive, Sefton MBC	(MC)

### Minutes

Melanie Wright

\*left the meeting at 13.30

\*\*left the meeting at 14.23

No	Item	Action
13/30	<b>Apologies for Absence</b> were noted.	
13/31	<b>Minutes of Previous Meeting</b> 13/6 two way process between practices and district nurses was due to a licence issues with EMIS. 13/14 correct spelling of the word 'foveal'. Subject to the minor amendments above, the Minutes were <b>approved</b> as an accurate record of that meeting.	
13/32	<b>Action Points from Previous Meeting</b> All actions from the previous meeting were closed out, save for the following action notes.	

No	Item	Action
	<p>12/190 <b>QIPP Update</b> A spreadsheet will be circulated which demonstrates the QIPP projects which are currently ongoing. <i>Carried forward.</i></p> <p>12/199 <i>Performance and quality.</i> Malcolm Cunningham 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. <i>Carried forward.</i></p> <p>13/9 <b>Quality Update</b> Martin McDowell advised that the CCG has made provision for its AQuA membership and consideration of the type of work AQuA can support is required – it was suggested that this could be incorporated into a Development Session.</p> <p>13/13 <b>Virtual Ward Update</b> An update to be brought to the next Board meeting.</p>	<p>MMcD</p> <p>DF</p> <p>SA</p>
13/33	<p><b>Business Update</b> Dr Shaw reported that the CCG has been fully authorised without any conditions and expressed his congratulations to colleagues. The Constitution has been finalised and is due to be circulated to practices.</p>	SA
13/34	<p><b>Chief Officer Report</b> <i>111</i> The Board thanked the operational staff, namely Jane Uglow and Terry Hill for their work in relation to this project. Dr Mimmagh reported on progress with the 111 implementation, which had not gone well: on the day of mobilisation, the service was overwhelmed and implementation has therefore been suspended on the grounds of patient safety. Malcolm Cunningham formally extended thanks to the Out of Hours operator, who responded quickly to get the service operational once again. In the meantime, practices are asked not to direct patients to 111, but continue with the Out of Hours service. It was noted that the 111 Local Clinical Advisory Groups (LCAG) are accountable to CCG boards. <i>Procurement</i> The regulations that had been considered have been withdrawn and are under review. <i>Transfer Schemes</i> Delegated authority was sought for the Chief Officer and Chief Finance Officer to sign off the transfer schemes. An additional 12 months has now been agreed to finalise this. The Governing Body <u>approved</u> the Chief Officer signing off the transfer schemes. The Chief Finance Officer thanked staff for their contribution in the CCG achieving authorisation. <u>Noted.</u></p>	

No	Item	Action
13/35	<p><b>Portfolio Leads Update</b></p> <p>CG <i>Community Cardiac Service</i> - work in relation to the respecification of this service is ongoing.</p> <p><i>Ambulatory Blood Pressure Monitoring Service</i> – the Bootle locality are unhappy about the level of work generated by this. However, this is NICE guidance. There are risks in relation to a delay in patient diagnosis of hypertension. Consideration of the number of machines issued may need to be reconsidered. The possibility of withdrawing the service and referring elsewhere had been raised, but this was felt to be expensive. Dr Gillespie felt that a LES may have to be considered. This piece of work will then need to be brought to Finance &amp; Resource Committee as a priority.</p> <p>Dr Mimmagh felt it would be helpful to ask secondary care providers to cease communications with practices in this regard.</p> <p>PT <i>Virtual Ward</i> – following a meeting with the Community Geriatrician, two clinics have been set up in the community on Wednesday and Thursday mornings on Ward 35. The service will be shared with Liverpool and Knowsley CCGs.</p> <p><i>Stroke Peer Review Summary meeting</i> – Dr Thomas attended this meeting at which some challenges were identified, namely patients going through A&amp;E to the Stroke Unit, who seemed to be going to the MAU instead of the Stroke Unit at Aintree. This impacts on patients being seen within 4 hours. Direct referral to the Stroke Unit by GPs was raised as a possible solution.</p> <p>In terms of social impact, the Stroke Association are not attending the MDTs any longer, due to funding reductions. This will impact on discharges. There is also no dedicated social worker for this team. Improved links with social care are required</p> <p>The CCG confirmed its commitment to fund Year 2 (of 2) to support the Early Supported Discharge Project (initiated through Mersey QIPP) in 2013/14 financial year.</p> <p>Martin McDowell noted that he thought this funding was ‘pump priming’ to enable the Trust to safely reduce average length of stay for patients. This should provide funding for the Trust to pick up the service from 2014/15 onwards.</p> <p>The pathway through A&amp;E is being considered as part of the 2013/14 contract negotiations.</p> <p>SF <i>Prescribing</i> – the use of Scriptswitch will end at the end of this financial year. Replacements are being considered.</p> <p><i>Prescribing Budget Setting 2013/14</i> – 25% fair shares, 75% historical is being considered and this will be taken to localities for discussion. Martin McDowell advised that this will need to come to the May Finance &amp; Resource Committee. Clarity is also required on whether this will just be on a South Sefton CCG basis. Brendan Prescott to update the Governing Body via email.</p> <p>Tracy Jeffes advised that following a meeting with the CSU, a portal development group is to be set up to ensure development locally of the Intelligence Portal. Dr Shaw noted that the intelligence portal was originally a South Sefton innovation.</p>	<p>SA</p> <p>BP</p>


No	Item	Action
	<p>LK Community Champion Network – there are 22 champion centre sites in South Sefton and the patient experience information is coming through, particularly in relation to primary care. This will be handed over to Healthwatch as part of the LINKs legacy.</p> <p>LB Wished to acknowledge Angie Parkinson’s work on the LES and DES schemes, which was useful to practices.</p> <p><i>Contracting</i> – a meeting will not take place in March with LCH due to contract renegotiations, Dr Mimmagh reported on continuing difficulties with aspects of delivery with LCH specifically relating to the Single Point of Access for Community Care Assessment Unit and Community Respiratory Team.</p> <p>RS <i>Dementia</i> - Dr Sinha reported on a recent meeting where the importance of secondary care referrals direct to geriatricians was discussed.</p> <p>DMcD <i>Aintree</i> – in relation to community support, Dr McDowell felt that there was very little from Aintree, being more hospital-focused. There is also a lack of medical registrars.</p> <p>RD <i>Engagement and Patient Experience Group</i> – roles and expectations are in the process of being finalised.</p> <p><u>Noted.</u></p>	
13/36	<p><b>Performance Reports</b></p> <p><b>(a) Finance Update</b></p> <p>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.</p> <p>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.</p> <p>Restitution claims in relation to patients who consider themselves eligible for NHS funded care during April 2004 and 2011 have been received and are being assessed. The provision is £2.8m across the NHS Sefton footprint and the assessment process will continue throughout the next financial year. Martin McDowell felt the provision across both Sefton CCGs is sufficient, based on available data.</p> <p><u>Noted.</u></p>	
	<p><b>(b) Prescribing Update</b></p> <p>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. The work undertaken by practices to achieve this was noted.</p> <p><u>Noted.</u></p>	
	<p><b>(c) Performance and Quality Report</b></p> <p>The overall NHS Sefton position is amber. 62 day waits and CDiff remain an issue at Aintree.</p>	



No	Item	Action
	<p>Aintree reported green in January, except on CDiff. They are also compliant in relation to cancer targets.</p> <p>The Board noted that the format of the report will change for the next meeting as we will receive data relating to South Sefton only.</p> <p>Debbie Fagan advised that a Strategic Board has been set up with Aintree in relation to healthcare acquired infections to address some of the current issues.</p> <p>At the Quality Committee, the North of England Quality Dashboard was also considered. The Committee were concerned that Aintree's performance was second to bottom on the table in relation to quality across all North of England trusts.</p> <p>Dr Gillespie advised that the Quality Committee had concluded that the concerns must be formalised. A Quality Risk Review meeting has been requested, the National Commissioning Board Area Team are facilitating this.</p> <p>Dr Shaw reiterated that poor performance at acute trusts is something for which the CCG will be held accountable.</p> <p><u>Noted.</u></p>	
13/37	<p><b>Strategic Plan</b></p> <p>Martin McDowell advised that work continues in relation to the Strategic Plan. Under the Scheme of Delegation, the plan requires adoption by the Wider Constituent Group. Further patient engagement will also be sought. The plan will be brought back to the May Board meeting for ratification following review by the Wider Constituent Group. <u>Noted.</u></p>	
13/38	<p><b>Everyone Counts</b></p> <p>Tracy Jeffes drew the Board's attention to the three local priorities of the Quality Premium, following the recent Wider Constituent meeting.</p> <p>In relation to respiratory admissions to Aintree, this had to be altered to relate to respiratory admissions instead of COPD this would widen the number of patients affected in Sefton.</p> <p>Data for local priorities must be submitted today and Tracy invited views of the Board.</p> <p>Dr Shaw felt the change to respiratory conditions was significant and Dr Mimmagh expressed concern in the event of an influenza pandemic. There was then a discussion around how this might work in practice. Suspension of criteria in the event of a pandemic was suggested. Tracy Jeffes advised that a caveat in this respect could be included. Lin Bennett queried whether the SSCCG constituent Practices needed to be involved with the change from COPD to respiratory admissions.</p> <p>Dr Shaw's concern was around the difficulties of demonstrating a significant change in a small number of patients. Using the original codes exposes the CCG to problems with coding at Aintree.</p> <p>There then followed a discussion around coding issues at Aintree.</p> <p>Lin Bennett felt the wording needed alteration in relation to A&amp;E admissions.</p> <p>The Board <u>approved</u> the three priorities contained within the report, subject to a caveat in relation to an influenza pandemic.</p> <p>This will require further discussion at locality level and management by the CCG membership.</p>	TJ

No	Item	Action
	In the event any further minor alterations are identified, it was <u>agreed</u> that Chair's action can be taken in relation to such minor alterations to the plan.	
13/39	<p><b>2013/14 Financial Outlook Report</b></p> <p>Martin McDowell presented the opening report for 2013/14 and discussed the key points thereof.</p> <p>The Board then <u>approved</u> the CCG opening budgets.</p> <p>The Board <u>noted</u> that the CCGs plans met key targets, notably:</p> <ul style="list-style-type: none"> <li>• 1% overall surplus</li> <li>• remaining within running cost allowance</li> <li>• at least 0.5% contingency</li> <li>• 2% of recurrent resource deployed on non-recurrent basis.</li> </ul> <p>Martin McDowell then outlined the uncertainty that remained following the baseline exercise which had allocated funding to new organisations. A further report will be provided to the Board in May, including more detailed expenditure plans.</p> <p>Martin McDowell suggested that the Governing Body delegate authority to a sub-group to establish a joint risk pool to deal with in-year pressures by way of non-recurrent transfers across S&amp;F CCG and South Sefton CCG in the sum of up to 2% which would equate to circa £5m for South Sefton CCG.</p> <p>Dr Mimmagh did not agree with the balance between the two CCGs, as South Sefton would be contributing more. This meant that the possible result was a lesser return than the stake and suggested a fixed sum by way of alternative.</p> <p>Dr Gillespie felt that CCGs were funded on the basis of population size and this was not reflected by the current proposal.</p> <p>Dr Gillespie also asked in what situation the risk sharing agreement could be called upon. Martin McDowell responded that it would lower pressures that emerged across the Sefton health economy in 2013/14.</p> <p>Dr Gillespie asked whether there were any restrictions.</p> <p>Dr Mimmagh felt that historically the South has channelled money towards the North and this is likely to recur. He felt that the North needs to match the level of funding not in terms of percentage, but in cash terms. Further, the Board needs to be explicit that it will depend upon the approval of the full Board, not delegated responsibility, to ensure that the Board can scrutinise where the funding was going. Further, repayment in subsequent years could be sought.</p> <p>Martin McDowell responded that these terms could be included and advised that full Board discussion on this issue could take place in a Part 2 meeting in the future.</p> <p>Dr Mimmagh acknowledged that the system needs to be supported, but the Board also needed to support South Sefton.</p> <p>Dr Shaw advised that a risk sharing agreement is necessary to prevent the Sefton economy being destabilised. With this in mind, Dr Shaw was happy with a fixed term sum.</p> <p>Dr Shaw also felt a Board level discussion in terms of deployment of the reserve was appropriate.</p> <p>Martin McDowell advised that the Strategic Plan will set out a three-year spending plan. This plan will be reviewed regularly by the CCG Finance &amp; Resource Committee.</p>	

No	Item	Action
	<p>Dr Mimmagh reminded the Board that the CCGs were two separate statutory bodies and, as such, their interests may not be coterminous.</p> <p>The structure of the proposed risk sharing agreement requires further consideration in terms of:</p> <ul style="list-style-type: none"> <li>• equal sums from both CCGs; and</li> <li>• the possibility of repayment in future years.</li> </ul> <p>Martin McDowell agreed to consider this further.</p>	MMcD
13/40	<p><b>Plans for Healthwatch in Sefton</b></p> <p>The new chair of Healthwatch has been appointed, subject to references.</p> <p>The work LINKs is engaged in will transfer over to Healthwatch and a legacy document has been prepared. Organisational work has still to be done in relation to setting up the board, steering group etc.</p> <p>It was noted that Healthwatch Sefton will have a separate identity to Healthwatch, which is a national entity.</p> <p>Roger Driver suggested that the chair of Healthwatch be invited to present to the Governing Body on the some of the issues outlined in the legacy document.</p> <p><u>Noted.</u></p>	
13/41	<p><b>Low Utilisation of Summary Care Records</b></p> <p>Paul Shillcock advised that CCGs will be asked to comply with this directive by 31 March 2013 and asked for the Governing Body's support to address this via localities.</p> <p>One practice has uploaded, the rest are capable of uploading.</p> <p>Roger Driver asked what the main patient benefit was: Paul responded that for example, patients records will be capable of access in terms of allergies etc in the case a patient is urgently treated.</p> <p>Patients have been advised on a national basis and leaflets have been made available in practices.</p> <p>Dr Shaw asked for clarification whether the majority of work is done at a distance, to which Paul responded that it was.</p> <p>The type of data to be shared has been reduced dramatically from that originally proposed, following feedback from GPs nationally. Explicit consent is required to share anything other than the basic elements/urgent care record.</p> <p>Lin Bennett expressed concern regarding an auditable process of recording patient consent, which is assumed to be implied in the absence of advice to the contrary. Consent was addressed via the original mailing nationally.</p> <p>Dr Thomas advised that considerable numbers of patients had not consented following the previous discussion on this subject.</p> <p>Dr Thomas agreed to circulate the figures to the Board in relation to those opting out.</p> <p>Dr Gillespie did not feel all the issues had been appropriately considered.</p> <p>Paul Shillcock advised that CCGs will be challenged if they are not compliant.</p> <p>Dr Shaw advised the Board that the decision to share was not open for discussion at this meeting as the decision that they will be shared has been made nationally.</p>	PT

No	Item	Action
	<p>Dr Mimmagh advised that full access to records was subject to specific consent. However, in terms of limited access, the LMC felt by majority consensus that the advantages to this data set release outweighed the disadvantages. Practices will all have had leaflets to this effect.</p> <p>Dr Shaw acknowledged Dr Mimmagh's comments and asked Paul Shillcock for this comments on the way forward.</p> <p>Paul responded that the pathway to engage and answer any queries was via localities.</p> <p>Dr Thomas suggested a poster campaign would be helpful for surgeries.</p> <p>Dr Shaw closed the debate and suggested a different forum was appropriate for further discussion, noting the suggestions in relation to further communication to patients and via Patient LINKs and third sector. It will also be included on the EPEG agenda.</p> <p><u>Noted.</u></p>	TJ/PS
13/42	<p><b>Quality Premium</b></p> <p>There was a discussion around how payment of the Quality Premium would take place and it was felt that the wording of the report was incorrect as it could be perceived as practices receiving payment as practice income. It needs to be clarified to reflect that payment is made to the CCG.</p> <p><u>Noted.</u></p>	
13/43	<p><b>Francis II - Update</b></p> <p>Debbie Fagan noted the publication of the Francis II report containing 290 recommendations, together with the Government's response which is themed, given the number of recommendations.</p> <p>A CQUIN is being developed with providers to reflect these recommendations.</p> <p>High quality care and compassion is at the forefront, with a recommendation of bringing into post a Chief Inspect of Hospitals and a Chief Inspector of Social Care. Statutory duty of candour to identify poor practice and a suggested core programme for nursing, together with a revalidation process for nurses. A regulation system for healthcare assistants is also proposed. There is also an aim to reduce bureaucracy by a third. The Quality Committee will be formulating a response to the recommendations.</p> <p>DF agreed to produce a brief summary of the recommendations.</p> <p><u>Noted.</u></p>	DF
13/44	<p><b>Paediatric Update</b></p> <p>Dr Hewitt tabled a paper in relation to this update.</p> <p></p> <p>13.44 Paediatric Update.docx</p> <p><i>Alder Hey</i></p> <p>It would appear that a new care pathway has been implemented at Alder Hey in relation to discharge of non-invasive overnight ventilated patients, which has been identified by repeated funding requests. Work is underway to investigate this from a patient safety perspective with Alder Hey.</p>	

No	Item	Action
	<p>Dr Mimmagh felt it was clinically inappropriate to discharge patients requiring this level of care into the community as primary care did not have the skill set to deal with this type of care. Debbie Fagan responded that the service was life-enhancing, rather than life-saving and investigation of the pathway is under way.</p> <p>Roger Driver queried whether there was still a Healthy Schools Initiative; this is now led by Public Health and is being considered nationally. Debbie Fagan agreed to find out and report back outwith this meeting.</p> <p>Debbie Fagan noted that Dr Hewitt's representation on the Children's Trust Board on behalf of the South Sefton CCG was helpful.</p> <p>The best practice tariff for paediatric diabetes is due to commence in 2013/14.</p> <p><u>Noted.</u></p>	DF
13/45	<p><b>Prioritisation Framework</b></p> <p>The framework has been to the Finance &amp; Resource Committee where it was tasked with running a business case through it and only one has been available at the current time; further testing is therefore required.</p> <p><u>Noted.</u></p>	
13/46	<p><b>Board Committees – Terms of Reference</b></p> <p>Dr Shaw clarified that this was not an attempt to alter the Constitution. Under the Schemes of Delegation, the Governing Body can alter the terms of reference of committees, which are appendices to the Constitution.</p> <p>The Governing Body <u>approved</u> the alterations to the Terms of Reference of the Audit Committee and Finance &amp; Resource Committee.</p>	
13/47	<p><b>Register of Interests</b></p> <p>The Chair of the Mersey Audit Committee has written to the CCG Audit Chair to advise that GPs undertaking work on behalf of the CCG need also to declare their interests.</p> <p>Dr Mimmagh asked for clarity in relation to those required to declare and to what level.</p> <p><u>Noted.</u></p>	MMcD
13/48	<p><b>Hospitality Register</b></p> <p><u>Noted.</u></p>	
13/49	<p><b>Minutes of Committees</b></p> <p>a) Audit Committee were <u>noted.</u></p> <p>b) Quality Committee were <u>noted.</u></p> <p>c) Finance &amp; Resource Committee were <u>noted.</u></p> <p>Two recommendations were received by the Committee, but the meeting was not quorate. In these circumstances, the recommendations were passed on to Dr Fraser in relation to the Community Gynae Pilot and the Prescribing Quality Scheme, who also approved. The Board then <u>ratified</u> the decisions made at that Committee.</p> <p>d) Merseyside CCG Network were <u>noted.</u></p> <p>e) Health and Wellbeing Board were <u>noted.</u></p> <p>f) Medicines Management Operational Group were not yet available.</p> <p>g) Strategic Integrated Commissioning Group were <u>noted.</u></p>	

No	Item	Action
	<p>h) Engagement and Patient Experience Group were not yet available.</p> <p>i) Locality Meetings -  Crosby Locality were not yet available.  Maghull Locality were <u>noted</u>.  Bootle Locality were <u>noted</u>.  Seaforth Locality were <u>noted</u>.</p> <p>j) Remuneration Committee were <u>noted</u>.  <i>Remuneration Committee</i>  Non-Board Members and the Chief Finance Officer left the room for this item.  Dr Thomas asked for clarification on how the payment was split between the CCGs. Dr Shaw advised that the payment was split between the CCGs.  The impact of any future population changes was noted.  The Governing Body <u>approved</u> the recommendations made by the Remuneration Committee.  Martin McDowell then rejoined the meeting.  The ratio between the two CCGs is currently 60:40 but this may need to be 50:50 in future.</p>	
13/50	<p><b>Any Other Business</b></p> <p><i>IG Agenda</i></p> <p>The Board agreed its support to the Information Governance Agenda as specified in the recent communication to the CCG Board.</p> <p>There was then a discussion around whether Board members needed to repeat this training if they have already completed in their own organisations. Martin McDowell confirmed that they did not.</p> <p><i>Wider Constituent GP Attendance at Meetings</i></p> <p>Dr Thomas raised the issue raised by Dr Pfeiffer in relation to remuneration for attendance at meetings.</p> <p>Dr Shaw closed the issue down immediately and advised that an issue of this nature requires detailed debate and this was not the appropriate place for such discussion.</p> <p>It is being addressed by Fiona Clark in liaison with the LMC.</p> <p>This should be brought by way of a report to the next meeting.</p> <p><i>Liverpool Community Health</i></p> <p>The rectification plan has not been forthcoming.</p> <p>Dr Mimmagh asked the Board to consider the future implications if a provider consistently failed to deliver service specifications. What would be the process for sanctions and potential future tendering of services on a wide scale.</p> <p>Martin McDowell suggested this would be a suitable test case for learning about the possible sanctions that can be imposed. Dr Shaw suggested this would be a suitable subject for a development session.</p>	<p>FLC</p> <p>TJ</p>
13/51	<p><b>Date, Time and Venue of Next Board Meeting</b></p> <p>Thursday, 30 May 2013 at 1.00pm</p>	

## Board Meeting Action Points

Thursday, 28 March 2013 at 1.00 pm to 4.00 pm

No	Item	Action
13/32	<p><b>Action Points from Previous Meeting</b></p> <p>12/190 <b>QIPP Update</b> A spreadsheet will be circulated which demonstrates the QIPP projects which are currently ongoing. <i>Carried forward.</i></p> <p>12/199 <i>Performance and quality:</i> Malcolm Cunningham 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. <i>Carried forward.</i></p> <p>13/13 <b>Virtual Ward Update</b> An update to be brought to the next Board meeting.</p>	<p>MMcD</p> <p>DF</p> <p>SA</p>
13/33	<p><b>Business Update</b> The Constitution has been finalised and is due to be circulated to practices.</p>	SA
13/35	<p><b>Portfolio Leads Update</b></p> <p><i>Ambulatory Blood Pressure Monitoring Service</i> – Dr Gillespie felt that a LES may have to be considered. This piece of work will then need to be brought to Finance &amp; Resource Committee as a priority.</p> <p><i>Prescribing Budget Setting 2013/14</i> – 25% fair shares, 75% historical is being considered and this will be taken to localities for discussion. Martin McDowell advised that this will need to come to the May Finance &amp; Resource Committee. Clarity is also required on whether this will just be on a South Sefton CCG basis. Brendan Prescott to update the Governing Body via email.</p>	<p>SA</p> <p>BP</p>
13/38	<p><b>Everyone Counts</b> Lin Bennett felt the wording needed alteration in relation to A&amp;E admissions.</p>	TJ
13/39	<p><b>2013/14 Financial Outlook Report</b> The structure of the proposed risk sharing agreement requires further consideration in terms of:</p> <ul style="list-style-type: none"> <li>• equal sums from both CCGs; and</li> <li>• the possibility of repayment in future years.</li> </ul> <p>Martin McDowell agreed to consider this further.</p>	MMcD
13/41	<p><b>Low Utilisation of Summary Care Records</b> Dr Thomas agreed to circulate the figures to the Board in relation to those opting out.</p>	PT

No	Item	Action
13/43	<b>Francis II - Update</b> DF agreed to produce a brief summary of the recommendations.	DF
13/44	<b>Paediatric Update</b> Roger Driver queried whether there was still a Healthy Schools Initiative; this is now led by Public Health and is being considered nationally. Debbie Fagan agreed to find out and report back outwith this meeting.	DF
13/47	<b>Register of Interests</b> Dr Mimmagh asked for clarity in relation to those required to declare and to what level.	MMcD
13/50	<b>Any Other Business</b> <i>Wider Constituent GP Attendance at Meetings</i> This should be brought by way of a report to the next meeting. <i>Liverpool Community Health</i> Martin McDowell suggested this would be a suitable test case for learning about the possible sanctions that can be imposed. Dr Shaw suggested this would be a suitable subject for a development session.	FLC  TJ



MEETING OF THE GOVERNING BODY May 2013							
<b>Agenda Item:</b> 13/62	<b>Author of the Paper:</b>						
<b>Report date:</b> 20 May 2013	Fiona Clark Chief Officer <a href="mailto:fiona.clark@southseftonccg.nhs.uk">fiona.clark@southseftonccg.nhs.uk</a> Tel: 0151 247 7061						
<b>Title:</b> Chief Officer's Report							
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with the Chief Officer's monthly update.							
<b>Recommendation</b>  The Governing Body is asked to note the contents of this report.	<table style="border: none;"> <tr> <td style="padding: 2px;">Note</td> <td style="text-align: center; border: 1px solid black; width: 20px;">x</td> </tr> <tr> <td style="padding: 2px;">Approve</td> <td style="text-align: center; border: 1px solid black; width: 20px;"> </td> </tr> <tr> <td style="padding: 2px;">Ratify</td> <td style="text-align: center; border: 1px solid black; width: 20px;"> </td> </tr> </table>	Note	x	Approve		Ratify	
Note	x						
Approve							
Ratify							

Links to Corporate Objectives <i>(x those that apply)</i>	
	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement			x	

## South Sefton Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Clinical Engagement			x	
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees			x	

Links to National Outcomes Framework ( <i>x those that apply</i> )	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

**Report to Governing Body  
May 2013**

**1. Military Health**

Under the new commissioning arrangements, commissioning of services for Armed Forces Veterans, Reservists (when not mobilised) and Armed Forces Families (serving, reservist or veteran) are the responsibility of CCGs. CCGs will also be responsible for the commissioning of emergency care services for veterans and family members in their respective area.

**Regional Support**

- Military veteran IAPT Service: An IAPT based Psychological Service adapted for ex and current Service Personnel and their families.
- The Live at Ease Project – This project supports ex-service men/women adapt to civilian life and provide practical support including support with housing, employment, training, debt advice and drug and alcohol dependency issues.

**Local Commitment to the Military Health Agenda**

Sefton CVS has worked in partnership NHS Sefton, Sefton MBC and other Public, Voluntary, Community and Faith (VCF), and Private Sector partners have now developed, and signed off, a local Community Covenant which sets out commitments to supporting the Sefton Armed Forces Community

To support the future military health agenda, there is an agreement to use CCG resources to fund an existing staff member on a part time basis, for a period of 12 months. The aim of the post is to research the needs of the Sefton Armed Forces Community, map existing relevant services and structures across Sefton, and to enhance the co-ordination of a multi-agency approach to meeting this need. The employee would act as a link person to the Clinical Commissioning Group (CCG) lead on military health. The project aims to achieve a clearer understanding of the needs of veterans which will inform future commissioning decision making.

**2. Regulations on Procurement, Patient Choice and Competition**

Following the public consultation carried out in August 2012, the Government has now laid regulations to help ensure that commissioners' decisions on buying clinical services are transparent and fair and that they improve the quality and efficiency of health care services for patients.

A copy of the regulations can be viewed at <https://www.gov.uk/government/publications/regulations-on-procurement-patient-choice-and-competition>

### 3. Safeguarding Update

- 3.1. **Safeguarding Hosted Service** - a meeting took place on 8 May 2013 between the Chief Nurses to discuss and review the Safeguarding Hosted Service. All safeguarding children posts have now been recruited to within the structure for the children's team and the Chief Nurse from Halton CCG will advertising shortly to fill the remaining safeguarding adult post within the structure.

Discussions are taking place following publication of 'Working Together to Safeguard Children' (Department for Education 2013) and the 'Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework' (NHS England 2013) with NHS England (Merseyside) regarding the role of the Named GP for Safeguarding Children and where this function will be undertaken in the future.

- 3.2. **CCG Section 11 Audit Action Plan** - the Safeguarding Hosted Service is working with the CCG to progress the actions highlighted in the Section 11 Audit as reported previously.
- 3.3. **Safeguarding Annual Report** – the Chief Nurse has liaised with the Safeguarding Hosted Service regarding timelines for the presentation to the Quality Committee and Governing Body of the Safeguarding Annual Report. Providers should have submitted their reports to the Safeguarding Leads by the end of June 2013 which will enable the hosted service to present to the CCG in September 2013.
- 3.4. **Safeguarding Key Performance Indicators (KPIs)/Safeguarding Standards** – the Safeguarding Hosted Service are working collaboratively with the CCGs and the CSU to address final queries that have been raised by the providers regarding the safeguarding KPIs and the safeguarding standards. It is envisaged that these discussions will be concluded by the end of May 2013.
- 3.5. **Safeguarding Serious Untoward Incidents (SUIs)** – the Safeguarding Hosted Service are working in partnership with the CMCSU to support the Chief Nurse specifically with safeguarding SUIs. There is one on-going SUI relating to children which the Designated Nurse is liaising with the Designated Doctor to progress to closure by the CCG. There are two on-going SUIs relating to safeguarding adults both of which require further information from the provider following consideration of the Root Cause Analysis Reports/action plans before commissioners are happy to close.
- 3.6. **Safeguarding Reports to the Quality Committee** – from the June 2013 meeting of the Quality Committee, a separate written report regarding safeguarding will be produced by the Safeguarding Hosted Service for consideration.

### 4. Provider Quality Accounts

The NHS England (Merseyside) Area Team facilitated a Mersey-wide meeting for CCGs and the Area Teams (including Cheshire, Warrington & Wirral who lead on Specialist Commissioning) on 9 May 2013 in order for Providers to present their Quality Accounts. The Sefton Area were represented by the Chief Nurse on behalf of the CCGs, Head of Vulnerable Adults for the Local Authority and Sefton HealthWatch. The CCGs are in the process of collaborating on their responses/statements back to the providers. The providers have also been asked to present to the

respective Overview and Scrutiny Committees (OSC). The Chief Nurse has been asked to meet with the Chair of Sefton Health & Social Care OSC in order to support them with this process.

Working Together to Safeguard Children has been revised and republished in March 2013. It came into effect from 15 April 2013. The revised guidance clarifies the core legal requirements, giving more lucidity with regard to what individuals and organisations are obliged to do to keep children safe and promote their welfare. The NHS Commissioning Board also published its accountability and assurance framework for safeguarding at the same time, this framework complements the revised statutory Working Together guidance.

The Safeguarding Service will be working with the CCG's to better understand the implication this guidance has for them and to ensure that systems and processes within the CCG take account of all recent national directives to enable the Governing Body to effectively discharge their safeguarding responsibilities. Two briefs have been provided to the Chief Nurse and these will provide a sound basis and focus for further discussion and exploration at the Quality Committee. Key highlights for the CCG include :

- Responsibility for safeguarding quality assurance through contractual arrangements with all provider organisations.
- Greater emphasis on the role of the named GP and the vital role it plays within the quality and performance management of GP Practices as providers
- Places a duty on retaining the expertise of a designated and named professional for safeguarding children locally.
- CCGs are statutory members of the Local safeguarding children Boards (LSCB) and subject to Section 11 duties of the Children Act 2004.

## 5. CCG Assurance Framework

The publication of the CCG Assurance Framework is a statutory requirement on NHS England. Consultation and discussions are under way to determine the final approach, but the framework will act as an interim measure to cover the first six months of 2013/14.

The document clearly differentiates between:

- the on-going assessment of performance and delivery which it is proposed involves quarterly checkpoint meetings where NHS England will review information which the CCGs will publish for the local population; and
- an annual health check which will consider both the CCG's track record and its organisational health as a predictor of its future success.

The core elements of assurance include:

- Delivery – ensuring that the CCG is delivering for its population the full range of outcomes and standards (both national and local) agreed in its plan;

## South Sefton Clinical Commissioning Group

- Capability – ensuring the CCG is set up to serve patients and communities effectively, both now and for future generations with the required skills and knowledge and is exhibiting the appropriate behaviours;
- Support – determining the nature and level of support a CCG needs to be a great commissioner.

All these areas are to be tied into a balanced scorecard approach and there will be quarterly formal checkpoint meetings around the following domains:

- are local people getting good quality care?
- are patient rights under the NHS Constitution being promoted?
- are health outcomes improving for local people?
- are CCGs commissioning services within their financial allocations?
- are conditions of CCG authorisation being addressed and removed (where relevant)?

CCGs will be expected to publish the data no more than six weeks after the end of the quarter on the CCG website, as a record of progress. Any support conversation will also be published alongside the scorecard.

NHS England intends to establish a programme oversight group, co-chaired by a CCG leader and an NHS England Team Director. This will also involve other members of the CCGs, local authorities and patient representatives.

The Governing Body will receive more details as the CCG Assurance Framework is coproduced in conjunction with NHS England (Merseyside).

<http://www.england.nhs.uk/wp-content/uploads/2013/05/ccg-af.pdf>

### 6. A&E Performance

NHS England (Merseyside) has been asked by Dame Barbara Hakin to oversee the facilitation of a local partnership approach to improve A&E performance. The CCG is co-operating fully with this request to produce the local recovery and improvement plan.

### 7. Recommendation

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

**Fiona Clark**  
**Chief Officer**  
**20 May 2013**

## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/64(a)	<b>Author of the Paper:</b> Clare Shelley Head of Financial Management and Planning NHS South Sefton Clinical Commissioning Group <a href="mailto:Clare.shelley@southseftonccg.nhs.uk">Clare.shelley@southseftonccg.nhs.uk</a> 0151 247 7035
<b>Report date:</b> 21 May 2013	
<b>Title:</b> Finance Update	
<b>Summary/Key Issues:</b>  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 annual budget and shows the end of year 2012/13 financial position.	
<b>Recommendation</b>  The Governing Body is asked to note this report.	
	Note <input checked="" type="checkbox"/> Approve <input type="checkbox"/> Ratify <input type="checkbox"/>

Links to Corporate Objectives <i>(x those that apply)</i>	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Patient and Public Engagement	x			Presented to Lay Members at Finance and Resource Committee May 2013
Clinical Engagement	x			Presented to GP Board Members at Finance and Resource Committee May 2013
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered		X		
Locality Engagement		x		
Presented to other Committees	x			Will be presented as part of Finance and Resource Committee in Minutes sent to Audit Committee

Links to National Outcomes Framework ( <i>x those that apply</i> )	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm



## Report to the Governing Body May 2013

### 1. Introduction and Background

This paper provides the Governing Body with an overview of the Financial Performance for South Sefton Clinical Commissioning Group for the financial year 2012/13.

### 2. Healthcare Financial Position

#### 2.1 The Year End Financial Position for 2012/13

The financial position against the operational budget at the end of month 12 is £2m under spent. This is a favourable movement of £1.3m when comparing to the month 11 financial position.

The 2012/13 indicative budgets delegated to South Sefton CCG equate to £237.43 million.

The table below provides a summary of financial position as at the 31<sup>st</sup> March 2013.

Detail	Annual	Year to Date	
	Plan	Actual (YE Outturn)	Variance
	£	£	£
Secondary Care Total	135,390,878	135,675,420	284,542
Block Contract Total	37,590,518	37,588,585	(1,933)
Prescribing Total	29,757,253	27,861,869	(1,895,384)
Other Healthcare Total	17,226,497	17,304,251	77,755
Risk Share Total	17,009,236	18,353,951	1,344,715
Miscellaneous Total	(1,126,680)	(1,246,464)	(119,784)
<b>Sub Total</b>	<b>235,847,702</b>	<b>235,537,613</b>	<b>(310,090)</b>
Reserves	1,578,743	(118,334)	(1,697,077)
<b>Grand Total</b>	<b>237,426,445</b>	<b>235,419,279</b>	<b>(2,007,167)</b>

Please note figures in brackets within the variance column represent an under spend. Positive figures represent an over spend.

A further breakdown is available in Appendix A.

The year end out turn position for South Sefton CCG prior to the application of CCG contingency reserves is £310k under spent. The outturn financial position following the application of reserves is £2m under spent. An explanation of the key variances are as follows:

## **Secondary Care**

The year end position on secondary care is £285k overspent. Of this overspend, £95k has predominantly been caused by Non Contracted Activity and relates to a number of high cost patients including:

- Belfast HSC Trust a total of £75,098 across the 2 CCGs – Patient spent 23 days in Intensive Care Unit and 8 days in High Dependency Unit
- Oxford University Hospitals NHS Trust total of £37,352 across the 2 CCGs of which £16,353 relates to Trauma & Orthopaedics (multiple trauma diagnostic) and £16,560 relating to Critical care (3 Organs supported 13/01/13 – 20/01/13)
- Kingston Hospital NHS Trust a total of £37,086 across the 2 CCGs of which £30,082 relates to Critical care (3 Organs supported 20/06/12 – 06/07/12)

Other over performance includes The Christies Hospital NHS FT for the sum of £75k due to Chemotherapy Outpatient activity (Medical Oncology £36k and Clinical Oncology £23k) as well as Elective Medical Oncology - Chemotherapy £13k. Wrightington, Wigan and Leigh NHS FT also over performed by £36k due to an increase in activity within Trauma and Orthopaedics for reconstruction procedures.

## **Prescribing**

The year end position within the prescribing budget was £1.89m underspent. The under spend has continued throughout the year and has been caused by reduced activity as well as a number of drugs coming off patent during the year.

## **Other Healthcare**

The Other Healthcare position was £78k over spent. The Independent sector ended the financial position with a £220k overspend in relation to Ramsay Healthcare and Spire Liverpool activity.

## **Risk Share**

The Risk Share position was £1.34m overspent. Of this, £900k relates to an over spend within Pharmacy spend in secondary care which has been cause by high cost drugs. High cost drugs are charged via an invoice of which 30% have been raised by Southport and Ormskirk NHS Trust. Other charges have been received by Independent organisations such as BUPA.

Continuing Care also ended the year end with an over spend of £479k. The year end provision for CHC restitution cases across the 2 CCGs was £2.109m of which £1,168k relates to South Sefton CCG. This provision is based on the activity assumptions provided by the CHC team.

## **3. Recommendations**

The Governing Body is asked to note the year end position of the CCG.

## **Appendices**

Appendix A Summary of the Financial Position to month 12

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

APPENDIX A

Summary Financial Position as at Month 12 (March) 2012/2013

Consortium: South

Detail		Annual Plan	Actual Outturn	Variance
		£	£	£
Secondary Care	Aintree University Hospitals NHS Foundation Trust	84,479,837	84,479,836	(1)
	Non Contract Activity	1,388,328	1,483,227	94,899
	The Christie NHS Foundation Trust	91,220	166,450	75,230
	Royal Liverpool And Broadgreen University Hospitals NHS Trust	11,848,878	11,848,878	(0)
	Liverpool Women's NHS Foundation Trust	8,773,161	8,773,161	0
	Wrightington, Wigan And Leigh NHS Foundation Trust	439,908	476,252	36,344
	Southport And Ormskirk Hospital NHS Trust	7,255,904	7,255,904	(0)
	Alder Hey Children's NHS Foundation Trust	10,127,792	10,127,760	(33)
	Clatterbridge Centre For Oncology NHS Foundation Trust	8,013,934	8,033,130	19,196
	Central Manchester University Hospitals NHS Foundation Trust	24,152	49,578	25,426
	University Hospital Of South Manchester NHS Foundation Trust	57,660	80,140	22,480
	Warrington And Halton Hospitals NHS Foundation Trust	61,995	83,684	21,689
	Lancashire Teaching Hospitals NHS Foundation Trust	106,471	124,662	18,191
	St Helens And Knowsley Hospitals NHS Trust	1,514,831	1,514,908	78
	Liverpool H&C NHS FT CCG	840,088	840,088	(1)
	Countess Of Chester Hospital NHS Foundation Trust	96,250	94,807	(1,443)
Wirral University Teaching Hospitals NHS Foundation Trust	270,468	242,954	(27,514)	
<b>Secondary Care Total</b>		<b>135,390,878</b>	<b>135,675,420</b>	<b>284,542</b>
Block Contract	Cheshire And Wirral NHS FT	38,581	56,399	17,818
	Lancashire Care NHS FT	123,921	126,778	2,857
	Merseycare NHS Trust	15,549,763	15,549,763	0
	Southport & Ormskirk Community Services	7,893,534	7,893,534	(0)
	Liverpool Community Health NHS Trust	13,984,719	13,962,111	(22,609)
<b>Block Contract Total</b>		<b>37,590,518</b>	<b>37,588,585</b>	<b>(1,934)</b>
Prescribing	Prescribing	29,757,253	27,861,869	(1,895,384)
<b>Prescribing Total</b>		<b>29,757,253</b>	<b>27,861,869</b>	<b>(1,895,384)</b>
Other Healthcare	Independent Sector Treatment Centres	2,844,454	3,156,224	311,770
	North West Ambulance NHS Trust	5,909,397	6,106,358	196,961
	The Walton Centre NHS FT	402,447	402,776	328
	Patient Transport Services North West Ambulance NHS Trust	11,803	12,055	252
	Glucose Tolerance Tests	40,000	23,572	(16,428)
	PbR Reserve	1,830,276	1,804,985	(25,291)
	Anticoagulation	64,770	18,378	(46,392)
	Children's Services	1,466,697	1,379,200	(87,497)
	Dermatology Assura	558,511	433,058	(125,453)
Other Commissioned Healthcare	4,098,141	3,967,645	(130,496)	
<b>Other Healthcare Total</b>		<b>17,226,497</b>	<b>17,304,251</b>	<b>77,755</b>
Risk Share	Pharmacy	963,384	1,863,683	900,299
	Continuing Care	15,719,869	16,199,349	479,480
	Oxygen	325,983	290,919	(35,064)
<b>Risk Share Total</b>		<b>17,009,236</b>	<b>18,353,951</b>	<b>1,344,715</b>
Miscellaneous	Prior Year SLA's	0	44,983	44,983
	Primary Care	430,700	430,700	0
	Melling Practice Recharge	(3,387,334)	(3,387,334)	0
	GP Consortia	1,829,954	1,665,187	(164,767)
<b>Miscellaneous Total</b>		<b>(1,126,680)</b>	<b>(1,246,464)</b>	<b>(119,784)</b>
<b>Sub Total</b>		<b>235,847,702</b>	<b>235,537,613</b>	<b>(310,090)</b>
	PCT Allocations	1,578,743	(118,334)	(1,697,077)
<b>Reserves Total</b>		<b>1,578,743</b>	<b>(118,334)</b>	<b>(1,697,077)</b>
<b>Grand Total</b>		<b>237,426,445</b>	<b>235,419,279</b>	<b>(2,007,167)</b>



## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/64(b)	<b>Author of the Paper:</b>		
<b>Report date:</b> 14 May 2013	Brendan Prescott CCG Lead, Medicines Management <a href="mailto:Brendan.prescott@southportandformbyccg.nhs.uk">Brendan.prescott@southportandformbyccg.nhs.uk</a> 01704 387010 / 0151 247 7093		
<b>Title:</b> Prescribing Update			
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with an update on the prescribing budget position based upon month 11 (February 2013) prescribing data.			
<b>Recommendation</b>		Note	<input checked="" type="checkbox"/>
The Governing Body is asked to note the contents of this report.		Approve	<input type="checkbox"/>
		Ratify	<input type="checkbox"/>

Links to Corporate Objectives <i>(x those that apply)</i>	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
	To sustain engagement of CCG members and public partners and stakeholders.
	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement		x		
Clinical Engagement	x			
Equality Impact Assessment				
Legal Advice Sought		x		

## South Sefton Clinical Commissioning Group

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Resource Implications Considered		x		
Locality Engagement		x		
Presented to other Committees		x		

Links to National Outcomes Framework ( <i>x those that apply</i> )	
	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
	Treating and caring for people in a safe environment and protecting them from avoidable harm

**Report to Governing Body**  
**May 2012**

**1. Executive Summary**

The South Sefton CCG position for month 11 (February 2013) was a forecast under spend of £2,648,095 or 9.2 % underspend. This is a slight decrease of £23,000 on the January 2013 forecast.

**2. Introduction and Background**

This is a regular monthly update on the management of the South Sefton prescribing budget.

**3. Content**

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

The medicines optimisation plan for 2013-14 has been presented and approved at the Medicines Operational Group and Finance and Resource Committee.

**4. Recommendations**

The Governing Body is asked to note the prescribing update.

**Appendices**

Appendix 1 : Performance table of budget versus spend

**Brendan Prescott**  
**10 May 2013**

**Appendix 1 : Performance table of budget versus spend (month 11, February 2013 data)**

Prescriber Code	Prescriber Name	Total YTD Spend	Total Budget	Total FOT	Variance £	Variance (%)
N84001	42 KINGSWAY	£922,920	£1,076,004	£1,004,156	-£71,848	-6.7
N84002	AINTREE ROAD MEDICAL CENTRE	£453,614	£517,946	£493,542	-£24,405	-4.7
N84003	HIGH PASTURES SURGERY	£1,628,855	£1,908,763	£1,772,228	-£136,534	-7.2
N84004	GLOVERS LANE SURGERY	£1,140,023	£1,362,115	£1,240,369	-£121,746	-8.9
N84007	LIVERPOOL RD MEDICAL PRACTICE	£916,332	£1,069,478	£996,988	-£72,490	-6.8
N84009	AZALEA SURGERY	£417,376	£525,614	£454,114	-£71,499	-13.6
N84010	MAGHULL HEALTH CENTRE (DR SAPRE)	£340,997	£392,996	£371,012	-£21,983	-5.6
N84011	EASTVIEW SURGERY	£1,022,863	£1,242,705	£1,112,896	-£129,808	-10.4
N84015	BOOTLE VILLAGE SURGERY	£1,175,720	£1,406,987	£1,279,208	-£127,780	-9.1
N84016	MOORE STREET MEDICAL CENTRE	£1,165,741	£1,411,630	£1,268,350	-£143,280	-10.1
N84019	NORTH PARK HEALTH CENTRE	£1,192,988	£1,488,613	£1,297,996	-£190,617	-12.8
N84020	BLUNDELLSANDS SURGERY	£1,239,294	£1,472,105	£1,348,378	-£123,726	-8.4
N84023	BRIDGE ROAD MEDICAL CENTRE	£1,265,332	£1,437,289	£1,376,708	-£60,581	-4.2
N84025	WESTWAY MEDICAL CENTRE	£1,109,509	£1,283,494	£1,207,169	-£76,324	-5.9
N84026	CROSBY VILLAGE SURGERY	£376,011	£440,388	£409,108	-£31,280	-7.1
N84027	ORRELL PARK MEDICAL CENTRE	£433,625	£550,721	£471,793	-£78,929	-14.3
N84028	THE STRAND MEDICAL CENTRE	£1,246,617	£1,449,526	£1,356,346	-£93,180	-6.4
N84029	FORD MEDICAL PRACTICE	£915,073	£1,077,176	£995,618	-£81,558	-7.6
N84034	PARK STREET SURGERY	£919,955	£1,170,171	£1,000,930	-£169,241	-14.5
N84035	15 SEFTON ROAD	£754,660	£912,064	£821,086	-£90,978	-10.0
N84038	CONCEPT HOUSE SURGERY	£646,693	£614,377	£703,615	£89,238	14.5
N84041	KINGSWAY SURGERY	£655,843	£814,793	£713,571	-£101,222	-12.4
N84043	SEAFORTH VILLAGE PRACTICE	£224,507	£276,184	£244,268	-£31,916	-11.6
N84605	LITHERLAND TOWN HALL HTH CTR (TAYLOR)	£492,039	£590,255	£535,349	-£54,906	-9.3
N84615	RAWSON ROAD MEDICAL CENTRE	£380,431	£449,904	£413,917	-£35,987	-8.0
N84616	SEFTON ROAD SURGERY	£217,495	£414,326	£236,639	-£177,687	-42.9
N84621	THORNTON PCT PRACTICE	£420,739	£510,473	£457,773	-£52,700	-10.3
N84622	MAGHULL HEALTH CENTRE (DR THOMAS)	£351,169	£410,667	£382,079	-£28,589	-7.0
N84624	MAGHULL HEALTH CENTRE	£260,993	£447,885	£283,966	-£163,919	-36.6
N84626	HIGHTOWN VILLAGE SURGERY	£337,775	£420,594	£367,506	-£53,087	-12.6
N84627	CROSSWAYS PCT PRACTICE	£356,067	£460,661	£387,408	-£73,253	-15.9
N84630	NETHERTON PCT PRACTICE (DR CHOUDHARY)	£284,875	£340,686	£309,950	-£30,736	-9.0
Y00446	MAGHULL PCT PRACTICE	£589,924	£675,339	£641,849	-£33,490	-5.0
Y02514	LITHERLAND PRIMARY CARE WALK-IN SERVICE	£50,500	£37,000	£54,945	£17,945	48.5
<b>Total</b>		<b>£23,906,554</b>	<b>£28,658,926</b>	<b>£26,010,831</b>	<b>-£2,648,095</b>	<b>-9.2</b>



## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/64(d)	<b>Author of the Paper:</b>						
<b>Report date:</b> 16 May 2013	Brendan Prescott Medicines Management Lead <a href="mailto:brendan.prescott@southseftonccg.nhs.uk">brendan.prescott@southseftonccg.nhs.uk</a> Tel: 0151 247 7093						
<b>Title:</b> South Sefton Sip Feed Project Report							
<b>Summary/Key Issues:</b>  This paper summarises the South Sefton sip feed review project which ran for 12 months to promote effective use of oral nutritional supplements and promote education on nutritional screening							
<b>Recommendation</b>  The Governing Body is asked to note the report and consider future investment in dietetic support to build on this project.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Note</td> <td style="width: 20%; text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td>Approve</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Ratify</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Note	<input checked="" type="checkbox"/>	Approve	<input type="checkbox"/>	Ratify	<input type="checkbox"/>
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Approve	<input type="checkbox"/>						
Ratify	<input type="checkbox"/>						

Links to Corporate Objectives <i>(x those that apply)</i>	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement		x		
Clinical Engagement	x			

13/64(d)

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered	x			
Locality Engagement		x		
Presented to other Committees		x		

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

## **Report to the Governing Body May 2013**

### **1. Executive Summary**

This project was approved by South Sefton CCG in 2011 and commenced in May 2012 and looked to promote appropriate prescribing of Oral Nutritional Supplements (ONS). Medicines management in South Sefton CCG referred 262 patients to the LCHT dietetic service for review of ongoing use of ONS.

### **2. Introduction and Background**

The sip feed project was joint 1 year project between the Sefton Medicines Management Team (MMT) and the Nutrition and Dietetic Department in working South Sefton. The aims were to promote effective nutritional screening for malnutrition and appropriate methods of nutritional support including effective use of ONS.

The cost of ONS in the UK has increased annually. An increase of 5.19% was seen in England from February 2012 to February 2013 mirrored within the North West Region, showing an annual increase of 4.48% during the respective period.

As a result, appropriate prescribing in this area and training made available to aid this would provide a benefit, not only to patients due to the quality of their care, but to the NHS as a whole.

### **3. Key Issues**

The main aim of the project was to improve the identification of those at risk of malnutrition and improve the quality of care they receive including promoting appropriate use of prescribed ONS. From other similar projects that have been run in the country it was identified that an added benefit would be reducing waste and prescribing costs due to inappropriate prescribing.

#### **Other benefits of the project include-**

1. Identification of current use of sip feeds within the South Sefton population.
2. Review appropriate prescribing- cross reference of patients prescribed ONS with those already under review/care of the dietetics team to ensure all patients needing ONS are receiving the appropriate care.
3. Promote formulary adherence- update practice computer system formularies to ensure local formulary recommendations are top of the formulary list.
4. Re-enforcement of the local formulary product choice via scriptswitch
5. Promotion of the Malnutrition Universal Screening Tool (MUST) nutrition screening tool, MUST Care Pathway and food first dietary advice- through implementation of a programme of training across all Provider clinical staff and nursing/ care home staff .

## Project Plan/method

All patients prescribed an ONS from section A7- borderline substances in the British National Formulary were screened by a member of MMT using criteria to assess their need for on going ONS or a requirement for them to be referred for review by the project dietician.

Following review of the patient by the dietician recommendations were made which were sent to the GP for them to decide on the appropriate action to take. The MMT member who referred the patient for review also received a copy of the recommendations to follow up which were actioned.

The MMT completed the following steps:

- Ran search to identify practice patients prescribed ONS from section A7- borderline substances in the BNF were reviewed by a member of MMT
- Discontinued any sip feeds that have not been collected by the patient for 3 months or longer
- Referred any patients to the dietician who were:
  - Aged 18 years and above
  - Not under the care of a dietician
  - In receipt of ONS
  - Palliative care patients who fulfil this criteria were excluded from the Project
- Reviewed what actions had been taken following the dietician's recommendations

The dietician completed the following steps:

- Reviewed cohort of patients referred by MMT
- Recommended changing or stopping of ONS as appropriate
- Recommended stopping ONS if the patient did not attend (DNA) their appointment
- Where appropriate, patients were referred to the Community Dietetics team or GP for further review
- Identify and educate healthcare professional and nursing/ care home staff on MUST, MUST Care Pathway and food first dietary advice

The prescribers' responsibility

- The prescriber reviewed and if in agreement actioned the dietetic recommendations made about patients' ONS prescription.

## Project Results

As of 16<sup>th</sup> May 2013 data was available from 22 practices with a total of 262 patients being referred and assessed by the dietician. Other patients were excluded as they had either died or it was deemed that they were not appropriate because they were currently under the care of a dietician, the patient was tube fed or that they had moved out of area.

Some practices were revisited towards the end of the project and when revisited it was found they had more patients on ONS who needed review by the dietician resulting in further savings. This suggests unless there is ongoing investment in this work there is a potential for patients to be prescribed inappropriate ONS.

Actual annualised savings amounted to £ 156,520 with a potential £15,533 worth of savings not actioned. This corresponded to a 4.5 % reduction in spend on enteral nutrition between April 2012 and February 2013 compared with the same period the previous year and compared to an average growth of 1.9 % in Mersey CCGs.

## Reasons for reduction in costs

Common reasons for discontinuation of or modification to prescription for ONS include the following:

- Inappropriate initial prescription – patients were able to meet their nutritional requirements via normal oral intake
- Patients were receiving ONS due to drug or alcohol abuse
- Patients were receiving ONS due to poor intake as a result of dementia
- Patients had received ONS for an extended period of time with no benefit
- Patient did not meet ACBS criteria for prescribing
- Patient had not received appropriate first line dietary advice
- Inappropriate doses of formats of ONS was being prescribed such as 1kcal/ml supplements or given od.

## Promotion of screening and first line dietary advice:

A total of 99 staff members received training as part of this project. The majority of which took place within care homes and care home staff accounted for 43 % of staff undergoing training.

## 4. Conclusions

The initial investment of 1 WTE dietician at a cost of £40,000 has resulted in gross savings so far of £156,520 ( net saving £ 115,520 ). Some data was unavailable from some practices for this report but this clearly demonstrates a different focus of dietetic review has maintained quality of care for the patient, has had some impact on nutritional assessment training and has proved to be value for money.

## 5. Recommendations

The Governing Body is asked to consider and approve a business case to be written for on going investment in dedicated dietetic resources for review of ONS patients and to carry out education on nutritional assessment. This role would ensure-

- Regular ongoing monitoring of patients on ONS on the GPs system and review where appropriate or discontinue if sip feeds not collected for  $\geq 3$  months
- Refresher training sessions for MUST and food first dietary advice especially in areas of high staff turnover to ensure regular screening for malnutrition as per NICE guidance (2006) and use of MUST Care Pathway
- Reduce waste by the Dietician recommending ONS prescription as an acute prescription whilst patient remains under the care of a dietician and avoidance of repeat prescriptions of starter packs and less effective 1kcal/ml products
- Regular review of the most effective and cost efficient ONS for use including awareness of new products
- To ensure regular review of trends in ONS spend in South Sefton
- To explore reasons why some of the recommendations made by the dietician are not actioned and any recommendations from this

Dietetic staff would recommend that ONS is not prescribed for a patient until they have been seen by the dietician. It is also recommended patients discharged from hospital with ONS prescribed are reviewed by the dietician and that the dietician has access to patient information to identify patients who need to be reviewed.

**Appendix 1 Sip feed review Actions for South Sefton**

**Brendan Prescott  
May 2013**

## Appendix 1

### Sip feed review Actions for South Sefton

Practice Code	Practice	Date Template Completed	No. pts referred to dietitian	No. pts reviewed by dietitian	No. Dietitian recommendations actioned	No. not actioned	Savings made (annualised) £	Savings missed (annualised) £	Completed by
N84035	<a href="#">15 SEFTON ROAD</a>	14/05/2013	6	5	4	1	£1,750	£0.00	Jane Tosi
N84001	<a href="#">42 KINGSWAY</a>	15/05/2013	4	3	3	0	£0.00	£0.00	Sara Boyce
N84002	AINTREE ROAD MEDICAL CENTRE								
N84009	AZALEA SURGERY								
N84020	BLUNDELSANDS SURGERY								
N84015	<a href="#">BOOTLE VILLAGE SURGERY</a>	01/03/2013	25	25	20	5	£14,176.80	£1,375.00	Gillian Beardwood
N84023	BRIDGE ROAD MEDICAL CENTRE								
N84038	<a href="#">CONCEPT HOUSE SURGERY</a>	12/03/2013	3	3	2	0	£2,602.74	£0.00	Alain Anderson
N84026	<a href="#">CROSBY VILLAGE SURGERY</a>	13/05/2013	15	9	9	0	£3,401.32	£0.00	Sean Reck
N84627	<a href="#">CROSSWAYS PCT PRACTICE</a>	09/05/2013	9	4	4	5	£4,603.20	£0.00	Shaun Roche
N84011	<a href="#">EASTVIEW SURGERY</a>	03/05/2013	11	7	7	0	£8,740.32	£0.00	Gillian Beardwood
N84029	<a href="#">FORD MEDICAL PRACTICE</a>	06/03/2013	20	20	14	6	£12,325.04	£4,815.72	Gillian Beardwood
N84004	<a href="#">GLOVERS LANE SURGERY</a>	28/02/2013	25	21	19	2	£18,262.39	£126.00	Alain Anderson
N84003	<a href="#">HIGH PASTURES SURGERY</a>	13/05/2013	31	7	7	0	£4,438.85	£0.00	Jennifer Johnston
N84626	HIGHTOWN VILLAGE SURGERY								
N84041	<a href="#">KINGSWAY SURGERY</a>	31/01/2013	17	12	8	4	£4,560.00	£1,556.00	Alain Anderson
N84605	<a href="#">LITHERLAND TOWN HALL HTH CTR (TAYLOR)</a>	04/03/2013	19	12	10	2	£9,815.00	£1,674.00	Sean Reck
N84007	<a href="#">LIVERPOOL RD MEDICAL PRACTICE</a>	05/02/2013	17	13	13	0	£17,600.24	£0.00	Chris Barnes
N84624	<a href="#">MAGHULL HEALTH CENTRE</a>	06/02/2013	6	4	4	0	£3,851.40	£0.00	Alain Anderson
N84010	<a href="#">MAGHULL HEALTH CENTRE (DR SAPRE)</a>	03/04/2013	7	6	5	1	£1,821.00	£688.00	Janet fay
N84622	<a href="#">MAGHULL HEALTH CENTRE (DR THOMAS)</a>	04/03/2013	7	7	5	2	£2,275.00	£1,857.00	Gillian Beardwood
Y00446	<a href="#">MAGHULL PCT PRACTICE</a>	25/02/2013	11	10	9	1	£7,711.00	£476.00	Gillian Beardwood
N84016	<a href="#">MOORE STREET MEDICAL CENTRE</a>	15/03/2013	29	29	24	5	£9,836.28	£537.84	Gillian Beardwood
N84630	NETHERTON PCT PRACTICE (DR CHOUDHARY)								
N84019	<a href="#">NORTH PARK HEALTH CENTRE</a>	28/02/2013	31	29	25	4	£14,603.96	£0.00	Gillian Beardwood
N84027	<a href="#">ORRELL PARK MEDICAL CENTRE</a>	14/05/2013	6	3	1	2	£277.50	£899.64	Caroline Gunson
N84034	<a href="#">PARK STREET SURGERY</a>	31/01/2013	18	17	13	4	£5,766.78	£1,136.66	Gillian Beardwood
N84615	<a href="#">RAWSON ROAD MEDICAL CENTRE</a>	23/03/2013	10	7	5	2	£4,141.20	£259.20	Shaun Roche
N84043	SEAFORTH VILLAGE PRACTICE								
N84616	<a href="#">SEFTON ROAD SURGERY</a>	02/04/2013	10	9	8	1	£3,960.31	£132.00	Alain Anderson
N84028	THE STRAND MEDICAL CENTRE								
N84621	THORNTON PCT PRACTICE								
N84025	WESTWAY MEDICAL CENTRE								

13/64(d)





## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/64(c)	<b>Author of the Paper:</b>						
<b>Report date:</b> 14 May 2013	Brendan Prescott CCG Lead Medicines Management <a href="mailto:brendan.prescott@southseftonccg.nhs.uk">brendan.prescott@southseftonccg.nhs.uk</a> Tel: 0151 247 7093						
<b>Title:</b> Summary of the South Sefton Care Home Service							
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with a summary of outcomes of the South Sefton Care Home Review Service.							
<b>Recommendation</b>  The Governing Body is asked to note the contents of this report and approve the recommendation for a business case for a substantive service.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Note</td> <td style="width: 20%; text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td>Approve</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td>Ratify</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Note	<input checked="" type="checkbox"/>	Approve	<input checked="" type="checkbox"/>	Ratify	<input type="checkbox"/>
Note	<input checked="" type="checkbox"/>						
Approve	<input checked="" type="checkbox"/>						
Ratify	<input type="checkbox"/>						

Links to Corporate Objectives <i>(x those that apply)</i>	
	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement	x			

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Clinical Engagement		x		
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered	x			
Locality Engagement		x		
Presented to other Committees		x		

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

## **Report to the Governing Body** **May 2013**

### **1. Executive Summary**

In 2012, South Sefton CCG Governing Body agreed a proposal to invest in a care home review service for care home/ nursing home patients registered at South Sefton CCG practices. The service was scheduled as a fixed term service to March 31st 2013.

This paper provides an update on progress against the objectives and recommendations to continue to invest in the service.

### **2. Introduction and Background**

A care home service was commissioned from NHS Sefton medicines management team:

- 2.1. To carry out a medicines use review on all patients resident in nursing / care homes within the CCG area every 12 months.
- 2.2. To improve the quality of prescribing for a vulnerable group of patients by making appropriate recommendations to prescribers for medicines to be stopped, commenced or changed for each patient reviewed.
- 2.3. To provide advice on medicines management issues from procurement to disposal to staff working in the care home on an annual basis and ensure systems in place at the home promote effective use of medicines.
- 2.4. To develop relationships and improve communications with care home staff and act as a link between care homes and the practice.
- 2.5. To ensure cost effective prescribing for care home patients and to make an average annual saving on prescribing of £50 per patient per year.
- 2.6. To engage with secondary care providers in ensuring medicines reconciliation when a patient is discharged to a care home.

The background to the service was based on nationally published evidence (CHUMS, DoH, 2009) where a review of care home patient's medication showed medicines errors in 69.5 % of cases. Local work also showed cost efficiencies could be realised on review of care home patient medicines.

Based upon the workload of a care home patient population of 1,115, approval was given to fund the equivalent of 2 band 7 Pharmacist posts on a fixed term to carry out reviews across South Sefton.

The investment to commission the service was £93, 334 per year.

### 3. Key Issues

At the start of April 2012, data facilitators for individual practices ran searches to ascertain the actual numbers of patients in care /nursing homes within South Sefton CCG (n=1134). Number of surgeries to be reviewed (32)

Objective 1 – Number of patients to be reviewed, actual patients reviewed.

As of May 1<sup>st</sup> 2013, 756 patients have had a pharmacist medication review across all South Sefton practices. The initial facilitator patient count for the 14 surgeries was 569 (25% difference) as the initial search was on post code rather than the name of the residential or nursing home

Objective 2 and 5 - Number of medicines stopped commenced or changed. Average annual saving on prescribing of £50 per patient per year.

Number of medications stopped	422
Number of medications commenced	47
Number of medications changed	780
Number of QOF interventions	2553
Current Cost Savings	<b>£76,655</b>
Outstanding Cost Savings	<b>£60,968</b>
Potential Cost Savings	<b>£137,623</b>
Current average annual saving per patient	<b>£101.39</b>
Outstanding average annual saving/ patient	£182.04

Outstanding actions are being followed up at practice level through May and June to realise maximum benefits from the service.

Examples:

Contraindicated medications stopped.

Toxic Digoxin level that had not been monitored for a couple of years.

Theophylline levels not checked despite change in smoking status.

Tiotropium respimat (increased mortality) being prescribed over tiotropium handihaler

Medication continued long term without review; naseptin nasal cream, terbinafine cream

Zopiclone prescribed in a patient with a history of regular falls. Stopped at a cost saving of £2500 (liquid special)

Objective 3- Medicines management advice to care homes.

Medicines management advice and support was provided and welcomed in every home. One home was unaware of methotrexate being classed as a cytotoxic and buprenorphine being a controlled drug.

Objective 4- To develop relationships and improve communications.

All nursing homes and residential homes found the project to be very beneficial. Feedback included that the process allowed them to highlight areas of concern not just from a medication perspective but as an overall holistic approach.

Objective 6- Medicines reconciliation with secondary care

- Patient on isosorbide mononitrate was admitted to hospital with ACS. Patient was to continue his nitrate tablets on discharge, however due to it not being prescribed on his take

home prescription; the residential home stopped giving it, and stopped ordering it for him. Secondary Care contacted and correspondence received to continue (Avoided admission).

- Epileptic medication not increased as advised by secondary care.
- Quetiapine dose incorrect in primary care, which was commenced in secondary care and subsequently stopped due to over sedation. Recommended on a lower dose.
- No correspondence received from certain clinics, for example some glaucoma and Parkinson's disease patients have not been reviewed by secondary care for 2-3 years in some patients, which is a quality issue.

### Challenges

- Time to recruit pharmacists to review patients took longer than expected as the pharmacists had to work their notice period from their previous employment.
- Total number of patients reported was inaccurate as data facilitators ran searches on postcodes of care homes.
- Different levels of engagement between surgeries. Meeting with a GP for three hours each week to discuss the review in comparison to non-engagement.
- Original paperwork used for the review was time consuming. The process was amended and increased the turnaround time of reviews

## **4. Conclusions**

The care home review service objectives have been met during the time the project has been running. The cost to the CCG has been £16,679 but the project was set up with other outcomes other than cost savings. Actual savings per patient were double initial targets. There has been very positive feedback data from GP practices and care homes alike and what cannot be quantified is the potential cost avoidance from hospital admission.

Care home reviews have carried through into Q1 2013-14 using accrual of staff budget. This is as a result of being unable to recruit full time to the posts until quarter 2 2012-13.

During 2013-14, it is planned to assess all patients again on a 12 month review cycle. It is also planned to implement a process with all care homes in South Sefton to prioritise a medication review for care home patients discharged from hospital within a 2 week period.

## **5. Recommendations**

The Board is asked to note the outcomes of the report and approve, subject to PMO appraisal, a business case to go to the Finance and Resource Committee proposing a recurrent resource to employ 2 WTE band 7 practice pharmacists.

This would ensure annual reviews can continue alongside developments of the service to prioritise recently discharged patients / new admission to care homes in South Sefton.

### Recommended actions if the service is to continue

- Maintain annual reviews with patients, (or more frequently if the patient is discharged from hospital, or concerns are raised by the patient's GP or carer).
- To act as an Interface Care Home Team, ensuring to further develop bridge building between primary-care/ nursing home/ secondary care/ community pharmacies.

- Discharged patients or new patients to the practice to be reviewed in a maximum of four weeks.
- Recurrent hospital admission patients/ A+ E attendees to be reviewed more frequently and referred to the virtual ward for a multi-disciplinary approach, with the aim to reduce inappropriate attendances.
- Generic Clinical Management Plan across South Sefton CCG, but tailored to the individual surgeries need to be developed. This in turn will reduce the time needed for GPs to action suggestions made by individual pharmacists.
- To provide training to nursing staff and carers on a regular basis as part of medicines management.

**Brendan Prescott**  
**May 2013**

## BOARD MEETING May 2013

<b>Agenda Item:</b> 13/64(e)	<b>Author of the Paper:</b>	
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<b>Report date:</b> 14 May 2013		
<b>Title:</b> Activity and Quality Report		
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with the Activity and Quality Report.		
<b>Recommendation</b>		Note <input checked="" type="checkbox"/>
The Governing Body is asked to note the contents of this report.		Approve <input type="checkbox"/>
		Ratify <input type="checkbox"/>

Links to Corporate Objectives <i>(x those that apply)</i>	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement		x		
Clinical Engagement		x		
Equality Impact Assessment		x		
Legal Advice Sought		x		

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Resource Implications Considered		x		
Locality Engagement		x		
Presented to other Committees	X			Quality Committee

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm



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## **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.

## Executive Summary on Performance Trends

KPI	Underperforming Trusts	Underperforming PCTs
MRSA Bacteraemia	Aintree ↓	
C-Difficile Infections	Aintree ↓	
Mixed Sex Accommodation	The Walton Centre ↓	
Referral to Treatment (RTT)	<b>% Admitted Within 18 Weeks</b> Southport & Ormskirk ↓	<b>Numbers Waiting on an Incomplete Pathway</b> Sefton ↑  <b>% Admitted Within 18 Weeks</b> Sefton ↓
<b>Cancer Waits:</b>  All cancer two month urgent referral to treatment  Cancer 62 day waits (aggregate measure)  62 day wait for first treatment following referral from an NHS Cancer Screening Service  62 day wait for first treatment following a consultants decision to upgrade the patient's priority	  Southport & Ormskirk ↔ Hospitals Trust  Aintree ↔  Southport & Ormskirk ↑	  Sefton ↔
% who had a stroke & spend at least 90% of their time on a stroke unit	Aintree ↓	Sefton ↓
A&E 4 Hour Wait W/E 14 <sup>th</sup> April 2013	Aintree Southport & Ormskirk	
Ambulance Cat A response within 8 minutes	NWAS R1 ↑ NWAS R2 ↓	

## Executive Summary on Performance Trends

### Key

- ↑ Performance Improving
- ↓ Performance Worsening
- ↔ Performance Remaining the Same

## CLUSTER CORPORATE PERFORMANCE DASHBOARD – COMMISSIONER LEVEL

Performance Indicators		Halton & St Helens	Knowsley	Liverpool	Sefton	Mersey Cluster
<b>Headline Measures</b>						
<b>Quality (Safety, Effectiveness &amp; Patient Experience)</b>						
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - March	13.00	5.00	16.00	6.00	40.00
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - March	89.00	45.00	145.00	126.00	405.00
<b>Resources (Finance, Capacity &amp; Activity)</b>						
PHS16: Numbers Waiting on an Incomplete Referral to Treatment Pathway	12/13 - February	16,916	8,825	22,464	14,748	62,953
<b>Supporting Measures</b>						
<b>Quality (Safety, Effectiveness &amp; Patient Experience)</b>						
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - February	87.95	87.05	88.54	84.64	87.17
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - February	89.32	89.13	89.95	86.06	88.68
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - February	96.81	97.73	97.04	95.74	96.73
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - February	91.18	97.37	91.77	86.21	90.88
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 - February	99.24	98.68	97.62	97.80	98.22
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - February	99.03	100.00	99.47	98.09	99.03
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - February	98.75	100.00	99.47	98.79	99.20
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - February	96.17	95.24	95.87	97.85	96.37
PHQ12: Mental health measures - CPA	12/13 - Q4 Jan - Mar	96.53	97.14	95.65	97.67	96.57
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - March	92.62	93.28	93.35	92.75	93.00
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - March	98.03	97.94	98.14	97.70	98.00
PHQ21: RTT - % of incomplete pathways within 18 weeks	12/13 - March	95.61	96.05	95.19	95.12	95.40
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - March	0.11	0.50	0.96	0.31	0.50
SQU06 01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 - Q4 Jan - Mar	67.0	64.8	79.4	74.8	73.0
SQU06 02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 - Q4 Jan - Mar	50.0	100.0	100.0	80.7	88.5
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - February	95.31	95.23	95.76	94.54	95.25
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - February	95.36	95.45	95.77	94.61	95.33
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - February	95.61	96.96	95.87	95.23	95.81

■ Achieving Plan      ■ Variance from Plan  
■ Significant variation from plan

## PROVIDER CORPORATE PERFORMANCE DASHBOARD

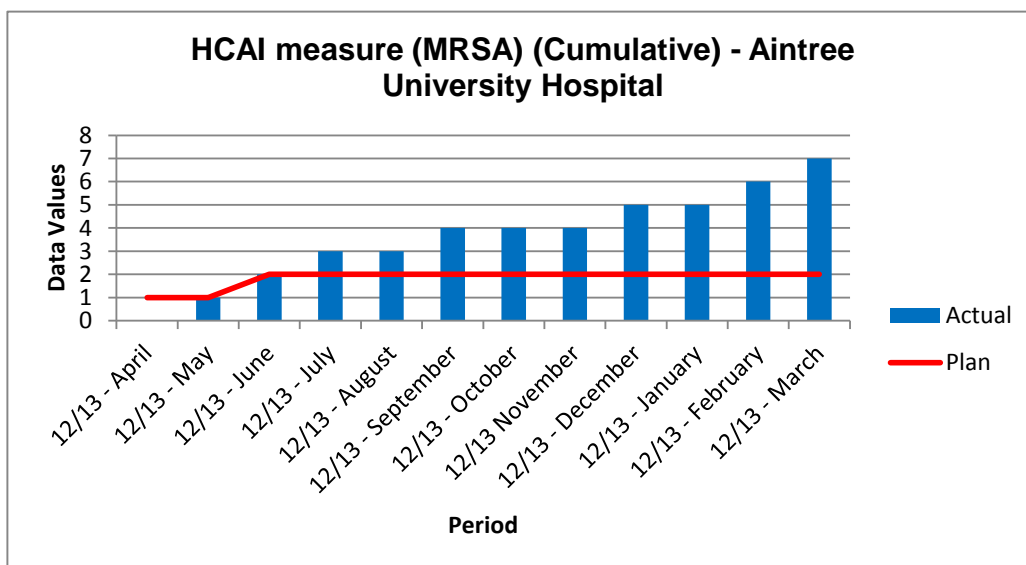
Performance Indicators		Aintree University Hospitals NHS Foundation Trust	Alder Hey Children's NHS Foundation Trust	Liverpool Heart & Chest NHS Foundation Trust	Liverpool Womens NHS Foundation Trust	Royal Liverpool & Broadgreen University Hospitals NHS Trust	Southport & Ormskirk Hospital NHS Trust	St Helens & Knowsley Teaching NHS Trust	The Walton Centre NHS Foundation Trust	Warrington & Halton Hospitals NHS Foundation Trust
<b>Headline Measures</b>										
<b>Quality (Safety, Effectiveness &amp; Patient Experience)</b>										
PHQ26: 01: MSA Breaches - No. of unjustified breaches	12/13 - Feb	0	0	0	0	0	0	0	2	0
PHQ27: HCAI measure (MRSA) (Cumulative)	12/13 - March	7.0	1.0	0.0	0.0	3.0	0.0	10.0	0.0	1.0
PHQ28: HCAI measure (Cdif) (Cumulative)	12/13 - March	72.0	0.0	8.0	0.0	53.0	22.0	31.0	7.0	19.0
<b>Supporting Measures</b>										
<b>Quality (Safety, Effectiveness &amp; Patient Experience)</b>										
PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait (Cumulative)	12/13 - Feb	87.4		81.4	87.9	92.0	85.7	91.1		91.3
PHQ03-05: Cancer 62 Day Waits (aggregate measure) (Cumulative)	12/13 - Feb	89.1		80.7	89.8	95.5	85.5	92.0		92.2
PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service (Cumulative)	12/13 - Feb	86.8			94.1	99.2	100.0	100.0		98.4
PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority (Cumulative)	12/13 - Feb	93.3		72.4	96.6	98.8	69.2	84.6		90.3
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 - Feb	98.0	100.0	98.4	97.3	98.8	99.0	99.5	100.0	100.0
PHQ07: 31-Day Standard for Subsequent Cancer Treatments-Surgery (Cumulative)	12/13 - Feb	98.8	100.0	100.0	98.7	99.3	96.0	99.3	100.0	100.0
PHQ08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens (Cumulative)	12/13 - Feb	100.0	100.0			99.1	100.0	100.0	100.0	100.0
PHQ09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy (Cumulative)	12/13 - Feb	94.4				100.0	100.0	100.0		
PHQ19: RTT - % of admitted pathways within 18 weeks	12/13 - Feb	90.2%	90.2%	92.8%	97.9%	95.1%	78.5%	94.2%	93.6%	90.5%
PHQ20: RTT - % of non-admitted pathways within 18 weeks	12/13 - Feb	97.4%	96.5%	95.2%	95.2%	98.5%	95.7%	98.6%	97.3%	97.4%
PHQ21: RTT - % of incomplete pathways within 18 weeks	12/13 - Feb	96.6%	93.1%	92.1%	93.1%	95.2%	94.1%	97.4%	97.0%	92.0%
PHQ22: % of patients waiting 6 weeks or more for a Diagnostic Test	12/13 - Feb	0.2%	0.0%	0.0%	0.9%	0.0%	0.1%	0.0%	0.0%	0.0%
PHQ24: All Cancer Two Week Wait (Cumulative)	12/13 - Jan	96.6		99.3	97.3	95.0	93.1	94.7	100.0	96.1
PHQ24-25: Cancer 2 Week Waits (aggregate measure) (Cumulative)	12/13 - Jan	96.5		99.3	97.3	95.1	93.4	95.0	100.0	95.7
PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) (Cumulative)	12/13 - Jan	95.3				96.0	95.6	97.0		94.2
PHQ29: VTE Risk Assessment	12/13 - Q3	92.60		96.30	95.20	90.40	93.60	90.00	92.00	94.0
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit	12/13 - Q4 Jan - March	73.1				83.2	84.7	63.8		74.0
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours	12/13 - Q4 Jan - March	100.0				100.0	64.3	78.3		23.8
<b>Resources (Finance, Capacity &amp; Activity)</b>										
A&E % Patients waiting <4 Hours	W/E 14th April	80.4%	96.1%		100.0%	90.1%	87.7%	93.1%		94.0%
<b>North West Ambulance Service</b>										
	2012/13	June	July	August	Sept	October	November	December	January	February
Cat A response within 8 mins % R1	75%	75.7%	76.9%	75.2%	75.1%	73.6%	72.0%	70.8%	73.1%	71.4%
Cat A response within 8 mins % R2	75%	79.4%	79.8%	78.7%	76.6%	76.8%	76.1%	72.9%	76.0%	74.4%
Cat A response within 19 mins	95%	95.6%	95.9%	95.8%	94.6%	94.6%	95.1%	94.2%	95.1%	94.5%

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

## Performance Recovery Action Plans

### 1. MRSA

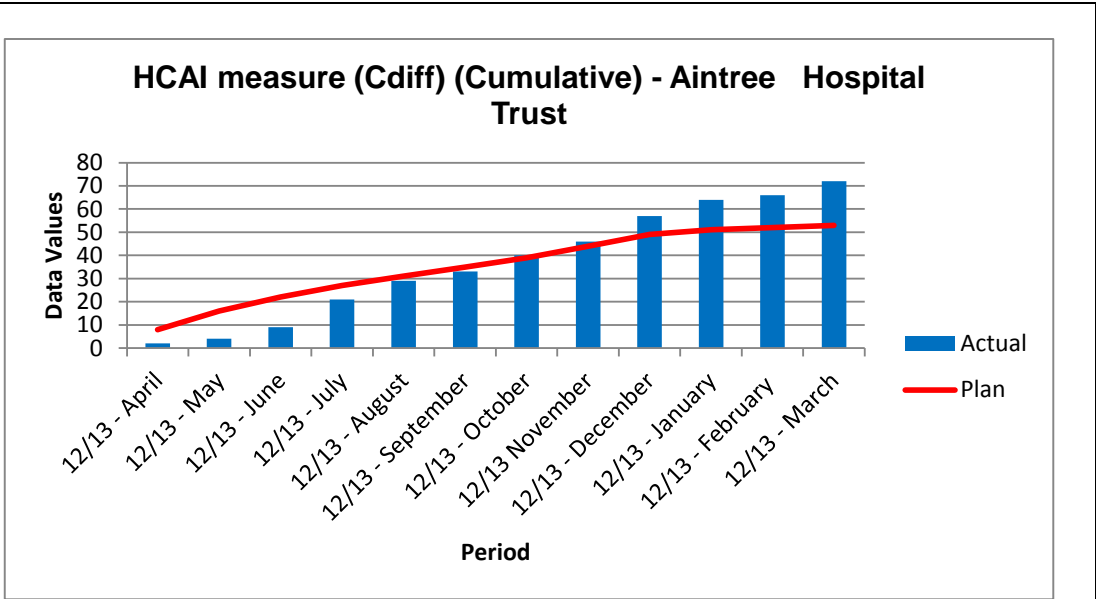
For March 2013 Aintree Hospital Trust is reporting one further case of MRSA which brings the total for the year to seven against the tolerance of two. The Trust continue to reassess and update their plans which have been previously shared with CCGs for assurance Each case has been thoroughly investigated and discussed at contract meetings and was presented at the October quality meetings by the Lead Nurse. A Health Care Acquired Infection (HCAI) group is being set up and will be 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. The year-end target has been breached.



### 2. Cdifficile Infections

In March 2013 for Aintree Hospital Trust there were 72 cases of Cdifficile infections year to date against the tolerance of 53. The year-end target has been breached. The Trust is over testing compared to other providers and national guidance. The Trust will continue testing in the same way but will adjust their reporting which will show an improved position going forward into 2013/14. Plans in place for improved performance in 2013/14.





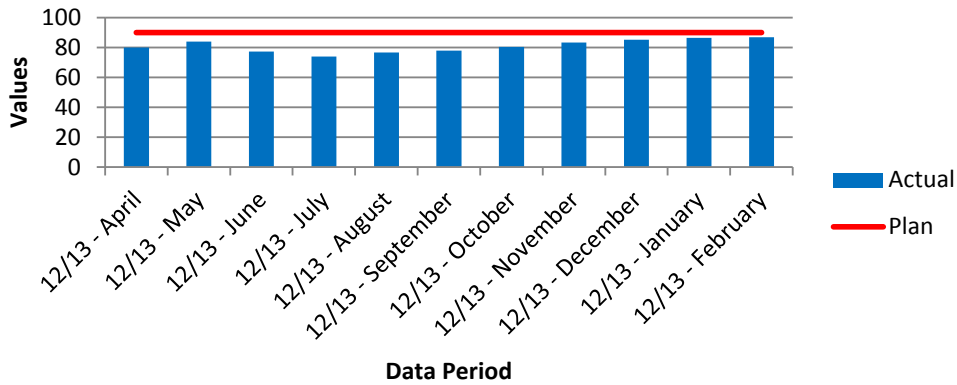
**3. Mixed Sex Accommodation – MSA**

In February 2013 there were two Mixed Sex Accommodation (MSA) breaches in The Walton Centre. This was a one patient breach but this patient was in a bay with another patient so two are therefore recorded. The breach was in the high dependency unit and the patient was transferred back to the ward within 24 hours. The reason for the delay was a lack of ward beds. It was previously agreed with commissioners that due to the bed base and increased activity, patients would be returned to the ward within 48 hours, however it is always recorded when a patient exceeds 24 hours and this is the first time this has happened. This is the first occurrence of a breach and there have been none recorded since this. The Walton Centre is fully compliant in all inpatient areas with same sex accommodation.

**4. Cancer Waits**

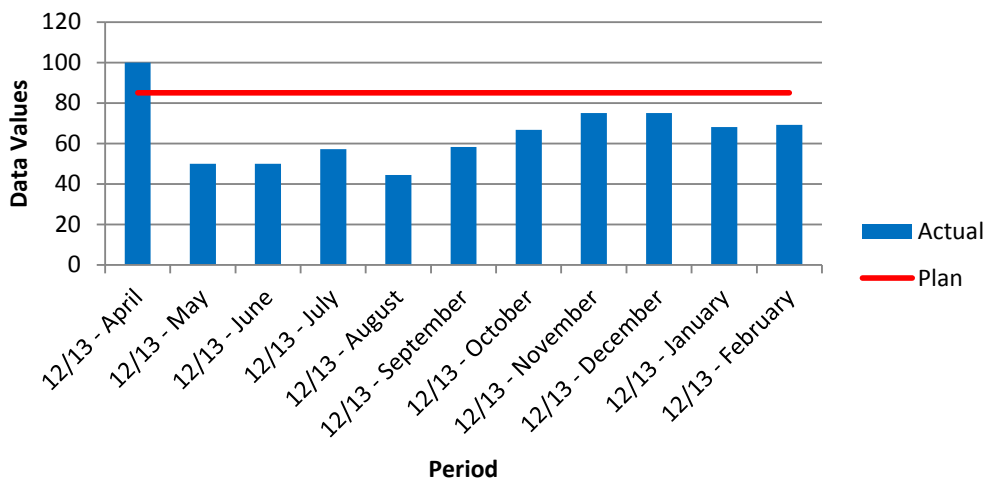
At Aintree Hospital Trust, the 62 day wait for first treatment following referral from an NHS cancer screening service at February 2013 is 86.75%. The 90% target was also breached for March 2013 but the Q4 target was achieved. Monitor has agreed a target of 81.8% for screening for this provider, recognising the challenges facing it faces. The Trust is reviewing all pathways in order to tighten up processes and reduce time to 1st appointments and diagnostic tests which will impact on 62 day performance.

**62-Day Wait for First Treatment Following Referral  
from an NHS Cancer Screening Service (Cumulative)  
- Aintree Hospital Trust**



For the 62 days wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority in February 2013, Southport and Ormskirk Hospitals Trust are reporting 69.23%. There is no current national standard/target set for 62 day upgrade for non-foundation trusts. The Sefton target was set for reporting purposes at 85% in line with the other 62 day categories. The Mersey and Cheshire Network wide target was never finalised. The numbers reported for the Trust are low for this indicator and as a consequence half a breach significantly affects performance. In addition the tumour sites being reported are lung and haematology which are the most complex pathways. There is a target for Foundation Trusts and as Southport and Ormskirk progress to FT status they will be working to achieve compliance of this target.

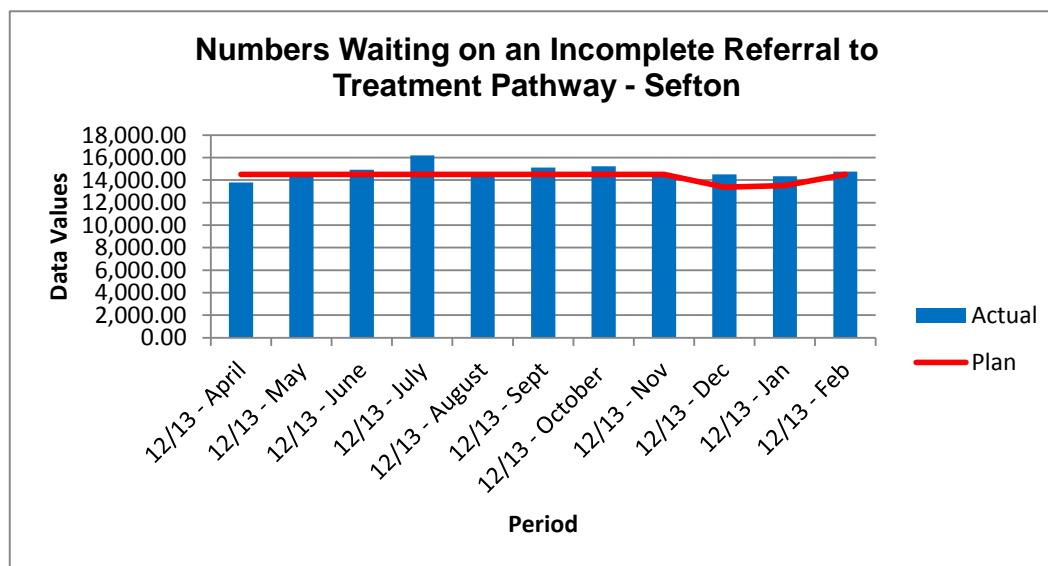
**62-Day Wait for First Treatment For Cancer Following a  
Consultants Decision to Upgrade the Patient's Priority  
(Cumulative) - Southport & Ormskirk**



For Cancer 62 day waits (aggregate measure) for February 2013 Southport and Ormskirk are showing 85.50% against the 86% target which is lower than last month. The Trust breached for March 2013 but it is understood that Q4 2012/13 86% target has been achieved. There are small numbers involved with breach reasons being patient choice and/or complex pathways. The Trust have implemented the recommendations made by the Intensive Support Team including the development of the Trust Cancer Access Policy, pathway redesign and timed pathways for each tumour site, demand and capacity modelling, standardised breach analysis and dissemination and clear and robust escalation procedures.

### 5. RTT – Numbers waiting on an incomplete 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.



### 6. % Patients who had a stroke & spend at least 90% of their time on a stroke unit

Aintree Hospital Trust is reporting 73.1% in Q4 against a target of 80% for stroke (the percentage of stroke patients spending 90% of their stay on a stroke unit).

Commissioners are working with the Trusts to address performance issues

and ensure clinical pathways are being adhered to. Underperforming Trusts are being asked to provide exception reports and recovery plans where Q4 targets have not been achieved; these will be shared with commissioning CCGs by the end of May 2013.

### **7. RTT Admitted pathways within 18 weeks**

For this indicator for Southport and Ormskirk Hospitals Trust, February performance was at 78.5%% against the 90% target. The clearing of the backlog of patients waiting over 18 weeks continues and it is not possible to carry out additional activity to clear the longer waiters and still meet RTT targets. There is agreement with local commissioners for the Trust to breach February 2013 as part of the plans to clear the backlog of long waiters.

### **8. A&E - % patients waiting <4 hours**

The figure for A&E <4 hour wait at w/e 14<sup>th</sup> April 2013 for Aintree Hospital Trust is showing 80.4% against the 95% target. Previously reported challenges and pressures remain. The Trust is continuing to work on patient flow and direct entry for GP admitted patients should relieve some pressure on A&E going forward. Multiple actions have been listed by the Trust with the aim of improving performance. April and Q1 performance are at risk.

For Southport and Ormskirk Hospitals Trust, the w/e 14<sup>th</sup> April 2013 A&E <4 hour waiting figure was 87.7% against the 95% target. Again the challenges of the last few months remain. All available escalation beds are in use and additional staffing utilised for A&E to help meet demand. The acuity level of patients presenting has increased. The Trust continues to put in place additional measures to meet demand but as above, April and Q1 performance are at risk.

### **9. Ambulance Response**

Overall regional performance in February against the Red 8 minute target was 74.1%, with cumulative Red 8 minute performance at the end of February falling slightly to 76.6% from 76.7% in January but this remains well ahead of the 75% target. National Ambulance Performance data for the twelve Ambulance Service Trusts is available to the end of January and shows that NWS Red A8 cumulative performance is in the top three performing Trusts in the country for the seventh month running.

February performance for Merseyside against the overall 8 and 19 minute targets was 76.3% and 94.0% respectively. Cumulatively positive performance against these targets is shown at 79.9% and 95.5% at the end of February, with year-end delivery of the targets expected.

NWS performance however against the trajectories to deliver Red 1

performance of 80% within 8 minutes by the year-end will not be achieved. At the end of February, NWAS cumulative performance against the revised clock start was 74.4% having dropped from 74.7% in January. Performance has remained below the expected trajectory, similar to many other services, since the clock start was implemented in mid-2012. Performance in February was 71.4%. The number of incidents in February was more than predicted which affects both the in-month and cumulative position. Achievement of the 80% Red 1 target has proved difficult for all Ambulance Trusts nationally. It should be noted that the NHS Commissioning Board's Everyone Counts 'Planning for patients 2013/14' introduces revised ambulance performance on Red 1 to be 75% from April 2013 onward.



NHS Merseyside - Actual activity compared to planned activity - Cumulative to March 2013 for General & Acute Specialities

	2011/12						2012/13						Growth 11/12 to 12/13	
	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
PHS07	GP G&A Referrals for First Outpatient Appointment													
PCT	73544	65394	-8150	-11%	65686	68999	3313	5.0%	3313	68999	3605	6%	3605	6%
Halton & St Helens	46043	47276	1233	3%	48000	47939	-61	-0.1%	48000	47939	-61	-0.1%	663	1%
Knowsley	119103	117672	-1431	-1%	120337	118846	-1491	-1.2%	120337	118846	-1491	-1.2%	1174	1%
Liverpool	66794	68803	2009	3%	68739	68894	155	0.2%	68739	68894	155	0.2%	91	0%
Sefton														
PHS08	Other Referrals for First G&A Outpatient Appointment													
PCT	29804	37155	7351	25%	36796	39768	2972	8.1%	36796	39768	2972	8.1%	2613	7%
Halton & St Helens	25550	25420	-130	-1%	24536	25538	1002	4.1%	24536	25538	1002	4.1%	118	0%
Knowsley	101223	100776	-447	0%	102323	90695	-11628	-11.4%	102323	90695	-11628	-11.4%	-10081	-10%
Liverpool	41274	41836	562	1%	42086	42400	314	0.7%	42086	42400	314	0.7%	564	1%
Sefton														
PHS10	All referrals for first G&A outpatient appointment													
PCT	103348	102549	-799	-1%	102482	108767	6285	6.1%	102482	108767	6285	6.1%	6218	6%
Halton & St Helens	71593	72696	1103	2%	72536	73477	941	1.3%	72536	73477	941	1.3%	781	1%
Knowsley	220326	218448	-1878	-1%	222660	209541	-13119	-5.9%	222660	209541	-13119	-5.9%	-8907	-4%
Liverpool	108068	110639	2571	2%	110825	111294	469	0.4%	110825	111294	469	0.4%	655	1%
Sefton														
PHS10	All first G&A outpatient attendances													
PCT	93370	95173	1803	2%	94080	97242	3162	3.4%	94080	97242	3162	3.4%	2069	2%
Halton & St Helens	65865	62605	-3260	-5%	61822	63277	1455	2.4%	61822	63277	1455	2.4%	672	1%
Knowsley	205341	203321	-2020	-1%	204082	197226	-6856	-3.4%	204082	197226	-6856	-3.4%	-6095	-3%
Liverpool	99325	96854	-2471	-2%	96004	98345	2341	2.4%	96004	98345	2341	2.4%	1491	2%
Sefton														



PCT	2011/12						2012/13						Growth 11/12 to 12/13	
	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
	Elective Ordinary G&A Admissions													
Halton & St Helens	8958	10457	1499	17%	10245	10370	125	1.2%	10245	10370	125	1.2%	-87	-1%
Knowsley	5553	5275	-278	-5%	5116	5131	15	0.3%	5116	5131	15	0.3%	-144	-3%
Liverpool	13287	14072	785	6%	14086	13612	-474	-3.4%	14086	13612	-474	-3.4%	-460	-3%
Sefton	8989	9170	181	2%	8923	8906	-17	-0.2%	8923	8906	-17	-0.2%	-264	-3%
Elective Daycase G&A Admissions														
PCT	2011/12						2012/13						Growth 11/12 to 12/13	
	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
	Elective Daycase G&A Admissions													
Halton & St Helens	31578	35102	3524	11%	33790	37894	4104	12.1%	33790	37894	4104	12.1%	2792	8%
Knowsley	19016	19621	605	3%	18804	20759	1955	10.4%	18804	20759	1955	10.4%	1138	6%
Liverpool	49266	52787	3521	7%	51748	55388	3640	7.0%	51748	55388	3640	7.0%	2601	5%
Sefton	35897	38094	2197	6%	36408	38274	1866	5.1%	36408	38274	1866	5.1%	180	0%
All Elective G&A Admissions														
PCT	2011/12						2012/13						Growth 11/12 to 12/13	
	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
	All Elective G&A Admissions													
Halton & St Helens	40536	45559	5023	12%	44035	48264	4229	9.6%	44035	48264	4229	9.6%	2705	6%
Knowsley	24569	24896	327	1%	23920	25890	1970	8.2%	23920	25890	1970	8.2%	994	4%
Liverpool	62553	66859	4306	7%	65834	69000	3166	4.8%	65834	69000	3166	4.8%	2141	3%
Sefton	44886	47264	2378	5%	45331	47180	1849	4.1%	45331	47180	1849	4.1%	-84	0%
Non-Elective G&A Admissions														
PHS06	2011/12						2012/13						Growth 11/12 to 12/13	
	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Plan	Actual	Diff	% Diff	Diff	% Diff
	Non-Elective G&A Admissions													
Halton & St Helens	41092	42024	932	2%	41,300	43,492	2192	5.3%	41,300	43,492	2192	5.3%	1468	3%
Knowsley	23377	21838	-1539	-7%	21,951	23,056	1105	5.0%	21,951	23,056	1105	5.0%	1218	6%
Liverpool	57778	57430	-348	-1%	56,326	57,588	1262	2.2%	56,326	57,588	1262	2.2%	158	0%
Sefton	34068	33627	-441	-1%	33,430	35,104	1674	5.0%	33,430	35,104	1674	5.0%	1477	4%

Data Sources

Plans - Vital Signs/IPM Submissions

Actuals - Monthly Activity Return

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

## General & Acute Activity Monitoring

These figures refer to the period **April to March 2013**

The period **April to March** contains two less 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 1.8% (5,533 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 three months at 0.6% above plan (1,916 referrals), compared to around 2% below plan in previous months. This may warrant further investigation if it continues at a more significant percentage.

Sefton has seen an increase in year-to-date referrals in November. The Trust was below the 2012/13 plan in October. Sefton are now 0.2% (155 referrals) over plan, which shows an increase in over performance compared to November.

In comparison with the same period last year, Sefton are 0.1% above.

### **Other referrals for a first outpatient appointment**

Other referrals are down on last year with an under performance of -3.3% (-6,786 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 9.0% over the previous year's figures. The under-performance has shown a particular growth between October and November.

The Month 12 figures also show that Merseyside is -3.6% (-7,340) under planned levels for 'Other' Referrals in the year to February.

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 decrease of -0.2% (-1,253 referrals) since last year, while referrals are below plan for 2012/13 by -1.1% (-5,424 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 0.7% (314) above plan after reducing consistently in previous months.

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

In March, Merseyside shows a -1.4% (1,863) decrease in attendances compared with same period in the previous year. There is also a 0.02% (102) over performance compared to plan.

Sefton is showing the second most significant growth from the previous year. They are 1.5% (1,491) up on 2011/12.

### **Elective Ordinary G&A Admissions**

Elective ordinary G&A admissions for Merseyside are -0.9% (315 spells) under plan for the year and -2.5% (-955) 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 8.2% (11,565 Day Cases) and 4.6% (6,711 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 2011/12 continues its downward trajectory from April.

When combining day case and ordinary elective admissions, all CCGs show an over-performance against plan. When comparing against last year, Sefton is showing a slight decrease of -0.2%. Again, this is a return to the levels of performance seen in the August report.

### **Non-Elective G&A Admissions**

Merseyside is currently 4.1% over plan for the year to March and 2.8% over the activity levels for Non-Electives in the same period last year. There has been a slight drop compared to last month against plan and a slight drop compared to last year. Overall they 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 9.2% increase in spells, there was a particularly high number of spells in May. Work is ongoing with the Trust to understand the Non-Elective/Urgent Care pressures currently being experienced, and the scale of the over-performance is diminishing.

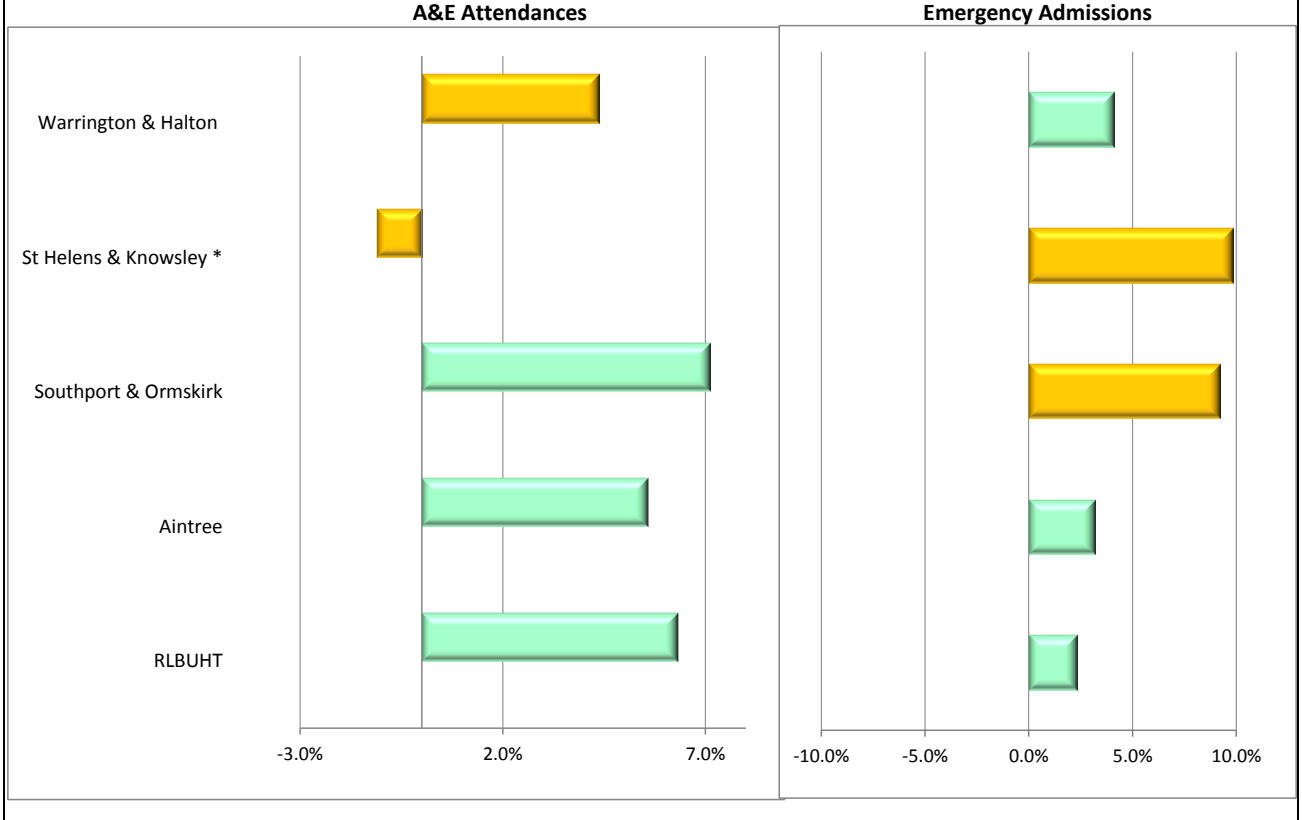
For Halton & St Helens, the main driver of over-performance appears to be St Helens & Knowsley, which is continuing to see increases in non-elective

admissions. The current position shows a 9.8% increase against last year. The increase is significantly greater when comparing current performance to the 2012/13 Plan – this shows a 5.3% over-performance against plan. This suggests that part of the explanation may lie in the calculation of the plan for 2012/13. Performance will continue to be monitored.

**Change in A&E Attendances & Emergency Admissions**

**24th March 2012 - 24th March 2013**

(Year to Date Compared With the Previous Year)



	A&E Attendances			Emergency Admissions		
	YTD 2012/13	YTD 2011/12	% change	YTD 2012/13	YTD 2011/12	% change
RLBUHT	218844	205890	6.3%	38294	37433	2.3%
Aintree	178148	168760	5.6%	31390	30424	3.2%
Southport & Ormskirk	207910	194130	7.1%	28500	26101	9.2%
St Helens & Knowsley *	229142	231714	-1.1%	45077	41046	9.8%
Warrington & Halton	214090	205116	4.4%	35627	34220	4.1%

Source: NHS Northwest

\* Includes 'type' 3 attendances and is not directly comparable with the previous year

## A&E Attendances & Emergency Admissions

### A&E Attendances

This activity covers the period 24<sup>th</sup> March 2012 to 24<sup>th</sup> March 2013:

All providers have had a higher number of A&E attendances in 2012/13 than they had in 2011/12 (to date) apart from St Helen's & Knowsley. Overall, there has been an increase of 4.2% for A&E attendances and 5.7% for emergency admissions.

Southport & Ormskirk have had the largest increase of 7.1% (13,780) up on last year. Emergency admissions have also grown over the same period by 9.2% (2,399).

Royal Liverpool University Hospital has seen an increase on 2011/12 of 6.3% (12,954).

Aintree has seen an increase on 2011/12 of 5.6% (9,388).

Warrington has seen an increase on 2011/12 of 4.4% (8,974).

St Helens & Knowsley however have had 2,572 (-1.1%) less A&E attendances this year. This decrease is not reflected in a similar decrease in emergency admissions which has had an increase of 9.8% (4,031). The situations with both A&E attendances and emergency admissions have worsened in the past three months.

### Cheshire and Merseyside Commissioning Support Unit Early Warning Quality Dashboard May 2013 Update

This report highlights the current position for hospital providers of interest to Sefton CCG against a number of quality measures listed within the following domains;

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Organisational Quality Measures

Further analysis is available for each of the measures which you can view by clicking on 'Click Here' within the Data sheets column.

[Click on the domain below to access dashboard](#)

Domain 1 - [Patient Safety](#)

Domain 2 - [Clinical Effectiveness](#)

Domain 3 - [Patient Experience](#)

Performance Trend Key	Reg Rating Key	Care Quality Commission Reg Ratings
↑ Increase in performance compared to previous reporting	Performing against plan	Compliant
↗ Slight increase in performance compared to previous reporting	Work in progress/Average compared to other trusts	Not Compliant (compliant actions requiring improvement)
↔ No change in performance compared to previous reporting	Underperforming against plan/Drop in performance	Not Compliant (Enforcement action taken)
↘ Slight drop in performance compared to previous reporting	Indicator not applicable to trust	CCC are currently conducting checks at this provider
↓ Drop in performance compared to previous reporting	Not applicable to reg rate indicator	

Patient Safety Quality Measures											
Indicator	Data Sheets	Reporting Frequency	Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust
Hospital Care Acquired Infections		Monthly									
MRSA Cases Reported	<a href="#">Click Here</a>	Mar-13	Actual/Plan	7/2	3/4	0/3	1/1	0/0	0/1		
Cdiff Cases Reported	<a href="#">Click Here</a>	Mar-13	Actual/Plan	72/53	53/73	22/30	0/3	0/0	7/8		
Venous thromboembolism (VTE) risk assessment		Monthly									
VTE Risk Assessments	<a href="#">Click Here</a>	Mar 13 *Feb 13	Actual/Plan	91.7%/90%	91.1%/90%	93.2%/90%		↗	↑		
Local Incident Reporting		Monthly									
Never Events Reported		Apr 13 *Feb 13	Actual (YTD)	1 (1)	*0 (0)	0 (0)	*1 (1)	*0 (0)	0 (0)	*0 (0)	*0 (0)
Never Events Currently Open		Apr 13 *Feb 13	Actual	1	*0	1	*1	*0	0	*0	*0
Serious Untoward Incidents Reported	<a href="#">Click Here</a>	Apr 13 *Feb 13	Actual (YTD)	1 (25)	*1 (3)	0 (24)	*1 (13)	*2 (12)	0 (3)	*1 (33)	*4 (42)
SUIs Currently Open		Apr 13 *Feb 13	Actual	21	*2	22	*4	*12	3	*23	*33
National Patient Safety Incident Reporting (*Per 100 admissions, **Per 1,000 Reporting Rates)		Bi-Annual									
Total Incidents Reported			Actual	2692	1938	2102	792	1270	186	170	2082
% Incidents reported resulting in Severe Harm	<a href="#">Click Here</a>	April 12 - Sep 12	Rate/Nat Median Rate	*7.2/6.7	4.5/6.8	6.9/6.7	4.7/5.8	8/5.8	*4.5/7.0	14.8/41.8	30.7/23.8
% Incidents reported resulting in Death			Actual (%)	0.20%	0.20%	0.30%	0.00%	1.30%	0.00%	0.60%	0.20%
Mixed Sex Accommodation		Monthly									
Mixed Sex Accommodation Breaches	<a href="#">Click Here</a>	Mar-13	Actual (YTD)	0 (7)	0 (0)	0 (10)	0 (0)	0 (0)	0 (2)	0 (0)	0 (0)
National COQUIN - Safety Thermometer		Quarterly									
Timeliness submission of data harms data to Unify2	<a href="#">Click Here</a>	Mar-13	Compliance								
National COQUIN - Dementia		Quarterly									
Screening for Dementia (Find)		Mar-13	Compliance								
Risk Assessed (Assess and Investigate)	<a href="#">Click Here</a>	Mar-13	Compliance								
Patients Referred		Mar-13	Compliance								

Clinical Effectiveness Quality Measures											
Indicator	Data Sheets	Reporting Frequency	Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust
Mortality Indicators		Monthly									
Hospital Standardised Mortality Ratio (HSMR)	<a href="#">Click Here</a>	Apr 12-Nov 12	Relative Risk (Actual)	96.50%	91.00%	90.60%	162.00%	40.20%	80.5%	27.20%	89.60%
Summary Hospital-Level Mortality Indicator (SHMI)		Jul 11-June 12	Relative Risk (Actual)	116.40%	106.40%	104.70%					
Patient Reported Outcome Measures		Annual									
Groin Hernia - Average increase in health gain		2011/12	Actual/Nat Avg	7.5%/8.7%	3.6%/8.7%	7.1%/8.7%					
Hip Replacement - Average increase in health gain		2011/12	Actual/Nat Avg	38.1%/41.6%	29.5%/41.6%	32.6%/41.6%					
Knee Replacement - Average increase in health gain	<a href="#">Click Here</a>	2011/12	Actual/Nat Avg	30.1%/30.3%	32.5%/30.3%	29.7%/30.3%					
Varicose Vein - Average increase in health gain		2011/12	Actual/Nat Avg	Low Response Rate	Low Response Rate	Low Response Rate					

Performance Trend Key	Rag Rating Key	Care Quality Commission Rag Ratings
↑ Increase in performance compared to previous reporting	Green	Compliant
↗ Slight increase in performance compared to previous reporting	Yellow	Compliant
↔ No change in performance compared to previous reporting	Orange	Not Compliant (compliant actions requiring improvement)
↘ Slight drop in performance compared to previous reporting	Red	Not Compliant (Enforcement action taken)
↓ Drop in performance compared to previous reporting	Dark Red	CQC are currently conducting checks at this provider
		Indicator not applicable to trust
		Not applicable to rag rate indicator

Indicator	Data Sheets	Reporting Frequency	Patient Experience Quality Measures																	
			Detail	Aintree University Hospital	Royal Liverpool & Broadgreen	Southport & Ormskirk	Alder Hey Children's Hospital	Liverpool Women's Hospital	The Walton Centre	Liverpool Community Health	Mersey Care Trust									
<b>Regional CQUIN - Advancing Quality</b>		Quarterly																		
Acute myocardial infarction		Apr 12-Oct12	Actual/Plan	100.03%/95%	99.42%/95%	99.50%/95%														
Hip and Knee		Apr 12-Oct12	Actual/Plan	97.12%/95%	97.12%/95%	97.28%/95%														
Heart Failure		Apr 12-Oct12	Actual/Plan	85.81%/86.36%	90.36%/95%	87.38%/95%														
Pneumonia		Apr 12-Oct12	Actual/Plan	74.9%/85.9%	93.80%/95%	89.33%/95%														
Stroke	<a href="#">Click Here</a>	Apr 12-Oct12	Actual/Plan	84.18%/90%	95.43%/90%	89.33%/90%														
Coronary Artery Bypass Graft		Apr 12-Oct12	Actual/Plan																	
Dementia		Apr 12-Oct12	Actual/Plan																	
Psychosis		Apr 12-Oct12	Actual/Plan																	
<b>National Community Mental Health Survey</b>		Annual																		
Overall Care		2012	Trust score																	
			Compliance (Nat Avg)																	7.7/10
			Trust score																	
			Compliance (Nat Avg)																	6.6/10
			Trust score																	
			Compliance (Nat Avg)																	7.7/10
<b>National Accident and Emergency Survey</b>		Annual																		
Overall view of A&E experience; for feeling their experience of being treated and cared for in the A&E had been good		2012	Trust score	7.5/10	7.9/10	7.8/10														
			Compliance	Aout the same	Aout the same	Aout the same														
			Trust score/Nat Avg	82%/78%	81%/78%	81%/78%														
			Compliance (Nat Avg)	Above	Above	Above														
			Staff recommendation	3.68/3.57	3.65/3.57	3.39/3.57														
			Compliance (Nat Avg)	Above	Above	Below (Worst 20%)														
<b>National Inpatient Survey</b>		Annual																		
Q41: Involved satisfaction in decisions about care & Treatment		2012	Trust score	71%/75.4%	79.1%/75.4%	68%/75.4%														
			Compliance (Nat Avg)	About the same	Better	About the same														
			Trust score	88.9%/90.4%	92%/90.4%	84.8%/90.4%														
			Compliance (Nat Avg)	About the same	About the same	About the same														
<b>National Outpatient Survey</b>		Annual																		
Satisfaction with visit		2011	Trust score	8.8/10	8.8/10	8.7/10														
			Compliance (Nat Avg)	Aout the same	Aout the same	Aout the same														
			Trust score	8.5/10	8.7/10	8.5/10														
			Compliance (Nat Avg)	Aout the same	Aout the same	Aout the same														





## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/65	<b>Author of the Paper:</b> Martin McDowell Chief finance Officer <a href="mailto:martin.mcdowell@southseftonccg.nhs.uk">martin.mcdowell@southseftonccg.nhs.uk</a> Tel: 0151 247 7065
<b>Report date:</b> 21 May 2013	

**Title:** Strategic and Operational Commissioning Plan 2013-2016

**Summary/Key Issues:**

This plan sets out the CCG's 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 c.£240m in 2013-2014 and will need to work innovatively and link with key partners to deliver improvements. 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.

**Next Steps**

	South Sefton CCG
Send out plan to Wider Group for comment	31st May 2013
Comments back for inclusion in revised draft	11th June 2013
Present final plan to Wider Group adoption	13 <sup>th</sup> July 2013
Ratification of plan by Board	25th July 2013

<b>Recommendation</b>	Note	<input checked="" type="checkbox"/>
The Governing Body is asked to note this report.	Approve	<input type="checkbox"/>
	Ratify	<input type="checkbox"/>

<b>Links to Corporate Objectives</b> ( <i>x those that apply</i> )	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Patient and Public Engagement	x			Lay Member contribution at Governing Body Meeting in March 2013
Clinical Engagement	x			Clinician contribution at Governing Body Meeting in March 2013
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered	x			
Locality Engagement	x			Contribution from Head of CCG Development
Presented to other Committees		x		

<b>Links to National Outcomes Framework</b> ( <i>x those that apply</i> )	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS South Sefton Clinical Commissioning Group

## Strategic & Operational Commissioning Plan 2013 –2016



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LEAF BRAND

## Definitions

<b>Acute Trust</b>		Hospitals are managed by acute trusts. Acute trusts make sure that hospitals provide high-quality healthcare and that they spend their money efficiently. They also decide how a hospital will develop, so that services improve
<b>Acute Service Review</b>	ASR	Will consider the future configuration of services currently provided in a hospital setting. The aim is to improve healthcare services ensuring that they deliver higher quality, local services for the population which are also more cost effective.
<b>Agenda For Change</b>	A4C	NHS pay, terms and conditions for staff
<b>Allied Health Professional</b>	AHP	Allied health professions are clinical healthcare professions distinct from medicine, dentistry, and nursing, including audiology, midwifery, speech and language therapy
<b>Ambulance Trust</b>		There are 11 ambulance services in England, providing emergency access to healthcare
<b>Ambulatory Care</b>		Ambulatory care is a type of medical care given to patients who do not need to be admitted to a hospital
<b>Any Qualified Provider</b>	AQP	When a service is opened up to choice of "Any Qualified Provider", patients can choose from a range of providers all of whom meet NHS standards and price
<b>Benchmarking</b>		Benchmarking is the process of comparing the cost, cycle time, productivity, or quality of a specific process or method to another that is widely considered to be an industry standard or best practice.
<b>Best Practice Tariff</b>	BPT	Enables the NHS to improve quality by reducing unexplained variation and universalising best practice (best clinical care and most cost effective). The aim is to have tariffs that are structured and priced appropriately both to incentivise and adequately reimburse providers for the costs of high quality care.
<b>British Medical Association</b>	BMA	The professional medical association and trade union for doctors and medical students
<b>British Medical Journal</b>	BMJ	Open access medical journal; most influential and well read academic journals in the field of medicine.
<b>Care Quality Commission</b>	CQC	Regulate, inspect and review all adult social care services in the public, private and voluntary sectors in England
<b>Community Elderly Care Service</b>	CECS	Will prevent admission to hospital of some elderly patients by arranging their care at or near home



## South Sefton CCG – An 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 20 months, SSCCG has played an active role in local commissioning. It initially operated in shadow form until 1<sup>st</sup> April 2013 but now operates as a statutory body, 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. Clinical commissioning groups are established under the Health and Social Care Act 2012 ("the 2012 Act"). They are statutory bodies which have the function of commissioning

services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 ("the 2006 Act"). The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision. The constitution is:

- a) published on the group's website at [www.southseftonccg.org.uk](http://www.southseftonccg.org.uk)
- b) or available in hard copy by writing to **Melanie Wright** at NHS SSCCG, 3rd floor, Merton House, Bootle

SSCCG's plans for the three years 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

# Our Vision, Values and Commitments

## 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

## The importance of our work:

We understand that our work has a significant impact on people's lives.

In a complex health economy we will remain clear that our core responsibility is to do the best we possibly can for the patients of South Sefton.

Our Core Values will support our culture to deliver the vision for South Sefton.

## 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 for 2013-2014 are:

- To take on full responsibility for 'commissioning' or buying local health services by April 2013

- Improve the health of all south Sefton residents and reduce the differences in health which exist in different parts of the area
- To commission services of the highest possible quality to ensure south Sefton residents get the best care available to them
- Ensure that the services we commission deliver good value for money
- Involve south Sefton residents in the decisions we make about their local healthcare

WE WILL	THROUGH
<ul style="list-style-type: none"> <li>• Guarantee that no community is left behind or disadvantaged</li> <li>• Focus on reducing health inequalities and advancing equality to improve outcomes for all our patients</li> <li>• Treat patients as respectfully and put their interests first</li> <li>• Transform NHS services to enable patients to take more control and make informed choices if they want to</li> <li>• Involve South Sefton residents in the decisions we make about their local healthcare</li> </ul>	<p>Working closely with Public Health on Needs Assessments and planning delivery accordingly</p> <p>Increased Public and Patient Engagement (see Enabling Area 4)</p>

# Local Needs Assessment & Priorities

## Introduction

The CCG strives engage with key stakeholders and to evaluate all available and relevant data to ensure the best quality, evidence-based decision making. Critical to this is the Joint Strategic Needs Assessment which is developed with Sefton Council and input through to other engagement events (Big Chat, SSNA, Talking Health and Wellbeing – See Appendix 3)

## Overview

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. Over the same period, it is forecast that there will be a reduction in the population of 15-64 year olds of 7%. This forecast suggests an increase in expenditure for both the health service and local authority in caring for the older population. This is compounded by a reduction in working age population, resulting in less economically active residents and a potential reduction in Council Tax revenue. These will become a major long term issue for the area.

There are stark social and health inequalities within Sefton. South Sefton has significantly higher levels of deprivation, child poverty, worklessness and crime and disorder. Within the areas of South Sefton that are most deprived, average life expectancy is 11 years less than in the more affluent parts of the Borough.

For more South Sefton information (data and statistics) please see Appendix 1 (Health) and Appendix 2 (Non Health) below

Despite the proportions of residents that say they drink to levels that are high or increased risk being largely in line with regional and national figures, alcohol related health problems are a major issue for Sefton. Alcohol specific mortality continues to rise across the Borough with the rates for both males and females amongst the 10% highest across England. The cost of alcohol related hospital admissions is thought to be in the region of £2,000 per admission or £50m per year.

## Key findings and Conclusions

Sefton has a higher than national average proportion of older residents and the population is aging faster than national rates; this will affect all localities. This will place increasing pressure on acute health services. The increase will also lead to more people living with a long term condition such as diabetes and dementia. It is therefore increasingly important to build close partnerships with the local authority and other strategic partners in order to tackle these significant challenges over the longer term. Finally, all localities have set as a priority the need for better long term condition management and the need to develop a comprehensive service model for frail older people.

This plan distinguishes between a focus on Delivery and also on those areas that will facilitate and Enable delivery to take place:

## Enabling Area 1 - The Approach

### **Innovation is about step change;**

Innovation is doing something different – not just doing the same things better.

While cuts to public expenditure ramp up, demand for public services is forecast to increase. Pressure to deliver more for less will increase over the coming months and years and that will require innovation in the way that public services and the health economy are provided, supported and managed. Sefton and Formby CCG will accomplish innovative change through more effective products, processes, services, technologies, and ideas.

### **Information technology (IT)**

Sefton and Formby's intention is to maximise the use of information technology to automate business processes, provide information for decision making, better connect clinicians with their patients, and to provide productivity tools to increase efficiency. We will make more use of informationbased technologies to design new models of care as well as improving the performance of existing services. We will integrate information around the patient, deliver relevant information at the right time to clinicians and use technology to drive efficiency for both patients and clinicians.

### **Programme Management**

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 our 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 5. These leads have worked in conjunction with key stakeholders, across the NHS, Sefton Council, 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.

## Diagram 1 – The Commissioning Cycle

**Engagement:** Joint Strategic Needs Assessment  
Commissioning Priorities & QIPP Plans; Public  
Patient Advisory Group; Public Health

**Information:** Local commissioning intelligence;  
Quality Alliance (AQuA) and Academic Health  
Care Atlas, NHS CB Outcomes Framework,

**Governance:** GP Clinical Leads for Quality and  
Performance Groups and Contract Performance  
Warning System; Commissioning Support from the  
inspection; Peer Review; SUIs

**Procurement** and how it is managed is a key  
when incentives are structured to encourage

### Any Qualified Provider (AQP)

The Any Qualified Provider (AQP) scheme means that, for some conditions, patients will be able to choose from a range of approved providers, such as hospitals or high street service providers. Patients and GPs can choose a service based on what's important to them – perhaps one that is closer to home, has a shorter waiting list or better outcomes.

This will require diligent management over the coming years to ensure an improved service to patients; all the principles associated with VFM will need to be applied in this process.



(JSNA); Health & Wellbeing Strategy; CCG  
Consultation; Stakeholder Engagement; Expert  
Memorandum of Understanding

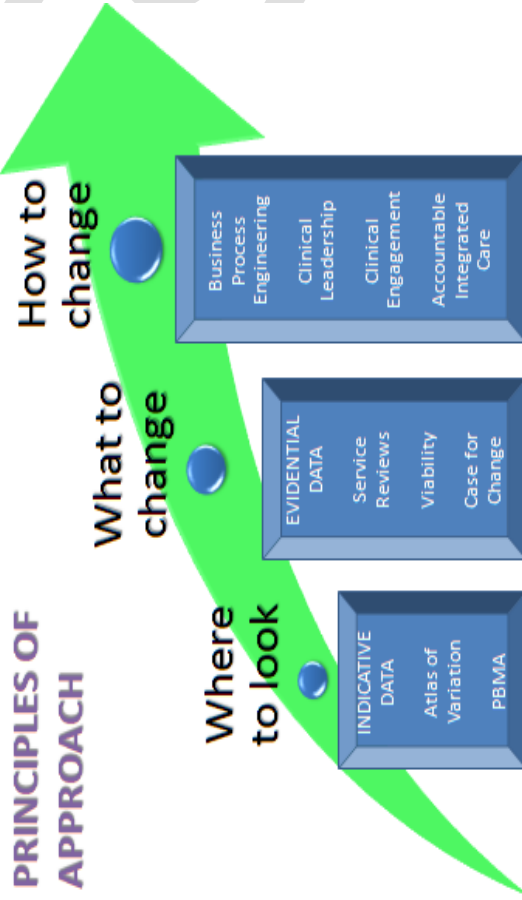
NICE guidelines; comparator information; Advancing  
Science Network (AHSN) membership support; Right  
Merseyside Intelligence Portal.

Contracting; CCG Collaboratives; Clinical Quality &  
Meetings; CCG Quality Committee; CCG Early  
Commissioning Support Unit (CSU); External

theme; systems lose all capacity for innovation  
people to focus on the bottom line

## Project Management and the National Approach

The CCG's approach to identification, development and delivery of healthcare improvement, and thereby the achievement of the objectives and aims of this strategic plan, align with the thinking, tools and philosophy of the NHS RightCare programme ([www.rightcare.nhs.uk](http://www.rightcare.nhs.uk)). The RightCare programme, a part of the national QIPP architecture, advocates the principle of increasing system-wide value via a three step approach, underpinned by robust business processes within a programme management model. Adopting this principle supports the delivery of continuous improvement leading to a sustainable, high value health system for the population. The three step approach is summarised nationally as:

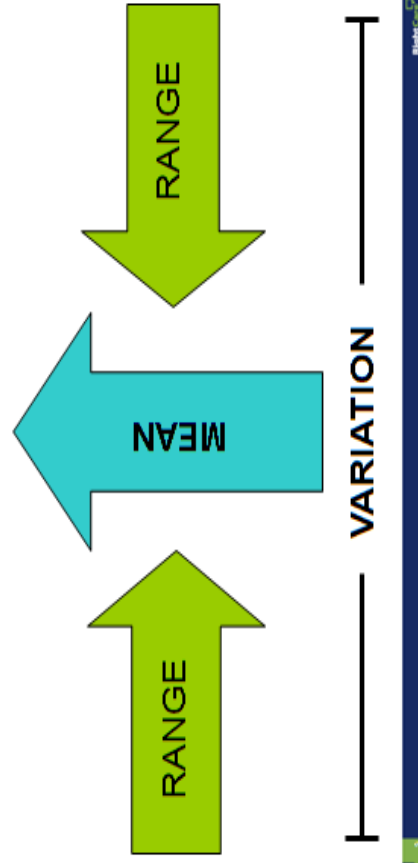


The CCG's programme approach, as described in the Establishment of a Programme Management Office document, builds on the RightCare approach for local implementation. The CCG works with NHS RightCare to

ensure continuous improvement in the healthcare system and in the processes and approach used to increase value in it.

The approach focuses on the use of data on variation as its first phase. This is used to prioritise improvement effort that develops into the programmes and projects of reform that feed through the project management process. The ultimate measure of increasing value via this approach can be described as:

**What are we trying to achieve?**  
Reduce the range of variation, Increase the mean



That is, if the range of unwarranted variation is reducing and the value measure is improving (increasing for quality, decreasing for spend), then the direction of travel of the health economy is correct.

National indicators of value have highlighted the need for the CCG to prioritise, or evidence that this is not required, the following areas for improvement:

**Disease areas:**

Cancer, Kidney Care, Child Health and GI (spend and quality);

Respiratory, including COPD (quality but with unplanned care spend opportunities), and;

Diabetes (quality).

**System areas:**

Unplanned Care – avoiding ‘flow’ into secondary care via ambulatory care, enhanced referrals protocols and emergency triage and the reduction in need for unplanned care, such as via;

Care planning/ Case management across all appropriate disease pathways, including those listed above, and;

Shared Decision Making – the use of the growing number of effective patient decision aids in primary and secondary care, including use of the new Android and iPhone Apps.

**Improvement levers:**

CQuINS – the insertion of Patient Decision Aid implementation, reform milestones and efficient ratios;

Contract management/ Service Specifications – the insertion of service specifications into contracts and subsequent management of pathways via the relevant contract clauses, and;

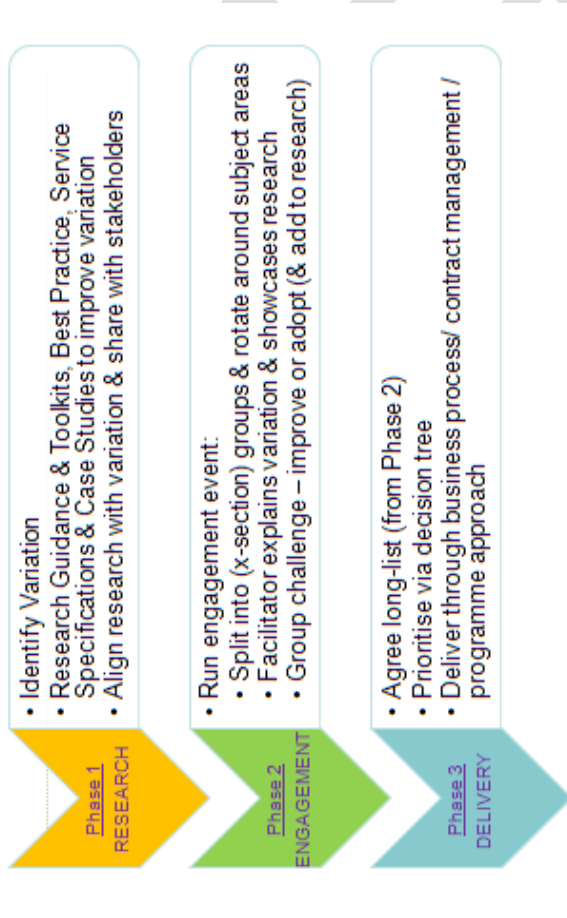
Local market management.

The latest Programme Budgeting national data is due to be published soon after the completion of the local strategic plan. As a consequence it will be necessary to review this and ensure that the CCG priorities remains robust where relative spend has been a criterion in the selection of projects. The need for review of the ongoing production of disease-specific Atlases of Variation also exists. This is in order to ensure that when opportunities for improvement come to light that ought to be prioritised, the CCG’s approach to project management is able to flex for the best benefit to the population. The same is also true for locally generated improvement ideas that come to light outside of the annual planning round.

**Programme Management and Engagement**

The next phase of development from the RightCare approach provides a method that optimises the integration of the engagement programme with the reform and improvement programme. The technique is called Copy or Explain and it is planned for the CCG to use this model in year 1 of the strategic plan to develop the detail of Year 2 and 3’s delivery. The local approach will be developed in the first quarter of year 1 and will follow the principles and process as described in the following flowchart:

**Copy or Explain – The NHS RightCare Process**





## Enabling Area 2 – (Build a stronger CCG Team) Key Priorities, Objectives & Measures

Given the structural changes in the Health Economy, the demographic changes that South Sefton is facing and the generic financial pressures ahead for all NHS organisations, South Sefton CCG has a huge challenge ahead. The organisation will be best placed to meet this challenge when Managers and Clinicians work together as a cohesive team.

We are a member organisation that will only thrive if together we deliver on the promises we make to our patients and communities. South Sefton will strive to maximise clinical knowledge and experience to tackle the major health challenges that are faced in South Sefton's local communities in addition to a focus on improving teamwork and clinical input, South Sefton will also look to tackle the infrastructure barriers, (poor IT and information sharing) that will allow South Sefton to deliver against its objectives.

Together we will:

- Develop local healthcare services by pursuing innovative, high value solutions
- Develop relationships built on openness and honesty, with transparency in our decision making
- Support and develop all clinicians, managers and teams across the organisation – they represent our greatest resource
- Make best use of the resources entrusted to us and hold each other to account for the way we use public funds, ensuring we live within our means and commission or deliver safe and high quality services

The Organisational Development Plan is one of four core documents which the interim South Sefton CCG has produced to guide and shape its early development. These are: the Strategic Commissioning Plan; the Organisational Development Plan; the Structure of the organisation (both as structure and, as importantly, the rationale behind the structure); and the specification for the commissioning support the CCG will buy-in from the Commissioning Support Service. Each of these core documents links together.

The OD Plan is designed to show how the CCG will grow and develop as an organisation in order to deliver its key vision and objectives. Clearly the plan will change and evolve as the CCG develops and this early plan focuses on many of the issues any high performing organisation needs to have in place in order to deliver its business aims effectively. This is particularly relevant for a CCG which is in effect a new start up organisation from the 1<sup>st</sup> April 2013.

South Sefton CCGs aspirations are:

- To develop a more effective culture through the clinical commissioning structure
- Develop through innovation by harnessing the energy and expertise within the member practices
- Deliver a GP development programme to assist clinicians through the transition period.

**The Strategic Plan** defines health priorities and outcomes that CCG will deliver, and includes:

- Pledges to stakeholders
- Measurable outcomes
- Initiatives and timelines

**The specification** defines the capabilities and services that the CCG requires to buy in to support delivery and includes:

- Key capabilities map – critical and enabling
- Do / share / buy decisions
- Specification, and / or capability descriptions (and implications)
- Operating manual (process and procedure definitions, internal governance & business management systems)

**The structure** defines the organisation form, structure, roles and headcount.

Includes:

- • Narrative explanation
- • Structure
- • Roles
- • Headcount
- • Governance

**The OD Plan is based on 5 key themes:**

- Embedding the vision and culture of the CCG in everything we do
- Defining and consistently delivering our core business cycle and functions
- Establishing 'fit for purpose' governance
- Developing and delivering a truly effective membership organisation
- Improving our skills and learning in order to better deliver our vision and outcomes.

### **Our Organisational Development Priorities**

Our organisational development (OD) plan has been instrumental in our journey towards authorisation. Our refreshed plan for 2013-14 has two key objectives:-

- To continue to develop an effective commissioning organisation capable of delivering its key objectives for 2013-14 and beyond.
- To develop an organisation with the ability to bring about positive changes in the whole health system, for the benefit of local people.

Our plan has six priorities, which build on the foundations laid in our shadow year, but will regularly reviewed as the organisation develops. These are:-

#### **1. Leadership, Workforce and Team Development**

- Defining future capability and capacity required to develop a truly effective membership organisation
- Individual and team development plans and performance management in place to achieve objectives
- Board, locality and clinical leadership plans implemented
- OD and training support commissioned including mandatory training.

- 2. Communications, Engagement and Collaboration**
- On-going implementation of Communications and Engagement strategy
  - Collaborative working to fully embed our patient and public engagement model and structures and ensure they are working most effectively through EPEG, including monitoring of NHS constitution pledges.
  - Proactive management and development of reputation and relationships with all stakeholders inc LA, VCF sector, providers
- 3. Strategy and performance management around outcomes**
- Three year strategy developed with broad involvement and communicated effectively
  - Delivered through annual plans and programme management approach linked to national and local outcomes and regular performance tracking.
  - Development of GP Practice development planning, strengthening use of the intelligence portal and review of data facilitation.
- 4. Structure**
- Full recruitment to CCG structure
  - Effective development and performance management of CSU
  - Planning for future procurement of CSU services
- 5. Values, style and change management**
- Ensure CCG vision, values and culture is embedded across whole organisation and that the CSU operates on our behalf in this context through development of effective CSU locality team.
  - Ensuring innovation and systematic approaches to transformation and change management.
- 6. Integrated Governance and Quality Improvement**
- Full implementation of Quality strategy, dashboard and effective operation of and response to all feedback and early warning systems.
  - Review effectiveness of committees, business cycle planning and further development of effective risk management systems.
  - Full implementation of E&D strategy and IG toolkit.
  - Development of collaborative arrangements / agreements for commissioning and joint working with key partners

# Enabling Area 3 – (Achieve Financial Balance) Key Priorities, Objectives & Measures

## Financial Planning Financial Plan 2013/14:

It will be significant challenge to balance the books over the next three years. However, with a strong and dedicated team, and a robust financial management process in place, South Sefton believes that it is well positioned to meet the challenges ahead.

NHS Sefton has agreed that 100% of the relevant CCG budgets area delegated to the respective CCGs. In relation to South Sefton CCG, this equates to £243,076k

The 2003/14 financial plan for South Sefton CCG is set out in table 1

The medium term financial plan has been structured in line with key factors and best practice as set out by the Audit Commission to address the following:

- Leadership - Demonstrating strong leadership of finances and strategic direction
- Support Strategic Objectives - Using the MTFP to support the achievement of strategic objectives
- Establish lines of accountability - Establishing lines of accountability for producing and adhering to the MTFP
- Risk Management -Producing an MTFP that identifies and manages the financial implications of risk
- Understanding CCG cost drivers and achieve value for money- Through the collection and analysis of a wide range of data and planning over the medium term to improve value for money
- . Data Quality - Recognising the importance of good quality data

- Content of the MTFP - Producing an MTFP that is comprehensive, accurate and has content that is relevant and useful
- Scrutiny and Challenge - Providing internal and external stakeholders with an opportunity to scrutinise and challenge the MTFP
- Approval and Communication of the MTFP - Ensuring Board approval of the MTFP and that the MTFP is communicated to the right people
- Using, achieving, monitoring and updating the financial plan - Using the MTFP as the key financial document, from which the annual budget is developed and puts in place the systems for achieving, monitoring and continually refreshing the MTFP

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

**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.

**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

## QIPP

The QIPP programme is a national Department of Health strategy which aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15.

This strategic plan sets out the schemes where there is a future pipeline for delivery in 2013/14 and beyond.

As well as the financial targets attributed to QIPP, there are a range of Quality, Innovation, Productivity and Preventative merits and benefits that have been delivered via the QIPP programme implemented in South Sefton. For more information on historic QIPP performance, please see the report "QIPP Celebrating Success 2009/10 – 2012/13".

### Foundations for future delivery

There are a range of schemes where strong foundations have been set for delivery in 13/14 and beyond with continued focus and drive. These include:

Schemes	Next Phases	Financial Impact 13/14 £000's
Tailored Care	Continued implementation of personalised agenda in each locality	£3,492
Information Technology	Roll out of range of schemes and initiatives and further consideration of broader system opportunities	
Estates	Continuation and implementation of estates review and opportunities identified	
Children's and Young People	Continuation of listening exercises and patient and parent education	
Cancer	Continued development of new specialised cancer centre for Merseyside	
Rehabilitation	Continued implementation of rehabilitation strategy and provision of additional services and delivery model	
Cardiac Rehab		
Open Access Diagnostics		
Virtual Wards		
Ophthalmology		
Out Of Hours		
IAPT		£0
111		
Prescribing		£1,148
Provider Contracts	Tariff Efficiency 4%	£7,052
<b>Total</b>		<b>£11,692</b>

These initiatives will evolve to include detailed milestones and deliverables to ensure the delivery of wider service and financial sustainability. The CCG also understands the importance of past learnings so that improvements can be made for future initiatives. This is particularly important around the triangulation of activity, quality and cost data to drive QIPP planning and assurance.

Crucial for success will be clinical input at every step of each initiative in conjunction with local commissioning and public sector bodies to develop new ways of working through productivity and innovation.

The CCG will also look to a continued working relationship with the NCB Local Area Team to ensure that QIPP initiatives are mapped across the North West so that efficiencies and synergies are utilised where possible.

The CCG has 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 – the CCG has made provision for 1% contingency reserve within the financial plans to deal with the costs of any unexpected growth in activity. The CCG will work with public health colleagues to review these assumptions over the coming weeks and months ahead; local metrics will be continually reviewed using key tools, such as 'Right Care', to help shape and influence our plans in respect of the needs of the local health economy

# Enabling Area 4 – (Enable Richer Public and Patient Engagement)

## Key Priorities, Objectives & Measures

### Engagement

In line with the Big Chat and Talking Health and Wellbeing events, the CCG are keen to make a quantum leap in the development of its engagement arrangements, and like quality, embed them at the heart of all the commissioning arrangements.

South Sefton CCG is keen to strengthen its engagement with patients and key stakeholders. It will build on engagement successes to date such as the 'Big Chat' and the partnership working with LiNKS which was an identified strength within the authorisation process. Our CCG Expert Patient Advisory Group (EPAG) is Chaired by our Lay Member who has a lead around patient and public involvement .

Clinicians in South Sefton have always set great store on engagement of patients in decision making and service re-design. For example, engagement of patients is at the heart of the diabetes pathway re-design, with a focus on patient education and co-production of the care plan.

There will also be programmed meetings with key stakeholders such as the Overview and Scrutiny Committee, emergent Health and Wellbeing Board, MPs, LMC and social care and local authority representatives. We will also actively seek patient views about how they can be more closely involved with decision-making on both individual and collective levels.

The outcome of the listening campaign will be an evaluation which will lead to a new and dynamic 'multi-channel' methodology for capturing and acting upon patient experience on an 'industrial scale'. This 'multi-channel' methodology will include:

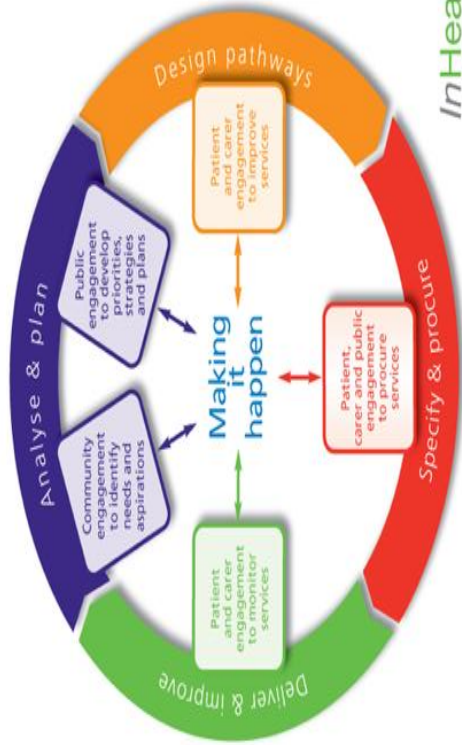
- Near time, post treatment, out-bound telephone follow-up interviews.
- On-line opportunities to comment on-line with moderated feedback and publication.
- Structured attitudinal surveys.
- Patient experience sampling across service lines and provider geography.
- Proactive mobilisation of community and voluntary groups to monitor.
- Primary care satisfaction surveys.
- Comments and notes boxes in every GP surgery.
- Requirements of providers to carry out satisfaction surveys in situ.
- Deliberative patient groups in every locality.
- Feedback loops to patients to demonstrate how their experience has been taken into organisational and contractual learning to make service changes.

The CCG will commission these services from an external agency to provide a regular and systematic monitoring of patient experience. This data will be reviewed by clinicians at monthly locality and CCG executive boards as a core metric in the quality dashboard and for contract monitoring and service development



We work with providers and partners to gather public insight into local health services, and our Quality Lead GP is working with Southport and Formby LINK and S&O 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:

## HOW SEFTON PATIENT AND PUBLIC INSIGHT INFORMS COMMISSIONING



### 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).

## SECURING PATIENT FEEDBACK

### WHO

- Comprehensive Stakeholder Database – segmented, and targeted for areas of interest
- Lay Board Members with lead for Public and Patient engagement
- EPEG (Engagement and Patient Experience Group) – Scrutinise and advise commissioners using auditable guide – reports through to the Board via the Quality committee - Takes reports from LINKs on Patient Experience data via community Champions Programme
- Patient Reference Groups in practices
- Targeted Patients and Carers – working with providers
- On-line two way feedback to and from the public via websites
- Partnership with VCS Networks to support hard to reach/relationships/trust
- Collaborative modelling with Council for Joint Commissioning insight plans (JSNA and JHWS)
- LINKS Community Champions Model at Locality level
- PALS Reports to the Quality committee
- Complaints & Compliments reporting to the Quality committee
- SUI Data Reports to the Quality Committee.

### HOW

- Annual Big Chats / Joint events with the Local Authority regarding the Health and Wellbeing strategy.
- Quarterly “Meet the Commissioner Events”
- Virtual Lay Reader Group for information and communication sense checking
- Tender and Procurement Training Opportunities
- Every commissioning work stream has a Communications and Engagement Plan that includes:
  - Scoping of the engagement activity to support the project
  - Stakeholder mapping and clarification of the level of influence of the stakeholders to be engaged
  - The engagement methods to be used, including lay members on steering groups or committees, focus groups, surveys etc., and
- The methods of feeding back to stakeholders on how their views/comments have influenced commissioning decisions.

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**

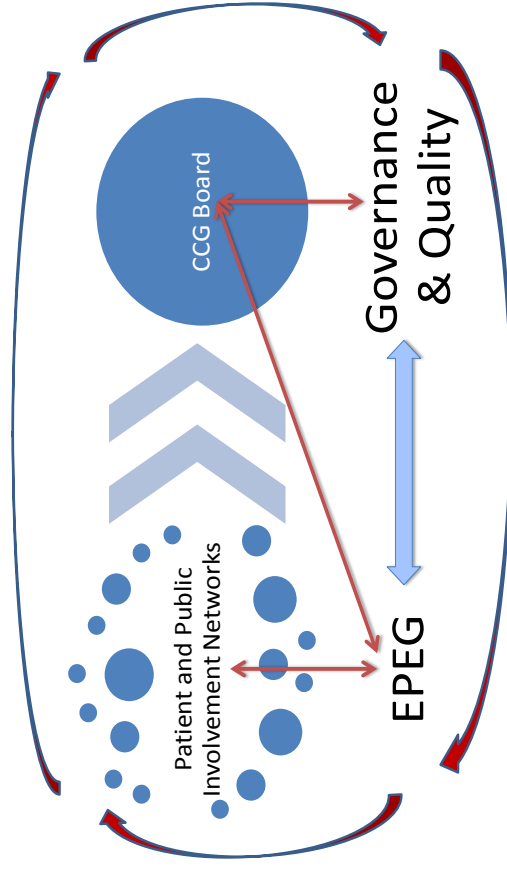
We will continue to:

- Work with the local Health and Wellbeing Board to assess population need
- Work with HealthWatch 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 3).

**CLOSING THE LOOP**



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, South Sefton CVS and South Sefton LINK. In future it is hoped members and officers of HealthWatch 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 HealthWatch to ensure that public involvement plans match local expectations for engagement at all levels.

### **Equality & Inequality**

The Cluster is reviewing EDS evidence with self assessment alongside providing training to enable grading of self assessment by wider Stakeholders. Equality Objectives will be drafted for verification by the Board leading to development of an Equality Strategy later in 2013. The Cluster and CCG will work together to develop performance measures to show how Equality Objectives will be met over the next 4 years.

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

There are a number of areas in this plan which will have a direct impact on reducing health inequalities, such as:

- Delivery of the South Sefton Cancer Strategy and the cancer access to treatment targets
- The new approach to long term conditions management
- The transformation of primary care programme

## Enabling Area 5 – (Build Stronger Partner Relations) Key Priorities, Objectives & Measures

The Health Economy in South Sefton and surrounding areas faces significant challenges for the foreseeable future, with aging populations and financial pressures from the centre. The best way to ensure a first class service to the population of South Sefton is to ensure that all the key stakeholders within the Health Economy are working in harmony.

Our commitment to you – our partners: those we work with to commission services and those who provide the services we commission

- We will build relationships based on openness, honesty and trust – this is a two way process
- As clinical commissioners we will work with you to ensure local health care is led by clinicians
- We want to develop partnerships that reward real improvements in quality and outcomes and where we share both risks and gains

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 & Formby CCG, Liverpool CCG and Knowsley CCG around the S&O NHS 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.

### **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.

# CCG Integrated Strategic & Operational Plan: 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	Consolidate robust CCG strategic plan within financial envelope Maintain systems to ensure quality and safety of patient care	Driving Improvement in Health & Wellbeing	Patient & Public Engagement	Unplanned	<ul style="list-style-type: none"> <li>Pro active case management</li> <li>Reviewing patient pathways with Aintree for emergency patients</li> <li>Support of the Community Geriatrician</li> <li>Supporting Nursing and Care Homes</li> <li>Investment in 111</li> <li>Risk stratification / Pro active case management</li> <li>Investment in Community services</li> <li>Health care acquired infections</li> <li>Roll out of Virtual Ward</li> </ul>	<ul style="list-style-type: none"> <li>Reduce emergency admissions to secondary care</li> <li>Reduce Follow Up Appointments</li> <li>Reduce Readmissions</li> <li>Redesigned community services to reduce hospital attendances and improve patient safety</li> <li>Increased independence of the frail &amp; old</li> <li>Reduction in avoidable admissions</li> <li>Increased non elective admissions over 65's – 5%, 13/14, 20% by 16/17</li> </ul>				
								<ul style="list-style-type: none"> <li>Primary Care L&amp;S primary care to improve diagnosis management of Vascular Health Checks</li> <li>Further investment in community respiratory services</li> <li>Primary care risk stratification</li> </ul>	<ul style="list-style-type: none"> <li>Reduced admissions with LTC as primary diagnosis</li> <li>Reduction under 75 mortality rates</li> <li>Earlier diagnosis of respiratory illness</li> </ul>	
Inequalities of health care	Deliver through establishment of PMO approach to CCG programmes Ensure CB&M CSU deliver successful support to the CCG	Optimising use of Secondary Care	The Francis Report	Long Term Conditions	<ul style="list-style-type: none"> <li>Performance management of IGH diabetes prevention pathway with Public Health colleagues against treatment targets and offer additional support to those not achieving</li> <li>Review training of staff in primary care in relation to diabetes</li> <li>Ensure patients receive foot care/screening</li> <li>Review multi-professional input into care homes</li> </ul>	<ul style="list-style-type: none"> <li>Increased numbers of unnecessary emergency admissions</li> <li>Increased numbers of people being returned to healthy lifestyle services</li> </ul>	<b>QUALITY PREMIUMS</b> Reducing potential years of life lost through amenable mortality Reducing avoidable emergency admissions			
								<ul style="list-style-type: none"> <li>Sustain engagement of CCG members, partners and stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Reduced length of stay</li> <li>Early identification of families in need of support to promote the safeguarding of Children &amp; Young People</li> </ul>	
Improving quality of life	Sustain engagement of CCG members, partners and stakeholders Drive clinical leadership development through Governing body, locality and wider constituency	Ensuring Cost Effectiveness in High Quality Tertiary Care	Any Qualified Provider	Diabetes	<ul style="list-style-type: none"> <li>Achievement of Care Programme Approach (CPA) follow up target</li> <li>Ensure full roll out of the access to psychological therapies programme to deliver a recovery rate of 50%</li> <li>Increase Dementia detection, including care home staff liaison (51% Referral Success Dementia strategy)</li> <li>Locality approach via psycho-geriatrician service</li> <li>Adoption of quality of life principles, safe models of care</li> </ul>	<ul style="list-style-type: none"> <li>Improved integration of services, including transition to Adult services</li> <li>Reducing emergency admissions and EG Asthma</li> <li>Reduced length of stay</li> <li>Early identification of families in need of support to promote the safeguarding of Children &amp; Young People</li> </ul>	<b>LOCAL PRIORITIES</b> Reduce Respiratory Disease admissions through A&E at Aintree Hospital Reduction in prescribing for three high risk antibiotics 1. Quinolones 2. Co-amoxiclav 3. Cephalosporins Reduce the number of GP referred patients (during normal working hours) who receive an A&E assessment before being admitted into Aintree Hospital care			
								<ul style="list-style-type: none"> <li>Programme Management Office</li> <li>CQUINS</li> </ul>	<ul style="list-style-type: none"> <li>Improved patient experience of hospital services – Ensuring roll out of Friends &amp; Family test</li> <li>Preventing healthcare associated infections</li> </ul>	
Care closer to home	Promote positive mental health & wellbeing Build capacity & resilience to empower & strengthen communities	Improving Quality of Primary Care and Delivery of Community Services	Information Management Technology Innovation	Children	<ul style="list-style-type: none"> <li>Review ADHD services</li> <li>Review of Children's Equipment Services</li> <li>Collaborative working with NCB/LA re: Health visitor and school health services</li> <li>Review the Health economy recommendations which result from the Youth offending service inspection</li> </ul>	<ul style="list-style-type: none"> <li>Patients receive care in the most appropriate setting and to improve the quality and experience of care for patients</li> <li>Reduced referrals to Secondary care</li> </ul>				
								<ul style="list-style-type: none"> <li>Value for Money through Finance and Contracting</li> </ul>	<ul style="list-style-type: none"> <li>Better Care Better Value benchmark indicators to support improved delivery of services</li> <li>Any Qualified Provider procurements podiatry, audiology and MSK</li> <li>Promote use of dysphagia pathway</li> <li>Commission Gynaecology community service pilot</li> </ul>	
Safe Care	Support Older People & those with long term conditions & disabilities to remain independent in own homes	Health and Wellbeing Board Objectives	Quality of Care	Prevention	<ul style="list-style-type: none"> <li>Develop CQUIN increase breastfeeding rates</li> <li>Develop an obesity strategy and clarify obesity treatment pathway</li> <li>Commission Alcohol Liaison Service at Aintree University Hospital</li> <li>Build capacity to facilitate the provision of Identification and Brief Advice (IBA) across ranges settings</li> </ul>	<ul style="list-style-type: none"> <li>Better Maternal Health / Early years health</li> <li>Reduce rate of alcohol related hospital admissions</li> <li>Reduce length of stay linked to alcohol related hospital admissions</li> <li>Increased skills/knowledge of Primary Care &amp; key stakeholders to identify those at risk of alcohol or drug dependency</li> <li>Reduced Obesity levels</li> </ul>				
								<ul style="list-style-type: none"> <li>Sustainable Change</li> <li>Promotion of Self Care</li> </ul>	<ul style="list-style-type: none"> <li>Ensure appropriate, timely Cancer treatment for our patients</li> <li>Improved survival rates through early detection</li> <li>Cancer Survivorship – Improved support for people and families affected by cancer</li> </ul>	
Financial Challenge	Seek to address social & economic issues which contribute to poor H&WB Ensure all children have positive start in life	CCG/ LA Joint Priorities	Clinical, Community, 3rd Sector collaboration	Primary Care Quality	<ul style="list-style-type: none"> <li>Compliance with cancer waits 31 and 62 day targets</li> <li>Peer review compliance</li> <li>Cancer CQUIN incentive 14 day key diagnostics pathway</li> <li>Optimise performance - Cancer referral 14 days</li> <li>Develop and implement the 111 Mark N&amp;EPI project</li> <li>Review CAB service for patients</li> <li>Undertake needs assessment for psychological support services / physical activity programmes</li> </ul>	<ul style="list-style-type: none"> <li>To increase the number of people at end of life dying in their normal place of residence + 1%</li> </ul>				
								<ul style="list-style-type: none"> <li>Sefton Needs Assessment</li> </ul>	<ul style="list-style-type: none"> <li>Improved quality, capability and productivity, and capacity of Primary care services</li> <li>Improved assurance that medicines are safe, appropriate, clinically effective and value for money</li> </ul>	
Winter Pressures	Children & Young People Adults Public Health	Fundamentals of Care	Sefton Needs Assessment	End of Life	<ul style="list-style-type: none"> <li>Develop End of life strategy</li> <li>Hospice at Home</li> <li>End of Life Facilitator</li> </ul>	<ul style="list-style-type: none"> <li>Develop Primary Care strategy</li> <li>Support improvements using the Quality Premium</li> </ul>				
								<ul style="list-style-type: none"> <li>Clinical, Community, 3rd Sector collaboration</li> </ul>	<ul style="list-style-type: none"> <li>Role out Optimisation plan across GP</li> <li>Patience education to reduce waste</li> </ul>	
Everyone Counts			Patients' Rights: The NHS Constitution		Patient Centred, Customer Focused		Transformation of Health and Social Care at CCG Level		Financial Planning	

## CCG Plan on a Page – Focus for Years 2 and 3

	2014-2015 (Year 2)	2015-2016 (Year 3)
Programmes / Enablers Medicines Management	To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money	To optimise prescribing and outcomes for patients by ensuring medicines used are safe, appropriate and are both clinically effective and provide value for money. ( This is day to day activity, responding to the needs of practices across the organisation )
Medicines Management	To ensure medicines management support is tailored to the individual constituent practice to meet both clinical governance and quality needs. ( building from the practice up to the organisation to support the unique requirements of practices and being able to respond with more clinical support if required )	To tailor medicines management support for care closer to home programme objectives in conjunction with providers.
Medicines Management	Where appropriate, assess and agree transfer of prescribing budget with providers to ensure both clinical governance and fiscal responsibility remain with the prescribing organisation.	
Organisational Development	Re-procurement of CSU provision for October 2014 to ensure effective on-going commissioning support.	Mature and fully empowered localities with significant increased budgetary and commissioning responsibilities and influence, underpinned by optimal use of the Intelligence Portal.
Organisational Development	Demonstrable broadening and strengthening of clinical leadership capacity and capability at Board, Locality and Practice level.	Demonstrable track record of significant transformational changes delivered within the system through the programme management approach
Organisational Development	Fully embedded engagement and patient experience systems (in conjunction with key partners LA, CVS, Healthwatch, Patient Reference Groups) which evidence a wealth of examples of changes made as a result of patient and public feedback	Reputation – the CCG continues to develop high levels of confidence, trust and respect amongst all stakeholders building on its first two years of operation, which has helped it to manage and plan for difficult decisions around healthcare affecting its patients, public and wider stakeholders
Urgent Care	Continue to review the impact of work with providers and primary care to manage the system for urgent care to ensure patients are treated in the right place and monitor the urgent care team aspects of the virtual ward model	
Integrated Care	Monitor and assess the impact of the virtual ward following its implementation stage	
Locality Development and Estate Review	The estate review should allow the CCG to improve care closer to Home and access to diagnostics in the locality 'hub and spoke' model	

Long Term Conditions		Promoting self-care for patients would be a priority at this time following the roll out and monitoring of the Virtual ward.
Frail Elderly		The CCG will continue to assess the on-going health care needs of these patients to reduce dependence on hospital services
Primary Care Development		The CCG will continue to promote a more collaborative locality approach to health care in the local area and invest in primary care

# Delivery Area 1 – (Improve Quality & VFM through redesign)

## Key Priorities, Objectives & Measures

**Quality is at the heart of everything the CCG does.** Quality in the CCG is driven by identified GP Clinical Leads with support from the Chief Nurse and other members of the CCG senior management and locality team. Our GP Clinical Leads for quality & contract performance together with the GP Clinical Pathway Leads work closely to ensure that quality is owned within the wider constituent membership and embedded into the CCG commissioning cycle.

The CCG recognises the importance of ensuring quality and is developing its approach to quality, with a focus on clinical leadership and embedding quality in the commissioning and contracting process. The CCG wishes to ensure that its approach to contracting and quality concentrates on the following major areas:

1. **Patient experience** – both more effectively acting upon what patients tell us and strengthening their voice in service improvement and in targeting specific aspects of patients experience, such as personal dignity and communication
2. **Safety of clinical services:** targeting areas of concern raised by external intelligence
3. **Local intelligence** including proactive assurance of performance against national standards and ensuring that action from lessons learnt is taken effectively
4. **Good clinical practice.** Ensuring that clinicians and services are systematically working to accepted good practice guidelines, and that there are good systems of clinical communication that are timely, accurate, relevant and systematic
5. **Agreed pathways of care,** ensuring the effective adoption by primary, community and secondary care services of agreed care pathways in South Sefton, with care indicators that measure the quality of a whole pathway of care
6. **Commissioning intentions** and implementing new models of service delivery

In each area there will be a strong emphasis on integration of care between providers, primary, community and secondary, with the CCG recognising its responsibility as a partner to ensure that primary care works effectively as part of the health system. The CCG understands integration to mean the effective management of care for a patient between providers, requiring collaboration and communication. From the patients perspective we need to ensure that the service they receive is coherent and of high quality. That requires individual NHS providers to provide good quality care, but it also requires collaboration between organisations and clinicians to make sure that the patient is the focus of how care is provided. Promoting and supporting that collaboration will be a key feature of the contracts with providers.

This will centre on an approach that:

- Incorporates common indicators across individual Trusts, to support
- integrated working and improved communication
- Is actively led by clinicians
- Motivates staff and focuses on direct patient care, at team or ward level



## Value and Value For Money (VFM):

Value for money' (VFM) is a term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it. Some elements may be subjective, difficult to measure, intangible and misunderstood. Judgement is therefore required when considering whether VFM has been satisfactorily achieved or not. It not only measures the cost of goods and services, but also takes account of the mix of quality, cost, resource use, fitness for purpose, timeliness, and convenience to judge whether or not, together, they constitute good value. (As described by HEFCE)

"Value in any field must be defined around the customer, not the supplier. Value must also be measured by outputs, not inputs. Hence it is patient health results that matter, not the volume of services delivered. But results are achieved at some cost. Therefore, the proper objective is... patient health outcomes relative to the total cost (inputs). Efficiency, then, is subsumed in the concept of value."

Source: Porter ME. (2008). What is Value in Health Care? Harvard Business School

Achieving VFM is also often described in terms of the 'three Es':

- **Economy** - careful use of resources to save expense, time or effort.
- **Efficiency** - delivering the same level of service for less cost, time or effort.
- **Effectiveness** - delivering a better service or getting a better return for the same amount of expense, time or effort.

**South Sefton will strive for Best practice** and this will require a well-planned, thorough and clear approach to all activities which will be delivered through the Programme Management Office (PMO). However, procedures by themselves are not necessarily sufficient, since the achievement of VFM requires **an attitude and culture that seeks continuous improvement**. The main benefits of promoting VFM principles are:

- **The clarification of objectives.** Rather than acting on assumptions about what is required, VFM principles will give managers a proper assessment of the objectives of an activity. This will maximise their chance of achieving the desired ends without unnecessary expenditure and effort.

- **Planning** is an essential part of all well managed processes. Good planning minimises the risk of an activity failing to deliver the intended outcome, at the right time and at the right price.
- **Openness and transparency of process.** Through properly documented planning and assessment, and the adoption of open processes involving all interested parties, organisations can publicly demonstrate a commitment to achieving propriety as well as VFM.
- **Compliance with statutes and regulations.** All organisations need to comply with legal and other associated requirements. By adopting good practice, the risk of failing to identify and comply with such requirements is significantly reduced.
- **Risk assessment.** All activities have risks attached. These include, for example, a reputational risk, control risk, financial risk (including financial health risk), health and safety risk, and a business risk. Risk assessment is an area that can often be improved. Although it is often not necessary to undertake a full risk assessment for every activity, an inadequate risk assessment, particularly for significant activities, can result in poor value for money.

A description of a value organisation is one that makes arrangements to secure continuous improvement in the way in which its functions are exercised. The objective of this continuous improvement in a CCG is to deliver optimally economic, efficient and effective healthcare services (systems).

The three areas of focus for an organisation seeking continuous improvement are:

1. Managerial processes and systems.
2. The inputs and processes by which services are provided, by and/or for the Organisation.
3. The achievement of outcomes in line with intent – that is, outcomes that meet the appropriate objectives of the service.

The CCG will endeavour, through its strategy, objectives and operations to give due focus to these areas and adopt best practice in delivering optimal internal business processes that drive continuous improvement in the local healthcare system.

### Systems Review

Systems, or service review, is a key tool in driving continuous improvement towards optimal value. A systems review is an assessment of the inputs and processes to ensure they are economic and efficient. The key, when looking at a current service, is to identify the existence of waste:

- For inputs, waste constitutes an input that could be more cost effectively provided.
- For processes, waste constitutes an activity that adds nothing to the outcome or delivers an outcome that is not of value.

With regard to the latter, value assessments – such as in workstreams that deliver clinical policies, referral thresholds and protocols – are built into the delivery of projects and programmes prioritised in this strategic plan.

The above description of value and continuous improvement towards value, alongside the tools and approaches described, is a foundation stone in the design of the CCG's overall reform business process and informs its workstreams, service reviews and reform project generation and prioritisation.

The following pages provide more detail on each of the key programme areas.

## D1 Programme 1 - Unplanned Care

**A&E waits** – The CCG will 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

- patients get the best possible outcomes,
- reduction in emergency admissions by better managing people in the community.

**Category A ambulance calls** – The CCG will 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.

**The 111 helpline** will be made available in 13/14 and will provide support 24 hours a day, every day of the year. It is intended for 'urgent but not life-threatening' health issues and complements the long-established 999 emergency telephone number for more serious matters. The 111 operators are able to dispatch ambulances when appropriate.

**Ambulatory care sensitive conditions** (ACSC) are a group of 19 chronic or acute diseases for which hospital admission in adults may be avoidable by effective management in primary care. They fall into three groups – those preventable by vaccination; those avoidable through secondary prevention or better patient self-management; and those amenable to lifestyle interventions. The most frequent constituent conditions are angina, asthma, chronic obstructive pulmonary disease, cellulitis, complications of diabetes, heart failure, gastroenteritis and dehydration, epilepsy, iron deficiency and pyelonephritis. Productivity metrics identify potential savings from hospital admissions that could be made if CCGs are able to reduce admission rates to that of the best 25% in the country.

# D1 Programme 1 - Unplanned Care – Plan on a Page



South Sefton Clinical Commissioning Group

**Programme: Unplanned Care**      **Clinical Lead: Dr Andy Mimmagh**

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	TAR GET	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 £
2013/14	SAVINGS £
2014/15	
2015/16	
Total	



**Programme: Virtual Ward**

**Clinical Lead: Dr Peter Chamberlain**

South Sefton Clinical Commissioning Group

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: <ul style="list-style-type: none"> <li>Integration - Holistic integrated health and social care system at the community level.</li> <li>Long Term Conditions - Improve secondary disease prevention</li> <li>Information Technology - Empowering clinicians, facilitating communication &amp; rapid patient flow.</li> <li>Self-Care Approach - Empowering patients, families and carers.</li> </ul> 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 21 <sup>st</sup> 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.

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)

## D1 Programme 2 - Long Term Conditions

South Sefton has higher than average levels of long term conditions. Contributory lifestyle factors (excess drinking, smoking, lack of exercise & poor diet) are improving but still vary across the borough. Asthma, kidney disease, CHD, dementia and diabetes are all areas of concern....

### Dementia

We plan to continue improvements to dementia services for patients and carers in 2013-14 and actions include:

- Refresh of the South Sefton Dementia Strategy 2009-14 in line with recent policy changes, including the targets in the Prime Ministers Dementia Challenge. Both diagnosis and understanding of the condition are key to making a difference to people's lives
- Voluntary, community and faith sector services include awareness raising across South Sefton and support for carers
- Alzheimer's Society commissioned to lead on awareness raising and community support via Community Coordination workers. They also provide the following - Singing for the Brain®, Music and Wellbeing Therapy, Reading Aloud, Maintaining Skills Group, Carers Educational Course
- Continue to share good practice across South Sefton Dementia Action Alliance with statutory, voluntary, community and faith sector

The diagnosis rate we are aiming for in 2013-14 and 2014-15 is an increase from 51% to 75% by 2015-16 in line with GMS Contractual Changes 2013-14, through an enhanced service for Dementia Case Finding.

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%

- 'Care Closer to Home' and 'Virtual Ward' approaches 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 Sefton

- 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
- Asses 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



**Programme: 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



# D1 Programme 3 – Diabetes



**South Sefton Clinical Commissioning Group**

**Programme: Diabetes**      **Lead Clinician: Dr Nigel Taylor**

OBJECTIVE	WHY CHANGE IS NEEDED?	DESCRIPTION
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)	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 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 the 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	<ul style="list-style-type: none"> <li>Performance management of IGR diabetes prevention pathway (activity to include annual review, patient education and weight management) – work with public health</li> <li>Explore the benefits of commissioning education for patients with established diabetes</li> <li>Improve recording of all nine care processes using the diabetes dashboard</li> <li>Benchmark practices against treatment targets (HbA1c, blood pressure, cholesterol) and offer additional support to those not achieving.</li> <li>Review training needs of staff in primary care in relation to diabetes</li> <li>Ensure patients receive foot care/screening as agreed within Nice Guidance the foot care pathway as agreed by North Mersey Network Group</li> <li>Review multi-professional input into care homes for residents with diabetes</li> <li>Explore the potential working with intermediate care to increase care closer to home.</li> <li>Work with secondary care to understand diabetic patients flow through improved coding of data</li> <li>Ensure that patients are discharged as appropriate from secondary care to be managed in a primary/community setting</li> <li>Encourage healthy lifestyles in particular to reducing obesity levels</li> </ul>

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	Potential use of PC investment (£3/head)			
Lack of capacity within GP practices	Primary Care Quality Strategy			
Educational issues	Use of protected learning times			
WORKFORCE IMPLICATIONS				
None at this time				
RESOURCE IMPLICATIONS				
YEAR	INVESTMENT £	SAVINGS £		
2013/14				
2014/15				
2015/16				
Total				

## D1 Programme 4 – Mental Health



### Programme: Mental Health

### Lead Clinician: Dr Ricky Sinha

South Sefton Clinical Commissioning Group

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	11%	11%	15%	

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		

## Mental Health - Military/Veteran Health

### Military Veteran health

The North West is the largest recruitment area for the British Armed Forces and accounts for 33% of the annual intake - in comparison to other regions. It is estimated that nearly 20% of all Military Veterans may suffer with anxiety and/or depression upon leaving the Services with a smaller percentage suffering from Post-Traumatic Stress Disorder and alcohol/substance misuse.

#### 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 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 (see appendix 5) commissioning of services for Armed Forces Veterans, Reservists (when not mobilised) and Armed Forces Families (serving, reservist or veteran) are the responsibility of the CCG in each area. CCGs will also be responsible for the commissioning of emergency care services for veterans and family member in their area. It is also

recommended that the hosting of the Armed Forces Network will be handed over to CCGs from the SHA.

Sefton Community Voluntary Services have led on the establishment and servicing of a Sefton Armed Forces Community Covenant Partnership to coordinate 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.

All CCGs across Merseyside were asked to consider continuation funding of 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 and Southport & Formby CCGs (SS & S&F CCGs) have signed up to this for 2013-2014. The funding will be used for providing access to veterans to the MV IAPT Service which is Psychological therapies service based on the original IAPT model but adapted for ex and current Service Personnel and their families. This project is hosted by Pennine NHS Foundation Trust

The NHS is also supporting the Live at Ease Project – This project supports ex-service men/women to adapt to civilian life. The support includes help with housing, accommodation, employment, training, and debt advice and drug and alcohol dependency issues. The project will also support family members.

Liverpool Public Health Observatory is currently carrying out a health needs assessment for ex armed forces personnel and their families, on behalf of Merseyside and Cheshire Directors of Public Health. Initial findings have identified families:

- Have poor access to health and wellbeing advice
- Have depression, reliance on alcohol and anxiety as being common within service families
- Worry about a husband/wife/partner who is away on active service

- Struggle to cope alone and with children
- Live far away from their immediate family, lack of immediate support
- Have a limited social network, moving around prevents friendships and support networks forming
- Have financial insecurity, unable to work due to house moves and caring commitments.

- Suffer domestic abuse as both victims and perpetrators

There are no definitive figures on the total number of veterans in the UK at the present time. Estimates produced in 2007 by the Office of National Statistics in conjunction with the Royal British Legion (RBL). RBL extrapolated the findings of this survey to provide an estimate of 4.8 million veterans in the UK, with approximately 3.9 million in England. This equates to approximately 8% of the UK population aged over 16 years and over.

Local Authority	16-24yrs	25-34yrs	35-44yrs	45-54yrs	55-64yrs	65-74yrs	75+yrs	Total	Total Under 65yrs
*Sefton	516	797	1,996	2,282	2,400	6,569	9,567	24,128	7992
*Please note information currently not available at CCG level									

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.

SS & S&F CCGs 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.

## D1 Programme 4 - Mental Health (Dementia)



**Programme: Dementia**      **Lead Clinician: Dr Ricky Sinha**

South Sefton Clinical Commissioning Group

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.

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	

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.

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

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

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

## D1 Programme 4 - Mental Health (Learning Disabilities)



### Programme: Learning Disabilities

### Lead Clinician: Dr Ricky Sinha

South Sefton Clinical Commissioning Group

OBJECTIVE	WHY CHANGE IS NEEDED?	DESCRIPTION	KEY MILESTONES	Q1	Q2	Q3	Q4
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)		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.	Local register of people with challenging behaviour for NHS funded care.				
		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.	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	1 <sup>st</sup> April 2013 Action plan			
Annual Health Checks	Yearly			
RISKS		MITIGATING ACTIONS		
WORKFORCE IMPLICATIONS				
RESOURCE IMPLICATIONS		INVESTMENT £	SAVINGS £	
2013/14		£60,000 for Annual Health Checks		
2014/15		Possibly NCB investment		
2015/16				
Total				

## D1 Programme 5 – Children’s



**Programme: Children**

**Lead Clinician: Dr Wendy Hewitt**

South Sefton Clinical Commissioning Group

OBJECTIVE
<p>Improve outcomes for children through integrated commissioning and service delivery (Domain 1,2,3,4,5)</p>
WHY CHANGE IS NEEDED?
<ol style="list-style-type: none"> <li>1. Alder Hey are not providing the same support in South Sefton as exists in North Sefton from LCH</li> <li>2. Service restructured to improve access and outcomes on previous poor performance</li> <li>3. ADHD has no agreed multi-disciplinary pathway – works on historic practice</li> <li>4. Demand for children’s equipment has significantly increased</li> </ol>

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

DESCRIPTION
<p>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</p>

WORKFORCE IMPLICATIONS

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

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

**Programme: Children**      **Lead Clinician: Dr Wendy Hewitt**

South Sefton Clinical Commissioning Group

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
Reduced A&E attendances at point of primary care	N/a			CCNT activity aims to reduce PBR activity/income to meet service costs, therefore cost neutral
Reduced length of stay	N/a			

OBJECTIVE
<p><u>Children's Community Nursing Team</u>                      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)</p>

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

WHY CHANGE IS NEEDED?
<p>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.</p>

WORKFORCE IMPLICATIONS
<p>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.</p>

DESCRIPTION
<p>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</p>

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

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				



## D1 Programme 6 – Planned Care



### Programme: Planned Care    Lead Clinician: Dr Peter Chamberlain    South Sefton Clinical Commissioning Group

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		

## D1 Programme 7 - Prevention

For the NHS to be sustainable in the 21st century, it needs to focus on improving health as well as treating sickness.

This is not just the right thing to do for patients, but it is also a financial necessity. The benefit created by an NHS that promotes health, self-care and early intervention, and that integrates services around patients, is potentially sizeable, amounting to billions of pounds.

We will need to work more effectively with national and local partners, including local authorities and the third sector, to make a stronger contribution to promoting health and to ensure easier access to prevention services.

We will also need to think innovatively about how we can engage with other stakeholders, such as the life sciences industry, to achieve these aims.

Our prevention focus in this strategic plan is based around alcohol, obesity and maternal health.

## D1 Programme 7 – Prevention (Alcohol Services and Addiction)



South Sefton Clinical Commissioning Group

**Programme: 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.

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

The funding of this service is reliant on 3 separate CCGs

Sefton MBC is tendering for a new integrated substance misuse provider - possible implications for current pathways

### MITIGATING ACTIONS

Negotiate with Knowsley & Liverpool CCGs re continued investment in the service

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

KEY MILESTONES	Q1	Q2	Q3	Q4
To be agreed				

## D1 Programme 7 - Prevention (Obesity)



**Programme: Obesity**      **Lead Clinician: Dr Steve Fraser**

South Sefton Clinical Commissioning Group

OBJECTIVE	Q1	Q2	Q3	Q4
Develop an obesity strategy and clarify obesity treatment pathway. (Domain 1,2,4,5)				
<b>WHY CHANGE IS NEEDED?</b>				
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.				
<b>DESCRIPTION</b>				
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				
<b>KEY MILESTONES</b>				
Sefton wide obesity strategy agreed				
Every contact counts implemented				
Review bariatric surgery pathway				

PERFORMANCE INDICATOR	TARGET	2013/14	2014/15	2015/16
<b>RISKS</b>				
Funding only ring fenced for 2 years	Value for money evidenced			
<b>WORKFORCE IMPLICATIONS</b>				
<b>RESOURCE IMPLICATIONS</b>				
	YEAR	INVESTMENT £	SAVINGS £	
	2013/14			
	2014/15			
	2015/16			
	Total			

# D1 Programme 7 - Prevention (Maternal Health)



**Programme: Maternal Health**      **Lead Clinician: Dr Steve Fraser**

South Sefton Clinical Commissioning Group

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 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		

# D1 Programme 8 – Cancer



## Programme: Cancer

### Clinical Lead : Dr Debbie Harvey

#### South Sefton Clinical Commissioning Group

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

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
<ul style="list-style-type: none"> <li>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</li> <li>Provide support ( Cancer Network NAEDI project) to encourage reflective practice in relation to the management of potential cancer symptoms by general practitioners</li> <li>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</li> </ul>

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

RISKS	MITIGATING ACTIONS
Lack of engagement by practices	Work through localities and educational opportunities
Delays in data provision	Work with the data provider
Sustainability of project manager roles	Review workload on regular basis

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		

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			

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

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

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

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

**Programme: Cancer**      **Clinical Lead: Dr Debbie Harvey**

**South Sefton Clinical Commissioning Group**

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%

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

RISKS	MITIGATING ACTIONS

WORKFORCE IMPLICATIONS

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

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



**Programme: Cancer**      **Clinical Lead: Dr Debbie Harvey**

South Sefton Clinical Commissioning Group

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

**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.

RISKS	MITIGATING ACTIONS

**WORKFORCE IMPLICATIONS**

**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

**RESOURCE IMPLICATIONS**

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

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

## D1 Programme 9 - End of Life Care



### Programme: End of Life

### Lead Clinician: Dr Debbie Harvey

### South Sefton Clinical Commissioning Group

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)
<b>WHY CHANGE IS NEEDED?</b> 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.

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	Engagement strategy			
Funding for EOL Care Home Facilitator not available after October 2013	Business case to Finance & Resource committee			
Patients not being identified as being at end of life	Full review of pathway			

DESCRIPTION
<b>Hospice at Home</b> 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. <b>End of Life Care Home Facilitator</b> 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.
<b>WORKFORCE IMPLICATIONS</b> No End of Life Care Home Facilitator

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		

# D1 Programme 10 – Primary Care Quality



## Programme: Primary Care Quality

**Clinical Lead: Dr Bal Duper**

South Sefton Clinical Commissioning Group

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 <ul style="list-style-type: none"> <li>• practice demographics</li> <li>• Workforce development</li> <li>• Clinical services particularly primary care through locality model</li> <li>• Premises / estate management</li> <li>• IT</li> <li>• Health outcomes of primary care activity</li> </ul>				
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				

## D1 Programme 11 – Medicines Management



**Programme: Medicines Management**    **Lead Clinician: Dr Steve Fraser / Jill Thomas**

South Sefton Clinical Commissioning Group

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				

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

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.

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

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

## 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.

### 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

## D1 Local a) - 1) To bring about a reduction in Respiratory Disease 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 Aintree Hospital, through 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 Respiration because it would bring about a real quality improvement for patients and would demonstrate sufficient "stretch" compared to the 0% of the national target.

It should be noted that target would exclude any impact of an influenza epidemic.

South Sefton Local Priorities Mapping			
To bring about a reduction in Chronic Obstructive Disease (COPD) admissions through A&E at Aintree Hospital			
Health and Wellbeing Strategy Priorities 2013 – 2018	South Sefton CCG Commissioning intentions	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
<p><b>Strategic Objective</b></p> <p>Support Older people and those with long term conditions and disabilities to remain independent in their own homes.</p> <p>Consultation and engagement identified that the following was important :-</p> <p>“ 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</p>	<p><b>Commissioning intentions</b></p> <p><b>Improving Primary Care</b></p> <p>Health Checks – continuing to promote the scheme to detect those at risk of heart disease and diabetes</p> <p><b>Improving Community care</b></p> <p>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.</p> <p><b>Long term conditions</b></p> <p>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</p> <p><b>Improving the use of hospital care</b></p> <p>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 use of emergency services to South Sefton residents.</p> <p>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</p>	<p>“Access to timely services”</p> <p>“proper and effective advice and support for people with long-term conditions.”</p> <p>“Self-help support. Need to distinguish when self-care is appropriate and when it is appropriate to seek professional”</p> <p>“As soon as the patient is diagnosed with LTC/WHATEVER, get the Proper Discharge Planning in place – NOT SELECTIVELY</p> <p>Everyone to get same service level to eliminate gaps in Discharge planning”</p> <p>“Thinking of the virtual ward, can the patient still get a second opinion?”</p> <p>“The challenge of multi complex health needs, i.e. Lung disease, COPD, Cancer etc.”</p> <p>“Tele health technology”</p> <p>“Virtual wards – keep people at home and deliver services”</p> <p>“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.”</p> <p>“Try to get appropriate use of secondary care”</p>	<p>“ More access to services at a local level , rather than going in to hospital –using voluntary and community organisations locally” (Bootle)</p> <p>“Better respite for long term illness sufferers and better promotion of these services” (Bootle)</p> <p>“Give confidence in self-management” (Bootle)</p> <p>“Hospital at Home service will positively support older people with long term conditions” (Maghull)</p> <p>“Virtual Ward and Long term conditions objectives – a good idea” (Maghull)</p> <p>“more social care in hospital to support discharge” (Maghull)</p>

## D1 Local b) 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 HCAs, has been the prescribing of high risk antibiotics both in primary and secondary care, without an appropriate indication according to local or national guidance.

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 be an offer to audit prescribing activity of the three antimicrobials and linking to appropriate / inappropriate indications.

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

**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

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



### D1 Local c) 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 booked in via 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.

## South Sefton Local Priorities Mapping

To bring about a reduction in prescribing for three high risk antibiotics			
Health and Wellbeing Strategy Priorities 2013 – 2018 Strategic Objective	South Sefton CCG Commissioning intentions <b>System Wide Improvements</b>	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
Support people early to prevent and treat avoidable illness and reduce inequalities in Health	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 niggles."	" Take control of own lives , manage sickness" (Boothle)  " Stop pharmacy repeat prescriptions service" (Crosby)
Consultation and engagement identified Find different ways to support people early to avoid them needing expensive acute services and surgical procedures		"Look at prescriptions— issue of wasted repeats"  "Understanding when to access services ie campaigns for coughs"	"Cost of medication not being used"

To reduce the number of GP referred patients who receive and AED assessment before being admitted to Aintree Hospital			
Health and Wellbeing Strategy Priorities 2013 – 2018 Strategic Objective	South Sefton CCG Commissioning intentions <b>System Wide Improvements</b>	Feedback from Big Chat	Feedback from Sefton Strategic Needs Assessment Consultation
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	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)

## Delivery Area 2 – (Improve Quality and VFM through Contracting & CQINS) Key Priorities, Objectives & Measures

During the next few years the CCG wishes to develop alternative approaches to contracting that better support integrated working between primary, community and secondary care and place quality at the heart of the contracting process. In agreeing contracts for 2013/14 the CCG wishes to anticipate those developments by laying foundations for this changed approach, by maximising the potential in existing contracting arrangements towards supporting its aims for quality.

The CCG regards contracting as a major lever, for both commissioners and providers, in driving attention to improved performance in the quality of health and health care in South Sefton. It wishes to see contracting used as an integrated part of its commissioning processes to support the focus on quality.

The CCG will utilise the following contract levers to ensure that we obtain the best VFM from the Trust. The following clauses from the National Contract 2013/14 will be of particular importance for the CCG going forward:

SC7.2 - "The provider may reject a referral on the grounds:  
SC7.2.1 - Of any service limitations in the service specifications set out in Schedule 2 Part A; or...SC7.2.3 That a prior approval request made by the provider under the prior approval scheme has been rejected by the commissioner"

SC7.9 - "Unless a relevant Prior Approval Scheme applies, the Provider must not carry out, nor refer to another provider to carry out, any non-urgent or routine physical treatment and/or care that is unrelated to a Service User's original Referral or presentation without first consulting the Service User's GP"

SC10.1 - "The provider must share decision making...with the relevant service user, carer and legal guardian"

SC12.2 - Providers must demonstrate SDM to the commissioner on request.

SC29.4 - "The Provider must manage Activity in accordance with any caseloads, occupancy levels and clinical thresholds set out in the Service Specifications and Activity Planning Assumptions and/or published in Choose and Book. The Provider must:

SC29.4.1 - "comply with the reasonable requests of the Commissioners to assist the Commissioners in understanding and managing Referrals;

SC29.4.2 - "and require its agents, sub-contractors and employees to adhere to any Referral and treatment protocols that may be agreed between the Parties"

CQUIN will be agreed in 2013/14 and beyond as an incentive to improved performance. This may be performance beyond that nationally mandated or in areas of specific local concern. CQUIN will not be used to incentivise practice or performance which would normally be expected to be delivered as part of the national NHS contract. In line with national guidance, targets previously incorporated within local CQUIN schemes will be incorporated within the main contract, with CQUIN focussing on new areas of improvement or higher levels of performance in areas that remain a priority.

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.

The CCG wishes to work supportively with its NHS Provider partners to ensure that we have a small number of highest priority areas that remain at the top of our agenda, and drive our overall approach to quality care. These will be:

1. **Service Reviews.** We will work with Aintree to develop a shared understanding of Hospital Mortality data (SHMI) and the NHS Atlas of Variation. The reviews will be against NICE or best practice guidelines with the review scope jointly agreed with Commissioners. Improvement plans, where required, will be jointly agreed between commissioners and providers and progress monitored through the Quality- Contract Meetings
2. **Lessons Learnt.** S&O will be required to report regularly on the outcome of lessons learnt from complaints, serious incidents and external service reviews, providing evidence of the effective implementation of lessons learnt or agreed action plans
3. **The Clinical Senate,** will meet monthly to share and review clinical data to improve the quality of care and health outcomes
4. **Collaborative working.** The Trust will be invited to include within its contract a 'shared incentive' approach to two designated clinical areas, that through collaborative working across all providers will improve the quality of care for patients. Targets will be agreed that share the commissioning expenditure 'saved' in each area across the commissioner and participating providers.

### The CCG will:

- Not pay a Trust for care carried out that is agreed locally or nationally as a 'never' event
- Reduce the total contract payment to a Trust should the Trust be in receipt of an improvement notice from the CQC.

Clear expectations for performance and quality are embedded in the CCG's relationship with its providers, with all quality and performance standards mapped against the NHS Outcome Framework, developed in collaboration with the CSU.

The CCG is developing its governance arrangements and its intelligence systems with clinical leadership, through forums such as Clinical Advisory Groups where clinical leaders from all Trusts address outcome, service quality and development issues in open discussion and work projects across Trusts.

The CCG's localities ensure clinician and patient feedback are as close to the patient as possible, with delegated authority to address local issues. This local intelligence, is brought together with information from a broad range of data sources ( lessons learnt, public health mortality and trend data, etc) to proactively identify quality issues for action at local, or countywide level.

Quality contracting meetings will be appropriately supported at Director level with clear communication between and within organisations.

Each quality component of the contract, individual targets and major areas of focus, will have a named clinical lead from the CCG and from the NHS Provider Trust.- It is expected that this lead will be a Consultant, GP or Senior Clinical Professional at an equivalent level

The provider Quality and Contract Performance Meetings are lead by our CCG Clinical Leads with support from the senior management team and the Commissioning Support Unit. From 2013/14 onwards the recommendations from the Francis Inquiry, the vision set out within the national care strategy

'Compassion in Practice' (NCB 2012) and the Friends and Family Test feature strongly within the quality elements of our local provider contracts. Quality and Performance reporting is a standard agenda item at every Quality Committee and Governing Body Board Meeting.

During the next few years our CCG wishes to develop alternative approaches to contracting that supports integrated working and has quality at the heart of the process.

In 2013/14 our CCG will be working in collaboration with a neighbouring CCG to progress work regarding the introduction of an Alternative Quality Contract with a local NHS Integrated Care Organisation.

Contracting is an important part of commissioning for quality and improved outcomes and our CCG will agree local CQUIN schemes with providers who meet the nationally set pre-qualification criteria in order to focus on higher levels of performance that are a priority locally. If a provider fails to meet the expected level of performance as outlined within the contractual agreement for the CQUIN then it is likely that payment will not be made.

The CCG is in the process of further developing its commissioning support arrangements from the Commissioning Support Unit who will provide the necessary support to assist the CCG in delivering our commissioning responsibilities through the contracting processes.

### Key performance indicators (KPIs)

We have a clinical lead for quality who, with our Lead Nurse, will develop our KPIs with 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.

## Appendix 1 (Health related data for South Sefton)

- The population of Sefton (as a whole) 2010 is 272,900 and has declined each year since 1989
- The average life expectancy for Sefton males is 77 years and for females it is 82 years, both of which are below the England averages of 78.6 years
- Sefton's 65+ population is 56,300 accounting for 21% of the total
- Sefton's 0-15 years population is 47,340 (17%)
- Sefton children aged 4-5 years, 10.4% are classed as overweight or obese this rises to 21.3% at 10-11 years, and both figures are above the England average
- Sefton's CO2 Emissions (tonnes) per head: total is 5.2t for 2009 an improvement of 5.5% on 2008, with this year's figure is better than the English average
- 85.4% of Sefton's older people have achieved independence through rehabilitation/intermediate care this is higher than the all England average and has improved by 3% since 2009/10
- Sefton scored 19.4 out of 24 for self-reported experience of social care users
- 1,110 of adults aged 65+ in Sefton are receiving home care service's this is lower than the England average
- Generally, health outcomes for Sefton's children and young people are improving, but some are still below the England average
- There are 900+ children on Sefton's voluntary disabled children register
- Over the past decade, there has been a shift in the patterns of birth locations, with a higher% choosing Southport and Ormskirk
- Sefton's breastfeeding initiation rates are rising but still comparatively low. Both initiation and duration are strongly linked to deprivation
- Childhood Immunisation rates are generally either close to or above national averages
- Whilst childhood smoking rates are average, alcohol consumption rates are higher than average
- Rates of teenage conceptions (u18) are amongst the lowest in the North West and the gap between Neighborhood Renewal and non-Neighborhood Renewal areas is narrowing
- Most elective admissions for u18s are Ear, Nose and Throat (ENT) related; non elective admissions tend to be neonates, viral infections or respiratory
- Sefton has the highest proportion of residents aged 65+ and 75+ than both its neighboring and demographically similar CCGs- 21% are currently aged 65+- and Sefton's population is growing older
- An increasingly elderly population are likely to attend A&E and be admitted to hospital as a result of falls
- Deaths at home in Sefton are rising and Sefton's rate of deaths at home is better than comparable LAs and is similar to other north Mersey Las
- There are potentially 6,600 carers in Sefton aged over 65 -the numbers receiving a needs assessment or review is rising
- Top causes of elective hospital admissions for older people are knee and hip operations, diagnostic bladder procedures, hernia repairs and prostate operations- costing £3.6m per year
- Day Case operations are largely for diagnostic procedures and cataract operations at a cost of £4.6m
- Top causes of non-elective hospital admissions for older people are heart problems, respiratory problems, kidney or urinary infections and sprains
- Overall, whilst there is some progress on reducing health inequalities, inequalities persist

- Life expectancy in Sefton is rising and is currently 77 for males and 82 for females. The gap between males and females is narrowing slowly
- CHD, lung cancer and chronic airways diseases, other cancers, liver cirrhosis and suicide (for men) are the main causes of excess deaths
- There a number of vulnerable groups in Sefton whose health outcomes are likely to be worse than the majority of Sefton residents
- Premature and avoidable mortality rates are falling
- Sefton has higher than average levels of long term conditions. Contributory lifestyle factors are improving but still vary across the borough
- Sefton generally has slightly higher levels of diagnosed long term conditions than average. Asthma, kidney disease, CHD, dementia diabetes
- In 5 years, Sefton's ageing population could mean 5,300 more people with hypertension and 2,200 with CHD
- Premature cancer mortality rates are higher than the national average but are falling at a similar rate to the average. A gap remains between rates in the most deprived areas compared to the rest of Sefton
- Whilst smoking and drinking rates in Sefton are lower than average, rates vary greatly within the borough. Whilst good progress has been made in reducing smoking prevalence, we need to ensure focus is maintained on our deprived areas and look at ways of preventing people from taking up smoking in the first place. Alcohol related hospital admissions continue to rise
- Whilst Sefton's rate of admissions is lower than other Merseyside LAs, it is higher than other comparable LAs
- Almost half of the population of Sefton may be classified as overweight or obese. Childhood obesity in Sefton is above average in Reception year but closer to average levels in year 6
- Most patients think their GP practices met or exceed the national benchmark for access and overall practices improved last year
- Chest & abdominal pain & delivery of new-borns cause most non-elective admissions for u65s costing around £6m. Heart problems, respiratory problems, kidney or urinary infections and sprains or strains account for most admissions for over 65s
- Increased non elective admissions over the next 5 years may mean extra costs in the region of £0.5m among over 65s
- Estimates of the use of, so called recreational drugs, such as cocaine, which are often linked to alcohol and socializing have increased significantly
- Every year approximately one in four people will suffer a mental health problem, with costs expected to double in the next twenty years. Mental health is a priority for the government for a focus on better outcomes for those affected by mental illness
- Dementia and depression are the most prevalent form of mental illness
- A recent review showed that between 12 and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing- between £8 billion and £13 billion in England each year. Moreover, by interacting with and exacerbating physical illness, the researchers calculated that total healthcare costs are raised by at least 45% for each person with a long-term condition and a comorbid health problem

## Appendix 2 (Other data and statistics for South Sefton)

- Sefton has the third lowest Local Authority rate of population growth across England & Wales and second worst within the North
- A further 169,200 (62%) of the population are aged 16-64, of which more than three quarters (131,200) are economically active, with 45,200 (27%) qualified to NVQ level 4 or above
- Sefton is ranked 92 out of 326 authorities in the 2010 Index of Deprivation (1 is most deprived).
- The level of child poverty in Sefton has risen slightly from 21% to 21.8% in 2010 and is slightly worse than the English average
- 16% of school children in Sefton receive free school meals, higher than the England average of 14%
- The children achieving a good level of development at age 5 in Sefton is 59% (1,720) which is in line with the English average for 2011
- In 2010 the teenage pregnancy rate in Sefton is 29.1% this is lower than the England average of 32.84%.
- As of April 2012 8,848 (5.2%) are claiming Job Seekers Allowance
- 2640 of all Sefton JSA claimants are aged between 18-24, an increase of 58% over 5 years
- Sefton's job density figures for 2010 is 0.59 per 100,000 this shows a reduction from 2009 in the ratio of total jobs to population
- There are currently 10 JSA claimants in Sefton for every Job Centre Plus vacancy
- The number of older people receiving pension credits has increased from 16,740 in August 2009 to 16,840 in 2010
- 38% of Sefton's land has been identified as previously developed land unused or available for redevelopment that is vacant or derelict. This is below the England average
- Sefton has approximately 400 green spaces and equates to 1.2 hectares per 1,000 population
- 82% of people of economically active age that have access within a reasonable time to more than 500 jobs by public transport, cycling and/or walking
- 81% of Sefton residents are satisfied with their local area as a place to live
- Across Sefton approximately 23% of residents surveyed say they have given voluntary help to a group or club in the last 12 months, and of these two thirds have volunteered for at 2 hours per week



- 80% of Sefton's pupils achieved level 4 or above in both English and Maths at Key Stage 2 this was higher than the England average of 74.66% and in the top 10% of all English authorities
- 59.5% of Sefton's pupils achieved 5 or more A \* to C grades at GCSE or equivalent including English and Maths, this has risen from 55.8% in 2009/10
- Central government has estimated there are 650 Troubled Families within Sefton
- The under 20 population has fallen from 71,500 in 2000 to 62,200 in 2010
- The numbers of births to non-British born mothers is rising, particularly for Polish and Latvian born
- The areas of highest income deprivation affecting children are concentrated in the south, but there are pockets of deprivation around the Southport
- The areas of highest income deprivation affecting older people are concentrated in the south, and in central Southport. There are some pockets of income
- The Black and Minority Ethnic population of Sefton is growing, mainly in the 16-retirement age group
- Almost one quarter of Sefton is classed as belonging to the 20% most deprived area of England. There are wide variations in deprivation levels across Sefton that are masked when looking at deprivation levels for the whole area

## Appendix 3 – 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 Southport and Formby LINK (the forerunner to Southport and Formby HealthWatch, 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 Southport and Formby**

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 4 – Formal Leads

Area	South Sefton CCG Lead	CCG Team Lead
Alcohol	<i>Dr Sunil Sapre</i>	Tina Ewart
Cancer	Dr Debbie Harvey	Sarah Reynolds
Children	<i>Dr Wendy Hewitt</i>	Jane Uglow
Contracting	Dr John Wray	Stephen Astles / Jan Leonard
Communication	Roger Driver / Sharon McGibbon	Lyn Cooke / Tina Ewart
Contract Management - Commissioning Unit	Dr Steve Fraser	Tracy Jeffes
Dementia / Mental Health / Learning Disabilities	Dr Ricky Sinha	Geraldine O'Carroll / Kevin Thorne
Dermatology		Billie Dodd
Diabetes	<i>Dr Nigel Taylor</i>	Moira McGuiness
End of Life	<i>Dr Debbie Harvey</i>	Moira McGuiness
Governance	Lynda Elezi	Tracy Jeffes
Integrated Care / Planned Care	Dr Peter Chamberlain	Stephen Astles / Billie Dodd
IT	Dr Steve Fraser	Alison Johnson
Long Term Conditions	Dr Craig Gillespie	Stephen Astles / Sandra Boner / Jenny Kristiansen
Maternity	<i>Dr Wendy Hewitt</i>	Jane Uglow
Medicines Management / Prescribing	Dr Steve Fraser / <i>Jill Thomas</i>	Brendan Prescott
Obesity	Dr Paul Thomas	
Organisational Development / Training & Development	Lin Bennett	Tracy Jeffes
Patient and Public Involvement	Roger Driver / Sharon McGibbon	Jackie Robinson / Tracy Jeffes
Prevention and Public Health	Dr Paul Thomas	Morag Reynolds / Margaret Jones
Primary Care Quality	<i>Dr Bal Duper / Lin Bennett</i>	Angela Parkinson / Debbie Fagan
Quality	<i>Dr Gina Halstead</i>	Debbie Fagan / Steve Astles / Billie Dodd
Unplanned Care / 111 Care	Dr Andy Mimmagh	Billie Dodd / Stephen Astles / Malcolm Cunningham

*\*Italics – not a Board member*

## Appendix 5 – NHS Outcomes Framework Measures

### Annex A

NHS Outcomes Framework measures which the NHS Commissioning Board and Clinical Commissioning Groups will use to track progress (ie data can be generated at Clinical Commissioning Group level and a baseline can be determined against which progress can be considered).

#### 1. Preventing people from dying prematurely

- 1.1 Potential years of life lost (PYLL) from causes considered amendable to healthcare
- 1.2 Under 75 mortality rate from cardiovascular disease
- 1.3 Under 75 mortality rate from respiratory disease
- 1.4 Under 75 mortality rate from liver disease
- 1.5 Under 75 mortality rate from cancer

#### 2. Enhancing quality of life for people with long term conditions

- 2.1 Health-related quality of life for people with long-term conditions
- 2.2 Proportion of people feeling supported to manage their condition
- 2.3 Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)<sup>1</sup>
- 2.4 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s<sup>1</sup>
- 2.5 Estimated diagnosis rate for people with dementia

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

- 3.1 Emergency admissions for acute conditions that should not usually require hospital admission<sup>1</sup>
- 3.2 Emergency readmissions within 30 days of discharge from hospital
- 3.3 Total health gain assessed by patients i) Hip replacement ii) Knee replacement iii) Groin hernia iv) Varicose veins
- 3.4 Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)<sup>1</sup>

#### 4. Ensuring that people have a positive experience of care

- 4.1 Patient experience of primary care i) GP Services ii) GP Out of Hours services
- 4.2 Patient experience of hospital care

4.3 Friends and family test

## **5. Treating and caring for people in a safe environment and protecting them from avoidable harm**

5.1 Incidence of healthcare associated infection (HCAI)

i) MRSA ii) *C. difficile*

<sup>1</sup>Will be used as part of a composite measure on emergency admissions

## **Annex B**

Expected rights and pledges from the NHS Constitution 2013/14 (subject to current consultation) including the thresholds the NHS Commissioning Board will take when assessing organisational delivery.

### **6. Referral To Treatment waiting times for non-urgent consultant-led treatment**

6.1 Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%

6.2 Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%

6.3 Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%

### **7. Diagnostic test waiting times**

7.1 Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%

### **8. A&E waits**

8.1 Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%

### **9. Cancer waits – 2 week wait**

9.1 Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%

9.2 Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%

### **10. Cancer waits – 31 days**

10.1 Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%

10.2 Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%

- 10.3 Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
- 10.4 Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
- 11. Cancer waits – 62 days**
- 11.1 Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
- 11.2 Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
- 11.3 Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
- 12. Category A ambulance calls**
- 12.1 Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
- 12.2 Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%
- 13. Mixed Sex Accommodation Breaches**
- 13.1 Minimise breaches
- 14. Cancelled Operations**
- 14.1 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 patient's treatment to be funded at the time and hospital of the patient's choice.
- 15. Mental health**
- 15.1 Care Programme Approach (CPA): The proportion of people under adult mental illness specialities on C

## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/66	<b>Author of the Paper:</b>  Jan Leonard / Tracy Jeffes / Lyn Cooke Head of CCG Development / Head of Delivery <a href="mailto:Jan.leonard@southportandformbyccg.nhs.uk">Jan.leonard@southportandformbyccg.nhs.uk</a> <a href="mailto:Tracy.jeffes@southseftonccg.nhs.uk">Tracy.jeffes@southseftonccg.nhs.uk</a>						
<b>Report date:</b> 17 May 2013							
<b>Title:</b> Draft CCG Prospectus							
<b>Summary/Key Issues:</b>  CCGs have a responsibility to publish a prospectus by 31 May 2013. The purpose of the prospectus is to market the organisation to a large audience, engage with partners and justify what we are spending public money on. The prospectus is in draft form pending approval from the Governing Body.							
<b>Recommendation</b>  The Governing Body is asked to approve the Prospectus.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Note</td> <td style="width: 20%; text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Approve</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td>Ratify</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Note	<input type="checkbox"/>	Approve	<input checked="" type="checkbox"/>	Ratify	<input type="checkbox"/>
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### Links to Corporate Objectives *(x those that apply)*

	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
	To maintain systems to ensure quality and safety of patient care.
	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
X	To sustain engagement of CCG members and public partners and stakeholders.
	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Patient and Public Engagement			x	
Clinical Engagement			x	
Equality Impact Assessment		x		
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement		x		
Presented to other Committees			x	

Links to National Outcomes Framework ( <i>x those that apply</i> )	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm



## **NHS South Sefton Clinical Commissioning Group**

### **A guide to who we are and what we do**

We are a new kind of NHS, led by local doctors, nurses and other healthcare professionals. On 1 April 2013 we took over the majority of planning and buying or 'commissioning' of local health services. This guide tells you more about what this means for you, what we plan to do in our first year of full operation and how you can get involved. You will also find some useful contacts, if you want to know more about our work, or who to contact if you have questions or comments about your local health services.



## What makes us different?

Because we see hundreds of South Sefton residents in our surgeries and clinics every day, we know what are the main health problems affecting people in the area. As medical professionals, we also have a better understanding of which treatments work best and how we can help people to stay as well as possible, for as long as possible.

We believe our patients are best placed to tell us what local health services are really like - how they can be improved, why they work well and what is needed in the future. Over the past year we have been collecting the views and comments of south Sefton residents, and these are already helping us to shape our plans.

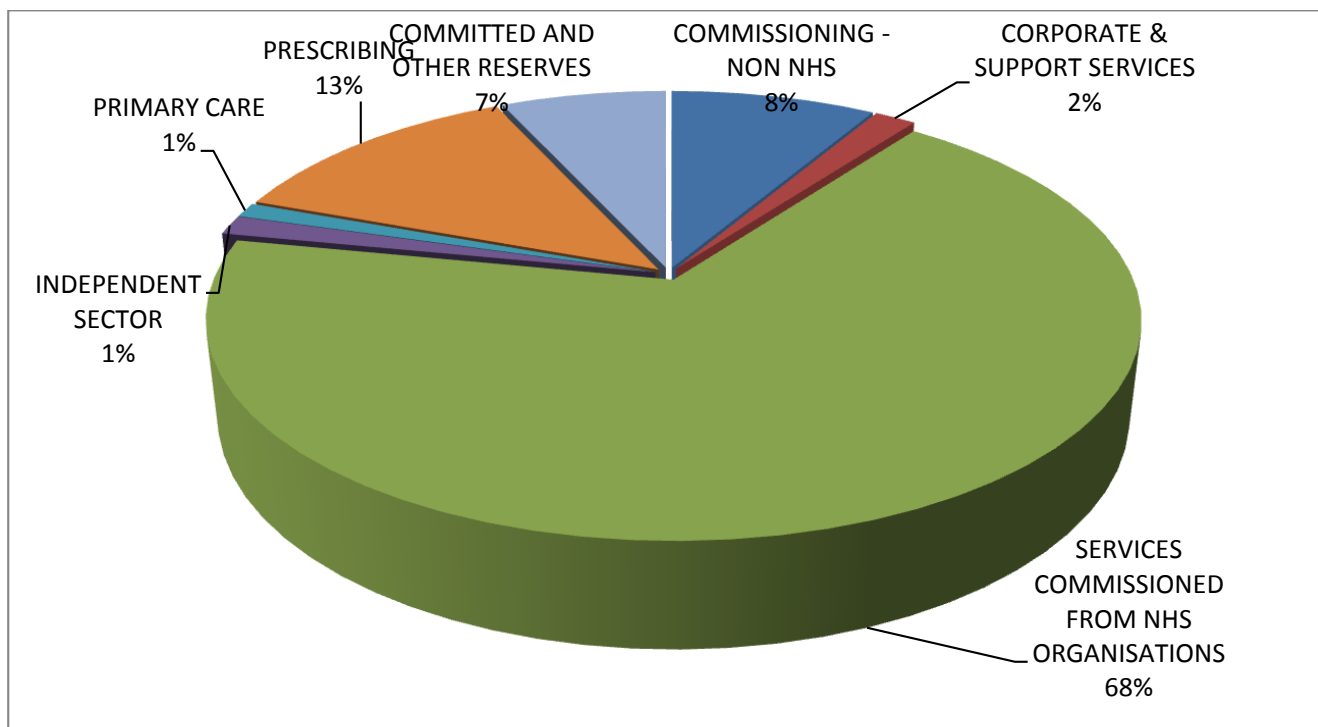
We know we can achieve more by working together with our partners like Sefton Council, patient groups and other NHS organisations. We now have the chance to work even closer with these organisations than ever before.

We are a membership organisation, bringing together all doctors' practices in south Sefton. Our members are actively involved in making health services better for you.

You will read more about how we are working differently to improve health and health services in south Sefton later in this guide.

## What we spend on your health services

We have a budget of just over £241million for 2013-2014. This is how we intend to spend it on your healthcare.





## Meet our Board

Because it would not be possible or practical for all of our x practice members to make all the decisions we need to make all of the time, they have elected a Board to do this on their behalf. You may even recognise some of the faces and names below from your doctor's practice.

- Dr Clive Shaw – Chair
- Dr Craig Gillespie – Clinical Vice Chair
- Lynda Elezi – Vice Chair and Lay Member, Governance
- Fiona Clark - Chief Officer
- Martin McDowell – Chief Finance Officer / Deputy Chief Officer
- Dr Steve Fraser
- Dr John Wray
- Dr Andy Mimmagh
- Dr Ricky Sinha
- Dr Paul Thomas
- Dr Dan McDowell – Secondary Care Clinician
- Debbie Fagan – Board Nurse
- Lin Bennett – Practice Manager
- Sharon McGibbon – Practice Manager
- Roger Driver – Lay Member, Patient and Public Engagement

Our Board meets in public every two months and you can see a list of dates, times and reports by visiting [www.southseftonccg.nhs.uk](http://www.southseftonccg.nhs.uk) or by calling 0151 247 7000.



## **What we do**

We are responsible for commissioning the following services and making sure they are safe and the highest possible quality:

- Most hospital services – including Accident and Emergency (A&E) care, maternity and mental health services, routine surgery and outpatient clinics
- Community healthcare – including blood testing, heart, diabetes and asthma clinics, rehabilitation, speech and language, podiatry, dermatology and district nursing
- Out of hours GPs – this service means you can still see a doctor outside normal practice opening hours if you need to. Simply call your practice phone number and follow the instructions

## **Who else is responsible for my healthcare?**

These are some of the organisations we work closely with, and nearly all of them are new. They are all responsible for looking after different bits of your healthcare, although we come together to make sure services and programmes are the best they can be.

## **Other CCGs**

Sometimes we commission services and treatments with neighbouring CCGs because it is more effective to do so. We share a small management team with NHS Southport and Formby CCG, which means we can learn and benefit from each other's good work, avoid duplication and reduce costs, so as much of our money as possible is spent on your care.

## **Sefton Council**

The council hosts the Health and Wellbeing Board (HWBB). This new committee brings together everyone with a responsibility for health and social care in Sefton. Whenever we can, we will join forces to make improvements. By working together we will be able to do and achieve more.

Sefton Council is now also responsible for promoting and protecting good health. It has taken on much of the Public Health work previously carried out by your local NHS, like commissioning Healthy Sefton - the telephone and internet support service that puts people in touch with free programmes to help them live healthier by stopping smoking, being more active, drinking and eating sensibly, or offering health checks to those most at risk of preventable conditions such as heart disease and diabetes. To do this, the council works in partnership with us, NHS England and another new national body – NHS Public Health England – which has a lead role in promoting and protecting health.





## NHS England

This new body leads the commissioning of primary care services. It oversees standards and holds the contracts for doctor's surgeries, dentists, pharmacists and opticians. NHS England is now the organisation to contact with queries or concerns about any of these, or for help to find your nearest. NHS England also commissions specialist healthcare, screening and immunisation programmes, and prison and armed forces healthcare.

## Healthwatch Sefton

The new independent consumer's champion, that gathers and represents the views of people living in the borough. Because it is independent, Healthwatch can challenge those who provide services but it can also work in partnership with the CCG and others to improve frontline health and social care. One of the ways Healthwatch gains feedback is through its network of Community Champions but there are many other ways Healthwatch works on your behalf to ensure health and social care services are safe, effective and right for you.

### Need to speak to someone about your health services?

Here's who to contact if you have a question, comment or concern about ...

- Your doctor, dentist, pharmacist or optician – NHS England Customer Contact Centre **<add details>**
- Your treatment in hospital or by a community clinic / clinic – most hospitals and community health care providers have their own customer contact team, ask them for details, but because we commission most of these services, you can also call our Patient Advice and Liaison Service if you would prefer 0800 218 2333 [pals@sefton.nhs.uk](mailto:pals@sefton.nhs.uk)

Here are some other useful contacts...

- Healthwatch – to find out more about the independent champion for patients or raise your comments **<add details>**
- Active Sefton – to find the right programme to support you to a healthier lifestyle call 0300 100 100
- Looking Local – our digital TV and intranet information service can be found on Sky px, or Virgin Media by **<add details>**



## Our plans for 2013 -2014

We have spent a lot of time speaking to local people and our partners to make sure we spend our budget for your health care wisely. From these discussions, there are some clear and consistent themes about what people want from their health services:

- More care closer to home rather than in hospital
- Joined up 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

### Listening to you

Our plans for 2013-2014 reflect what south Sefton residents have told us. So, as well as providing a full range of hospital and community services, we will focus a number of other schemes during our first year. Here are some examples:

#### Improving primary care

- **Obesity** – develop an obesity strategy that looks at a comprehensive list of programmes to promote a healthy weight, including a review of bariatric surgery to ensure it is as effective as possible
- **Diabetes** - review and improve services, including developing a structured education programme for people newly diagnosed with diabetes
- **Alcohol** - review the alcohol hospital liaison service and current pilot in doctor's surgeries - which identifies and supports people with an alcohol dependency - and consider rolling out to more practices in south Sefton

#### Improving Community Care

- **Virtual Ward** –further develop this programme which brings together a wide range of health and social care professionals to better manage a patient's condition. Virtual Ward focuses on people with long term conditions, dementia and those at the end of their life. It provides intensive, more joined up care for people, with the aim of supporting them as early as possible to avoid their condition worsening unnecessarily, which can often result in them needing hospital care
- **Long term conditions** – alongside the Virtual Ward, we want to increase screening and provide specific services to improve the care for people with dementia and lung and heart disease
- **End of Life** – better support patients at the end of their life to die in the place of their choice



## Improving your experience of care

- **Treatment for eye conditions** – develop a new service so people with some with eye conditions can be treated closer to home rather than travel to hospital
- **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 of deterioration whilst in hospital. We will also promote appropriate use of health services to south Sefton residents, so they get the right treatment in the right place for their condition
- **Ensuring hospital and community services work better together** –ensure every patient's care is as smooth and seamless as possible when it crosses different hospital, community or primary care services, including better discharge planning and services for diabetes and cancer and through our Virtual Ward

## Supporting you to manage your health

- **Self –care** –work with our partners to support prevention initiatives, provide training to health and social care staff to support their patients and clients, and we will look at how we can help people with long term illnesses to better manage their conditions – this will include support for cancer patients and survivors.
- **Improving mental health** –provide counselling services to more people, develop initiatives with Sefton CVS to promote wellbeing for those with mild to moderate mental ill health and carry out more health checks for those with severe and enduring mental illness
- **Child health** –review the health visitor service and ensure it is better connected to the community midwife service, review the options available to parents of children with life limiting conditions, reduce the high number of children admitted to hospital with asthma and support a health visitor led dental health campaign. We will also continue to support initiatives tackling smoking in pregnancy and that promote breastfeeding

You can see our full work programme for 2013-2014 on our website

[www.southseftonccg.nhs.uk](http://www.southseftonccg.nhs.uk)



## Working on your doorstep

We know that different parts of south Sefton often have differing health needs, so our four locality groups bring together doctors, nurses and staff from practices to design healthcare which tackles these differences.

Below are some examples of the work being developed by localities this year benefiting residents across south Sefton. They are also examples of how NHS SSCCG is providing services closer to home whenever it is safe and right, so hospitals can concentrate on services for more complex conditions:

<Map – linking to each locality update>

### Bootle <photo – chair>

- New Spirometry Service – this service operates in four community clinics in each locality area of south Sefton, so more people can be tested for the breathing illness, Chronic Obstructive Pulmonary Disease (COPD)

### Crosby <photo – chair>

- LUTS service – LUTS, or Lower Urinary Tract Symptoms, is a prostrate condition affecting men and now south Sefton residents can choose to be tested for the condition in a community clinic rather than travel to hospital if they do not want to. It also means more men can be tested for LUTS

### Maghull <photo – chair>

- Blood testing – a number of practices in south Sefton now offer blood testing, giving people more choice about where and when they can be seen. If your practice does not offer testing, you can choose to go to a neighbouring surgery to have your bloods taken

### Seaforth and Litherland <photo – chair>

- Treating eye conditions – this service, which will be launched later in 2013, will allow people to be tested and treated for conditions like glaucoma at their local opticians rather than hospital. Opticians will be able to refer people with more complex conditions directly to hospital rather than them having to go back to their doctor first, making it easier and quicker for people to get the treatment they need





## How you can get involved

There are a number of ways you can get involved in our work and your local NHS:

- Come to our public events – last year we held two ‘Big Chat’ events and jointly hosted a number of ‘Talking Health and Wellbeing in Sefton’ sessions with the council, and the views we collected have informed our plans for 2013-2014
- Come to our Board meetings – we hold bi-monthly Board meetings in public, so you can hear us discussing our work and making decisions about local health services
- Sign up for our quarterly newsletter – it includes our latest news, dates of our Board meetings, and it tell you about our public events when they happen
- Join your practice’s patient group – ask at reception for details of how you can get involved and have a say in services at your practice

## How to contact us

Call us – 0151 247 7000

Email us – [communications@sefton.nhs.uk](mailto:communications@sefton.nhs.uk)

Visit our website – [www.southseftonccg.nhs.uk](http://www.southseftonccg.nhs.uk)

Write to us - NHS South Sefton CCG, 3<sup>rd</sup> floor, Merton House, Stanley Road, Bootle, L20 3DL



**MEETING OF THE GOVERNING BODY  
May 2013**

<b>Agenda Item:</b> 13/67	<b>Author of the Paper:</b>
<b>Report date:</b> 17 May 2013	Dr.Peter Chamberlain <a href="mailto:peter.chamberlain@southseftonccg.nhs.uk">peter.chamberlain@southseftonccg.nhs.uk</a>
<b>Title:</b> Virtual Ward Quarterly Update	
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with the second agreed quarterly update of the processes relating to the implementation of the Virtual Ward Model of care. The next report will be August 2013. Specific comment is required regarding risk stratification.	
<b>Recommendation</b>  The Governing Body is asked to note the contents of this report and comments thereon are welcomed.	Note <input checked="" type="checkbox"/> Approve <input type="checkbox"/> Ratify <input type="checkbox"/>

<b>Links to Corporate Objectives</b> ( <i>x those that apply</i> )	
X	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
X	To maintain systems to ensure quality and safety of patient care.
X	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
X	To sustain engagement of CCG members and public partners and stakeholders.
X	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Patient and Public Engagement		X		
Clinical Engagement	X			
Equality Impact Assessment		X		
Legal Advice Sought		X		
Resource Implications Considered	X			
Locality Engagement	X			
Presented to other Committees		X		

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
X	Preventing people from dying prematurely
X	Enhancing quality of life for people with long-term conditions
X	Helping people to recover from episodes of ill health or following injury
X	Ensuring that people have a positive experience of care
X	Treating and caring for people in a safe environment and protecting them from avoidable harm

**Report to the Governing Body**  
**May 2013**

**1. Executive Summary**

The Governing Body have approved a model developed and led by Dr. Peter Chamberlain named the Virtual Ward System. The aim of this is maintaining happy independence for frail and elderly people. This paper presents the Governing Body with the agreed quarterly update of the processes relating to the implementation of the Virtual Ward model of care.

**2. Introduction**

The challenge of frail, elderly and long term conditions will most likely be the health care focus for the coming decade. Within South Sefton over the next 20 years the calculated increase in financial demand from merely demographic change is estimated to be over 20%. Increase in patient expectation and high cost treatments is not factored into this calculation.

The NHS is required to make 20% efficiency savings over the next 5 years and the local authority having savings cuts of over 40% in social care over a similar period. Maintaining the status quo is therefore not an option – especially as the increase in demand in services will not be met by an increase in financial provision.

The target is therefore to reduce the crises of care resulting in unplanned care admissions by improving prevention and treatment of illness and coordination of care in the community. Each unplanned care admission represents a decline in a patient's health, disruptive and risky patient experience and financial strain on the system. This will need to be matched by closure of unnecessary acute care beds, allowing the money to be reinvested and support other essential aspects of care.

The four keys aspects we are sequentially working on to address this challenge are:

- Enabling Integration
- Addressing Long Term Conditions
- Streamlining Information Technology
- Supporting Self Care.

A positive involvement of primary care and GPs in particular is critical to success of the project, along with a robust and efficient integrated community sector.

This update is broken down into the following areas

**Contents:**

- A. Commissioning Processes
- B. Project Management
- C. Quality Improvement
- D. GP Engagement and Enhanced Schemes
- E. Wider aspects relating to the project.

### **3. Content**

#### **A. Commissioning Processes**

##### **1. Strategic Overview**

Version 1 was completed in August 2012 and widely circulated within and beyond South Sefton CCG. Version 2 is expected by July 2013.

##### **2. Business Case**

The business case has been agreed for 2013/14 and 2014/15 by respective Directors of Finance following input from the Virtual Ward Team and respective managers for Liverpool Community Health, South Sefton CCG Medicines Management and Sefton Council of Voluntary Services.

##### **3. Service Specification**

The initial Virtual Ward Specification for Liverpool Community Health (major provider) has been completed and is currently at the ratification stage between the CCG Virtual Ward Team and Liverpool Community Health.

##### **4. Commissioning for Quality and Innovation (CQUINs)**

A Virtual Ward CQUINs has been finalised and agreed for 2013/14. It supports the function of the following:

- a. Integrated working between different disciplines
- b. Integrated working between respective Virtual Wards and GP practices
- c. Dementia Screening on behalf of GP practices#

*Please note the National Commissioning Board Enhanced Scheme supporting risk profiling and pro-active case management is designed to work in tandem with CQUIN.*

The LCH EMIS Web CQUIN is also a key in ensuring IMT integration occurs in tandem with clinical integration.

##### **5. Integrated Operating Framework**

An integrated operating framework is being brought together with contributions from all major stakeholders. This should be completed by July 2013. The Virtual Ward Team is taking initiative on this but providers are contribute. It will cover the following areas:

- 1) Governance: Model oversight and clinical
- 2) Staff Roles
- 3) Day to day working
- 4) Performance: Targets, Capacity, copy of CQUINs
- 5) Specific Virtual Ward Processes
- 6) IMT operation and function of honorary contracts

- 7) Incident, Complaint and Compliments procedure
- 8) Assessment and Screening Protocols
- 9) Urgent Care Team: Patient Pathways.

## **B. Project Management**

### **1. Gantt Chart**

The gantt chart is in operation and assisting in accountability. Provider input was requested in January 2013. We received detailed submission of the project timescales by the main provider (Liverpool Community Health) in April. This is a standing item on the contract meeting agenda. We are still in discussion and liaising with UHA regarding the development of innovative community geriatrician posts.

### **2. Work streams**

**Steering Group:** Main focus on project roll-out and operational framework with oversight of Peter Chamberlain. More initiative would be appreciated from providers.

**Pro-active nursing and re-ablement:** Aim to move to locality based implementation groups with oversight of Tina Ewart and Kevin Thorne

**IM&T:** Currently active within iMerseyside through oversight of Paul Shillcock and linking to the Merseyside Operational Group focussing mainly

**Quality Improvement:** Monthly meetings shoring up measures feedback and development of PDSA cycles with oversight of James Hester

**Urgent Care:** Re-launch in May 2013

**Care Planning:** LES under construction – aim for finalised product early June

**A SWOT analysis of project roll-out so far has been undertaken**

## **C. Quality Improvement**

Quality improvement methodology is essentially live evaluation coupled with an active, cyclical and structured improvement process.

### **1. Measures**

A dashboard and run-charts for each measure is currently expected by June 2013. These measures essentially form the key performance indicators for the project.

### **2. PDSA cycles**

There are 3 cycles currently running.

- 1. Risk Stratification
- 2. Pro-Active Care Program
- 3. Dementia Screening

The plan is to move PDSA cycles to the functional Virtual Ward implementation groups and use the work stream to collate the process.

### **3. Quality Feedback Mechanism**

We are still scoping out the 'catch-all', soft feedback from patients and health care professionals alike. We are seeking to glean positive and negative front line experience without replicating a complaints procedure or create excess administration for CCG staff.

Such soft feedback will provide an invaluable insight into the functioning of the Virtual Ward system long before any changes may occur through intelligence data. A lack of such a system in Mid-Staffs has been quoted by the Francis report to have been a contributing factor to the disastrous decline in quality and care.

### **D. GP engagement and enhanced schemes**

1. Engagement through locality meetings
2. Locality based service development GP champions
3. Uptake of risk profiling
4. Risk profiling and Pro-Active Management Enhanced Scheme (National with local top-up)
5. Shared Care Planning Enhanced Scheme (Local)

### **E. Wider aspects relating to the project**

#### **1. Urgent Care**

- Work has been in place at reviewing all SPC referral protocols
- The tri-CCG Urgent Care Commissioners have agreed what the UHA front end plan should be like. Detailed ratification from UHA has not occurred yet and this is on going
- The development of a front end frailty unit will provide a greater integration with community services.

#### **2. Intermediate Care**

- Number of CCAU patients remains low and there have been anecdotal issues regarding GP cover. This remains under monitoring.

#### **3. Re-ablement**

- The CCG has planned meetings with SMBC re-ablement strategy.



#### **4. Recommendations**

The Governing Body is asked to note the contents of the report and comment on the progress of the Virtual Ward implementation and the incentive scheme for risk stratification.

**Dr Peter Chamberlain**  
**May 2013**



## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/68	<b>Author of the Paper:</b>  Sarah McGrath Locality Development Manager and Cancer Services Lead <a href="mailto:sarah.mcgrath@southportandformbyccg.nhs.uk">sarah.mcgrath@southportandformbyccg.nhs.uk</a> Tel: 01704 387008
<b>Report date:</b> May 2013	
<b>Title:</b> Cancer Services Update	
<b>Summary/Key Issues:</b>  The paper presents the Governing Body with an update on local cancer services issues.	
<b>Recommendation</b>  The Governing Body is asked to note the contents of this report and approve the direction of travel.	<b>Note</b> <input checked="" type="checkbox"/> <b>Approve</b> <input checked="" type="checkbox"/> <b>Ratify</b> <input type="checkbox"/>

Links to Corporate Objectives <i>(x those that apply)</i>	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement			x	

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Clinical Engagement	x			
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered		x		Business cases to be developed for several areas
Locality Engagement	x			Practice Cancer Profiles
Presented to other Committees		x		

<b>Links to National Outcomes Framework</b> ( <i>x those that apply</i> )	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

## **Report to the Governing Body May 2013**

### **1. Context**

In the region of 970 people are diagnosed with cancer each year in South Sefton and 550 die of cancer. Approximately 2.3% of general practice lists are people who have received a cancer diagnosis at some time, meaning that there are approximately 3600 people who are living with and beyond cancer in South Sefton.

As a nation, our one year cancer survival falls short of European figures and late detection is considered to be the major explanation for this. The NHS Outcomes Framework indicators will measure 1 and 5 year survival for all cancers and for breast, lung and colorectal cancers specifically as well as premature mortality rates from cancer.

### **2. South Sefton CCG Cancer Strategy**

South Sefton CCG working with Southport and Formby CCG are currently developing a CCG Cancer Strategy to cover the next five year period mirroring the local Health and Wellbeing Strategy.

The Strategy focuses on commissioning services which will detect cancers earlier, ensure timely access to optimum treatments and enhance survivorship following a cancer diagnosis. It is intended that the Strategy will be ready for presentation to the Board in the next quarter.

### **3. Cancer Waits Performance**

#### **3.1 Cancer Waits targets for 14 day and 62 days**

Patient initiated cancellations and DNAs are a particular issue for Aintree Hospital affecting capacity to achieve 14 days from referral to first appointment. Both Sefton CCGs have produced a leaflet, to be given at referral, reinforcing the importance of attending appointments. The Trust is reviewing all cancer pathways aiming to shorten the time to first appointment and key diagnostic tests. This will give an increased timeframe for treating the minority of patients who do receive a positive cancer diagnosis following referral under the two week system.

#### **3.2 Manchester Model**

A majority of cancer pathways will involve more than one acute Trust. This can affect the delivery of the waiting time targets within acute Trusts. Several Acute Trust cancer pathways are commonly difficult to manage due to the configuration of specialist surgical centres for several tumours and chemotherapy and radiotherapy being provided by the Clatterbridge Cancer Centre. The Manchester Model aims to simplify and standardise allocation of breaches across trusts against the 62 day waiting times standard from referral to treatment.

#### 4. National Awareness and Early Detection (NAEDI) Project

- 4.1 Cancer Research UK fund a project manager to work with general practices encouraging earlier cancer detection. Examples of action plans include reflective practice by primary care staff on the pathway leading up to a cancer diagnosis and personalised letters to patients who do not take part in cancer screening programmes.
- 4.2 All practices now have access to their cancer profiles through the National Cancer Intelligence Network. These enable clinicians to benchmark practice referral rates for suspected cancers, yield rates and cancers detected through non-optimum pathways. In addition we are working with local trusts to provide cancer staging data at a practice level.

#### 5. Strategic Clinical Networks

The Merseyside and Cheshire Cancer Network has now become part of the Merseyside and Cheshire Strategic Clinical Networks resulting in a reduction in staffing dedicated to cancer. There are implications for management support to the tumour specific Clinical Network Groups (CNGs) which have a pivotal role in shaping and standardizing clinical practice across its member Trusts. The level of input to cancer peer review internal validation processes is also likely to be reduced and increased commitment from commissioners may be sought to ensure balanced membership of peer review panels.

#### 6. Survivorship

The National Cancer Survivorship Initiative published a document *Living With and Beyond Cancer: Taking Action to Improve Outcomes* in March 2013. The document focuses on five areas:

- Information and support
- Promoting recovery
- Sustaining recovery
- Managing the consequences of treatment
- Supporting people with active and advanced disease.

Locally our priorities are likely to be promoting self- management and physical activity, getting the best out of the cancer care review in primary care and addressing gaps in psychological support at all stages of the pathway. There is also work to be done in aligning the management of cancer to other long term conditions and incorporating into the virtual ward model.

#### 7. Community Cancer Information and Support Service

There are Macmillan information points based in 3 areas within Aintree Hospitals. The broader messages around prevention and early detection of cancer and generic support can be targeted at the whole range of hospital patients, staff and visitors. However it is likely that only those patients undergoing active treatment and hospital follow up will access more specialised information and support. There is a strong case to develop a community- based information service available in a non -clinical setting for everyone affected by cancer and particularly those needing support in the survivorship phase. Further work is required to develop a case of need, find suitable premises and consider partner organisations.

## **8. Protected Learning Time Event**

A cancer-themed protected learning time event for general practice is planned for September which will include items on CCG Cancer Strategy, using practice level cancer profiles including staging data, sharing good practice around quick diagnosis and models of support post treatment.

## **9. HPV Testing as Primary Triage**

CCG cancer leads have successfully influenced the selection of Sefton as a national pilot study group in providing HPV testing as primary triage (TaPS) for cervical screening. The approach has been shown to improve the specificity and selectivity of cervical screening, leading to increased prevention of invasive cervical cancer and in the medium to long term should reduce the frequency of cervical screening required and demand for colposcopy.

## **Recommendations**

The Governing Body is asked to note the contents of this report and approve the direction of travel.

**Sarah McGrath**  
**Locality Development Manager and Cancer Services Lead**  
**14.5.13**





## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/69	<b>Author of the Paper:</b>  Melanie Wright Business Manager <a href="mailto:melanie.wright@southseftonccg.nhs.uk">melanie.wright@southseftonccg.nhs.uk</a> Tel: 0151 247 7069
<b>Report date:</b> 14 May 2013	
<b>Title:</b> Managing Conflicts of Interest	
<b>Summary/Key Issues:</b>  Managing conflicts of interest appropriately is essential for ensuring sound decision-making and that the CCG can demonstrate the highest levels of integrity in the way that it conducts business. The Governing Body is now presented with the CCG's Policy on Managing Conflicts of Interest.  Please note that the Register of Interests which is published in the May Board papers includes Governing Body members only. A full register to include all CCG members and employees is in development and will be brought to the next public Governing Body meeting.	
<b>Recommendation</b>  The Governing Body is asked to approve the CCG Policy on Managing Conflicts of Interests.	Note Approve <input checked="" type="checkbox"/> Ratify <input type="checkbox"/>

Links to Corporate Objectives <i>(x those that apply)</i>	
	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement			x	

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Clinical Engagement	x			
Equality Impact Assessment			x	
Legal Advice Sought	x			Expert advice sought from CSU
Resource Implications Considered			x	
Locality Engagement	x			Locality engagement will be required as to roll out the policy at locality level
Presented to other Committees		x		

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
	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 following injury
x	Ensuring that people have a positive experience of care
	Treating and caring for people in a safe environment and protecting them from avoidable harm

## **Report to Board** **May 2013**

### **1. Introduction and Background**

On 28 March 2013, NHS England published the document “Managing Conflicts of Interests: Guidance for Clinical Commissioning Groups” (<http://www.england.nhs.uk/wp-content/uploads/2013/04/ccg-conflict-int-guide.pdf>)

The Governing Body received a presentation on the new guidance and considered a range of scenarios based on managing conflicts of interest at the Joint Board Development session held on 18 April 2013.

### **2. Key Issues**

As a commissioner, the CCG needs the highest levels of transparency so it can demonstrate that conflicts of interest (a definition of which can be found at Appendix 1, paragraph 3) are managed in a way that cannot undermine the probity and accountability of the organisation. This will be particularly important when decisions are taken by member practices.

The need for NHS bodies to identify and manage conflicts of interest is not new. Healthcare professionals have always had to manage competing interests, for example when having multiple roles on PCT Boards, professional executive committees and practice based commissioning groups, as well as separating their own provider and commissioning functions

It will not be possible to avoid conflicts of interest. They are inevitable in many aspects of public life, including the NHS. However, by recognising where and how they arise and dealing with them appropriately, the CCG can ensure proper governance, robust decision-making and appropriate decisions about the use of public money.

The Health and Social Care Act sets out clear requirements of CCGs to make arrangements for managing conflicts of interest and potential conflicts of interest, to ensure they do not affect or appear to affect the integrity of the CCG’s decision making processes.

### **3. Conclusions**

Managing conflicts of interest appropriately is essential for protecting the integrity of the CCG from any perceptions of wrongdoing.

With this in mind, the Governing Body is now presented with the CCG’s Policy on Managing Conflicts of Interest.

### **4. Recommendations**

The Governing Body is asked to (a) approve the Policy on Managing Conflicts of Interest and (b) formally endorse and adopt the Seven Principles of Public Life (Nolan Principles) as highlighted in Appendix 1.

**Appendices**

Appendix 1 Managing Conflicts of Interest Policy

**Melanie Wright  
Business Manager  
14 May 2013**

**Policy on Managing Conflicts of Interest**

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## 1. Introduction

This policy sets out how NHS South Sefton Clinical Commissioning Group (CCG) will manage conflicts of interest and potential conflicts of interest.

## 2. Conflicts/Potential Conflicts covered by this Policy

2.1. The NHS Model Standing Orders, Reservation and Delegation Of Powers and Standing Financial Instructions, page 23 Department of Health (2006) defines relevant and material interests as:-

- Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
- A position of authority in a charity or voluntary organisation in the field of health and social care;
- Any connection with a voluntary or other organisation contracting for NHS services;
- Research funding/grants that may be received by an individual or their department;
- Interests in pooled funds that are under separate management.
- Clause 7.15 of the Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions states that such directorships should be included in the Trust's annual report.
- Interests *"...must not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less."*

2.2. The Royal College of General Practitioners in its Guidance on Ethical Commissioning (October 2011) stated that:-

*"A conflict of interest can occur when an individual's ability to exercise judgement in one role is impaired by their obligation in another because of the existence of competing interest(s). For members of a CCG, a conflict of interest would exist when their duties as a commissioner could be, or could be perceived to be, influenced or impaired by their other concerns and obligations. It could arise because they are an owner, director or shareholder"*

*in an organisation doing business with the NHS, or because they are a professional or member of a special interest group, or because of their relationship to a close family member.*

*Such concerns may be financial but could also relate to personal commitments (qualifications to friends, colleagues, peers), special interests (for example, in a particular treatment or condition due to an individual's own experience or that of a family member), other non-financial objectives (status or kudos), or professional loyalties or duties. There is nothing inherently wrong in having conflicts of interest and seeking to avoid or eliminate them entirely is unlikely to be possible or desirable for the CCG. But if they are not managed effectively, and GPs and their colleagues are seen or perceived to be misusing their new commissioning powers, the consequences will be serious. It could undermine providers and regulators' confidence in the probity and fairness of commissioning decisions, damage patients' confidence in the independence of healthcare professionals and ultimately destabilise public confidence in the system as a whole."*

### 2.3. Code of Conduct: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services (NHS Commissioning Board July 2012)

- This "Code of Conduct" sets out additional safeguards that CCGs are advised to use when commissioning services for which GP practices could be potential providers of services or where it is appropriate to commission community-based services through competitive tender or an Any Qualified Provider (AQP) approach and where through single tender. In general, commissioning through competitive tender or AQP will introduce greater transparency and help reduce the scope for conflicts.
- There may, however, be circumstances where CCGs could reasonably commission services from GP practices on a single tender basis, i.e. where they are the only capable providers or where the service is of minimal value.
- This Code sets out the following arrangements to preserving integrity of decision making process when all or most GPs have an interest in a decision:-
  - where certain members of a decision-making body (be it the Governing Body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (ie not have a vote). In many cases, for example, where a limited number of GPs have an interest, it should be straightforward for relevant individuals to be excluded from decision-making;
  - Where all of the GPs or other practice representatives on a decision making body could have a material interest in a decision, particularly where the CCG is proposing to commission services on a single tender basis from all GP practices in the area, or where it is likely that all or most practices would wish to be qualified providers for a service under AQP the CCG will:-
    - refer the decision to the Governing Body and exclude all GPs or other practice representatives with an interest from the decision-making process (ie so that the decision is made only by the non-GP members of the Governing Body including the lay members and the registered nurse and secondary care doctor);
    - consider co-opting individuals from a Health and Wellbeing Board or from another CCG onto the Governing Body – or inviting the Health and Wellbeing Board or another CCG to review the proposal – to provide additional scrutiny, although such



individuals would only have authority to participate in decision-making if provided for in the CCG's constitution; and

- ensure that rules on forming a quorum (set out in the CCG's constitution) enable decisions to be made.

2.4. Depending on the nature of the conflict, GPs or other practice representatives could be permitted to join in the Governing Body's discussion about the proposed decision, but should not take part in any vote on the decision.

2.5. The Procurement Guide for Commissioners of NHS Funded Services Issued by the Department of Health (DH) in July 2010 contains the following paragraphs in respect of conflicts of interest:-

- *a conflict of interest is an issue that commonly arises during procurement activity and can occur when a commissioner is developing a service specification, when a commissioner is engaging incumbent or potential providers in preparing them to provide solutions to deliver that service, or during the procurement process itself. When conflicts of interest arise, it is the responsibility of the commissioner to manage them appropriately to ensure a robust and transparent procurement;*
- *in some circumstances, a bidder's involvement in previous or parallel projects, its participation in multiple bids, or its participation in the commissioner's activities (eg as a provider of commissioning or consultancy services) may give rise to a possible conflict of interest in bidding for certain contracts. Ideally, this should have been identified at the pre-procurement stage. The use of contractual mechanisms or ethical walls may be sufficient to mitigate such conflict of interest;*
- *in other cases, it may be appropriate to exclude the bidder and associated parties from the tender process to ensure equality of treatment between bidders if it is concerned about conflicts of interest. The bid documentation should clearly state the commissioner's policy on managing conflict issues, which should be applied consistently;*
- *a commissioner needs to strike an appropriate balance between working with providers to ensure innovative and deliverable service specifications, and working too closely to provide an unfair advantage. Therefore, transparency and equality of treatment are paramount.*

2.6. The Principles and Rules for Cooperation and Competition issued by the DH also in July 2010 states:

*"The principles and rules are intended to apply to all commissioners and providers of NHS services irrespective of whether they are public, private or third sector organisations. The principles governing commissioning apply to PCTs, to specialist commissioners and to practice-based commissioning consortia, shadow GP commissioning consortia (now CCGs) or any other bodies with express delegated responsibility to commission or subcontract on behalf of the PCT."*

### 3. Definition of a Conflict of Interest

- 3.1. A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A potential for competing interests and/or a perception of impaired judgement or undue influence can also be a conflict of interest.
- 3.2. Conflicts can arise from an indirect financial interest (eg, payment to a spouse) or a non-financial interest (eg, kudos or reputation). Conflicts of loyalty may arise (eg, in respect of an organisation of which the individual is a member or has an affiliation). Conflicts can also arise from personal or professional relationships with others (eg, where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions or could be perceived to do so). These are all conflicts of interest.
- 3.3. For a GP or any other individual involved in commissioning, a conflict of interest may, therefore, arise when their own judgment as an NHS commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a healthcare or related provider, as a member of a particular peer, professional or special interest group, or as a friend or family member.

*"It is crucial that an interest and involvement in the local healthcare system does not also involve a vested interest in terms of financial or professional bias toward or against particular solutions or decisions. The fact that in their provider and gatekeeper roles GPs and their colleagues could potentially profit personally (financially or otherwise) from the decisions of a commissioning group of which they are also members, means that questions about their role in the governance of NHS commissioning bodies are legitimate. Failure to acknowledge, identify and address them could result in poor decision making, legal challenge and reputational damage."*<sup>1</sup>

- 3.4. In summary, conflicts of interest can arise from a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring. If in doubt, it is better to assume a conflict of interest and manage it appropriately rather than ignore it. For a conflict to exist, financial gain is not necessary.

### 4. Scope

- 4.1. This policy applies to all employees, appointed and elected individuals who are working for NHS South Sefton CCG, members of the CCG's Governing Body and committees of the Governing Body or any other committees or task groups, or individuals with a lead role within a particular clinical speciality (ie, diabetes), together with the wider membership of the CCG, given the CCG's status as a membership organisation.
- 4.2. The policy should be read in conjunction with the following documents, which also set out generic guidelines and responsibilities for NHS organisations and general practitioners (GPs) in relation to conflicts of interests:-
  - the CCG's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

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<sup>1</sup> RCGP and NHS Confederation's briefing paper on managing conflicts of interest September 2011

- Managing Conflicts of Interests: Guidance for Clinical Commissioning Groups<sup>2</sup>
- Code of conduct for NHS Managers 2002<sup>3</sup>
- Appointments Commission: Code of Conduct and Code of Accountability<sup>4</sup>
- The Healthy NHS Board: Principles for Good Governance<sup>5</sup>
- General Medical Council: Good Medical Practice 2006<sup>6</sup>
- Towards Establishment: Creating Responsive and Accountable CCGs. (Technical Appendix 4)<sup>7</sup>
- Bribery Act 2010<sup>8</sup>
- The Nolan Principles (Appendix 1)
- The CCG's Constitution.

## 5. Aim

5.1. The aim of this policy is to support a culture of openness and transparency in business transactions. It is also to protect both the organisation and the individuals involved from any appearance of impropriety. All members and employees, appointed and elected individuals of the CCG referred to in section 4.1 of this policy are required to:-

- ensure that the interests of patients remain paramount at all times;
- be impartial and honest in the conduct of their official business;
- use public funds entrusted to them to the best advantage of the service, always ensuring value for money;
- ensure that they do not abuse their official position or confidential information acquired in the pursuit of their role for personal gain or to the benefit of their family or friends;
- ensure that they do not seek to advantage or further, private or other interests, in the course of their official duties.

5.2. The Governing Body of NHS South Sefton CCG has ultimate responsibility for all actions carried out by members, staff and committees throughout the CCG's activities. This responsibility includes the stewardship of significant public resources and the commissioning of healthcare services to the local community. The Governing Body is therefore determined to ensure the organisation inspires confidence and trust amongst its patients, staff, partners, funders and suppliers by demonstrating integrity and avoiding any potential or real situations of undue bias or influence in the decision-making of the CCG by holding in high regard the requirements set out above.

<sup>2</sup> NHS Commissioning Board, March 2013

<sup>3</sup> Code of Conduct for NHS Managers, Department of Health, Oct 2002

<sup>4</sup> Code of Conduct in the NHS, page 2, Department of Health/Appointments Commission 2004

<sup>5</sup> The Healthy NHS Board: Principles for Good Governance, page 31, NHS/National Leadership Council 2010

<sup>6</sup> General Medical Council: Good Medical Practice 2006 Sec 73, 74, 75, 76

<sup>7</sup> NHS Commissioning Board 2011

<sup>8</sup> [www.legislation.gov.uk/ukpga/2010/23/contents](http://www.legislation.gov.uk/ukpga/2010/23/contents)

5.3. This conflict of interest policy respects the seven principles of public life promulgated by the Nolan Committee (Appendix 1). The seven principles are:-

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership.

## **6. Responsibilities**

6.1. The Governing Body has a legal obligation to act in the best interests of NHS South Sefton CCG and in accordance with the CCG's Constitution and terms of establishment created by the NHS Commissioning Board and to avoid situations where there may be a potential conflict of interest. Conflicts of interest may arise where an individual's personal, or a connected persons interests and/or loyalties conflict with those of the CCG. Such conflicts may create problems such as inhibiting free discussion, which could:

- result in decisions or actions that are not in the interests of the CCG and the public it was established to serve;
- risk the impression that the CCG has acted improperly.

6.2. It is for each individual to decide whether to register any interests that may be construed as a conflict and to declare any gifts, hospitality or sponsorship offered and/or received. Gifts of low intrinsic value such as calendars, diaries, flowers or chocolates need not be regarded as subject to this rule. It is the responsibility of all staff employed, appointed or elected by the CCG and those serving in a formal capacity to ensure that they are not placed in a position which creates a potential conflict between their private interests and their CCG duties.

6.3. The CCG needs to be aware of all situations where an individual has interests outside of his/her NHS Contract of Employment or other involvement with the CCG, where that interest has potential to result in a conflict of interest between the individual's private interests and their CCG duties.

6.4. All individuals must therefore declare relevant and material interests to the CCG upon appointment, when a new conflict of interest arises, or upon becoming aware that the CCG has entered into or proposes entering into a contract in which they or any person connected with them has any financial interest, either direct or indirect.

6.5. CCG managers must ensure members of staff are aware of the policy and process to be followed.

6.6. It is the responsibility of all employees, appointees and those elected to familiarise themselves with this policy and comply with the provisions set out in it.

## **7. When to Declare an Interest**

7.1. NHS South Sefton CCG Governing Body members and staff should declare an interest in the following circumstances:-

- direct financial interests: these arise when an individual involved in taking or influencing the decisions of an organisation could receive a direct financial benefit as a result of the decisions being taken. This may arise as a result of holding an office or shares in a private company or business, or a charity or voluntary organisation that may do business with the NHS;
- indirect financial interests - arise when a close relative of a director or other key person benefits from a decision of the organisation. As healthcare providers as well as commissioners, individual healthcare professionals sitting on the governing bodies of CCGs (and their family members or business partners) may have commercial interests in organisations that their commissioning group is already purchasing from or that could potentially bid/offer to provide services that the group might procure and fund;
- gifts, hospitality or sponsorship offered to you by external bodies and whether this was declined or accepted in the last twelve months;
- non-financial or personal interests;
- conflicts of loyalty;
- any other conflicts that are not covered by the above.

7.2. Where individuals are unsure whether a situation falling outside of the above categories may give potential for a conflict of interest they should seek advice from the Head of Corporate Delivery.

## **8. Declaration of Interests**

- 8.1. Governing Body members and employees (as referred to under section 4.1 above) are required to declare any relevant and material interests (see above) together with any gifts, hospitality or sponsorship offered and/or received in connection with their role in the CCG.
- 8.2. A Declaration of Interests Form is provided for this purpose (see Appendix 2). To be effective, the Declaration of Interests Form must be completed prior to appointment, then updated at least annually and when any material changes occur. The CCG's Accountable Officer must be informed within 28 days of any changes to registered interests. If an individual is unsure what to declare, or whether/when the declaration needs to be updated, they should err on the side of caution and declare the interest.
- 8.3. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the Group, in writing to the Accountable Officer, as soon as they are aware of it and, in any event, no later than 28 days after becoming aware.
- 8.4. Where an individual is unable to provide a declaration in writing, for example, if it becomes apparent in the course of a meeting, they will make an oral declaration before witnesses and provide a written declaration as soon as possible thereafter.
- 8.5. Interests, gifts, hospitality and sponsorship will be recorded on the CCG's Register of Interests and Hospitality Register, which will be maintained by the Business Manager on behalf of the Accountable Officer. The register will be accessible by the public by postal application (or for inspection on request) at the CCG Headquarters, 3rd floor, Merton House, Stanley Road, Bootle, Liverpool L20 3DL and at all Local Authority public libraries in Sefton.

## **9. Data Protection**

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act 1998. Data will be processed only to ensure that the board members and employees act in the best interests of the CCG and the public and patients the group was established to serve. The information provided will not be used for any other purpose. Signing the declaration form will also signify that you consent to your data being processed for the purposes set out in this policy.

## **10. Action to take when faced with a Conflict of Interest**

- 10.1. All Governing Body members, wider group members and CGG employees (as referred to in Section 4.1 above) in attendance taking part in discussion are required to declare their interests in relation to any items on the agenda at the start of each meeting. Where certain members have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (ie not have a vote). The Chair of the meeting will decide if a member is to be excluded from the relevant part of the meeting. The conflict and the action will be recorded in the minutes of the meeting and the register of interests updated accordingly.
- 10.2. The Chair of the meeting, supported by the Lay Member with the lead role for overseeing governance, has the responsibility for deciding whether there is a conflict of interest and the course of action to take. All decisions will be recorded in the minutes of the meeting.
- 10.3. It is the responsibility of the Chair of the meeting to monitor quorum to ensure it is maintained throughout the discussion and decision of the agenda item. Should the withdrawal of the conflicted Governing Body member result in the loss of quorum, the item cannot be concluded at that meeting.
- 10.4. Once a conflict of interest is declared, the Accountable Officer should be notified, in writing, of any individual arrangements for managing the conflict of interests or potential conflicts of interests, within seven days of declaration. These arrangements should confirm the following:
  - when an individual should withdraw from a specified activity, on a temporary or permanent basis;
  - monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

## **11. Decisions taken where a Governing Body Member has an Interest**

- 11.1. In the event of the Governing Body having to decide upon a question in which a member has an interest, all decisions will be made by vote, with a simple majority required. A quorum must be present for the discussion and decision; interested parties will not be counted when deciding whether the meeting meets quorum. Interested members must not vote on matters affecting their own interests. The Vice Chair will take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.
- 11.2. All decisions under a conflict of interest will be recorded, at the meeting of the Governing Body, by the Chief Finance Officer and reported in the minutes of the meeting. The report will record:

- the nature and extent of the conflict;
- an outline of the discussion;
- the actions taken to manage the conflict;
- use of the waiver and reasons for its implementation.

11.3. Where a Governing Body member benefits from the decision, this will be reported in the annual report and accounts, as a matter of best practice. All payments or benefits in kind to Governing Body members will be reported in the CCG's accounts and annual report, with amounts for each member listed for the year in question. Independent external mediation will be used where conflicts cannot be resolved through the usual procedures.

## **12. Managing Contracts**

If any person has a conflict of interest, they should not normally be involved in procuring, tendering, managing or monitoring a contract in which they have an interest. However, occasions may arise where the contribution of a professional with particular expertise or research knowledge in a field is desirable in support of the commissioning process. In such cases full disclosure should be made. Monitoring arrangements will include provisions for an independent challenge of bills and invoices, and termination of the contract if the relationship is unsatisfactory.

## **13. Breaches of the Policy**

Breaches of the policy may result in the Governing Body or other member being removed from office in line with the CCG's constitution. A member of staff breaching the policy will be reported to the Accountable Officer and invoke the disciplinary procedure.

## **14. Monitoring Compliance and Effectiveness of the Policy**

The policy will be reviewed annually by the CCG's Audit Committee. Staff and decision-makers will be reminded of the policy and register of interests at least annually. The Head of Delivery will review register entries on a monthly basis and take any action necessary as highlighted by the review.

Mandatory training and awareness sessions on this policy will be delivered annually for Governing Body Members, member practices and staff as detailed in the CCG's Organisational Development Plan. In this respect South Sefton CCG does not differentiate between permanent or temporary staff. Details of training programmes and attendance sheets will be retained centrally by South Sefton CCG for audit and compliance monitoring.

## **Appendices**

- Appendix 1 The Nolan Principles
- Appendix 2 Declaration of Interests Form

## **The Seven Principles of Public Life (the Nolan Principles)**

### **Selflessness**

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

### **Integrity**

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

### **Objectivity**

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

### **Accountability**

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

### **Openness**

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

### **Honesty**

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

### **Leadership**

Holders of public office should promote and support these principles by leadership and example.



## South Sefton Clinical Commissioning Group

### Declaration of Financial and Other Interests for Members/Employees

Name

Position or role within  
NHS South Sefton CCG

Member / Employee/ Governing Body Member / Committee or Sub-Committee Member (including Committees and Sub-Committees of the Governing Body) [*delete as appropriate*]

Date

This form is required to be completed in accordance with the CCG's Constitution and Section 140 of *The National Health Service Act 2006*.

#### Before completing this form, please note:

- Each CCG must make arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and the public for whom they commission services in relation to a decision to be made by the CCG.
- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.
- If any assistance is required in order to complete this form, then the individual should contact Tracy Jeffes ([tracy.jeffes@southseftonccg.nhs.uk](mailto:tracy.jeffes@southseftonccg.nhs.uk)).
- The completed form should be sent by both email and signed hard copy to Melanie Wright ([melanie.wright@southseftonccg.nhs.uk](mailto:melanie.wright@southseftonccg.nhs.uk)).
- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.
- The register will be published as part of the CCG's Governing Body meeting papers and will be available on the website.
- Any individual – and in particular members and employees of the CCG - must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.
- If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities
- held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG;
- shareholdings (more than 5%) of companies in the field of health and social care;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- any connection with a voluntary or other organisation contracting for NHS services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
- any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.

In the event of no interests to be declared, the form should be completed below with 'nil return' and signed/dated.

## Declaration

Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Roles and responsibilities held within member practices		
Directorships, including non-executive directorships, held in private companies or PLCs		
Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG		
Shareholdings (more than 5%) of companies in the field of health and social care		

Type of Interest	Details	Personal interest or that of a family member, close friend or other acquaintance?
Positions of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care		
Any connection with a voluntary or other organisation contracting for NHS services		
Research funding/grants that may be received by the individual or any organisation in which they have an interest or role		
Any other specific interests?		
Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG		

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG's Constitution and published accordingly.

**Signature**

**Date**



## BOARD MEETING May 2013

<b>Agenda Item:</b> 13/70	<b>Author of the Paper:</b>  Tracy Jeffes Head of Delivery <a href="mailto:tracy.jeffes@southseftonccg.nhs.uk">tracy.jeffes@southseftonccg.nhs.uk</a>
<b>Report date:</b> 14 May 2013	
<b>Title:</b> Board Assurance Framework	
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with the Board Assurance Framework (BAF) which contains the strategic risks relating to the achievement of the CCG's corporate objectives, with the key purpose of providing assurance to the Governing Body that the risks have been identified and are being effectively managed.  This report closes down the 2012/13 with a Quarter 4 update and a new BAF will be presented to the Governing Body in July, reflecting on the new corporate objectives.	
<b>Recommendation</b>  The Governing Body is asked to note the contents of this report.	<b>Note</b> Approve <input checked="" type="checkbox"/> Ratify <input type="checkbox"/>

<b>Links to Corporate Objectives</b> ( <i>x those that apply</i> )	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Patient and Public Engagement			x	
Clinical Engagement			x	
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees			x	

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

South Sefton CCG Assurance Framework – May 2013

Reasonable Goal 1: Establish an authorised CCG without conditions				Board Reports				
<b>Key Objective 1</b>								
Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013								
Principal Risks <a href="#">Risk Owner</a>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date	
1.1 Insufficient capacity of clinical leaders to maintain commitment due to pressure on time.	3x4	Regular meetings with clinical leaders to assess and update prioritising time.  OD Plan developed	Documented presence of clinical leaders at all relevant meetings  Ongoing development sessions with clinicians in place including time management  Full capacity currently maintained no gaps identified	Significant	(GIC) Review capacity issues during Q3	Examine options for backfill of clinical sessions	February 2013 Head of CCG Development	
				Reasonable				
				Limited				
<b>Risk Owner: Head of Development</b>								
<b>Committee: Governing Body</b>								
<a href="#">Progress Reports</a>	Q1						<a href="#">Assurance Rating</a>	
	Q2							
	Q3							
	Q4	New time table for Governing body meetings and development sessions has meant that attendance has been good						
							<b>Responsible</b>	

## South Sefton CCG Assurance Framework – May 2013

Board Reports			
Goal 1: Establish an authorised CCG without conditions			
<b>Key Objective 1</b> Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013			
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls
1.2 That our plan is not considered clear and credible – that all plans do not coherently fit together and link to our vision, based on need.  Risk Owner: <i>Head of Development</i>  Committee: <i>Governing Body</i>	3x3	Working Group  Strategic Plan  Locality Groups  Commissioning Intentions based on JSNA	Feedback from NHS North of England Working group/management team scrutiny and review of plans to ensure consistency  Wider group meeting on Strategic Plan in March 2013.  Monthly meetings of Locality Groups strategic plan is a standing item on the agenda  Partnership meetings with Local Authority and Providers to ensure commissioning intentions are aligned with local Health & Wellbeing Strategy
			Key Positive Assurance (**External / Independent)  Significant  Reasonable  Limited
			Gaps in Control or Assurance (GIA) or (GIC)  (GIA) Communication of Strategy required  (GIC) CCG Website required
			Corrective Action  Hold a number of public meetings with patients/carers/public to engage in sharing CCG vision and commissioning intentions for local populations  Develop and implement website for CCG commissioning intentions and vision and values
			Responsibility Target Date  February 2013 Head of Development  End of December 2012
<b>Assurance Rating</b>			
<b>Reasonable</b>			
<b>Progress Reports</b>			
Q1			
Q2			
Q3			
Q4	'Everyone Counts' plan completed and to go to public consultation. Strategic plan and Health and wellbeing plan continue to be refined. Strategic plan well received at wider group.		





## South Sefton CCG Assurance Framework – May 2013

Board Reports			
Goal 1: Establish an authorised CCG without conditions			
<b>Key Objective 1</b> Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013			
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls
1.4 Inability to gain / maintain active involvement of all constituents & stakeholders	<b>3x4</b>	<p>Communications &amp; Engagement Strategy</p> <p>Implementation of action plan Communications and Engagement Plan. Strengthening of Locality teams</p> <p>EPEG Group involving all major stakeholders has been established which is a sub-committee of the Quality Committee which co-ordinates public engagement activity</p>	<p>Documented evidence of involvement</p> <p>Community Champions through LINK identified for each locality</p> <p>Lead Locality GP, Practice Nurse &amp; Practice Manager meeting on a monthly basis for each locality</p> <p>Quarterly wider constituent meetings with GP attendance.</p>
		Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)
		Significant	<p>Further development of patient reference groups required</p> <p><b>(GIA)</b> Further development of wider stakeholder events required</p>
		Corrective Action	Responsibility Target Date
		<p>Identified lead officer to develop further meetings with patients in the local community</p> <p>Board development session on the voluntary sector to develop relationships further</p>	<p>March 2013 Head of Delivery</p> <p>February 2013 Head of Delivery</p>
<b>Risk Owner: Head of Delivery</b>		<p>Significant</p> <p>Reasonable</p> <p>Held a number of stakeholder events during summer 2012 .</p> <p>Through winter 2, public events run in conjunction with the local authority consulting on the health and wellbeing strategy and commissioning intentions.</p> <p>Website launched in December 2012</p> <p>Chair of CCG has regular article in local press regarding CCG development and health messages</p> <p>Limited</p>	
<b>Committee: Finance &amp; Resource Committee</b>			
<b>Progress Reports</b>			<b>Assurance Rating</b>
<b>Q1</b>			
<b>Q2</b>			
<b>Q3</b>			
<b>Q4</b>	<p>Ongoing implementation of Communications and Engagement Strategy. EPEG development sessions completed. Board development session held on CVF sector. Programme of public events regarding Health and Wellbeing Strategy and Commissioning Intentions completed.</p>		<b>Reasonable</b>

South Sefton CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.5 Inability to create sufficient time for team/ individual development	3x3	OD plans / T&D scheduled to an achievable pace.	Records of development sessions  Monthly Governing Body Development sessions  Individual governing body's members undertaking development sessions  Team coaching for the governing body	Significant    Reasonable  Individual governing body's members undertaking development sessions  Team coaching for the governing body  Completion of national governing body development framework  Management team timeout sessions in November 2012  Secured funding for locality development work through the national CCG development programme. To be implemented from January to March 2013  Limited			
<i>Risk Owner: Head of Delivery</i> <i>Committee: Finance &amp; Resource Committee</i>	Q1						
	Q2						
<u>Progress Reports</u>	Q3						
	Q4		Board development sessions ongoing. Locality leadership development nearly completed. Management Team time outs delivered.				
						<u>Assurance Rating</u>	
							<b>Reasonable</b>

South Sefton CCG Assurance Framework – May 2013

Goal 1: Establish an authorised CCG without conditions				Board Reports			
Key Objective 1 Ensure all domains are for authorisation are met and CCG is established without conditions by April 2013							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.6 Re-election of CCG Board clinical Board members during Authorisation process is detrimental to authorisation.	2x3	Management of process to ensure smooth transition. Strong clinical leadership role	Board elected to satisfaction of membership through memorandum	Significant			
				Reasonable			
				Limited			
<i>Risk Owner: Head of Delivery</i>							
<i>Committee: Finance &amp; Resource Committee</i>							
<u>Progress Reports</u>	Q1						
	Q2						
	Q3						
	Q4						
			Re-election completed and new Board in place with smooth transition.				
						<u>Assurance Rating</u>	
							<b>Reasonable</b>

South Sefton CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.1 Long Term Conditions Increase in numbers and complexity of LTC in population could lead to increased pressure on services and resources	4x4	Education, IGR, LES, Health Check, Development of North Mersey pathways Lead GPS for diabetes in place in South Sefton Will be discussed network wide Providers need to be aware as this will be a financial risk Local Implementation Team/Steering Group Developed + Education packs for Clinicians Sefton – wide Strategy group actions.	Board reports Communications through strategy groups Reports to steering group Performance reports	Significant	Increasing ageing population, not necessarily a gap that can be controlled  (GIC) Coordinated approach to provision of Public Health intelligence data/advice to understand health needs for local communities		
<b>Risk Owner: Head of Performance &amp; Health Outcomes</b>				Reasonable			
<b>Committee: Name of responsible committee</b>				Limited			
	Q1			Evidence of use of JSNA to inform CCG commissioning intentions			
	Q2						
	Q3						
	Q4						
<b>Progress Reports</b>						<b>Assurance Rating</b>	<b>Limited</b>
It is unlikely that the risk score for this objective will improve in the near future. There is a great deal of work being done within the local health economy in particular around the management of patients with LTCs in the community. This will be led by the new Urgent Care Network in partnership with Aintree Hospitals.							

## South Sefton CCG Assurance Framework – May 2013

### Goal 2: Improve health and reduce inequalities of practice populations

### Board Reports

Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes				Responsibility Target Date		
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action
<b>2.2 Mental Health</b> Introduction of new CAMHS service specification may not be successfully negotiated into the contract impacting upon ability to deliver improved health outcomes  Risk Owner: <b>Chief Nurse</b> Committee: <b>Quality Committee</b>	<b>3x3</b>	Quality Committee	Monthly Quality Committee meetings  Performance reports to Quality Committee on progress from Strategic Commissioning Group	Significant	(GIC) Specification not agreed  (GIA) Consultation on new specification required  (GIC) Performance Framework required	Final draft specification for consultation required.
		Sefton Integrated Commissioning Group	Joint / Integrated commissioning approach with Sefton Council through the Sefton Integrated Commissioning Group – key work area	Reasonable		Specification to be consulted upon and inserted into provider contract for 2013/14
		Sefton CAMHS and Performance Group	6 weekly meetings for Sefton CAMHS and Performance Group reporting into the Childrens Trust, CCG Governing Body and Childrens Services Overview and Scrutiny. Chaired by Sefton MBC Director of Childrens Services	Limited		Performance Framework in final draft format to be completed and to be included in specification
		Wider Emotional Health and Wellbeing Stakeholder Group	Emotional Health & Wellbeing Stakeholder Group inputted into specification and 6 monthly meetings in place			
<b><u>Progress Reports</u></b>	<b>Q1</b>					
	<b>Q2</b>					
	<b>Q3</b>					
	<b>Q4</b>		Service specification not yet agreed. Chief Nurse has asked for it to be an agenda item on the CAMHS Partnership Board, the date of which has yet to be set. Once finalised, it will be negotiated in year into the contract. Chief Nurse discussed update with Director of Children's Service; remains a priority area within the workplan for the Integrated Commissioning Group (sign-off next meeting on 3 June 2013).			
						<b>Limited</b>

South Sefton CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2							
Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (G/A) or (G/C)	Corrective Action	Responsibility Target Date
2.3 Dementia Lack of agreement for the Dementia Liaison Service pathway will prevent full implementation	3x3	Provider Contract  Quality Committee  Merseyside QIPP Group	Monthly Contract meetings with Provider  Monthly communication meeting with Provider and commissioners  Monthly reports on progress to Quality Committee  Bi-monthly meeting to discuss progress	Significant			Kevin Thome
<i>Risk Owner: Chief Nurse Committee: Quality Committee</i>							
<u>Progress Reports</u>	Q1						
	Q2						
	Q3						
	Q4						
Discussions with Merseycare NHS Trust indicate that they have implemented part of the Contract Variation. The liaison service for Accident & Emergency Departments is in place and early evidence indicates a positive impact for people attending hospital with dementia. Further discussion and clarity is needed to identify a work plan with Sefton MBC and Merseycare NHS Trust to fully implement the Care Home Liaison Service.							
						<u>Assurance Rating</u>	Reasonable

South Sefton CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
<b>2.4 Children's Services</b> Ensuring on-going joint commissioning with SMBC whilst developing CSU is robust and continues to commission for quality and within available resource during transition	3x3	SLA with CSU	Meetings with CSU to begin January 2013. SLA monitoring	Significant	<b>(GIA)</b> Insufficient capacity in CSU service for Childrens Commissioning of individual packages of care  <b>(GIC)</b> Operating Model for Childrens Commissioning of individual packages of care required	CSU leading on recruitment to posts created to increase capacity and capability within the service;  CSU to develop Operating Model for Childrens Commissioning of Individual Packages of care to ensure integration with the local authority	January 2013 Chief Nurse
		Sefton Commissioning Panel	Sefton Commissioning Panel decisions to report to Quality Committee & Finance and Resource Committee	Reasonable			Yvonne Lockhead February 2013
		Quality Committee	Monthly Quality Committee meetings and exception reporting on Performance of CSU team via contract monitoring. Intelligence on providers of individual packages of care via CSU staff and complaints process.	Limited			
		Finance Committee	Review of budget and management arrangements via integrated working with LA and SLA with CSU				
<b>Risk Owner: Chief Nurse</b>  <b>Committee: Quality Committee</b>			Joint Commissioning Team to inform and highlight any issues that may impact upon the transition regarding commissioning of individual packages of care to CSU locality team.				
<b><u>Progress Reports</u></b>	Q1					<b><u>Assurance Rating</u></b>	
	Q2						
	Q3						
	Q4	CSU structure now fully staffed, the last postholder started on 20 May 2013. The team are developing an operating model and will ensure integrated working with the Local Authority remains robust. (Lead: Yvonne Lockhead, CSU.)					



South Sefton CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (G/A) or (G/C)	Corrective Action	Responsibility Target Date
2.5 Planned Care Increased referrals and not managing inappropriate follow ups effectively could have a negative financial impact	3x4	Close monitoring of activity at Practice, Locality and Board level using the Intelligence Portal.  Locality meetings	Performance reports  Monthly contract meetings with Trusts	Significant	Ability of portal to deliver required information	Meetings with CSU business intelligence re portal developments	June 2013
				Reasonable			
				Limited			
<b>Risk Owner: Head of CCG Development</b>							
<b>Committee: Name of responsible committee</b>							
<u>Progress Reports</u>	Q1						
	Q2						
	Q3						
	Q4		The information provided on the portal has not been as good as it might have been during the transition of the PCT. Numerous discussions with CSU BI have resulted in some improvement. The next step is to achieve more timely data uploads. This year's contract has set targets for New to follow-up ratios.				
						<u>Assurance Rating</u>	
							Limited



South Sefton CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports				
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes								
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date	
<b>2.7 Cancer</b> Targets not met because of failure of providers to provide sufficient capacity in health system.	3x4	Cancers leads Plan in place Provider contracts in place Delivery Plans	Performance Reports to Governing Body Weekly performance updates from acute Trust Weekly teleconferences with NCB LAT Performance monitored.	Significant	GIC – refer to Q4 Update on Cancer Strategy.			
								Reasonable
								Limited
<b>Risk Owner: Head of Performance &amp; Health Outcomes</b>  <b>Committee: Name of responsible committee</b>	<b>Q1</b>							
	<b>Q2</b>							
	<b>Q3</b>							
<b>Progress Reports</b>	<b>Q4</b>		The CCG are currently developing a Cancer Strategy to cover the next five year period mirroring the local Health and Wellbeing Strategy. The Strategy focuses on commissioning services which will detect cancers earlier, ensure timely access to optimum treatments and enhance survivorship following a cancer diagnosis. It is intended that the Strategy will be ready for presentation to the Board in the next quarter.			<u>Assurance Rating</u>	Limited	

South Sefton CCG Assurance Framework – May 2013

Goal 2: Improve health and reduce inequalities of practice populations				Board Reports																																			
Key Objective 2 Ensure all 8 key priorities outlined in 2012/13 commissioning intentions deliver intended health outcomes																																							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date																																
<b>2.8 Prevention Programmes</b> Insufficient scale of investment will prevent expected maximum impact for local population  Risk Owner: Head of Performance & Health Outcomes  Committee: Name of responsible committee	4x3	Joint strategy with LA as PH move to LA, based on JSNA	Agreed strategy	Significant																																			
				Reasonable																																			
				Limited																																			
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				<b>Progress Reports</b>																																			
				Health and Wellbeing Board formally established and meeting on a regular basis.																																			

South Sefton CCG Assurance Framework – May 2013

**Goal 3: Ensure that our populations received best possible outcomes**

**Board Reports**

Key Objective 3 Develop the delivery of performance metrics which support the work of the CCG and track improvement in Health Outcomes				Board Reports			
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
3.1 Current system-wide lack of focus on defining and measuring progress towards health outcomes resulting in an inability to adequately track progress against planned improvement	3x3	Commissioning outcomes mapped to current performance  Outcomes will be reported on annual basis	Performance reporting will move towards outcomes framework  SMRs produced annually  Joint framework being delivered with Local Authority	Significant			
				Reasonable			
				Limited			
<i>Risk Owner: Head of Performance &amp; Health Outcomes</i>							
<i>Committee: Name of responsible committee</i>							
<u>Progress Reports</u>	Q1						
	Q2						
	Q3						
	Q4						
		NHS England have published CCG outcomes benchmark pack.					
						<u>Assurance Rating</u>	
							Limited

South Sefton CCG Assurance Framework – May 2013

**Goal 3: Ensure that our populations received best possible outcomes**

**Board Reports**

Key Objective 3 Develop the delivery of performance metrics which support the work of the CCG and track improvement in Health Outcomes			Board Reports				
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (G/A) or (G/C)	Corrective Action	Responsibility Target Date
3.2 Failure to recognise and manage the impact of key determinants on health on long term nature of health outcomes due to insufficient advice or information  Risk Owner: <i>Head of Performance &amp; Health Outcomes</i> Committee: <i>Name of responsible committee</i>	3x3	Head of Performance & Outcomes in place with lead responsibility	NHS Outcomes framework in development Support by CSU Joint framework being delivered with Local Authority	Significant			
				Reasonable			
				Limited			
	Q1						
	Q2						
	Q3						
	Q4		NHS England have published CCG outcomes benchmark pack.				
<u>Progress Reports</u>						<u>Assurance Rating</u>	Limited

South Sefton CCG Assurance Framework – May 2013

Goal 3: Ensure that our populations received best possible outcomes				Board Reports			
Key Objective 3 Develop the delivery of performance metrics which support the work of the CCG and track improvement in Health Outcomes							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (G/A) or (G/C)	Corrective Action	Responsibility Target Date
3.3 Knowledge / skills gap within CCG workforce in relation to setting and tracking health outcomes will prevent the CCG from delivering one of its key functions	2x2	Key action identified within OD plan	Update on progress to Board on OD plan Joint framework being delivered with Local Authority	Significant			
				Reasonable			
				Limited			
<b>Risk Owner: Head of Performance &amp; Health Outcomes</b>	Q1						
<b>Committee: Name of responsible committee</b>	Q2						
<b>Progress Reports</b>	Q3						
	Q4		NHS England have published CCG outcomes benchmark pack.				
						<b>Assurance Rating</b>	
							<b>Limited</b>

South Sefton CCG Assurance Framework – May 2013

**Goal 4: Ensure that the services we commission deliver good value for money**

**Board Reports**

Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan				Responsibility Target Date			
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)			
4.1 Quality Measures to improve productivity adversely affect quality of services in local providers	3x3	CQUINs incentive scheme  Quality Committee  Provider Contract  Governing Body	Monthly performance reports to Quality Committee  Clinical reviews of plans to ensure no adverse effect.  Governing Body Chief Nurse with lead on Quality to ensure that quality is maintained.  Quality reporting standing agenda item for Governing Body  Chief Nurse member of Finance Committee. Chief Finance member of the quality committee to ensure risk to quality is minimised.  Chief Nurse in attendance at single provider quality meetings with provider since October 2012.	Significant    Reasonable  Quality Committee met for the first time in November 2012 reviewed Quality & Performance Dashboards. Feedback to Committee from GP Clinical Lead for Quality & CQUIN. Provider performance and data quality issues identified and discussed. Action planning to be pursued via clinical performance and quality group for each provider.  Limited	Gaps in Control or Assurance (GIA) or (GIC)  (GIA) Attendance at all provider quality meetings	Corrective Action  Chief Nurse for CCG to ensure attendance at all quality meetings in accordance with collaborative contracting arrangements	January 2013 Chief Nurse
<i>Risk Owner: Chief Nurse</i> <i>Committee: Quality Committee</i>							
<b>Progress Reports</b>	Q1						
	Q2						
	Q3						
	Q4	Achieved.					
						<b>Assurance Rating</b>	<b>Reasonable</b>



South Sefton CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.2 Finance Failure to maintain financial balance due to increased demand and over activity in providers or failure to manage budgets robustly internally.	3x4	Robust financial planning identifying contingency reserves. Robust contracting with specified levels of activity and associated finances. Finance and Resource Committee and Governing Body reviews financial performance Signed contracts with provider are in place for 2012/13. External and Internal Audit in place to review systems of internal control and make recommendation where appropriate. Main contract using fixed price to address non elective flows	Financial Plan will be signed off by the F and R Committee / Governing body. Monthly Finance performance reports to F&R committee with exceptions reports to the Governing Body. Monthly finance reports for budget holders are produced. Monthly contract monitoring is in place to review and verify performance and activity on provider contracts including CQUIN. Budgets are monitored and corrective actions identified when necessary Review financial position at Wider Group meeting.	Significant			Ongoing throughout year
<i>Risk Owner: Chief Finance Officer</i> <i>Committee: Finance &amp; Resource Committee</i>	Q1						
<u>Progress Reports</u>	Q2						
	Q3						
	Q4		Opening financial budgets signed off by Governing Body.				
						<u>Assurance Rating</u>	
							<u>Reasonable</u>

South Sefton CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan							
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
4.3 QIPP Inability to deliver a credible QIPP plan that leads transformational change	3x4	QIPP plans are in place to deliver the required financial savings. QIPP targets are identified within the financial plan and signed off by the Governing Body. Finance and Resource Committee and Governing Body reviews financial performance including performance against QIPP targets and associated savings	Finance performance reports to F&R committee from QIPP sub group Board reports	Significant			
				Reasonable			
				Finance report to F&R committee in November demonstrating the CCG is on track to deliver the required financial outturn including performance on QIPP.			
				Limited			
	Q1						
	Q2						
	Q3						
	Q4		Monthly Finance report to F&R committee demonstrating the CCG is on track to deliver its QIPP plans as part of delivering the required financial outturn position				
<u>Progress Reports</u>						<u>Assurance Rating</u>	<b>Reasonable</b>

South Sefton CCG Assurance Framework – May 2013

**Goal 4: Ensure that the services we commission deliver good value for money**

**Board Reports**

Key Objective 4 Ensure delivery of the CCG Quality, Finance, QIPP and Performance agenda in line with the agreed business plan					
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Responsibility Target Date
4.4. Performance Lack of Effective performance monitoring systems across CCG and CSU could result in failure to recognise early a system or provider failure clinically or financially	3x3	SLA with CSU. CCG monitoring group established Steering group to develop performance monitoring systems	Performance Reports to Governing Body Weekly performance updates from acute Trust Weekly teleconferences with NCB LAT Performance monitored	Significant   Reasonable   Limited	
<i>Risk Owner: Head of Performance &amp; Health Outcomes</i>					
<i>Committee: Name of responsible committee</i>					
<u>Progress Reports</u>	Q1				
	Q2				
	Q3				
	Q4				
	Monthly contract meetings with providers in place.				
				<u>Assurance Rating</u>	
					<b>Reasonable</b>

South Sefton CCG Assurance Framework – May 2013

Goal 4: Ensure that the services we commission deliver good value for money				Board Reports			
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
<b>4.5. Safeguarding Adults &amp; Children</b> Lack of clarity regarding roles and responsibilities during transition could impact on performance  Risk Owner: <i>Chief Nurse</i> Committee: <i>Quality Committee</i>	3x3	SLA with CSJ. CCG monitoring group established  Steering group to develop performance monitoring systems	Board reporting	Significant			
				Reasonable			
				Limited			
<u>Progress Reports</u>				<u>Assurance Rating</u>			
Q1							
Q2							
Q3							
Q4				Meeting held on 8 May 2013 to discuss progress to date and future development of CCG Safeguarding Hosted Service following the publication of Working Together (2013) and Accountability Framework (2013).			
				<b>Reasonable</b>			

South Sefton CCG Assurance Framework – May 2013

**Goal 5: Consult with patients, clinicians and stakeholders about the care we commission on their behalf**

**Board Reports**

<b>Key Objective 5</b>		Ensure effective consultation and engagement with patients, clinicians and stakeholders to shape commissioned services				Responsibility Target Date	
<u>Principal Risks</u> <b>Risk Owner</b>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	
5.1 Inability to clearly and succinctly articulate our vision and key plans to all constituent practices and stakeholders could result in reduced/lack of engagement	3x3	Communications and Engagement strategy  Strategic Plan  Locality Groups  Implementation Plan for Communications and Engagement Strategy	Governing Body report regarding Communications and Engagement Strategy delivery  Wider group meeting on Strategic Plan in March 2013.  Monthly meetings of Locality Groups strategic plan is a standing item on the agenda. Development of case studies.  Achievement of Milestones and delivery KPIs reported Governing Body	Significant   Reasonable   Limited	(GIA) Communication of Strategy required    (GIC) CCG Website required	Hold a number of public meetings with patients/carers/public to engage in sharing CCG vision and commissioning intentions for local populations  Design and launch website containing Communication and Engagement Strategy	February 2013 Head of Development    End of December 2012
<b>Risk Owner: Head of Development</b>							
<b>Committee: Name of responsible committee</b>							
<b>Progress Reports</b>	Q1						
	Q2						
	Q3						
	Q4	Wider group meetings of the last 2 quarters have been extremely well attended suggesting improved engagement and a good understanding of the CCG's responsibilities and role. There remains work to be done around public engagement for strategic planning which is planned for early summer 2013					
						<b>Assurance Rating</b>	<b>Reasonable</b>

South Sefton CCG Assurance Framework – May 2013

**Goal 5: Consult with patients, clinicians and stakeholders about the care we commission on their behalf**

**Board Reports**

Key Objective 5 Ensure effective consultation and engagement with patients, clinicians and stakeholders to shape commissioned services				Responsibility Target Date			
Principal Risks <u>Risk Owner</u>	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	
5.2 Insufficient CSU support for communications and engagement could result in an inability to maintain and develop proactive and local internal and external communications	3x3	SLA in place with Provider  Performance Monitoring Group  SMT	Performance Mont  Monthly meeting of Performance Monitoring Group  Head of Client Operations – CSU to attend weekly SMT meetings to support  Specific agreement reached with CSU to ensure continuation of locally based Communications and engagement capability.	Significant          Reasonable          Limited	Monitoring of SLA agreement is required	Review at regular performance monitoring group meeting as an agenda item reporting to Finance and Resource Committee	December 2012 Head of Delivery
<i>Risk Owner: Head of Delivery</i> <i>Committee: Finance &amp; Resource Committee</i>	Q1						
<u>Progress Reports</u>	Q2					<u>Assurance Rating</u>	
	Q3						
	Q4		Locally based team in place which ensures continuity of delivery.				<b>Responsible</b>

**Principal Risks:** are what could prevent key objectives from being achieved. Key risks should be true risks (rather than consequences), and so cannot just be the converse of the objective.

**Assurance Rating Section.** This shows section seeks to help the Governing Body to 'weight' the assurance provided by Risk Owners. It directs the amount of attention it need to spend in reviewing entries on the Assurance Framework. The categories are 'Limited', 'Reasonable' and 'Significant'. The Governing Body should be expecting to see 'Reasonable' assurance for the entries in the document unless there is a specific reason for this not to happen. For example a new care pathway introduced in quarter 1 might only have been given limited assurance as the implementation plan for the pathway has only just begun. As the year progresses the assurance rating should increase with the embedding of the pathway.

**Key Controls:** are factors, systems or processes that are in place to mitigate the principal risk(s) and assist in securing delivery of the relevant key objective. Key controls should be robust and specific, and properly match the associated key objective(s). For example; a sub committee or committee of the Board which is tasked with monitoring the specific risk.

**Assurance on Controls:** are sources of evidence that the key controls are effective. Assurances should be matched with specific key control(s) wherever possible.

**Key Positive Assurance:** assessment seeks to measure the level of assurance with which it can be determined that the key controls are mitigating the principal risks identified. The assessment also specifies how/where the organisation has evidence showing that principal risks are being managed reasonably. Descriptions should provide sufficient details to identify specific documentary evidence, e.g. dates of meetings, publications, reviews etc. External or Independent assurances are generally given more weight than internal sources.

**Gaps in Control:** indicates where the organisation has failed to put key controls in place, or has failed to make key controls effective.

**Gaps in Assurance:** indicates where the organisation is failing to gain evidence that key controls are effective.

**Corrective Action:** shows what will or is being done to address the gap(s) in control or assurance.

**Responsibility / Target Date:** shows the Director (or senior manager) responsible for appropriate and timely implementation of corrective action(s) and the expected date by which actions should be completed.

**Progress reports** provide a quarterly update on achievement of action plans and identify where gaps in control or assurance have been addressed. They should also indicate where the risk grading has changed for any risks associated with that objective.

**Generally, Assurance Frameworks** should map key objectives to principal risks, key controls and assurances explicitly. Assurance frameworks should be embedded and dynamic, providing regular Board information and not viewed as year-end exercises.

**Assurance Rating**

**Limited Rating – Insufficient Assurance Provided**

A limited assurance rating will be applied where a risk owner has failed to record any evidence within the 'Key Positive Assurance' column during that quarter or where only minimal evidence is provided, all of which is deemed as providing 'limited assurance'.

**Reasonable Rating – Adequate Assurance Provided**

A reasonable assurance rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column at least one piece of evidence deemed 'reasonable' assurance together with a number of pieces of evidence deemed 'limited' assurance.

**Significant Rating – Substantial Assurance Provided**

A significant risk rating will be applied where a risk owner has recorded in the 'Key Positive Assurance' column a minimum of one piece of evidence deemed as providing 'significant' assurance or a number of pieces relating to different aspects of assurance deemed 'reasonable'.

**Examples of what constitutes differing levels of assurance:**

Key Positive assurance (** External/Independent) <b>EXAMPLES OF TYPES OF ASSURANCE</b>	**SHA Audit of data quality indicating no significant concerns, reported to Trust Board January 2010, PCT commissioning committee February 2011. (significant assurance)  **COC indicators met for relevant targets as reported in periodic review, October 2011 (significant assurance)  Performance Report received by the Trust Board, most recent September 2009, showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance)  Contract monitoring report to commissioning committee in September 2010 showing performance within tolerance for overall achievement of target for Q1 (reasonable assurance)  Performance report to Trust Board, most recent September 2010, indicating current position against key targets (limited assurance)
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Key Positive assurance <b>EXAMPLE OF NEW LAYOUT</b>	<b>Significant Assurance</b>  2010/11 prospectus published March 2009, included for information in Board papers May 2010  Uplake report on attendance at Health & Safety courses at Health & Safety working group November 2010 shows 60% of staff have attended relevant courses, compared with 40% last year  <b>Reasonable Assurance</b>  Update report to HR committee September 2010 demonstrating 80% of required courses now established  <b>Limited Assurance</b>  Performance report to Trust Board, most recent September 2010, indicating current position against key targets
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**Risk Grading Matrix**

Consequence Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Risk	Score	Colour
Insignificant	1 - 3	Green
Low	4 - 6	Yellow
Moderate	8 - 12	Orange
High	15 - 25	Red

-----> Significant risk

**Significant Risk**

A risk which attracts a score of 8 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Directorate Risk Register.



## MEETING OF THE GOVERNING BODY May 2013

<b>Agenda Item:</b> 13/71	<b>Author of the Paper:</b>						
<b>Report date:</b> 21 May 2013	Tracy Jeffes Head of Delivery <a href="mailto:tracy.jeffes@southseftonccg.nhs.uk">tracy.jeffes@southseftonccg.nhs.uk</a>						
<b>Title:</b> Update of Terms of Reference – Board Committees							
<b>Summary/Key Issues:</b>  This paper presents the Governing Body with the revised Terms of Reference for the Quality Committee, Finance & Resource Committee and Audit Committee.  The changes have been highlighted in red, for ease of reference.							
<b>Recommendation</b>  The Governing Body is asked to approve the changes to the Terms of Reference for each Committee.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Note</td> <td style="width: 20%; text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Approve</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td>Ratify</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Note	<input type="checkbox"/>	Approve	<input checked="" type="checkbox"/>	Ratify	<input type="checkbox"/>
Note	<input type="checkbox"/>						
Approve	<input checked="" type="checkbox"/>						
Ratify	<input type="checkbox"/>						

Links to Corporate Objectives <i>(x those that apply)</i>	
x	To consolidate a robust CCG Strategic Plan within CCG financial envelope.
x	To maintain systems to ensure quality and safety of patient care.
x	To establish the Programme Management approach and deliver the CCG programmes for whole system transformation and improved CCG performance.
x	To ensure the Cheshire & Merseyside CSU delivers successful support to the CCGs.
x	To sustain engagement of CCG members and public partners and stakeholders.
x	To drive clinical leadership development through Governing Body, locality and wider constituent development.

Process	Yes	No	N/A	Comments/Detail <i>(x those that apply)</i>
Patient and Public Engagement			x	
Clinical Engagement			x	

Process	Yes	No	N/A	Comments/Detail ( <i>x those that apply</i> )
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees			x	

<b>Links to National Outcomes Framework (<i>x those that apply</i>)</b>	
x	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
x	Treating and caring for people in a safe environment and protecting them from avoidable harm

## **NHS South Sefton Clinical Commissioning Group**

### **Quality Committee**

### **Terms of Reference**

#### **1. Principal Functions**

The Quality Committee shall be established as a committee of the Governing Body in accordance with the CCG's Scheme of Delegation and will have key responsibilities to:

- Approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes
- Approve the arrangements for handling complaints
- Approve the Group's arrangements for engaging patients and their carers in decisions concerning their healthcare
- Approve arrangements for supporting **NHS England** in discharging its responsibilities to secure continuous improvement in the quality of general medical services

The approval of arrangements for safeguarding children and adults remains a matter reserved for the **Governing Body**. However, **monitoring of safeguarding arrangements and activity** is part of the Quality Committee's principal functions and duties.

In the event of overlap or conflict between the roles or responsibilities of the Audit Committee and the Quality Committee of the CCG, the role of the Audit Committee and any decisions made by the Audit Committee shall have precedence over those of the Quality Committee. The main functions of the Quality Committee are:

- To monitor standards and provide assurance on the quality of commissioned services, by the CCG to ensure that local and national standards are met.
- To promote a culture of continuous improvement and innovation with respect to safety, clinical effectiveness and patient experience.

- to provide an assurance to the **Governing Body** that there are robust structures, processes and accountabilities in place for identifying and managing significant risks facing the organisation (i.e. strategic, operational, clinical and organisational)
- To provide corporate focus, strategic direction and momentum for quality, and risk management within the CCG.

## 2. **Principal Duties**

The principal duties of the Committee are as follows:

- Ensure effective management of governance areas (clinical governance, corporate governance, information governance, research governance, financial governance, risk management and health & safety) and corporate performance in relation to all commissioned services:
- to ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control in line with the Integrated Governance Handbook (DoH February 2006), across the organisation's activities (both clinical and non-clinical), that support the achievement of the organisation's objectives;
- to provide assurance to the Audit Committee, and the **Governing Body**, that there are robust structures, processes and accountabilities in place for the identification and management of significant risks facing the organisation;
- to ensure the CCG is able to submit risk and control related statements, in particular the **Annual Governance Statement** and declarations of compliance.
- to ensure that the organisation has policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and to approve such policies;
- to monitor the CCG's Quality Strategy and ensure improvement in standards across all commissioned services that reflect all elements of quality (patient experience, effectiveness and patient safety)
- to receive, scrutinise and monitor progress against reports from external agencies, including the Care Quality Commission, Monitor and Health and Safety Executive;
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans
- to have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of Never Events and informing the CCG **Governing Body** of any escalation or sensitive issues in good time.
- to work collaboratively to identify and promote "best practice", the sharing of experience, expertise and success across the CCG and with key stakeholders;

- To monitor the CCG Performance Dashboard and drive year-on-year improvement in performance. The Committee will agree what information, reports, notes or minutes from other committees or **Cheshire and Merseyside CSU** colleagues that it needs to see on a regular or ad hoc basis and ensure they are scrutinised.
- to establish sub-groups or task and finish groups as and when appropriate to assist the Committee discharge its duties effectively. **These groups will be required to report to the Quality Committee by submission of meeting notes and key issues reports as stipulated by the Quality Committee.**
- the Quality Committee shall monitor the effectiveness of meeting the above duties by:
  - Reviewing progress against its own programme of business agreed by the **Governing Body**;
  - Producing an annual report for the CCG **Governing Body**.
- Support the **Governing Body** to meet its Public Sector Equality Duty
- Promote research and the use of research across the organisation
- Promote education and training across the organisation
- Support the improvement of primary medical services and primary care quality
- **To review and approve plans for Emergency Planning and Business Continuity**
- **To review and approve arrangements for the proper safekeeping of records.**

### 3. **Membership**

The following will be members of the Committee:

- Lay Advisor **Governing Body** Member (Chair)
- GP **Governing Body** Member
- Nurse **Governing Body** Member
- Practice Manager **Governing Body** Member
- **Chief Officer**
- Chief Finance Officer or **nominated** deputy
- Chief Nurse
- CCG Clinical Lead for Quality (non- **Governing Body** member)
- CCG Head of Corporate Performance & Outcomes
- Locality Manager with a lead for Quality
- A clinical lead from each locality ( x 4)
- Patient Representative (**HealthWatch**)

**The following leads have an open invitation for each meeting of the Quality Committee**

- Designated Professional Safeguarding Children & Adults

All Members are required to nominate a deputy to attend in their absence.

All members are expected to attend a minimum of 50% of meetings held.

Minutes and papers shall also be sent for information to CCG Chair who shall have a standing invitation to attend committee meetings.

#### **4. Chair**

A Lay Advisor **Governing Body** member nominated by the CCG **Governing Body** shall chair the committee. **The Committee shall select a Vice Chair from its membership**

#### **5. Quorum**

The quorum shall consist of **the Chair of the Quality Committee or Vice Chair**, one Member of **the Governing Body** that is also a member of the **CCG Senior Management Team**, a **Governing Body Clinician** and three other members from **within the Quality Committee Membership**.

#### **6. Frequency of Meetings and Reporting Arrangements**

The Committee will meet **at least 8 times per year** and **submit the ratified minutes of its meeting** to the next available Audit Committee and **CCG Governing Body**.

The Committee will submit an annual report to the **CCG Governing Body**.

#### **7. 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 or at the beginning of each meeting. The Chair shall consider such notices in accordance with NHS South Sefton CCG procedure for the management of Conflicts of Interest as set out in the Constitution.**

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

#### **8. Secretarial Arrangements**

PA to the **Chief** Officer shall provide secretarial support to the Committee.

The agenda for the meetings will be drawn up with the Chair of the Committee.

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

The minutes of the meeting will be produced in 10 working days.



<b>Version No.</b>	<b>Approving body</b>	<b>Date</b>	<b>Review Date</b>
Version 1	CCG Governing Body	June 2012	June 2013
Version 2	CCG Quality Committee CCG Governing Body		December 2013



# **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.
- **Determining banking arrangements**
- **Approving arrangements for exceptional/novel treatments**
- **To receive recommendations from the local Individual patient review (IFR) panel and approve as appropriate.**

### 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. **These sub groups will be required to provide key update reports as stipulated by the Finance and Resources Committee and submit ratified notes of meetings to the Finance and Resources Committee.**

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.

**In the event that there is a Conflict of Interest declared before or during a meeting the procedure for dealing with Conflicts of Interest as set out in the NHS South Sefton CCG Constitution shall apply.**

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. 2

Review dates  
November 2013  
March 2014  
September 2014  
March 2015

## **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 (or Vice Chair) and one other member will be necessary for quorum purposes.

As per section 5.1 of the NHS South Sefton CCG Constitution, the quorum shall exclude any member affected by a Conflict of Interest under Clause 19 of the NHS South Sefton CCG Constitution. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

## 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.

The Chair shall consider such notices in accordance with NHS South Sefton CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

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 Number: 2

Review dates  
November 2013  
March 2014  
September 2014  
March 2015

Version: 16 May 2013

Important note: this Register of Interests is currently in development and contains interests declared by members of the Governing Body, with the intention to include full declarations of all CCG Members and Employees shortly.

Name	Date	Position/ Role	Interests Declared	Personal interest or that of family, friend or colleague	Potential or actual area where interest could occur	Action taken to mitigate risk	Comments
Dr Clive Shaw	16.05.13	Chair, GP Governing Body Member	GP Partner, 30 Kingsway	Personal	Decision making re remuneration of GPs undertaking CCG work	Exclusion from decision making process around GP remuneration, which will be undertaken by a subgroup of the Governing Body comprised of the lay membership, CO and CFO	
Dr Craig Gillespie	13.05.13	Clinical Vice-Chair, GP Governing Body Member	GP Partner, Blundellsands Surgery  Chief Officer, 3TC (Voluntary Sector) Employed by Liverpool Community Health Services	Personal  Friend Friend	Decision making re remuneration of GPs undertaking CCG work Decision making re Voluntary Sector Decision making re Liverpool Community Health Services	Exclusion from decision making process around GP remuneration, which will be undertaken by a subgroup of the Governing Body comprised of the lay membership, CO and CFO Exclusion from decision making around Voluntary Sector Exclusion from decision making around Liverpool Community Health Services	
Dr Paul Thomas	13.05.13	GP Governing Body Member	GP Partner, High Pastures Surgery	Personal	Decision making re remuneration of GPs undertaking CCG work	Exclusion from decision making process around GP remuneration, which will be undertaken by a subgroup of the Governing Body comprised of the lay membership, CO and CFO	
Dr Steve Fraser	13.05.13	GP Governing Body Member	Salaried GP Principal, Seaforth Village Surgery	Personal	Decision making re remuneration of GPs undertaking CCG work	Exclusion from decision making process around GP remuneration, which will be undertaken by a subgroup of the Governing Body comprised of the lay membership, CO and CFO	
Dr John Wray	13.05.13	GP Governing Body Member	GP Partner, Westway Medical Practice	Personal	Decision making re remuneration of GPs undertaking CCG work	Exclusion from decision making process around GP remuneration, which will be undertaken by a subgroup of the Governing Body comprised of the lay membership, CO and CFO	
Dr Andy Mimmagh	15.05.13	GP Governing Body Member	GP Partner, Eastview Surgery  Director of Strategy and Innovation, University Hospital Aintree Director of Clinical Strategy at Liverpool Health Partners	Personal  Family Family	Decision making re remuneration of GPs undertaking CCG work Decision making re University Hospital Aintree Decision making re Liverpool Health Partners	Exclusion from decision making process around GP remuneration, which will be undertaken by a subgroup of the Governing Body comprised of the lay membership, CO and CFO Exclusion from decision making re University Hospital Aintree Exclusion from decision making re Liverpool Health Partners	

			Member of Sefton Local Medical Committee	Personal	Decision making re Local Medical Committee	Exclusion from decision making re Local Medical Committee
Dr Ricky Sinha	04.05.13	GP Governing Body Member	Interested in natural justice Practising Member of the Roman Catholic Religion GP Partner, North Park Health Centre Elected Member, Sefton Local Medical Committee	Personal Personal Personal Personal	None None Decision making re remuneration of GPs undertaking CCG work Decision making re Local Medical Committee	Exclusion from decision making process around GP remuneration, which will be undertaken by a sub-group of the Governing Body comprised of the lay membership, CO and CFO Exclusion from decision making re Local Medical Committee
Lin Bennett	08.05.13	Practice Manager Governing Body Member	Practice/Business Manager at Ford Medical Practice	Personal	Decision making re remuneration of GPs undertaking CCG work	Exclusion from decision making process around GP remuneration, which will be undertaken by a sub-group of the Governing Body comprised of the lay membership, CO and CFO
Sharon McGibbon	16.05.13	Practice Manager Governing Body Member	Practice Manager, Eastview Surgery Employed by Sefton Council	Personal Family	Decision making re remuneration of GPs undertaking CCG work Decision making re Local Authority	Exclusion from decision making process around GP remuneration, which will be undertaken by a sub-group of the Governing Body comprised of the lay membership, CO and CFO Exclusion from decision making re Local Authority
Roger Driver	13.05.13	Lay Member, Governing Body	Ordained as a Minister in the Church of England Chair, Sefton Health & Social Care Forum Team Rector, Bootle Team Ministry Area Dean, Bootle Deanery Hon. Canon, Liverpool Cathedral Charity Trustee, Together Liverpool Chair, Sefton Council Independent Remuneration Committee Administrator, Liverpool Diocesan Board of Education	Personal Personal Personal Personal Personal Personal Personal Family Family	Decision making re Faith Sector None None None None None None None None	Exclusion from decision making around Faith Sector
Lynda Elezi	16.05.13	Vice Chair, Lay Member, Governing Body	Employed by St Helens & Knowsley NHS Trust	Family	None	
Dr Dan McDowell	14.05.13	Governing Body Member	Nil return		None	
Fiona Clark	03.05.12	Chief Officer, Governing Body Member	Dual role as CO between Southport & Formby CCG and South Sefton CCG	Personal	In the event of an issue between Southport & Formby CCG and South Sefton CCG	Each of the CO and CFO to work specifically for one CCG pending resolution of the issue
Martin McDowell	02.05.13	Chief Finance Officer, Governing Body Member	Dual role as CFO and Deputy CO between Southport & Formby CCG and South Sefton CCG Employed by Liverpool Community Healthcare Trust	Personal Family	In the event of an issue between Southport & Formby CCG and South Sefton CCG Decision making re Liverpool Community Healthcare Trust	Each of the CO and CFO to work specifically for one CCG pending resolution of the issue Exclusion from decision making around Liverpool Community Healthcare Trust

**Hospitality Register  
May 2013**

Recipient:	Nature of Gift / Hospitality:	Date Received	Approximate Value	Donated by:
-	-	-	-	-

No hospitality received.



## Audit Committee Agenda

Thursday 7<sup>th</sup> February 2013, 1.30pm to 3.00pm  
3C, Merton House

<b>Attendees</b>		
Linda Elezi (Chair)	Lay Member	LE
Roger Driver	Lay Member	RD
Lin Bennett	Practice Manager	<b>LB</b>
<b>In Attendance</b>		
Debbie Fagan	Chief Nurse (Designate)	DF
Adrian Poll	Audit Manager (Mersey Internal Audit Agency)	AP
Stuart Baron	Audit Manager, Price Waterhouse Coopers	SB
Karen Lloyd for Minutes		

No	Item	Action
13/1.	<b>Welcome &amp; Introductions and Apologies for absence</b> The Chair welcomed everyone to the meeting and recorded the following apologies: Martin McDowell Chief Finance Officer Stuart Davison, Local Counter Fraud Specialist, (Mersey Internal Audit Agency)	
13/2.	<b>Declaration of Interest</b> It was recorded that Debbie Fagan has a dual role being employed at both South Sefton CCG and Southport and Formby CCG	
13/3.	<b>Minutes of the meeting of 29<sup>th</sup> November 2012</b> The minutes of the previous meeting were signed as true and accurate record with the following note. Annual Governance Statement to be circulated.	MMD
13/4.	<b>Matters arising from the minutes not covered elsewhere on the agenda</b> There were no matters arising that were not covered elsewhere on the agenda.	
13/5.	<b>Terms of Reference</b> The Terms of Reference were agreed by the Committee and will go to the Governing Body for ratification in March 2013.	MMD
13/6.	<b>Internal Audit Update</b> Adrian Poll of MIAA presented this update. The Committee were advised of work undertaken, key issues and progress against the Internal Audit	

No	Item	Action
	<p>Work Plan for 2012/2013. AP advised the Committee that MIAA will begin with a review of the Committee structures and Terms of Reference.</p> <p>MIAA Events – It was noted that the list of events appeared to be particularly useful and relevant.</p> <p>AP will provide copies of the NHS Audit Committee Handbook</p> <p><b>Agreed: The Committee noted the update from MIAA Internal Audit.</b></p>	
13/7.	<p><b>External Audit Update</b></p> <p>SB from PWC presented this report. SB gave an overview of the features and benefits of audit and responsibilities of both PWC and South Sefton CCG.</p> <p>LB noted that with regard to monitoring value for money, there may be an issue surrounding the prescribing of high cost drugs which may be essential.</p> <p>SB assured the Committee that the value for money measures would address strategic spending by the CCG rather than individual cases.</p> <p><b>Agreed: The Committee noted the update from PWC.</b></p>	
13/8.	<p><b>Information Governance Toolkit</b></p> <p>MMD presented this report which gave assurance of compliance with the IG Toolkit.</p> <p><b>Agreed: The Committee delegated responsibility to MMD to oversee and sign of the final submission of the IG Toolkit.</b></p>	
13/9.	<p><b>Work Schedule</b></p> <p>The Committee noted that all appropriate additions have been made to the work schedule.</p> <p><b>Agreed: Quality Committee will draft an action plan in response to the Francis Report. Progress against the action plan will be monitored by Audit Committee.</b></p>	
13/10.	<p><b>Meetings Schedule</b></p> <p>The Committee reviewed the Meeting schedule. It was agreed that the meeting in June 2013 was no longer required as the final accounts will be presented to committees of the PCT.</p> <p><b>Agreed: all committee members will be notified that the meeting of 5<sup>th</sup> June 2103 will not be required</b></p>	
13/11.	<p><b>Any Other Business</b></p> <p>There was no other business</p>	
13/12.	<p>Date and Time of Next Meeting: Thursday, 2 May 2013, 1.30pm to 3.00pm, 3C, Merton House</p>	



## South Sefton Quality Committee

Thursday 21 February 2013  
 15:30 pm – 17:00 pm  
 Conference Room 3C, Merton House

<b>Members</b>		
Dr Craig Gillespie	GP Board Member	(CG)
Lin Bennett	Board Member,	(LB)
Stephen Astles	Head of CCG Development	(SA)
Roger Driver	Lay Member	(RD)
Debbie Fagan	Chief Nurse	(DF)
Dr Andrew Mimmagh	Board member	(AM)
Fiona Clark	Chief Officer	(FLC)
Martin McDowell	Chief Finance Officer	(MMcD)
<b>Guest Speaker - Item's 13/30 and 13/31</b>		
Geraldine O'Carroll	Integrated Commissioning Manager	(GO)
<b>Minutes</b>		
Tracey Cubbin	Administrator Sefton CCG Team	(TC)

No	Item	Action
13/22	<b>Welcome and Introductions</b> CG welcomed all and introductions were given.	
13/23	<b>Apologies</b> Dr Gina Halstead, Martin McDowell, Ann Dunne, Dr Debbie Harvey.  - <i>Please note MMcD attended for part of the meeting as FLC had to leave early due to prior commitments.</i>	
13/24	<b>Declarations of Interest</b> DF / FLC / MMcD are all joint post for both CCGs; all clarified there was nothing on the agenda that will be of any issue.	
13/25	<b>Minutes of the Last Meeting – 24 January 2013</b> Minutes of the last meeting were agreed as an accurate record.	
13/26	<b>Matters Arising</b> <b>13/18 – Local Care Homes</b> AM advised that the issue regarding DNAR forms has been actioned outside of the meeting. There is no further action for the Quality Committee at this time.	
13/27	<b>Chief Nurse Report</b> - <b>Matters Arising</b> CG thanked DF for the report and stated that it was excellent. The committee discussed the report in detail and the following was noted:	

No	Item	Action
	<p><b>1 – Francis (2) Inquiry Report</b> DF, AM and GH will meet with GP Colleagues and colleagues from Aintree Hospitals on Monday 4 March, to discuss the report and to talk about how we widen our response as a CCG to the inquiry. DF to feedback any comments of the meeting at the next Quality Committee in March.</p> <p><b>5 – Quality Dashboard Development</b> DF advised that Dr Bal Duper and Angela Parkinson have recently met with the Commissioning Support Unit (CSU) and Bal has also spoken to the Local Medical Committee (LMC) regarding Primary Care and the Quality Dashboard. BD/AP to update at a future meeting. DF asked the Committee if they were happy for Dr Bal Duper to resume his membership to which all confirmed yes they were happy and would welcome Bal back to the committee.</p> <p><b>12 – C-Diff Strategic Meeting</b> This meeting has been scheduled for 7 March 2013, DF to update at a future meeting.</p> <p><b>14 – Corporate Risk Register</b> This has not yet been reviewed and will be discussed at the next meeting subject to it being updated and discussed at Senior Management Team.</p> <p><b>20 – North of England DNAR (Adult) Policy</b> This has now been received by Moira McGuinness, Locality Lead, S&amp;F CCG. Moira will be invited to the next Quality Committee to give an update.</p> <p><b>21 – Quality Contract Update for 2013/14</b> DF advised this nearly ready for sign off, will update at a future meeting. All agreed that they were happy with the feedback and would like to discuss as a standing item within the Chief Nurse's Report at future meetings.</p>	<p>DF</p> <p>BD/AP</p> <p>DF</p> <p>MMcD</p> <p>DF</p>
13/28	<p><b>Quality Dashboard</b> The Committee felt that this report raised many questions, but acknowledged that the Dashboard is one part of the CCG early warning system and that the Dashboard is still work in progress. The committee also felt that we need to look at both Pharmacy and Prescribing issues. DF has been made aware by Malcolm Cunningham, Head of Performance and Health Outcomes, SS &amp; S&amp;F CCGs, that there has been another case of MRSA at Aintree Hospitals which does not feature on the dashboard, due to reporting timelines. DF reported that she has recently met with Public Health regarding future plans relating to health care acquired infections (HCAI).</p>	
1329	<p><b>Contract Update</b> This item was covered previously by DF within the Chief Nurse Report in item 13/27.</p>	
13/30	<p><b>Winterbourne – CCG/LA Joint Paper</b> GO presented the Winterbourne paper and explained the background. In response to this investigation the Department of Health (DOH) have responded with a review and timetabled actions for Health and Local Authority Commissioners working together: There is a programme of local actions for Sefton which GO discussed in detail including developing a local register for all people with learning disabilities who have challenging behaviour in NHS funded care; there will also be a database to support this information. The National</p>	

No	Item	Action
	<p>Commissioning Board (NCB) Local Area Team action plan was also discussed at the meeting which outlines key contacts for local areas across Merseyside.</p> <p>The committee agreed to look at this on a quarterly basis.</p>	
13/31	<p><b>Learning Disabilities Health Self-Assessment and Performance Framework 2012/13</b></p> <p>GO presented this single delivery system for PCTs/CCGs in partnership with the Local Authority to assure the Strategic Health Authorities (SHA) and the DOH on the following:</p> <ul style="list-style-type: none"> <li>- Key priorities in the operating framework 2012/13 that apply to people with learning disabilities</li> <li>- Key levers for the improvement of health services for people with learning disabilities within the operating framework for example: <ul style="list-style-type: none"> <li>i. The equality delivery system</li> <li>ii. Safeguarding adults at risk</li> <li>iii. NHS outcomes framework</li> </ul> </li> <li>- Progress report on six lives and the provision of public services for people with learning disabilities</li> <li>- Responding to the national review following the abuse uncovered in Winterbourne View and subsequent CQC inspection of assessment and treatment units.</li> </ul>	
13/32	<p><b>Work plan</b></p> <p>DF has set up a work plan from November 2012 to March 2014; the plan gives information such as timescales for submitting of papers / sending out minutes etc. and agenda items for future meetings.</p> <p>TC to do re-send meeting schedule dates as timescales for papers have been list as working days and not days, this means that the dates will in effect change. TC to update and send to Committee.</p> <p>GH had discussed the work plan with DF prior to today's meeting.</p>	TC
13/33	<p><b>Commissioner Assurance of Provider Cost Improvement Plans</b></p> <p>SS CCG will have responsibility for Commissioner assurance of their provider cost improvement plans (CIPS). The Merseyside NCB will then be responsible for verifying commissioner assurance.</p> <p>DF advised that to date the CCG have received two provider CIPS – Liverpool Community Health and Aintree Hospitals. The original deadline for submission of provider CIPS was 15 February 2013.</p> <p>DF also provided a 'how to' guide which was presented to the committee as part of the work plan detailing the process that needs to be undertaken, FLC talked the Committee through the guidance.</p>	
13/34	<p><b>Any Other Business</b></p> <ul style="list-style-type: none"> <li>- <b>Membership</b></li> </ul> <p>DF has recently met with Diane Blair, Manager of LINKs / Health watch to discuss the role of the Lay Member. LINKs / Health watch will not send a representative to the Quality Committee unless it is formally requested in writing, DF to formally write as requested.</p> <p>The committee also clarified job titles for the purpose of future minutes / agendas.</p> <ul style="list-style-type: none"> <li>- <b>IG Policies</b></li> </ul> <p>MMcD, Designated Senior Information Risk Owner, advised that we will have a set of policies to follow reviewed scheme of delegation. These policies will not need to be ratified by the Quality Committee however; all CCG staff must be compliant with said policies.</p>	DF

No	Item	Action
	<p style="text-align: center;"><b>- Safeguarding – Whistleblowing Incident</b></p> <p>DF informed the Committee of a whistleblowing incident at an independent community provider that had been brought to the CCGs attention that morning. DF informed the Committee that the CCG will be temporarily suspending admissions to the establishment until an investigation has taken place. DF has informed FLC as the Chief Officer and will brief the Senior Leadership Team as necessary.</p>	
13/35	<p><b>Date and time of Next Meeting</b>  Thursday 21 March 2013  3:00 – 5:00  Room 3C, Merton House</p>	

# Finance & Resource Committee Minutes

Thursday 24<sup>th</sup> January 2013 1.30pm to 3.00pm  
Meeting Room 3C, Merton House, Bootle

<b>Members</b>	
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
<b>In attendance</b>	
Fiona Doherty (FD)	Project Manager
Dr Gustav Bernie (GB)	GP South Sefton
<b>Minutes</b>	
Karen Lloyd	PA to Chief Finance Officer

No	Item	Action
13.1	<p><b>Welcome &amp; Introductions</b></p> <p>The Chair welcomed everyone to the meeting and the committee members introduced themselves.</p> <p><b>Apologies</b></p> <p>Apologies were received from: Lynda Elezi, Fiona Clark and Geraldine O'Carroll.</p>	
13.2	<p><b>Notice to meeting of Any Other Business</b></p> <p>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.</p>	
13.3	<p><b>Declaration/Register of Interests</b></p> <p>The following declarations of interest were declared: 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.</p>	
13.4	<p><b>Minutes of the meeting of Thursday 22<sup>nd</sup> November 2012</b></p> <p>The minutes were approved as a true and accurate record.</p>	
13.5	<p><b>Action Points of the Previous Meeting (not covered elsewhere on the agenda)</b></p> <p>There were no action points to consider that were not included on the</p>	

13/74(c)

No	Item	Action
	agenda.	
13.6	<p><b>Terms of Reference</b></p> <p>The Terms of Reference were reviewed in line with amendments required at the previous meeting. DF will be added to the membership.</p> <p><b>Agreed: The Terms of reference will be submitted to the Board in March 2013 for ratification.</b></p>	
13.7	<p><b>Month 9 Financial Report</b></p> <p>MMD presented the F &amp; 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>MMD drew attention to the following risks:</b></p> <ul style="list-style-type: none"> <li>• Restitution Claims</li> <li>• PbR Contract with Wrightington, Wigan and Leigh NHS FT</li> <li>• Ambulance Services</li> <li>• Pharmacy</li> <li>• Independent Sector Treatment Centres</li> <li>• Continuing Healthcare &amp; Free Nursing Care</li> <li>• Prescribing</li> <li>• Melling Practice</li> </ul> <p>The 12/13 QIPP plans are RAG rated green as they are on track to be delivered in full this financial year.</p> <p>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</p>	

No	Item	Action
	<p>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</p> <p>RD requested clarification of data validation regarding high cost non contract patient activity. MMD responded that this service was provided by the CSU.</p> <p>SF commented on a positive report regarding activity and usage of Care at the Chemist Scheme. MMD requested that SF circulate this report.</p> <p>GB noted the financial pressure of an ageing population and the additional pressures that this will create in the future.</p> <p><b>Agreed: The Committee noted the contents of the Finance Report.</b></p>	<b>SF</b>
<b>13.8</b>	<b>Business Case reviews</b>	
<b>13.8.i</b>	<p><b>End of Life Care Home Facilitator</b></p> <p>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.</p> <p>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.</p> <p><b>Agreed: The Committee agreed to defer this business case pending further information.</b></p>	<b>SA/MM</b>
<b>13.8.ii</b>	<p><b>Hospice at Home Funding</b></p> <p>The Finance &amp; 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.</p> <p>The options for consideration were:</p> <ol style="list-style-type: none"> <li>1. Proceed with original arrangement to take the service through the procurement process in 2013</li> <li>2. Extend contract for one year</li> </ol> <p>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.</p> <p><b>Agreed: The Committee agreed to support option 2 – Extension of contract for one year.</b></p>	<b>SA/MM</b>
<b>13.8.iii</b>	<p><b>Inclusion Matters</b></p> <p>The Finance and Resource Committee were presented with options for improving access to talking therapies in primary care for the patients of South Sefton CCG.</p> <ol style="list-style-type: none"> <li>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%.</li> <li>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</li> </ol>	

No	Item	Action															
	<p>10.8%.</p> <p>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%.</p> <p>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.</p> <p><b>Financial Implications</b></p> <p>The financial implications for South Sefton CCG for each of the above proposals are as follows:</p> <table border="1" data-bbox="408 734 1283 909"> <thead> <tr> <th>Option</th> <th>2013/14 Cost</th> <th>Full Year Cost</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>* These are indicative costs as the current service contract is due to end on 31<sup>st</sup> March 2014 and therefore will be subject to retendering.</p> <p>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.</p> <p><b>Action:</b> Drs GB and SF will collaborate with MC during the drafting of tenders to ensure that they reflect local clinical input.</p> <p><b>Action:</b> GOC to meet with provider to ensure that CCG are receiving full value for money and to agree incremental improvement of prevalence targets.</p> <p><b>Agreed: The Committee agreed Option C</b></p>	Option	2013/14 Cost	Full Year Cost	a	41,969	44,035	b	105,308	110,088	c	135,542	170,556	d	236,735	*501,001	<p>MC/SF/ GB</p> <p>GOC</p>
Option	2013/14 Cost	Full Year Cost															
a	41,969	44,035															
b	105,308	110,088															
c	135,542	170,556															
d	236,735	*501,001															
13.8.iv	<p><b>Evidence into Practice supporting decision makers</b></p> <p>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."</p> <p>The cost of the proposal is £5700.</p> <p>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.</p> <p><b>Agreed: The Committee agreed to support this project with funding of £5700</b></p>																



No	Item	Action
13.8.v	<p><b>Rheumatology business case</b></p> <p>BP presented this business case on behalf of the author Graham Reader Lead Adviser Interface Meds Management.</p> <p>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.</p> <p>The Finance and Resource Committee 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.</p> <p>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.</p> <p><b>Agreed: The Committee approved the commissioning as requested and the continuation of funding.</b></p>	
13.8.vi	<p><b>Proposal for the establishment of a Spirometry assessment and Review Service for South Sefton</b></p> <p>SA presented this business case which proposed a Spirometry assessment and review service for South Sefton.</p> <p>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.</p> <p>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.</p> <p><b>Agreed: This business case to be resubmitted in February 2013 as part of Wider financial plan which includes other commissioning intentions.</b></p>	
13/9	<p><b>Contract Performance 12/13</b></p> <p>MMD noted that the Contract Performance Update had been dealt with in the Finance Report</p>	
13/10	<p><b>2013/2014 Contracting Update</b></p>	

No	Item	Action
	<p><b>MMD presented</b> the Finance and Resource Committee with the timetable in respect of the 2013/14 Planning and Contracting round.</p> <p><b>Agreed: The Committee noted the contents of this update.</b></p>	
13/11	<p><b>QIPP Update (Sub Group)</b></p> <p>MMD presented this item. A QIPP subgroup is required meet quarterly to monitor QIPP plans for South Sefton CCG.</p> <p>Membership agreed: MC, FD, Head of CCG Development, MMD, SA and DR GB.</p> <p><b>Action: Proposals for meeting dates will be circulated.</b></p>	MMD
13/12	<p><b>IFR (Individual Funding Requests) Update</b></p> <p>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.</p> <p><b>Action: MMD will advise IFR Team not to approve requests without funding estimates.</b></p> <p><b>Agreed: The Committee noted the contents of this report.</b></p>	
13/13	<p><b>Work Schedule:</b></p> <p>The Committee reviewed the Annual Work Schedule and agreed that it is currently fit for purpose.</p> <p><b>Agreed: The Annual Work Schedule will be reviewed in January 2014</b></p>	
13/14	<p><b>Meetings Schedule:</b></p> <p>The Committee reviewed the Meetings Schedule and agreed that it remains acceptable. The date of the next meeting was noted.</p>	
13/15	<p><b>Any other Business</b></p> <p>There was no other business</p>	
13/16	<p><b>Review of Meeting</b></p> <p>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.</p> <p>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.</p>	
13/17	<p><b>Date &amp; time of next meeting Thursday, 21<sup>st</sup> February 2013, 1.00pm to 2.30pm, 3C, Merton House</b></p>	



**NOTES OF THE MERSEYSIDE CCG NETWORK MEETING**  
**held on Wednesday 3<sup>rd</sup> April 2013**  
**Regatta Place**  
**Part 2**

<b>ATTENDEES</b>	
Dianne Johnson	Accountable Officer, Knowsley CCG (Network Chair)
Sarah Johnson	Head of Commissioning, St Helens CCG
Dr Steve Cox	Clinical Accountable Officer, St Helens CCG
Simon Banks	Accountable Officer, Halton CCG
Martin McDowell	Chief Finance Officer, South Sefton CCG & Southport & Formby CCG
Paul Brickwood	Chief Finance Officer, Knowsley, Halton & St Helens CCGs
Dr Nadim Fazlani	Chair, Liverpool CCG
Tom Jackson	Chief Finance Officer, Liverpool CCG
Katherine Sheerin	Accountable Officer, Liverpool CCG
Dr Niall Leonard	Chair, Southport & Formby CCG
Steve Corrigan	NHS England (Merseyside)
Dr John Hussey	NHS England (Merseyside)
Alison Tonge	Specialised Commissioning
Roger Booth	Senior Resilience Manager, C&M CSU

**Present:**

Andrea Kelly

Secretary – Knowsley CCG

**Action:**

<b>1</b>	<b>Welcome &amp; Introductions:</b>	
	Dianne welcomed everyone to the meeting and explained that she would be chairing the Network in Dr Pryce’s absence.	
<b>2</b>	<b>Apologies for Absence:</b>	
	<p>Apologies for absence were received from:</p> <ul style="list-style-type: none"> <li>• Dr Andrew Pryce (Knowsley CCG)</li> <li>• Fiona Clark (South Sefton and Southport &amp; Formby CCGs)</li> <li>• Dr Cliff Richards (Halton CCG)</li> <li>• John Caine (West Lancs CCG)</li> <li>• Dr Fiona Lemmens (Liverpool CCG)</li> <li>• Mike McGuire (West Lancs CCG)</li> <li>• Dr Clive Shaw (South Sefton CCG)</li> <li>• Tim Andrews (C&amp;M CSU)</li> <li>• Debbie Bywater (C&amp;M CSU)</li> <li>• Clare Duggan (NHS England Merseyside)</li> <li>• Jenny Scott (Specialised Commissioning)</li> </ul>	

<b>3</b>	<b>Notes from meeting held on 6<sup>th</sup> March 2013:</b>	
	The notes of the meeting were read and agreed to be accurate.	
<b>4</b>	<b>Matters Arising:</b>	
	There were no matters arising.	
<b>5</b>	<b>EPRR Scenario Planning</b>	
	<p>Steve Corrigan circulated a presentation to the Network.</p> <p>The CCG roles and responsibilities as identified in the guidance are:</p> <ul style="list-style-type: none"> <li>• A robust escalation process (24/7) for providers</li> <li>• Clear authorisation to act on behalf of other CCGs if they are to operate on each other's behalf</li> <li>• 24/7 business as usual contact arrangements are sufficient that should the NHS England (Merseyside) area team director need to contact out of hours.</li> <li>• Required to work with the area team in support of the wider NHS response to the incident through directing providers.</li> </ul> <p>The slides in the presentation indicate how this will look in the future. Workshops for scenario planning have been set for 29<sup>th</sup> April, 3<sup>rd</sup> May &amp; 7<sup>th</sup> May.</p> <p>Steve Corrigan noted that further development was needed regarding the specialised commissioning aspect of the roles and responsibilities.</p> <p>There was some discussion about the definition of 'times of severe pressure' with CCG colleagues raising concern this may be too vague.</p> <p>The Network discussed the UCAT Stakeholder Board and the part it could play in this process in particular diverts. It was agreed that the purpose and terms of reference of this board should be reviewed by the Network to ensure it is fit for purpose.</p> <p>Katherine suggested re-establishing a Mersey wide Board, inviting providers, reviewing the terms of reference and identifying work programmes. Steve Corrigan noted there is a meeting planned in early May and suggested using this date. Sarah agreed to pick this up with Johanna Reilly.</p> <p><b>Action – Sarah to liaise with Johanna Reilly regarding Mersey wide board meeting.</b></p> <p>NHS England (Merseyside) will communicate further information regarding the workshops.</p>	SJ/JR

6	<b>NHS England (Merseyside) Update</b>	
	<p>Dr Hussey updated the Network regarding the change from NHS Commissioning Board to NHS England (Merseyside) and congratulated the CCGs on achieving authorisation.</p> <p>Dr Hussey confirmed that the six CCG's plans on a page priorities and commitments have been incorporated in the area team plan on a page developments.</p> <p>Dr Hussey updated on complaints, there are 30 outstanding from PCT and NHS England (Merseyside) needs named to link in with for each CCG until the CSU arrangements are in place. Dr Hussey asked that each CCG lets Jo Richardson aware of the named person.</p> <p><b>Action – CCGs to contact Jo Richardson with named person for complaints.</b></p> <p>There is information available on the NHS England (Merseyside) website regarding direct enhanced services the funding for these new DES's has been reduced, but can be linked to other areas and co-commission.</p>	CCGs
7	<b>Update on Specialised Commissioning</b>	
	<p>Dianne fed back to Alison discussions that the CCG's have had under Part 1 of this meeting.</p> <p>Dianne explained that CCG's are keen to seek assurance that monthly meetings to have senior representatives from all organisations in attendance. Alison assured this would be the case.</p> <p>Dianne raised some concerns regarding patients in other areas and how CCG's would be aware of these individuals. Alison explained that national quality systems would pick up these patients experiences although the detail of this is TBC.</p> <p>Paul raised some concerns regarding the finance and activity schedule as CCGs have not received this information. Alison confirmed it is nearing completion and will be with CCG's very shortly.</p> <p>Alison advised that Specialised Commissioning are wanting to align plans and share their business plan with CCG colleagues.</p>	
8	<b>Healthy Liverpool Programme</b>	
	<p>Dr Fazlani introduced the Healthy Liverpool Programme and explained the aim is for a sustainable health service in Liverpool and the Healthy Liverpool Programme is an approach to achieve this aim.</p> <p>Katherine &amp; Dr Fazlani will be presenting this programme to the</p>	

<p>Mayor as well as at the Merseyside Wide Meeting on the 10<sup>th</sup> April 2013. This programme has been developed with consultation with Provider CE's.</p> <p>Vision is that by 2020 the population of Liverpool will have improved outcomes relative to the rest of England.</p> <p>Liverpool CCG have looked at care in 3 settings:</p> <ul style="list-style-type: none"> <li>• Outside of Hospital</li> <li>• General Hospital Services</li> <li>• Specialist Services in Hospital</li> </ul> <p>And for each setting have looked at 4 segments to be looked at for each setting:</p> <ul style="list-style-type: none"> <li>• Long Term Conditions</li> <li>• Episodic Care</li> <li>• Women &amp; Children</li> <li>• Mental Health</li> </ul> <p>Katherine is proposing that the Healthy Liverpool Programme is a Committee of the Governing Body and that a Business Case for each segment will be required with reports coming back to the Governing Body,</p>	
<p><b>Details of the next meeting:</b>  Wednesday 1<sup>st</sup> May 2013  1pm in Regatta Place</p>	

# Agenda Item 3

**SEFTON SHADOW HEALTH AND WELLBEING BOARD**  
**MEETING 17<sup>TH</sup> APRIL 2013**  
**AT BOOTLE TOWN HALL**

Present - Councillors Ian Moncur and John Kelly, Robina Critchley, Fiona Clark and Janet Atherton.

Also in attendance – Sam Tunney (Sefton Council).

<b><u>ITEM</u></b>	<b><u>TITLE</u></b>	<b><u>ACTION</u></b>
1.	<b><u>APOLOGIES</u></b> Councillor Paul Cummins, Niall Leonard, Clive Shaw, Colin Pettigrew, Maureen Kelly and Phil Wadeson.	Noted
2.	<b><u>NOTES OF THE LAST BOARD MEETING</u></b> The notes of the meeting held on 13 <sup>th</sup> March 2013 were circulated and noted as a correct record, subject to a correction to minute 6, by deleting the word 'Everybody' and addition of the word 'Everyone'	Noted
3.	<b><u>MATTERS ARISING</u></b> Councillor Moncur reported that he, Peter Morgan and Sam Tunney had recently met with Maureen Kelly, Chair of Healthwatch Sefton as an introductory session, and to explore the role of Healthwatch, and its relationship to the Board. Pursuant to minute 6, Councillor Moncur reported he had received a letter from Fiona Clark advising that there had been small amendments to the three local quality premiums priorities for both CCG's which were agreed at the last meeting by the Board. Fiona advised that she had asked for copies of the revised documents to be brought to the meeting, but in essence the priorities were: <u>South Sefton CCG:</u> <ul style="list-style-type: none"><li>• To reduce the number of respiratory admissions through A&amp;E at Aintree Hospital;</li><li>• To reduce prescribing for three high risk antibiotics;</li><li>• To reduce the number of GP referred patients (during normal working hours) who receive an AED assessment before being admitted into Aintree Hospital.</li></ul>	

# Agenda Item 3

ITEM	<u>TITLE</u>	ACTION
	<p><u>Southport and Formby CCG:</u></p> <ul style="list-style-type: none"> <li>• To bring about a reduction in the number of adults who have an emergency admission for dehydration (this is linked to the previous priority of improving care in care homes);</li> <li>• To reduce hospital admissions for patients under the age of 19 related to asthma;</li> <li>• To increase the number of patients who receive a healthcare intervention following an alcohol related admission to hospital.</li> </ul> <p>The Board was asked to agree to the amendments as reported verbally at the meeting on changes to priorities on South Sefton CCG and a change of emphasis/focus on Southport and Formby CCG quality premium priorities.</p> <p>Pursuant to minute 5, Councillor Moncur reported that the Health and Wellbeing Strategy had been approved by Cabinet and was due to be considered by Council the next day. He advised of the receipt, by the Leader of the Council, of a letter from the Police Commissioner requesting a position on the Board. He advised the Board that having considered the request that whilst the criteria for membership was quite tight, he was of the view that the Police Commissioner could meet that criteria.</p> <p>Pursuant to minute 4, Sam Tunney reported that all members of the Board would be formally written to in order to advise them of the provisions within the Code of Conduct, and in particular declaration of interests. The letter would be sent by the Head of Governance and Civic Services, and would invite members to meet with her to discuss a potential 121 induction, particularly with the CCG Chairs to explain the differences between their code of conduct and the Councils. Additionally, the Board was asked did it require any other induction arrangements to be put in place.</p>	<p>That the Board at its first formal meeting be requested to endorse the amendments submitted.</p> <p>That the Board agree to accept the request from the Police Commissioner to join the Board, and Councillor Moncur speak to her regarding membership</p> <p>That the arrangements for induction be noted</p>



# Agenda Item 3

ITEM	<u>TITLE</u>	ACTION
4.	<p><b><u>PERFORMANCE FRAMEWORK FOR THE HEALTH AND WELLBEING STRATEGY</u></b></p> <p>A draft report outlining the principles of a Performance Management Framework for the Health and Wellbeing Strategy, including agreement to a sub structure below the HWBB level, the development of a performance scorecard and ensuring that these remain at a level of satisfaction for HWBB to effectively manage performance, was submitted. The Board was asked to give a steer on the several matters presented in the draft report to enable it to be finalised for the formal meeting.</p> <p>Fiona reported that the CCGs had a performance dashboard. Robina asked how issues would be brought to the Board, which were outside of the dashboard, an example being how would the issue of measles be escalated. She indicated that the Board members networks' provided soft intelligence which may need a process for escalating matters. There was a need for soft intelligence to trigger consideration of an appropriate matter at the Board.</p> <p>Janet advised that the Board had a health protection role, and suggested that a Health Protection Forum could be established which could report into the Board so that it could give oversight of such issues.</p> <p>Janet further made reference to a group established across Merseyside, where soft intelligence issues could be raised, but her view was that there needed to be a wider range of representatives around the table. Fiona indicated that she had the Terms of Reference for the Group and agreed to circulate them to the Board.</p> <p>Councillor Moncur indicated there were networks and frameworks which the Board needed to link into and this wider view would need to be considered.</p> <p>Fiona reminded the members present that the Board had a role in relation to performance managing the CCGs.</p>	<p>That the steer given by the Board be taken account of in the final report to the Board</p>

13/74(e)

# Agenda Item 3

<b><u>ITEM</u></b>	<b><u>TITLE</u></b>	<b><u>ACTION</u></b>
	<p>A table showing the links between the themes in the strategy, potential lead Board Members, links to Cabinet Member portfolios, was tabled. Fiona asked for consideration to be given to joint CCG development and councillor development.</p> <p>Janet volunteered to meet with the Cabinet Members referred to in the report, along with Councillor Moncur.</p>	<p>That Councillor Moncur and Janet, brief other members of the Cabinet at the informal meeting on the linkages between the strategy and the cabinet member portfolios.</p>
<p><b>5.</b></p>	<p><b><u>COMMUNICATIONS PLAN</u></b></p> <p>A draft report outlining principles, methods, frequency, ownership and standards of a communications plan for the Board and its works was submitted and members were asked to give a steer. The draft plan was aimed at covering activity over the next 6 months, and the plan was to resource the activity by working collaboratively across Council and CCG Teams.</p> <p>Councillor Kelly asked whether the plan was too aspirational. The risks also needed to be included in the report.</p>	<p>That the steer given by the Board be taken account of in the final report to the Board</p>
<p><b>6.</b></p>	<p><b><u>Public and Patient Engagement</u></b></p> <p>A report outlining the importance of Public and Patient Voice and how to effectively engage with the system was submitted. Fiona indicated that the Panel was part of the CCG infrastructure, but she was happy for the remit and role of the board to be extended but it needed to keep to Integrated Commissioning. It would not be tasked by the Board but would be by default doing HWB activity.</p> <p>It was suggested that the role of Healthwatch needed to come across more strongly in the report.</p>	<p>That the steer given by the Board be taken account of in the final report to the Board</p>

# Agenda Item 3

<u>ITEM</u>	<u>TITLE</u>	<u>ACTION</u>
7.	<p><b><u>Operational Group</u></b></p> <p>A report was submitted which sought agreement to the migration of the existing Strategy Needs Assessment Planning Group into a form of an Operations Group to serve the Health and Wellbeing Board.</p> <p>It was suggested that rather than create a separate Group, that the role of the proposed Operational Group could be consumed within the existing Strategic Integrated Commissioning Group. The remit and membership of the Group would need to be refreshed in particular, membership to include representatives from the former Place Directorate on the Council.</p>	<p>That the steer given by the Board be taken account of in the final report to the Board</p>
8.	<p><b><u>Viral Change Workshop</u></b></p> <p>A report was submitted setting out the details of the viral change workshop. Fiona asked for it to be noted that the person running the workshop was her coach, and she had had no part in selecting who would run the workshop.</p>	<p>Noted</p>
9.	<p><b><u>Board Development</u></b></p> <p>Janet circulated a paper produced by the BI Team within the Council on large scale change, and suggested that the members present give some thought as to how the new membership of the Board skills, experiences, and talents could be tapped into. The Transition Alliance were now subsumed within the NWE0 and it was suggested that they may have done some work on a skills audit for Boards. The presentation outlined and built on previous development activity. One simple activity was to understand each other's networks.</p>	<p>;</p>

13/74(e)

# Agenda Item 3

<b>ITEM</b>	<b><u>TITLE</u></b>	<b><u>ACTION</u></b>
	<p>Janet advised that the LGA had launched its Peer Review of Health and Wellbeing Boards, but that it may be too early in the process for the Board to request a review. It was suggested that the Board reconsider this in 6 months. Janet suggested that she contact the LGA to check out their 360 degree toolkit.</p> <p>Janet indicated that she would work up a development plan for the Board.</p>	<p>That at this stage, the Peer Review be not pursued</p> <p>That Janet prepare a development plan for the Board;</p> <p>That Sam contact the NWE0 to seek to obtain, if possible, a skills audit for use with the Boar</p>
<b>10.</b>	<p><b><u>Forward Plan</u></b></p> <p>Fiona mentioned that she would need to bring their Strategic Plan to the Board before the end of May.</p>	

# Sefton Strategic Integrated Commissioning Group (SSICG)

## Minutes of the meeting held on 22<sup>nd</sup> April 2013

### Present :

Peter Morgan	Strategic Director People, Sefton Council CHAIR	PSM
Fiona Clark	Interim Chief Officer – Sefton CCGs	FLC
Janet Atherton	Director of Public Health for NHS Sefton and Sefton Council	JA
Robina Critchley	Director of Older People, Sefton Council	RC
Colin Pettigrew	Director of Young People & Families, Sefton Council	CP
Peter Moore	Head of Commissioning and Partnerships, Sefton Council	PM
Tina Wilkins	Head of Vulnerable People, Sefton Council	TW
Sam Tunney	Head of Business Intelligence & Performance, Sefton Council	ST
Billie Dodd	Acting Head of CCG Development Southport & Formby CCG	BD
Debbie Fagan	Chief Nurse for Sefton CCGs	DF
Tracy Jeffes	Head of CCG Corporate Delivery – Sefton CCGs	TJ
Steve Astles	Head of CCG Development South Sefton CCG	SA
Geraldine O'Carroll	Integration Commissioning Lead Sefton Partnership MCSS	GO'C
Malcolm Cunningham	Head of Performance and Health Outcomes – Sefton CCGs	MC
Carole White - (Minutes)	Senior Personal Assistant to Peter Morgan	CAW

### Apologies :

Dr Niall Leonard	Chair of Southport & Formby CCG	NL
Dr Clive Shaw	Chair of South Sefton CCG	CS
Martin McDowell	Chief Finance Officer	MMcD

No.	Item	Minute	Action
1.	Minutes of the previous meeting	Agreed	
2.	Matters Arising / Update – Carers Commissioning / Strategy	<ul style="list-style-type: none"> <li>Strategy ran out at the start of 2013 – started again week commencing 15<sup>th</sup> April 2013.</li> <li>Facilitation Event taking place to 'kick off' re-writing the strategy.</li> </ul>	
3.	Health & Well-Being Strategy	<ul style="list-style-type: none"> <li>Strategy went formally through Council last week.</li> <li>PSM thanked SSICG Members for all their help.</li> </ul>	
4.	Health & Well-Being Board Update	<ul style="list-style-type: none"> <li>Paper went to the Informal Health &amp; Well-Being Board last week regarding support to the Board.</li> </ul>	

No.	Item	Minute	Action
		<ul style="list-style-type: none"> <li>• The H&amp;WBB is looking to extend the remit of the SSICG to lead this work.</li> <li>• Terms of Reference for the SSICG to be re-looked at in order that consideration can be given to widening the scope of the SSICG Board.</li> <li>• Frequency and timings of meetings of the SSICG Board need to be revised.</li> <li>• Once the new timings of the Board has been finalised, one suggestion is for certain current SSICG/SSNA Group Members to attend on a 'when if required basis'.</li> <li>• Going forward the SSICG will take up responsibility to give support and assistance to the Health &amp; Well-Being Board.</li> </ul> <p><u>Action</u></p> <ul style="list-style-type: none"> <li>• ST to re-look at the SSICG Terms of Reference, and then come back with some thoughts / ideas on areas going forward.</li> </ul>	ST
5.	Reablement Progress	<ul style="list-style-type: none"> <li>• TW updated Members on the progress.</li> <li>• Gerald Pilkington has now been employed as the Project Lead, on a contractual basis.</li> <li>• Gerald to start on Friday 26<sup>th</sup> April, when an initial meeting will be held along with GP leads / Sefton Council to discuss how we go forward / our aims / how we manage the next 12 months and how we re-design our services etc.</li> <li>• The discussion / work to be carried out will be aimed at adults rather than children.</li> <li>• Effective turn around towards people being able to be independent in their own homes.</li> <li>• North scoped.</li> <li>• Boundaries need to be set for the scope in the South.</li> </ul> <p><u>Action</u></p> <ul style="list-style-type: none"> <li>• FLC to liaise with TW to organise a Strategic Meeting with LCH / Aintree / CCGs and Local Authorities – Sefton / Liverpool / Knowsley</li> </ul>	FLC / TW / RC
6.	CCG Programme Management Integration	<ul style="list-style-type: none"> <li>• Strategic Plan in place to look at the next 3 years.</li> <li>• MC informed Members that the timeframes given have to be adhered to.</li> <li>• Will be up and running in June.</li> <li>• Plan of engagement for the next 12 months to be put in place in order to shape the thinking in years 2 and 3.</li> <li>• Prioritisation framework also being looked at.</li> </ul>	

No.	Item	Minute	Action
		<ul style="list-style-type: none"> <li>A small group has been formed to look at the performance management.</li> <li>Once finalised to be brought back to the SSICG.</li> </ul> <p><u>Action</u></p> <ul style="list-style-type: none"> <li>FLC to ensure the Programme (and presentation where required) is e.mailed to the relevant Boards.</li> </ul>	FLC
7.	Mental Health Report	Deferred to the next meeting.	
8.	Multi-Agency Safeguarding Hub (MASH)	<ul style="list-style-type: none"> <li>DF updated Members, and asked for her proposal in terms of development of core specifications with Designated Nurses to be endorsed by Members.</li> <li>Health recruitment with LCH taking place for a person to be employed who we will be able to formulate to our requirements.</li> <li>Draft specification to be with DF by the end of the month.</li> </ul> <p><u>Action</u></p> <ul style="list-style-type: none"> <li>Proposal endorsed by Members.</li> </ul>	
9.	Any other Business	<ul style="list-style-type: none"> <li>TW raised 'Care Close to Home' (Step Up / Step Down) – Meeting held last week (Working Together). GO'C fed back progress at the Senior CCG Management Team Meetings and this was well received.</li> <li>Meeting to be held regarding Discharges.</li> <li>FLC – rush on beds over the past 2 weeks. This has been highlighted to Consultants who were taken around Aintree in order that they could see what it is like 'on the ground'.</li> <li>Working strategically with Liverpool, Knowsley and West Lancs.</li> <li>FLC informed Members that CSU was now up and running. Any interfaces needed now, with the relevant member of the team – link is TJ.</li> <li>Carrying out work with Cheshire CCGs to understand how they might want to work on the integration process. RC and TW have already held a meeting with Tim.</li> <li>FLC asked PM if prior to the SSICG Plan being finalised consideration could be given to the 'lay out' of the document i.e. could the information be shown by Quarters / who is doing what and timelines.</li> </ul> <p><u>Action</u></p> <ul style="list-style-type: none"> <li>RC to discuss / bring to the next SSICG Meeting a Highlight Report / minutes from the CEO Meeting on Re-Admissions.</li> <li>FLC to circulate to Members prior to and for inclusion in the next meeting a revised 'Plan on a Page'.</li> </ul>	PM  RC  FLC

No.	Item	Minute	Action
10.	Items for the next meeting	<ul style="list-style-type: none"> <li>• H&amp;WBB sub structure to incorporate SSICG</li> <li>• Update on Reablement and Gerald Pilkington's advice</li> <li>• MASH specification – to be signed off</li> <li>• Populated SSICG Work Plan</li> <li>• Mental Health Report</li> <li>• Re-Admissions</li> <li>• Plan on a Page</li> <li>• Strategic Meeting</li> </ul>	ST TW DF PM TW RC FLC FLC / RC
		Date and time of the next meeting – 3 <sup>rd</sup> June 2013 at 3.30 p.m. – venue – Conference Room, 3 <sup>rd</sup> Floor, Merton House, Stanley Road, Bootle, Merseyside, L20 3JA	